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Building Caregiver Resiliency in Global Health: Embodying the Catholic Social Tradition in the Face of COVID-19

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Abstract

For international healthcare NGOs, the impact of the COVID-19 pandemic has been significant. Healthcare workers in both LMICs and high-income countries have described the impact of the pandemic as traumatic. This article focuses on one initiative designed to address this impact: CMMB's Building Resiliency program. This article provides an overview of the structure and content of program, situating it within the landscape of global mental healthcare disparities and caregiver trauma. Designed to address caregiver mental health in Peru, Haiti, Kenya, South Sudan, and Zambia, the program sought to offset global mental healthcare disparities by bringing needed psycho-social-spiritual support to CMMB staff. It was intentionally shaped by the commitments of Catholic social thought—particularly to the well-being, dignity, and integral human development of CMMB staff members, to envisaging new forms of solidarity, and to prioritizing subsidiarity and participation. Theories of post-traumatic growth provided the theoretical framework for three remotely delivered seminar series, which made space for staff members to share their stories with their colleagues, to build community, to foster creativity and hope, and to intentionally integrate faith and spirituality into both personal self-care as well as the common life of the organization. Thus, this was designed equally to build the organizational resiliency that is the fruit of Catholic social thought. For attending to caregivers' mental health and well-being is crucial not only for the success of medical missions but for embodying and witnessing the Catholic commitment to the human dignity and the integral development of those who do the work of our organizations.

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In Spring 2020, the COVID-19 pandemic quickly and significantly disrupted the work of global health. Beyond interrupting supply chains and overburdening already-fragile health systems with a new highly infectious disease with no remedy, the pandemic required global health organizations to pivot to address new and immediate needs: ensuring a sustainable supply of personal protective equipment (PPE) for frontline healthcare workers; prioritizing water, sanitation, and hygiene to prevent the virus' spread; training health workers on COVID-19 prevention and protection; equipping healthcare facilities for better diagnosis, prevention, isolation, and treatment; restructuring operations to enable staff to work from home; and more. By hobbling operations, deflecting scarce resources, and exacerbating extreme poverty, the pandemic has also grimly setback progress toward other long-standing global health goals such as vaccinations, HIV/AIDs and TB treatment, and maternal/child health by—as one estimate states—"25 years in 25 weeks" (Branswell 2020).

One unanticipated impact of the COVID-19 pandemic was its effect on frontline healthcare workers. As discussed below, caregivers across the globe quickly began experiencing the pandemic as traumatic. While this effect received significant press in Europe and the US, it resonated equally through low-and-middle income countries (LMICs) where mental health resources have long been scarce.

In this article, we discuss one initiative designed to address the pandemic's impact on caregivers in the global South: CMMB's Building Resiliency program. Formerly known as Catholic Medical Mission Board, CMMB is an international, Catholic NGO that, since 1912, has been addressing maternal and child health inequities through healthcare services, medical supplies and health systems strengthening. They collaborate with hundreds of local and international partners to deliver locally sustainable, quality health solutions to the most vulnerable women and children in extremely poor and isolated communities in Haiti, Peru, Kenya, Zambia, and South Sudan (CMMB 2021).[1]

COVID-19's traumatic impact on healthcare staff quickly became apparent in Peru, where the pandemic surged early and which, as of June 2021, had suffered the world's highest COVID-19 mortality rate (Dwyer 2021).[2] Spurred by its Catholic identity, CMMB leadership proactively retooled its global volunteer program—brought to a standstill by pandemic lockdowns and travel restrictions—into a new remote modality for addressing a new and pressing mission need.[3]

In the following, we provide an overview of the Building Resiliency program. To assist organizations interested in developing similar programs, we provide three pieces of theoretical background. We first contextualize the program within the landscape of global mental healthcare disparities and caregiver trauma. We next describe how this program emerged naturally from CMMB's Catholic identity and commitment to Catholic social thought. Third, we outline the program's methodological framework, which intentionally integrated spirituality and faith. We then describe the program, evaluation results, and key learnings.

While still a pilot program, we hope that our experience with this program will be useful to other organizations on the frontlines of healthcare crises. Attending to healthcare workers mental health and well-being is crucial not only for the success of medical mission but for embodying the Catholic commitment to the dignity and integral development of those who do the work of our ministries.

COVID-19, Caregiver Trauma, and Global Mental Health Disparities

As early as February 2020, reports that health professionals caring for COVID-19 patients were experiencing high levels of stress, anxiety, depression, and trauma began to emerge—with up to 14% at risk for post-traumatic stress disorder (PTSD) (Demartini et al. 2020; Spencer and Jewett 2021; Wan 2021; and d'Ettore et al. 2021). Negative effects appeared to be greater in women healthcare workers (Iacobucci 2021). The World Health Organization: warned of a "looming mental health crisis," especially among children and healthcare workers (N.A. 2020; World Health Organization 2020. See also Gilbert 2021; and Verdery et al. 2020).

Caregivers in the global North were traumatized by their hospital context—lack of PPE and fear of becoming infected; having to work in protective gear; moral distress secondary to managing a crush of critically ill patients with no effective treatments; triage conditions of unprecedented duration; overwork in "combat-like" conditions due to an unprecedented volume and severity of illness and death; providing non-medical support to patients whose families could not visit, especially patients dying alone. These challenges were exacerbated by extra-clinical stresses—risks healthcare workers presented to their own family members, from whom they were often separated; social distancing and subsequent loss of usual coping mechanisms; job losses and the economic toll on themselves, family members, and their communities; the need to manage children's online education; the illness and deaths of friends, colleagues, and family; and more (Guo et al. 2021).

In LMICs especially, these factors were compounded by additional realities. Beyond those listed earlier, health workers in the global South lacked accurate epidemiological information and found themselves in contexts where the pandemic's uneven impact generated a lack of urgency about the pandemic as well as a social stigma against healthcare workers as possible virus carriers. In addition, small, densely populated home-settings and high-touch cultural practices rendered social distancing almost impossible; inadequate technology or internet access made working from home or children's schooling difficult; how to pay for testing or care was not clear; many community members prioritized survival rather than COVID-19 risk—especially after job losses due to social distancing policies; and more (Listening Session, CMMB Country Directors, June 1, 2020; see also Kola et al. 2021; Bartuska and Marques 2020; and Kumar and Kumar 2020).

Prior to 2020, healthcare workers were already experiencing troublingly high rates of burnout, depression, and suicide (Hoffman 2020). This growing epidemic was fueled by the neoliberal reconfiguration of the global healthcare infrastructure which, in its focus on profits and efficiencies, had been dismantling public health systems, increasing global inequalities, and eroding working conditions for healthcare professionals for decades (Navarro 2020; Albach, King, and Dzeng 2021). Health professionals are also often trained to compartmentalize their feelings—to not acknowledge emotions that patient care might trigger, to "tough it out" via long work hours and personal sacrifice.[4]

Likewise, before the pandemic, the global incidence of depression, anxiety, PTSD, and other mental health problems had been increasing (Ritchie and Roser 2018). Across the global South, the pandemic added yet another layer to years of prior, often unresolved, trauma experienced by many frontline caregivers and staff—from poverty, structural violence, sexual or domestic violence, war, natural disasters, previous pandemics, and more (Lee et al. 2007; and Jalloh et al. 2018). Yet in many LMICs, limited healthcare resources have been directed to select infectious diseases (WHO World Mental Health Survey Consortium 2004; Kar et al. 2020; and Banis 2019). Although LMICs carry an estimated 80% of the global mental disorder burden, mental health resources, such as psychologists

and psychiatrists, are rare and tend to practice in urban areas (Rathod et al. 2017). As a result, rural communities lack access to mental health resources. In these communities, mental illness can also carry significant stigma and taboo, and silence on these topics can lead to devastating outcomes like suicide, particularly amongst younger age groups (Javed et al. 2021).

Attending to caregiver well-being in global health contexts requires attention to these contextual factors. Moreover, much of the literature presumes an individual trauma model. While healthcare workers have been impacted as individuals, the shared nature of the pandemic experience requires a different approach to recovery. As Kimberly Resnick and Joseph Fins note, for health workers: "the path to resilience [must] be accomplished through a model of collective trauma and communal rebuilding" (Resnick and Fins 2021).

Caregiver Well-Being and Catholic Social Thought

Rooted in its Catholic identity, CMMB developed the Building Resiliency initiative to assist its in-country staff and healthcare workers. "Inspired by the example of Jesus," CMMB's mission of bringing the highest quality healthcare to some of the poorest and most marginalized communities around the globe is permeated by Catholic social thought. Working toward "a world in which every human life is valued, and health and human dignity are shared by all," CMMB embraces the Catholic commitments to address the needs of the poor and vulnerable, the sanctity of human life and the dignity of every human person. To these pillars of the Catholic social tradition, CMMB's core values are founded on participation and subsidiarity ("To work in partnership for locally sustainable solutions"), human dignity ("To act always with integrity, and to value and honor the dignity of all"), and the virtue of charity, expressed in their core value of love: "To embrace and be compassionate towards all people" (CMMB, "Our Mission"). Their website makes clear that Catholic identity is infused throughout the organization, providing inspiration, formation, and support for its staff, communities, and collaborators (CMMB, "Our Mission"; and CMMB, "Find Motivation and Inspiration").

As the pandemic emerged, CMMB leadership asked more specifically how these principles might be brought to bear not only on their work with patients and the communities they serve, but on their staff. How, they asked, can we help foster the dignity and well-being of our in-country staff and volunteers, people who themselves are often members of poor and marginalized communities? How can we concretely practice solidarity with our caregivers when travel bans prevent us from accompanying each other in person? And how can we do this in a way that embodies our core commitments to participation and subsidiarity while foregrounding the centrality of faith?

Here they recognized a core aspect of Catholic social thought—the commitment to worker dignity and well-being (US Conference of Catholic Bishops 2018). In his 1981 encyclical *Laborem Exercens* (On Human Work), written to commemorate the 90th anniversary of *Rerum Novarum*, John Paul II, notes that the question of human work has been at the heart of the Church's attention to "the social question" from the very beginning and "is a key, probably the essential key, to the whole social question" (§§2–3) (John Paul II 1981; see also Lysaught and Devita 2019; and Lysaught 2013). For John Paul II and the Catholic social tradition, work has extraordinary significance for the human person. It is a central and primary activity by which people move toward their fulfillment as human persons. It engages each person's essence, playing a key role in what Paul VI named, in his 1967 encyclical *Populorum Progressio*, their "integral human development." This concept crystallizes a central insight of the tradition—that just working conditions make possible the full flourishing of human persons in community in all their dimensions—physical, spiritual, emotional, psychological, social, and familial.

In this way, integral human development integrates the spectrum of Catholic social principles.[5] Just work environments that promote integral human development require *solidarity* between leadership and staff; practices of employee *participation* in decision-making and other essential aspects of organizational life; proper *subsidiarity* for decision-making and work-processes; attention to each employee's *familial* and communal realities; care for the *ecological* environment in which employees work and live; and more. As such, just work environments also promote the flourishing of the common good. And rather than being a burden on businesses, John Paul II maintained that "the integral development of the human person through work does not impede but rather promotes the greater productivity and efficiency of work itself" (Martin 2009).

Thus, under normal conditions, attending to the integral well-being of workers—physical, psychological and spiritual—is a key component of fostering a just workplace, promoting integral human development, and advancing the good of organizations and their communities. The COVID-19 pandemic made painfully clear that many organizations, Catholic and secular alike, needed to develop such practices.

Post-Traumatic Growth as an Integrative, Faith-Aligned Paradigm

The CMMB Building Resiliency program design was informed by four sources: caring-for-the-caregiver programs that were fast-tracked in mid-2020 by US Catholic health systems in response to the COVID-19 pandemic; pandemic and disaster transition models; current initiatives in global community-based mental healthcare; and research on post-traumatic growth (PTG) as applied to the clinical context. The PTG framework integrated key insights from the other theoretical paradigms while enabling us to foreground the role of faith and spirituality. In this section, we briefly describe how these inputs coalesced to provide the mission-aligned methodology for our program.

Preliminary Methodologies

Early in the pandemic, three methodologies shaped caregiver well-being initiatives: Maslow's Hierarchy of Needs; disaster transition models; and community-based frameworks for addressing mental health needs in low-resource settings. Programs fast-tracked by US Catholic health systems in spring 2020 generally theorized caregiver well-being on a basic whole-person/mind-body-spirit model or via Maslow's Hierarchy of Needs (Schmidt 2020).[6] For example, SSM Health focused on caregivers' basic physical and financial needs—safety, PPE, rest, food, job/income stability, child care subsidies, technology for working from home, ways to protect their families—and moved from there to creating spaces and activities (both virtual and physical) where caregivers could share their experiences or get short respites from the pressures of frontline care, as well as sustain community, mission, and creativity (Schmidt 2020; SSM Health 2020; and Corrigan 2020). Data presented by US health systems confirmed the urgent need for caregiver well-being interventions and provided concrete, real-time tools.

Disease modeling and disaster studies accurately predicted that the COVID-19 pandemic would be a long-term event, impacting caregivers per standard disaster transition curves (Babian 2020). These models suggested that in a pandemic, while disease burden, morbidity, and mortality would surge and wane in waves, the mental health burden on health workers would grow exponentially and remain elevated, not returning to baseline. PTSD rates among healthcare personnel in previous pandemics have reached 20% (see, e.g., the 2003 SARS outbreak) (Carmassi et al. 2020). The US Substance Abuse and Mental Health Services Administration (SAMHSA) community timeline for disaster recovery supported these assumptions (Simmen 2020).

These frameworks made clear that the timeline for addressing caregiver well-being would be a long-term, multi-year process.

Informed by commitments to cultural relevance, we recognized that we could not simply export US-based resources to CMMB sites. Not only were US Catholic health systems' programs highly specific to the US cultural needs and resources, they also presupposed a wealth of mental health professionals and support personnel (e.g., chaplains, social workers, counselors, psychiatrists). In order to adapt these resources to CMMB's diverse global contexts, we reviewed a number of initiatives designed to address global mental health disparities. A key source was Ted Lankester and Nathan Grills' *Setting Up Community Health and Development Programs in Low and MiddleIncome Settings,* fourth edition. Julian. Eaton's chapter "Setting Up Community Mental Health (CMH) Programmes" outlines key considerations for developing a holistic, integrated approach to mental health. Eaton emphasizes that the foundation for a long-term, community-based mental health program is self-care (Eaton 2019, 421). While noting the importance of trained mental health professionals, he also highlights the role of family, community members, and community health workers as key agents in addressing mild, short-term mental distress. He particularly emphasizes the importance of supporting caregivers, given their key role in supporting others in the community. Here he emphasizes teaching counseling skills, good communication, basic psychoeducation, basic techniques, and social care to non-specialists as a way to develop "effective, 'low-intensity, scalable interventions" (Eaton 2019, 424; see also Rathod et al. 2017; and WHO 2009).

Trauma and Post-Traumatic Growth

As noted earlier, many health workers around the globe named their experience with COVID-19 as one of trauma. To address this aspect of the pandemic, we turned to emerging theories on trauma and post-traumatic growth (PTG).

Research into the neurophysiology of trauma has made clear that life-threatening situations and events of significant loss activate evolutionary processes in the limbic system and brain stem designed to protect us from harm (Van der Kolk 2014). When trauma is not addressed, this stimulation of the lower brain stem (survival mode) can last for months or years, leaving people in permanent states of fight, flight, freeze, or collapse. Under ordinary conditions in global contexts, hospital staff have little control over the constant loss entailed by the life-and-death events that confront them every day. The pandemic has magnified this, creating for health workers in the global South a context where the surround of trauma can be ongoing, compounding layers of previously unresolved trauma, as noted earlier (Magruder, McLaughlin, and Borbon 2017).

Emerging theories on trauma recovery assert that, contrary to conventional wisdom, trauma can be healed. In fact, growth *after* trauma can be facilitated via certain interventions. This shift from a simply therapeutic approach to envisaging post-traumatic growth was pioneered in the late 1980s by psychologists Laurence Calhoun and Richard Tedeschi (Calhoun and Tedeschi 2006). Drawing on their seminal work, Beth Reece has distilled the growing literature on post-traumatic growth into a suite of five interconnected "tools" that can be used in any healthcare community to facilitate recovery: story, community, hope, creativity, and faith.

These tools do not work in a linear fashion but rather are practices that an individual—facilitated by a community—must recursively engage with over time in order to move from the brokenness of trauma to healing (Reece and Lysaught 2020). For Reece, the tool that integrates this upwardly spiraling process toward healing is faith (Figure 1).

Although people interviewed world-wide prioritize the role of faith in their stories of recovery from trauma, psychologists often hold it at arms-length. As Calhoun and Tedeschi notes: "The available data clearly indicate that a significant element of PTG can involve, for many persons, an increase in the

Tools for Post-Traumatic Growth

Story: Honest truth-telling is the first crucial tool. Trauma affects the frontal lobe areas related to speech, time, and continuity. As pioneering trauma theorist Bessel Van der Kolk notes, "trauma is primarily remembered not as a story, a narrative with a beginning, middle, and end, but as isolated sensory imprints: images, sounds, and physical sensations that are accompanied by intense emotions, usually terror and helplessness" (Van der Kolk 2014, 70). Putting words to trauma, emotions, and feelings assists in pulling the often-fragmented experience together, making sense of circumstances, and providing connection to one's life narrative.

Community: Storytelling requires community: a safe, nonjudgmental, accepting and loving environment where one can share one's experience with another person. Social support has been shown time and again to be a key factor in helping people recover from post-traumatic stress symptoms and even PTSD. Van der Kolk notes: "Social support is not the same as merely being in the presence of others. The critical issue is *reciprocity*: being truly heard and seen by the people around us, feeling that we are held in someone else's mind and heart" (Van der Kolk 2014, 81).

Hope: Out of the love and support of community the third tool can emerge: hope. Hope is a central emotion anchored in truth and not to be confused with optimism. Characterized by flexibility, activity, and openness, hope acknowledges difficulties and obstacles, but is open to pain and its eventual possibilities. It "gives courage to confront one's circumstances and the capacity to surmount them" (Groopman 2004, xiv). It "allows an open response to the distress of the trauma while revising one's goals, perspectives, and behaviors" (Calhoun, Parks, and Tedeschi 2014, 224).

Creativity: The emotional openness that comes from hope provides the courage for change or tool four: creativity. Trauma prevents the ability to envisage a future. Imagination shuts down, as the brain works in survival mode and focuses on protecting the person from possible harm (Van der Kolk 1987). Creativity works together with the other tools to facilitate the development of coping techniques, goal setting, and growth in self-efficacy. Creative activities such as prayer, music, and art foment reflection on the suffering and engage survivors in actions that help them begin to craft responses to trauma (Calhoun, Parks, and Tedeschi 2014, 225).

Faith: People interviewed world-wide about their recovery from trauma prioritize the role of tool five: faith. Faith, often shattered in trauma, provides a framework for who and how we are, connects us to God and reconnects us to the world. By recovering faith, we come to understand that we are part of a larger story. Faith can determine and fuel the reflections on life that we put in our stories. Thus, for those who have experienced trauma, their story, their sense of belonging, the courage of hope and openness of creativity in the face of suffering, may all be held inside of this dynamic circumference of meaning and invitation to transcendence.

importance of existential, spiritual, and religious matters. Although there has presumably been a recent surge in the interest and importance behavioral scientists and practicing clinicians have regarding the role of religion and spirituality in human behavior, this is an arena in which scientists, scholars, and to some degree clinicians, are distinctly uncomfortable" (Calhoun and Tedeschi 2006, 218). Thus, in the psychological literature, attention to the faith component of the PTG process is underdeveloped.

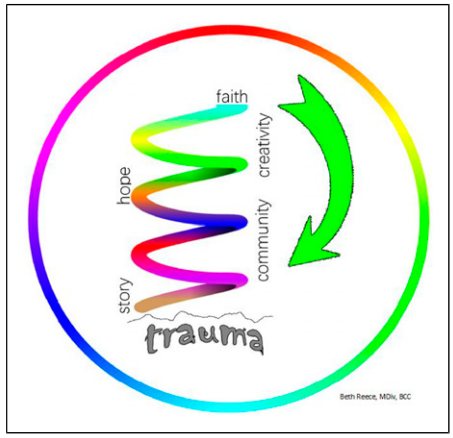


Figure 1. Five interconnected tools for post-traumatic growth.

The tool of faith makes the PTG framework particularly apt for Catholic and other faith-based organizations. It also directs us to the ways in which the PTG framework resonates deeply with the Christian tradition. At the heart of the Christian witness stands a traumatic event—the crucifixion and death of Jesus. Yet the Passion centers the conviction that out of suffering and even death can come new life. What is more, faith—challenged and shaken by trauma—powerfully weaves together and integrates the other tools in an ongoing cycle of healing.

While the Hebrew and Christian scriptures give many examples of transformation after trauma, the gospel story of the disciples on the road to Emmaus (Luke 24: 13–32) highlights particularly well how the five tools work together. The frightened, hopeless, confused, and emotionally exhausted disciples are fleeing Jerusalem after the devastating crucifixion and death of Jesus. Jesus comes alongside and says, "What's going on?"—he invites their *story*. He listens to their fear, their grief, their confusion. Their faith has been shattered. Everything they thought they knew and had hoped for has been destroyed. He connects their story to God's larger story. In response, they invite the stranger in for dinner. The *community* established on the road feels good, and they wish to extend that. Jesus, fostering community, breaks the bread and as he gives thanks, their eyes are opened.[7] In community, gratefulness, and God's presence, they receive the gift of *hope*. *Faith* is restored, and it is now even greater than it was before. They can now see in a new way; transformation comes. Instead of continuing in the way of despair, they return to Jerusalem, full of joy and energized to *create* a new future.

In short, in the Emmaus story, we see how faith powerfully weaves the tools of PTG together in an ongoing cycle of healing, enlarging story, igniting relationship, fostering hope, providing openness to change and transformation that is only possible out of the ashes of trauma. We also see that in the PTG framework, there is little that is completely new. But we agree with Tedeschi that "at the core of this approach [is] a very different kind of interaction with trauma survivors that emphasizes their possibilities and respects their struggle" through flexible, compassionate, patient accompaniment (Tedeschi and Moore 2021). For these reasons, we considered PTG to be the most fitting framework for the CMMB Building Resiliency program. And we found that its openness to faith—incorporating prayer, Scripture, and God—resonated deeply with many CMMB staff members, reflecting Eaton's recognition that for most people in LMICs, spirituality is deeply interwoven with all aspects of life. As she notes: "As healthcare workers we may wish to follow bio-medical approaches to treatment and care, but we need to recognize these spiritual dimensions and work with traditional healers if we want to develop an effective mental health programme [in Africa, Asia, and Latin America]" (Eaton 2019, 419).

Program Overview

The sources listed above informed our caregiver resilience initiative, with PTG as the integrating framework. When we began, CMMB had already begun attending to staff members' physiological and security/stability needs. We recognized that any intervention would need to be informed by the operative dynamics of trauma, and that a foundational component of this long-term intervention

would be self-care delivered via informal community care. In this section, we describe the structure and content of the Building Resiliency program for those interested in developing their own program.

Shaped by commitments to subsidiarity and participation, all program components were designed to work inductively and bi-directionally. Via regular listening and consultation, the program sought to address the specific social, emotional, moral, and spiritual issues participants were facing in their specific locations. Each session invited participants to collaboratively assist in adapting the materials to their specific cultures and contexts, so that we were learning from them as much as they were learning from us (embodying solidarity). All sessions also had the dual objectives of the following: (1) providing CMMB staff with spiritual, emotional, social, and moral support as persons and professionals and (2) equipping them with skills and resources to train and accompany other members of their staff and their communities. All sessions lasted from 1.5 to two 2 hours, were delivered via Zoom, and were recorded for individuals who could not attend or wished to revisit a particular session, and to build a library of materials for future use.[8]

Listening/Education Seminar Series for CMMB Country Directors

To develop the Building Resiliency program, from June 2020 through August 2020, the project leads hosted a six-session series for the five CMMB Country Directors (CDs). Modeling the first PTG tool, the series began with an initial 2-h listening session: providing the CDs an opportunity to tell their story of how the pandemic had affected both them and their site. This session was followed by four bi-weekly educational seminars on topics chosen by the CDs: trauma/post-traumatic growth, moral distress, ethical issues raised by the COVID-19 pandemic, and spiritual resources for caring during COVID. Presented by US-based experts, these sessions were framed by prayerful meditation and designed to provide concrete information, practical resources, and time for response, discussion, and feedback.[9] The series closed with another 2-h listening session designed to hear from CDs how the seminars affected their own personal resilience and to brainstorm with them the structure and content for next steps.

The CDs and program leaders determined that the next step should be a train-the-trainer (TOT) series designed to equip select local staff to then train members of their staff and communities. Again prioritizing subsidiarity and participation, the team decided that these efforts should be led by volunteer staff members interested in moving these initiatives forward rather than in a top-down manner by the CDs. The CDs proposed staff-wide educational sessions to gather insights on staff needs, socialize the initiative, and invite staff members to volunteer for the more in-depth train-the-trainer series.

Train-the-Trainer Seminar Series for CMMB Staff

Given the different needs and capacities of the CMMB countries vis a vis the pandemic, CMMB participants were divided into two groups. The staff in Kenya, Zambia, and South Sudan comprised the Africa region; the staff in Peru was constituted as its own region.[10] An initial staff-wide education session was held for each region, with participants consisting of program managers, project coordinators, technical staff, and administrative staff. Based on CD input and the staff-wide evaluations of these sessions, we determined that the content of train-the-trainer series would differ for the Africa and Peru regions. Each series consisted of six, bi-weekly, highly participative sessions, with concrete exercises, and multiple opportunities for group sharing, opening, and concluding with a relaxation/prayer/mindfulness exercise. This participatory method was designed for participants to practice the skills for their own personal/professional self-care and so that they could subsequently train others. Participants were given worksheets for each

session and encouraged to spend personal time reflecting further on the questions as able, to practice the skills presented each week with family members or co-workers, and to bring questions from that practice back to the next section.

Africa Region: For its opening staff-wide educational event, the Africa region requested a session on "Spiritual Resources for Caregivers," which was presented to the 46 members of the combined-CMMB staff in Zambia, Kenya, and South Sudan (Table 1).[11] Based on participant feedback from this session, the train-the-trainer series for the Africa region focused on "Self-Care for Caregivers," with an emphasis on spiritual care. Beth Reece facilitated sessions on dynamics and symptoms of stress/trauma and post-traumatic growth; identity; community; focus; balance; and a closing listening session to plan next steps. In order to optimize discussion, sessions were held separately for the CMMB Zambia and CMMB Kenya/South Sudan offices, with an average of 5–6 people participating in the six sessions at each site.

The content of the Africa region series was informed by Lipsky's work on the impact of traumas inherent in healthcare set within the framework of the PTG tools.[12] Based on research documenting "that having a safe haven promotes self-reliance and instills a sense of sympathy and helpfulness to others in distress," the sessions were crafted to provide a safe space for sharing, promote personal awareness, and encourage self-compassion (Van der Kolk 2014, 113). Each session opened and closed with a prayer and engaged participants to focus on one question—Who are you and why are you here? Who do you belong to and who belongs to you? What do you want? How will you find balance? Faith, calling, relationship with God and others were explored through questions, related scripture passages, and promoted sharing of reflection and insight. Participants were invited to reconnect that answer to the question asked at the beginning: What traumas are affecting you? Thus, the sessions were structured to integrate all the PTG tools—inviting participants to share their stories in compassionate community, toward creative, hope-filled goal setting, in connection with faith. The series also sought to equip the team leaders to carry this to their staffs, to help optimize an environment caring for each other and patients, and to encourage a compassionate ministry.

Peru: Given Peru's significant COVID-19 morbidity and mortality, the Peru leadership requested a one-hour session on "Grief, Loss, and Change," which was attended by 40 CMMB Peru staff members (Table 2).[13] Based on participant feedback from this session, the subsequent train-the-trainer series for Peru focused on "Tools for Supporting Families" with an initial session on how to develop and lead a grief ritual. To assist with cultural fit and Spanish language needs, two additional volunteers were recruited to serve as the Peru team.[14] The team developed sessions on: how to lead a grief ritual; understanding symptoms and dynamics of grief, stress, and trauma; listening and storytelling; helping grieving children; hope and creativity for adults; and a closing listening session to plan next steps. Unexpectedly, all staff members expressed an interest in participating. Again, to optimize discussion, sessions were held separately for CMMB's offices in Trujillo and Huancayo, with approximately 10–11 staff members participating at each site.

The content of this series was likewise informed by Reece's work on PTG, supplemented with resources from the Trauma Healing Institute, which has field tested faith-based trauma education and intervention across the globe (Trauma Healing Institute). The sessions were, again, crafted to provide a safe space for sharing. Each session sought to provide one or two "tools" for supporting families relevant to the topic—elements of a grief ritual; centering prayer breathing meditation; how to create a trauma narrative; active listening; how to work with grieving children; and how to cultivate hope through creative activity. Again, in addition to providing support for CMMB staff members, the series also sought to equip participants to carry this to their

Table 1. Africa Region Train-the-Trainer Series Modules.

Region/attendees	Topic	Content
Africa region: Self-care for caregivers	**Spiritual resources for caregivers**	Recognizing that spiritual resources are crucial for emotional and moral well-being, this session introduced participants to five key spiritual practices for countering the negative effects induced by working in an environment of ongoing daily trauma: Response, reflect, rest, rhythm, and relationship highlighting prayer practices such as the examen, Lectio Divina, contemplative, and meditative prayers.
	Trauma and post-traumatic growth	This session provided information on: the dynamics of trauma; how the pandemic might uniquely inflict trauma on patients, families, healthcare workers, and communities in diverse global settings; an overview of PTG; and an opportunity to collaboratively envisage how PTG resources might be implemented proactively ahead of the pandemic impact.
	Identity	This session encouraged participants to define purpose, meaning, and calling in their work.
	Community	This session focused on community and relationship, inviting participants to analyze and prioritize circles of support of self, others, and God.
	Focus	This session invited participants to explore wants, needs, goal setting, and future direction.
	Balance	This session focused on balance, reviewing how identity, community, and focus work to help integrate well-being along with the practices of gratitude, mindfulness and prayer, congruency, rest and rhythm to help achieve coping amidst ongoing traumas.
	Listening session	This session provided an opportunity for feedback and assessment from participants as well as an opportunity to begin to plan next steps.

staffs, community health workers, and communities. Unexpectedly, the participants began implementing the tools after the first session.

A key aim of this program was to assist CMMB staff members in addressing the spiritual dimensions of the trauma they were experiencing. The session on "Leading a Grief Ritual" began by inviting participants to participate in a theologically rich grief ritual, designed to help them address their own grief and loss. Subsequent sessions opened and/or closed with a time for reflective, meditative prayer, often based on a scriptural passage. Breakout conversations and large group sharing frequently surfaced powerful spiritual and existential questions.

Program Evaluation

From CDs to staff members, the "Building Resiliency" initiative met with an extraordinarily positive response from participants. They affirmed the initiative's importance and provided valuable recommendations for shaping the project's next phase. Program evaluations were administered to participants through pre- and post-testing surveys that consisted of 10–12 statements representing the expected learnings from the seminars, accompanied by a 5-point Likert scale and open-ended questions. The evaluation sought to assess the perceived need for the series' topics, participants' initial comfort level with the

Table 2. Peru Region Train-the-Trainer Series Modules.

Region/attendees	Topic	Content/key learnings
Peru: Tools for supporting families	**Grief, loss, and transition**	This session explored loss, its physical, emotional, and spiritual effects, the process of change and transition after loss, and finding resilience and recovery in grief work.
	Leading a grief ritual	In this session, staff members participated in a grief ritual in order to help them learn how to design and lead a grief ritual for their communities.
	Grief, stress, and trauma	This session explored trauma's effects and PTG. Participants were invited to identify and discuss one or more traumas that had affected them in their work.
	Inviting the story	This session focused on story and community as the first two PTG tools. It provided techniques for listening to others and assisting community members to tell the stories of their own losses and grief.
	Helping children cope with grief	This session focused on the dynamics of children's grief and how to support them.
	Hope and creativity for adults	This session focused on hope and creativity as tools 3 and 4 of PTG.
	Listening session	This session provided an opportunity for feedback and assessment from the participants as well as an opportunity to begin to plan next steps.

material, and their growth in facility with the material by the series' end. Given the different content for the Peru and Africa series, the assessment tool differed slightly for each region. The pre-test was delivered the week before the seminar series began and the post-test after the final session. Ten pre-series and seven post-series responses were obtained from the Zambian participants (70% post-series response rate), and 24 pre-series and 23 post-series responses from the Peru staff (96% post-series response rate). Due to a COVID-19 outbreak in Kenya and the demands of COVID-19 vaccine distribution in South Sudan, after the second session, the decision was made to suspend the Kenya/South Sudan training until 2022. The evaluations discussed below reflect only the Zambia and Peru responses.[15]

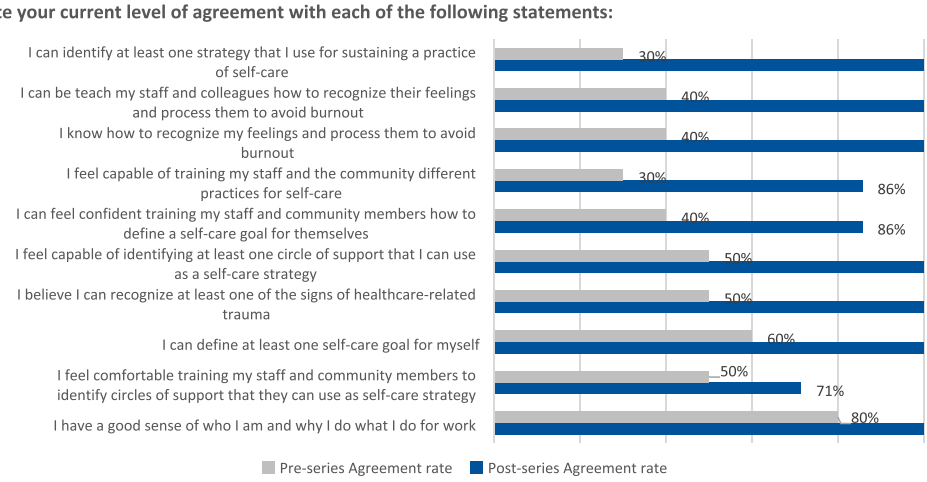
Zambia

All Zambia respondents rated the practice of self-care as "very important" for healthcare workers and public health professionals (Pre-series: 80%; Post-series: 86%) (Table 3). An aggregate of all agreement responses ("agree" and "strongly agree"), showed that prior to the program, less than half (47%) of the respondents seemed comfortable with self-care practices and with training their staff and communities on these practices; that percentage doubled to 94% after the program.

The highest variation on the agreement scores for Zambia respondents were related to "identifying one strategy used for self-care" (Pre-series: 30%; Post-series: 100%), followed by the ability to "teach my staff and community how to recognize their feelings and process them to avoid burnout" (40%; 100%), personally "recognizing my feelings and process them to avoid burnout" (40%; 100%), and "training staff and community different practices for self-care" (30%; 86%).

Areas of less variation for Zambia respondents were related to "knowing who I am and why I do what I do for work" (Pre-series:

Table 3. Zambia Responses to Agreement Scales.



80%; Post-Series: 100%), "training to identify circles of support and a self-care strategy" (50%; 71%), and "defining at least one self-care goal for themselves" (60%; 100%).

In the qualitative feedback section, the series was rated by Zambia participants 4.4 out of 5, indicating that the sessions provided valuable information around trauma, community, and how to practice self-care, while providing a space for participants to build a community with their colleagues. Qualitative comments included the following: "Being able to listen to the others during the training made me realize I was not the only one going through stressful times"; "identifying my support system especially with the current COVID pandemic is key to me"; and "the sessions to me were an eye opener. I was made to understand the forms of trauma and how best they can be handled. I need to always remember that self-care is never a selfish act it simply good stewardship"; and "the balancing and the community sessions were particularly helpful for me to think through my own life."

Peru

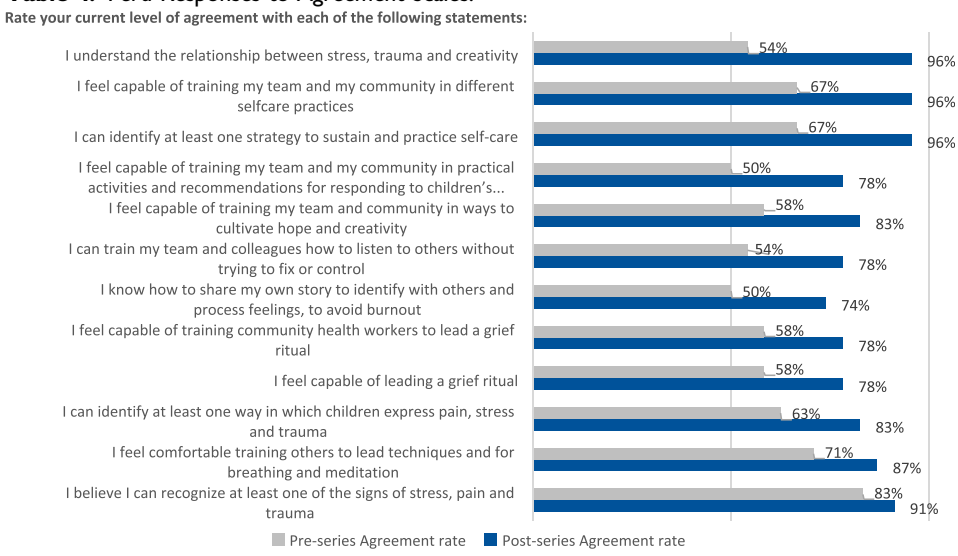
The majority of Peru respondents rated the practice of self-care as "very important" for health care workers and public health professionals, and this increased after the training (Pre-series: 67%, Post-series: 87%) (Table 4). While only 61% of the participants initially felt comfortable with self-care practices, this increased to 85% after the training.

For Peru respondents, the highest increase in agreement scores were related to the ability to "understand the relationship between stress, trauma and creativity" (Pre-series: 54%; Post-series: 96%), followed by the ability to "train my team and my community in different self-care practices" (67%; 96%), "identify at least one strategy to sustain and practice self-care" (67%; 96%) and "train their team on how to respond to children's questions" (50%; 78%).

The areas of less variation in agreement scores for Peru respondents were related to "recognizing at least one signal of stress, pain and trauma" (Pre-series: 83%; Post-series: 91%), "training others to lead techniques for breathing and meditation" (71%; 87%), "identify at least one way children express pain, stress and trauma" (63%; 83%), "training others to lead a grief ritual" (58%; 78%), and personally, "leading a grief ritual" (58%; 78%).

In the qualitative feedback section, the series was rated by Peru participants 4.5 out of

Table 4. Peru Responses to Agreement Scales.



5, indicating that the sessions provided a valuable space for participants to share personal experiences and build rapport with their colleagues. Participants particularly valued "gaining knowledge regarding tools to overcome trauma or losses during our life course"; and "techniques for dealing with and managing grief."

Discussion: Toward Integral Human Resilience of Caregivers in Medical Mission

In closing, we summarize key successes of the program to date, unanticipated challenges, and recommendations for those interested in implementing a similar program.

Successes fall into four main areas. First, across these diverse global contexts, participants reported that the materials strongly resonated with their experience. They reported relief in giving a name and language to the stress and trauma they were experiencing and in knowing that they were not alone in their feelings and reactions. As one participant noted: "This isn't foreign, these are things we have discussed within my team—feelings of inadequacy, you begin to realize that the feelings you have, it's not something you go through alone, but a collective feeling." They also reported a sense of clarity and compassion in having a new framework for understanding the reactions and behaviors of co-workers, direct reports, and family members.

A second positive outcome has been a sense of empowerment. Both CDs and staff reported feeling empowered simply by being given permission by their organization to talk about stress and trauma and to intentionally implement practices of spirituality and self-care as part of their work context. Participants were also deeply grateful for being given time to reflect on the simple questions in the self-care series and tools to help others. The self-care questions enabled them to find, again, their sense of purpose; to intentionally identify circles of support; to reflect on the balance amongst their many commitments. These outcomes, along with being encouraged by their supervisor to talk about these issues and to acknowledge God's accompaniment, re-invigorated them to be there for others. The direction on how to lead a grief ritual and the advice for active listening, eliciting trauma

narratives, accompanying children, and fostering hope provided concrete actions participants could take to help others address pressing spiritual questions and reconnect to themselves and their communities.

A third outcome was the deepening of relationships and the building of community among CMMB staff members. CDs reported that the opening series enabled them to get to know each other and the specifics of their different work contexts in ways that they had not done before, and they felt that they constituted a community of practice in a new way. CMMB staff members repeatedly remarked that the sessions enabled them to get to know personal aspects of their colleagues' lives, since previously all conversations at work had pertained almost exclusively to work tasks. Program leaders also emphasized the reciprocal gift of solidarity they experienced in accompanying the CMMB staff members through these sessions.

Finally, the participants appreciated the emphasis on faith and spirituality as key resources for resilience. Attentive to the fact that not all staff members shared the same religious faith, the African sites prioritized spiritual resources for caregivers as their first staff-wide presentation and continued to interweave these resources in their conversations during the self-care series. In Peru, the staff prioritized a grief ritual—for their organization and communities—and adverted again to spiritual questions and resources throughout their conversations.

These successes recommend that implementing a listening-based self-care series for staff and caregivers structured around the tools of post-traumatic growth should be a significant priority for all healthcare organizations.

As with any pilot program, there were challenges along the way. A significant obstacle is that people working in global health were already working at maximum capacity prior to the pandemic. Response-times for feedback or scheduling were, at times, long. Participants could not attend every session due to meetings, travel, and other emergent work and family issues. Due to a COVID-19 outbreak in one country and vaccine distribution rollout in another, the Kenya/South Sudan sessions had to be postponed mid-way through the series. We recommend working with site leadership to help craft structures (time and space) that will enable caregivers to commit both to self-care/PTG training and ongoing practice.

Technology was both a boon and a barrier. Internet connectivity and Zoom—with the ability to record sessions—made this project possible. At the same time, internet connectivity was uneven for participants, particularly in South Sudan. We had anticipated that smaller groups of 3–5 participants would be most ideal for approximating in-person sharing needed for TOT processes. We discovered, however, that on Zoom, smaller groups seemed to enhance reluctance to share. In Peru, with approximately 10 participants at each site, we opted for breakout rooms, which greatly increased individual discussion, sharing, and participation. We recommend that any future program that includes a virtual component assess upfront the technological capacities at the site (computers, smart phones, internet connectivity, electricity) so as to not frustrate participants. Post-pandemic, we also recommend that self-care/PTG programs will be strongest if conducted in face-to-face modalities or in a hybrid mode, with face-to-face interaction at the beginning and/or end.

A final concern was cultural barriers. We recognized from the outset that our materials were deeply informed by the US context. It was difficult to find non-Western, non-US-specific resources. While we did our best to anticipate and adapt our materials to CMMB's diverse global locations, we were very clear with participants that we recognized the resources' cultural specificity and that we considered our sessions to be processes of mutual learning—inviting participants to teach us how to amend the materials to fit their specific contexts. One of the richest veins of return were the deep resources of faith and spiritual practice collated and shared by the participants.

As anticipated, participants acknowledged that generally cultural factors could inhibit these sorts of programs: that talking to others about one's problems is not common; that certain issues (e.g., domestic violence) are considered private; that there is stigma to admitting mental health challenges, with those who seek help being judged, punished, or considered weak; that cultural factors (e.g., poverty and survival) render practices like self-care almost out of the question; that gender formation complicates it even further. Nonetheless, participants emphasized that the creation of spaces like this one was particularly important and that the program was beneficial despite potential cross-cultural differences. To attend to these cultural dynamics, we recommend opening and closing each series with a listening session, which will in turn inform the design of the program, and inviting participants to contribute local resources.

This program helped CMMB expand its volunteer program beyond the usual in-country, on-site volunteer medical mission work, developing new possibilities for ongoing remote support of international programs. While a model for the future, it also presented a unique set of issues. In addition to the significant donation of time from volunteer facilitators—a concrete practice of solidarity totaling approximately 83 days of work through August 2021 (valued as a GIK donation of around $28,644)—it also required significant time and coordination from the Volunteer Program Manager at every stage from constant communication with site leadership and participants, bringing in the leadership as needed to provide ongoing input and direction, and developing the program evaluation and reporting systems.

Per the SAMHSA timeline, this is long-term work. Addressing the impacts of the pandemic alone will take many months once the pandemic has ended, which with global inequities in COVID-19 vaccine distribution will likely be a number of years. While we move into the next phase of the CMMB program, we hope that this brief outline of our work encourages other faith-based global healthcare organizations to attend to caregiver and staff trauma and mental health, particularly in the challenging medical mission context. It all begins by making a space for caregivers to share their stories—which leads, we have found, to the deepening of community and the fostering of creativity, hope, and faith. The latter are not only tools of PTG but equally theological virtues—gifts that come from the *caritas* made real through the practices of solidarity, participation, and subsidiarity. We hope that this work brings healing to CMMB's staff, patients, and communities and lays the groundwork for their longer-term resilience as an organization. We are confident that, as John Paul II noted, this work will enable all of us to more effectively care for the poor and the sick, embodying a Catholic vision of caring for the dignity of each person and promoting their full flourishing.

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Notes

1. In 2020, CMMB reached 1,136,084 people with their critical health and social services; provided health services to 307,757 children under 5; and served 588,788 people at their CHAMPS sites.
2. As of January 27, 2022, Peru still ranked as the highest with a 6.8% observed case-fatality ration: Johns Hopkins University, "Morality Analyses," https://coronavirus.jhu.edu/data/mortality.

3. Annually, CMMB recruits, places, and supports approximately 100 US-based medical and public health professionals who serve overseas in remote communities in eight countries or assist CMMB's New York office. The pandemic spurred CMMB to imagine new ways to continue to deploy volunteer experts. With suddenly omnipresent virtual tools, CMMB created a new remote component of its volunteer program, providing opportunities for medical and public health students and professionals to support CMMB's global mission from their homes (https://cmmb.org/volunteer-blog/adapting-the-volunteer-program-during-covid-19/). Via discussions with country-based program managers, CMMB was able to deploy virtual volunteers in well-defined projects with clear deliverables and timeframes (https://cmmb.org/get-involved/volunteer/remote-volunteering/).
4. Resources discussing "trauma-informed care" in the medical setting have only recently begun to emerge. See, for example, Orr`u et al. 2021; and N.A., n.d., Champions of Wellness.
5. See also Benedict XVI 2007, and Pope Francis' consistent focus on workers oppressed and discarded by "an economy that kills" (Francis 2020).
6. See also webinars by Providence Health System and SCL Health: https://www.chausa.org/well-being/events-and-articles and https://www.chausa.org/well-being/well-being.
7. Catholic spiritual master Henri Nouwen wrote, "When the flesh—the lived human experience—becomes word, community can develop. When we say, 'Let me tell you what we saw. Come and listen to what we did. Sit down and let me explain to you what happened to us'…we call people together and make our lives into lives for others. The word brings us together and calls us into community. When the flesh becomes word, our bodies become part of a body of people" (*Daily Meditation*: "Words that Create Community," Henri Nouwen Society, June 25, 2018).
8. In order to protect confidentiality and foster open sharing, only the presentation portions of the sessions were recorded, not the discussion components nor the listening sessions.
9. Additional volunteer experts included the following: Katherine Wasson, MPH, PhD, Associate Professor, the Neiswanger Institute for Bioethics, Stritch School of Medicine, Loyola University Chicago; Alexandre A. Martins, PhD, Brazilian nurse, theological expert on the ethics of global health and Assistant Professor of Theology and Nursing, Marquette University; and Virginia McCarthy, MDIV, MPH, then Director of University Ministry and Director of the Center for Community and Global Health, Stritch School of Medicine, Loyola University Chicago.
10. Given the country's low COVID-19 incidence and the growing civil unrest of 2020, the Haitian office declined to participate in a TOT series at this time. See Human Rights Watch 2020; and Joseph 2021.
11. Eighteen evaluations were collected following this seminar. The overall satisfaction rate for the session was 88.8%, though the low response rate of 39% may limit its validity. Qualitative responses indicated that participants found the seminar to be useful especially in integrating spirituality into their work, practicing self-care, and the importance of rest. One participant comment illustrated the general feedback: "The session is full of valuable information especially for dealing with present situations imposed by coronavirus disease and managing stressful and stigma for those affected and impacted by the disease." The majority of respondents expressed significant interest in future seminars: "small group discussions for emotional and spiritual resilience" (83.3%); "self-care seminar series for team coordinators" (72.2%); "tools for supporting families and communities" (66.7%); and "individual discussions for emotional and spiritual support from a chaplain" (44.4%) as well as stress management and mental healthcare tools for staff and the community. Suggestions for improvement prioritized space for interaction enabling for participants to "to talk about their emotions around the changes the pandemic has brought." The following quote was highly illustrative of the respondents needs: "I felt the focus was on helping others which is vital, however sometimes we also need to help

ourselves, as some are not so good at sharing and talking about their feelings. And everyone is overwhelmed and might miss the signs their colleagues are not coping well."

12. Laura Lipsky's *Trauma Stewardship* connected PTG and Eaton's recognition of the foundational nature of self-care for developing community-based mental health programs. See Lipsky 2009.
13. Nineteen evaluations were collected following this session. The overall satisfaction rate was 100%. Respondents found most useful: recognizing loss and grief as natural parts of our lives and reviewing tools for better coping. A majority prioritized one topic for future seminars: tools for supporting families experiencing change, loss, and grief (89.5%). Additional activities were selected at roughly equal rates: "individual discussions for emotional and spiritual support" (52.6%); a "seminar on how to organize a community ritual" (47.4%); and "small group discussions for emotional and spiritual support" (42.1%). Participants also requested tools for managing emotions, stress, anxiety and depression; the need for valuing rest, forming new habits; setting a space for spirituality and gratitude; and supporting the families and children in their communities dealing with the loss of family members. Suggested improvements focused on creating further space and time for participants to share their personal experiences and discuss among themselves the difficulties they are dealing with. Additionally, they strongly emphasized the need to provide resources and tools for staff to deliver similar seminars to their communities. This comment from a Peru participant encourages further work as we move to the following phases: "It is motivating that CMMB is putting emphasis on working on these personal areas, and would be valuable to replicate these with the community-based agents."
14. Cecilia Bustamante-Pixa, MPH, MAHCML, a native Peruvian and Director of Community Health Investment, St. Joseph Hospital, Orange, CA; and Ana Victoria Guizado, MBA, M.Ed., MA, a native Panamanian and certified spiritual director joined the project in March 2021 to build and lead the Peru series.
15. This preliminary analysis neither compares individual responses, as the respondents' names were not collected for the pre-series, nor provides a statistical analysis.

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