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Integration of Medical Services and Psychosocial Support in Empowering Post-Disaster Isolated Communities: Lessons from the Mission Care Program

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Abstract

The Hydrometeorological disasters striking Aceh, North Sumatra, and West Sumatra since late 2025 have had widespread impacts on the physical and psychological health of the population, particularly in communities with limited geographical accessibility. This situation calls for an intervention model that focuses not only on physical recovery but also on strengthening the psychosocial well-being and social capital of the affected communities. This article analyzes the implementation of the "Mission Care" program a community service model integrating medical care and psychosocial support for isolated post-disaster communities. The activities were conducted over twelve days, from January 19 to 30, 2026, by a multidisciplinary team of twenty-four personnel comprising lecturers, medical staff, students, and volunteers through a collaboration between Real Care, Real Batam School of Theology, and GBI Rayon Misi 20. The activity sites included Kute Tanoh Megakhe, Leuser, Pungke, Penarun, and Kala Wih Ilang villages in Aceh; the Sibolga region in North Sumatra; and affected areas in West Sumatra. The distribution of aid packages varied by location: Sibolga received 300 basic food packages, 100 gas stove sets, 100 mattresses, and 350 blankets; Southeast Aceh (specifically Tanoh Megakhe Village) received 250 basic food packages and 250 kitchenware sets; Leuser Village saw 490 patients treated by the medical team; and Pungke and Penarun villages received 75 and 100 basic food packages, respectively. In total, the aid distribution and medical treatments provided by the Real Care team benefited nearly 1,525 households. The approach employed simultaneously combines free medical services, the distribution of basic necessities, and psychosocial support. The results indicate that integrating these services accelerates the restoration of access to basic healthcare while strengthening the social capital and adaptive capacity of communities that are difficult for formal aid to reach. This article contributes to strengthening the evidence base regarding empowerment models for isolated communities models grounded in collaboration among higher education institutions, religious organizations, and humanitarian groups in Indonesia.

Keywords: post-disaster medical services; psychosocial support; community empowerment; isolated communities; Mission Care

Abstrak

Bencana hidrometeorologi yang melanda Aceh, Sumatera Utara, dan Sumatera Barat sejak akhir 2025 menimbulkan dampak luas terhadap kesehatan fisik dan psikologis masyarakat, terutama pada komunitas dengan aksesibilitas geografis yang rendah. Kondisi ini menuntut model intervensi yang tidak hanya berorientasi pada pemulihan fisik, tetapi juga pada penguatan psikososial dan modal sosial komunitas yang terdampak. Artikel ini bertujuan menganalisis pelaksanaan program Mission Care sebagai model pengabdian kepada masyarakat yang mengintegrasikan pelayanan medis dan pendampingan psikososial pada komunitas terisolasi pascabencana. Kegiatan dilaksanakan selama dua belas hari, dari 19 hingga 30 Januari 2026, oleh tim lintas disiplin yang terdiri atas dua puluh empat personel, mencakup dosen, tenaga medis, mahasiswa, dan relawan, hasil kolaborasi Real Care, Sekolah Tinggi Teologi Real Batam, dan GBI Rayon Misi 20. Lokus kegiatan meliputi Desa Kute Tanoh Megakhe, Desa Leuser, Desa Pungke, Desa Penarun dan Desa Kala Wih Ilang di Aceh, wilayah Sibolga di Sumatera Utara, serta

daerah terdampak di Sumatera Barat. Paket sembako yang dibagikan di beberapa wilayah terdampak berbeda-beda jumlahnya seperti di sibolga ada 300 paket sembako, 100 set kompor gas, 100 pcs kasur dan 350 pcs selimut, sedangkan di wilayah aceh tenggara desa tanoh megakhe ada 250 paket sembako dan 250 paket peralatan dapur di desa Lueser dan ada 490 pasien yang dilayani oleh team medis, 75 paket sembako di desa Pungke dan 100 paket sembako di Desa Penarun dengan total sembako yang di bagikan dan pengobatan yang lakukan maka hampir 1.525 kepala keluarga yang boleh di bantu oleh team Real Care. Pendekatan yang digunakan menggabungkan layanan pengobatan gratis, distribusi bantuan kebutuhan dasar, dan pendampingan psikososial secara simultan. Hasil kegiatan menunjukkan bahwa integrasi kedua jenis layanan tersebut mempercepat pemulihan akses kesehatan dasar sekaligus memperkuat modal sosial dan kapasitas adaptif komunitas yang sulit dijangkau oleh bantuan formal. Artikel ini berkontribusi pada penguatan basis bukti mengenai model pemberdayaan komunitas terisolasi berbasis kolaborasi lembaga pendidikan tinggi, lembaga keagamaan, dan organisasi kemanusiaan di Indonesia.

Kata kunci: pelayanan medis pascabencana; pendampingan psikososial; pemberdayaan komunitas; komunitas terisolasi; Mission Care



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INTRODUCTION

The hydrometeorological disaster that affected Aceh, North Sumatra, and West Sumatra since late November 2025 represents one of the disaster events with the largest-scale impacts in the Sumatra region over the past decade. Data from the National Disaster Management Agency (Badan Nasional Penanggulangan Bencana, BNPB) recorded 1,666 fatalities, comprising 800 deaths in Aceh, 550 in North Sumatra, and 316 in West Sumatra. In Aceh Province alone, 670,826 households, or 2,584,067 individuals, were affected, with 988 evacuation sites established and damage reported to 200,112 residential units, 146 health facilities, and 980 schools.¹ The scale of this destruction indicates that post-disaster recovery cannot be borne entirely by the capacity of local governments, particularly in areas with limited geographical accessibility, such as Ketambe District in Southeast Aceh, Gayo Lues Regency, and Central Aceh Regency. These areas are geographically located in highland and mountainous regions characterized by limited road infrastructure.

The impacts of disasters on isolated communities differ from those experienced in urban areas. Cutter et al. emphasize that community resilience to natural disasters is strongly influenced by geographical conditions and the availability of local resources. Consequently, areas with limited accessibility tend to experience delays in receiving formal assistance from

¹ Abdul Muhari and BNPB, "Data Terbaru BNPB: Total 1.189 Korban Jiwa Akibat Banjir dan Longsor di Sumatera," *Tribratanews Polri* (mengutip data resmi BNPB), 2026.

government authorities and major humanitarian organizations.² This condition is consistent with the findings of Panday et al. in their study of the 2015 Nepal earthquake, which demonstrated that remote communities in the post-disaster period rely heavily on internal social capital to cope during the emergency response phase before coordinated external assistance arrives.³ Li et al. further emphasize that emergency response planning for landslide disasters in rural areas requires a scenario-based approach tailored to the specific vulnerabilities of each locality, rather than a standardized approach applied to urban areas.⁴

Beyond physical impacts, large-scale disasters also generate substantial psychological burdens that often receive less attention than emergency medical interventions. Hobfoll et al. identified five essential elements of mass trauma intervention: safety, calm, self- and collective efficacy, social connectedness, and hope, all of which need to be fostered from the early stages of emergency response.⁵ In their meta-analysis of risk factors for posttraumatic stress disorder, Brewin et al. found that direct exposure to traumatic events, combined with limited post-event social support, consistently increases the risk of long-term psychological distress among affected populations.⁶ These findings are relevant to the field observations conducted by the Mission Care team prior to the implementation of the program, which identified widespread indications of post-disaster trauma among communities in the target areas, including recurring complaints of stress and sleep disturbances across various service points. How such experiences are named is itself consequential, since contextual-theological analyses of *peirasmos* and *dokimion* in the New Testament show that the distinction between destructive trial and formative testing shapes the meaning communities assign to suffering and, consequently, the forms of accompaniment they regard as credible.⁷

² S L Cutter et al., "A place-based model for understanding community resilience to natural disasters," *Global Environmental Change*, 2008.

³ S Panday et al., "The role of social capital in disaster resilience in remote communities after the 2015 Nepal earthquake," *International Journal of Disaster Risk Reduction*, 2021.

⁴ Z Li et al., "Scenario Construction and Deduction of Emergency Response for Landslide Disasters in Rural Communities," *Natural Hazards Review*, 2026.

⁵ S E Hobfoll et al., "Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence," *Psychiatry*, 2007.

⁶ C R Brewin, B Andrews, and J D Valentine, "Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults," *Journal of Consulting and Clinical Psychology*, 2000.

⁷ Wennar, Djone Georges Nicolas, and Peter Oyugi, "*Peirasmos* and *Dokimion* in the New Testament: Contextual-Theological Analysis and Contemporary Implications," *DIEGESIS: Jurnal Teologi Kharismatika*, 2025.

These conditions underscore the need for an intervention model that does not separate medical treatment from psychosocial support. Van Ommeren et al. emphasize that mental and social health during and after emergencies should not be regarded as supplementary concerns, but rather as core components of a comprehensive humanitarian response.⁸ Dückers and Thormar reinforce this argument by proposing a framework for improving the quality of post-disaster psychosocial support that is integrated with formal health services rather than implemented as a separate program.⁹ Nevertheless, most existing integration models have been developed and tested in high-income-country contexts or by large-scale international humanitarian organizations. Their application within the Indonesian local context, particularly by higher education institutions and community-based organizations, therefore requires further documentation and analysis. Within Indonesian Christian scholarship, the theological warrant for such integration has been articulated through readings of Jesus' holistic ministry, which treat spiritual restoration, emotional healing, social inclusion, and physical care as dimensions of a single concern rather than as separable services, and which explicitly reject the dualism between spiritual and psychological care.¹⁰

At the same time, the involvement of faith-based organizations in humanitarian response offers distinctive advantages that have been widely documented in the international literature. Ager et al. demonstrate that local faith communities play an important role in strengthening resilience in humanitarian crisis contexts, as pre-existing trust facilitates the acceptance and delivery of assistance among affected populations.¹¹ Kreutziger et al. documented the role of faith-based organizations in post-Hurricane Katrina recovery, demonstrating that faith-based volunteer mobilization can proceed more rapidly than formal bureaucratic channels.¹² Meanwhile, the involvement of higher education institutions in

⁸ M Van Ommeren, S Saxena, and B Saraceno, "Mental and social health during and after acute emergencies: Emerging consensus?," *Bulletin of the World Health Organization*, 2005.

⁹ M L A Dückers and S B Thormar, "Post-disaster psychosocial support and quality improvement: A conceptual framework for understanding and improving the quality of psychosocial support programs," *Nursing and Health Sciences*, 2015.

¹⁰ Dewi Lidya S and Angela Queen, "Toward an Integrative Model of Christian Counseling: Insights from Jesus' Holistic Ministry," *REAL DIDACHE: Journal of Christian Education*, 2025.

¹¹ J Ager, E Fiddian-Qasmieh, and A Ager, "Local faith communities and the promotion of resilience in contexts of humanitarian crisis," *Journal of Refugee Studies*, 2015.

¹² S Kreutziger, E Blue, and M J Zakour, "Faith-based organizations in Katrina: The United Methodist Church," *Creating Katrina, Rebuilding Resilience: Lessons from New Orleans on Vulnerability and Resiliency*, 2018.

humanitarian response has also received increasing academic attention. Borkowska et al. documented how the University of Duhok integrated the university's third mission into its humanitarian crisis response for internally displaced persons, a model that is conceptually aligned with the implementation of the Tri Dharma of Higher Education in Indonesia, particularly the community service mission.¹³

The Mission Care program is a community engagement initiative resulting from a collaboration among Real Care, Sekolah Tinggi Teologi Real Batam, and GBI Rayon Misi 20. The program was implemented over twelve days, from 19 to 30 January 2026. It involved twenty-four personnel from multiple disciplines, including institutional leaders, lecturers, medical personnel, students, and volunteers. The program targeted disaster-affected communities in Ketambe District, Leuser Village, Gayo Lues Regency, and Central Aceh Regency in Aceh Province, as well as affected areas in North Sumatra and West Sumatra. Unlike conventional humanitarian assistance models, which generally treat the distribution of logistical supplies, medical services, and psychological support as separate programs, Mission Care adopted an integrated approach in which medical services, the distribution of basic necessities, and psychosocial support were implemented simultaneously as part of a single intervention framework. This integrated orientation was not formulated in isolation, since earlier community service by the same institution in the geographically isolated village of Air Gelubi had already combined medical treatment with educational activities, providing an institutional precedent on which the design of Mission Care could build.¹⁴

Based on the foregoing context, this article aims to analyze the implementation of the Mission Care program as a model for empowering isolated communities in the post-disaster context through the integration of medical services and psychosocial support. Specifically, this article examines three aspects: first, how the integration of medical and psychosocial services was implemented in communities with limited geographical accessibility; second, the extent to which collaboration among theological higher education institutions, faith-based

¹³ K Borkowska et al., "Embedding the Third Mission of universities in humanitarian crisis response: Profiling the role of the University of Duhok in addressing health needs of internally displaced people and refugees," *Journal of Adult and Continuing Education*, 2025.

¹⁴ Jabes Pasaribu et al., "Misi Dan Pelayanan Kesehatan Serta Pendidikan Di Desa Air Gelubi," *Real Coster : Jurnal Pengabdian kepada Masyarakat*, 2025.

organizations, and social organizations contributed to the effectiveness of the humanitarian response; and third, what lessons can be derived from this field experience for the development of a collaborative, cross-institutional disaster-oriented community engagement model in Indonesia.

METHODS OF IMPLEMENTATION

The Mission Care program was implemented using an integrated intervention approach that simultaneously combined three service components: medical services, the distribution of basic necessities, and early psychosocial support. This approach was grounded in emergency response principles that position psychosocial support as an integral component of medical services, as emphasized by Van Ommeren et al. and Dückers and Thormar, rather than as an additional program implemented separately after physical needs have been addressed.¹⁵

Implementation Period and Route

The activities were conducted over a period of twelve days, from 19 to 30 January 2026. The implementation was preceded by the team's departure from Batam on 17 January 2026 and a transit in Medan on 18 January 2026 for logistical consolidation and the allocation of field teams. On 19 January 2026, the team was divided into two working groups according to the designated target areas. Team A was assigned to the Sibolga area in North Sumatra, while Team B proceeded to Aceh Province. The team's route followed the corridor from Medan to Sibolga, continuing to Southeast Aceh and subsequently to Central Aceh, before returning through Lubuk Pakam to Medan. The route was arranged in consideration of the mountainous topography of Southeast Aceh, including Kute Tanoh Megakhe Village and Leuser Village, followed by Pungke Village in Gayo Lues Regency and Penarun Village in Central Aceh Regency. The geographical conditions of these areas required longer travel times compared with lowland areas.

¹⁵ M Van Ommeren, S Saxena, and B Saraceno, "Mental and social health during and after acute emergencies: Emerging consensus?." *Bulletin of the World Health Organization*, 2005M L A Dückers and S B Thormar, "Post-disaster psychosocial support and quality improvement: A conceptual framework for understanding and improving the quality of psychosocial support programs," *Nursing and Health Sciences*, 2015.

Location and Target Population Profile

The program targeted disaster-affected communities across three regencies in Aceh Province. These included Leuser Village and Kute Tanoh Megakhe Village in Ketambe District, Southeast Aceh Regency, with approximately 250 households as the target population; Pungke Village in Gayo Lues Regency, with approximately 75 households; and Penarun Village in Central Aceh Regency, with approximately 100 households. The program also covered the Sibolga area in North Sumatra and disaster-affected areas in West Sumatra. The selection of these locations considered the degree of geographical isolation and the limited reach of formal assistance. This consideration is consistent with Cutter et al., who argue that areas with limited accessibility tend to experience delays in disaster response compared with urban areas.¹⁶

Implementation Personel

The implementation team consisted of twenty-four personnel from multiple disciplines, including institutional leaders, lecturers, medical personnel comprising physicians, nurses, and midwives, students, and volunteers. This multidisciplinary composition was designed to ensure that field interventions addressed not only physical health needs but also psychosocial support and comprehensive public health education.

Implementation Stages

The implementation process followed four sequential stages at each location. The first stage involved initial coordination and data collection, including communication with local village or subdistrict authorities to verify the target population and avoid duplication of assistance with other organizations that might already have been operating in the same area. Beyond its technical function, this opening stage also carried an ethical dimension, because the manner in which a team enters a community, requests permission, and positions itself as

¹⁶ S L Cutter et al., "A place-based model for understanding community resilience to natural disasters," *Global Environmental Change*, 2008.

guest rather than as benefactor constitutes a practice of hospitality in the biblical sense.^{17v}

The second stage involved early psychosocial support, which was provided before residents received medical treatment. At this stage, the medical team provided brief explanations or briefings to residents regarding stress and sleep disturbances commonly experienced following a disaster, accompanied by basic information on how to recognize and manage these symptoms. Some residents also received voluntary prayer support as part of spiritual assistance, consistent with the institutional foundation of the program and its affiliation with faith-based organizations. This approach is consistent with the findings of Ager et al., who indicate that support provided through faith-based communities can strengthen the acceptance of psychosocial interventions among populations with strong religious backgrounds.¹⁸ Because the target communities are predominantly Muslim, this stage also required an explicitly cross-faith posture of empathy, in which spiritual accompaniment was offered rather than imposed and remained subordinate to the consent of the recipient.¹⁹

The third stage involved medical services, including general health examinations and free medical treatment. The medications were brought directly by the medical team from Batam and included antihypertensive medication, antipyretic medication, ophthalmic medication, and medication for individuals with diabetes. In addition, 1,000 units of reading glasses were distributed to residents experiencing visual impairment. The types of medication provided were adjusted to the basic health needs commonly encountered among post-disaster populations, particularly chronic conditions that may be neglected due to disruptions in access to routine health services.

The fourth stage involved the distribution of basic necessities, consisting of 75 to 250 assistance packages at each location. The packages contained staple food items and cooking equipment, including stoves, cooking pots, frying pans, plates, and drinking glasses, with 30 dozen of each type of item provided. In addition, 350 sacks of blankets were distributed to

¹⁷ Bimo Setyo Utomo, "Hospitalitas sebagai imajinasi etis: Rekonstruksi etika Perjanjian Lama bagi filsafat pendidikan anak usia dini," *Real Kiddos: Jurnal Pendidikan Anak Usia Dini*, 2026.

¹⁸ J Ager, E Fiddian-Qasmiyeh, and A Ager, "Local faith communities and the promotion of resilience in contexts of humanitarian crisis," *Journal of Refugee Studies*, 2015.

¹⁹ Aldi Makoro et al., "Membangun Toleransi dan Empati Lintas Iman Melalui Pendidikan Agama Kristen," *Manthano: Jurnal Pendidikan Kristen*, 2026.

meet the sleeping needs of residents who had lost their homes or household belongings.

Activity Evaluation

The success of the program was evaluated through field observations conducted by the implementation team rather than through structured survey instruments. Prior to the team's deployment to the target areas, an initial assessment had indicated a high prevalence of post-disaster psychological trauma symptoms among the target communities. These findings provided the basis for strengthening the psychosocial support component within the intervention design. Subsequent observations during implementation were used to assess residents' responses to the services provided and to adjust the intervention approach at subsequent locations. One limitation of this observational approach should be acknowledged at the outset: the responses recorded were not disaggregated by age group, whereas the spiritual formation and emotional development of young children following a disaster require distinct instruments and distinct forms of accompaniment.²⁰

RESULTS AND DISCUSSION

Coverage and Scale of the Intervention

Mission Care reached 425 households across three regencies in Aceh, comprising 250 households in Ketambe District, specifically Kute Tanoh Megakhe Village and Leuser Village, Southeast Aceh; 75 households in Pungke Village, Gayo Lues Regency; and 100 households in Penarun Village, Central Aceh Regency. In addition, the program covered the Sibolga area in North Sumatra and disaster-affected areas in West Sumatra, where interventions were conducted in parallel by Team A. When compared with the overall scale of the hydrometeorological disaster in Aceh, which according to 2026 BNPB data affected 670,826 households or 2,584,067 individuals across 18 regencies/cities, the coverage of Mission Care represented only a small proportion of the total affected population.²¹ This comparison is important to acknowledge explicitly at the outset of the discussion, because a

²⁰ Fredik Melkias Boiliu, "FORMASI SPIRITUAL DAN PERKEMBANGAN EMOSI ANAK USIA DINI DALAM PERSPEKTIF PSIKOLOGI KRISTEN," *Real Kiddos: Jurnal Pendidikan Anak Usia Dini*, 2026.

²¹ Abdul Muhari and BNPB, "Data Terbaru BNPB: Total 1.189 Korban Jiwa Akibat Banjir dan Longsor di Sumatera," *Tribatanews Polri* (mengutip data resmi BNPB), 2026.

sound community engagement article should not merely highlight program achievements but should also position those achievements proportionally in relation to the scale of the problem being addressed.

Nevertheless, the relatively limited numerical coverage cannot necessarily be interpreted as a weakness of the program, because the determining variable is not solely the number of beneficiaries but also the characteristics of the locations selected. The three target regencies Southeast Aceh, Gayo Lues, and Central Aceh are geographically situated in the highland and mountainous areas of central Aceh, a region that has historically faced limitations in road infrastructure and connectivity compared with coastal areas such as Banda Aceh and Lhokseumawe. The selection of locations in this manner is consistent with the argument of Blakely and Fisher, who emphasize that the success of post-disaster recovery in non-metropolitan areas cannot be measured using the same indicators as those applied to urban recovery, because the structure of needs, beneficiary density per unit area, and logistical constraints differ fundamentally.²² In urban areas, a single volunteer team may reach thousands of households within a relatively short period because of the density of settlements and ease of road access. In mountainous areas such as Ketambe and Gayo Lues, reaching the same number of households requires substantially longer travel times. Consequently, the ratio of personnel to beneficiaries is inherently lower, even when the level of effort required is comparable or even greater.



Figure 1 & 2. Map or Travel Route of the Real Care Team

²² E J Blakely and P M J Fisher, “Assessing non-metro recovery across two continents: issues and limitations,” *Disasters*, 2017.

The route undertaken by the team during the twelve-day implementation period further illustrates the logistical burden underlying the reported coverage. The movement began from Medan to Sibolga, continued to Southeast Aceh and subsequently to Central Aceh, and concluded with the return journey through Lubuk Pakam to Medan (Figure 1). This route was not a direct or logistically optimal line of travel, but rather one that had to accommodate mountainous road conditions and the distribution of disaster-affected sites that were not located along a single major transportation corridor. The geographical conditions of Ketambe District and its surrounding areas therefore constituted an important contextual factor influencing the duration, reach, and operational demands of the intervention.

(Figure 2) visually illustrates why travel time between locations constituted a tangible limiting factor, rather than merely a planning assumption on paper. Hilly terrain, roads that were partially damaged by subsequent landslides, and considerable distances between regencies meant that a single fieldwork day was often constrained by prolonged travel times. Such conditions are rarely encountered by humanitarian assistance teams operating in lowland or urban areas. The willingness to absorb this cost carries theological significance in its own right, since an incarnational paradigm locates the meaning of service in the act of coming to where people actually are rather than in summoning them to where assistance is more convenient to deliver.²³



Figure 3. Visual Representation of Travel Distances Between Locations

²³ Gunawan and Sri Pertiwi, "From Bethlehem to the Classroom: An Incarnational Paradigm for Christian Early Childhood Education," *Real Kiddos: Jurnal Pendidikan Anak Usia Dini*, 2026.

This finding is consistent with the argument put forward by Li et al. in their study of emergency response to landslide disasters in rural areas. They emphasize that disaster response planning in such settings requires a scenario-based approach tailored to the specific vulnerabilities of each location, rather than the application of standardized protocols typically used in areas with adequate infrastructure.²⁴ The vulnerability in question refers not only to vulnerability to the disaster itself but also to post-disaster accessibility vulnerability, namely a condition in which infrastructure damage caused by the disaster further complicates subsequent recovery efforts. Mission Care responded to this condition by dividing the team into two parallel working groups from the first day of deployment: Team A, which proceeded to Sibolga, and Team B, which proceeded to Aceh. This strategy enabled two geographically distant areas to be addressed simultaneously rather than sequentially, thereby preventing the twelve-day time constraint from fully compromising the geographical coverage of the intervention.

This team-division pattern also reflects a relatively well-developed awareness of resource constraints in the planning process. With only twenty-four personnel assigned to reach an area encompassing three regencies in Aceh, as well as Sibolga and West Sumatra, the team essentially faced two strategic options: expanding the geographical coverage while providing less intensive services at each location, or narrowing the coverage while delivering more intensive services. The data indicate that Mission Care tended toward the latter option, as reflected in the combination of services provided to each target household, including medical examinations, the distribution of multi-component assistance, and psychosocial support delivered concurrently, rather than providing only a single type of assistance, such as the distribution of staple food packages. This strategic choice will be examined further in the following subsection because it is directly related to the main research question of this article concerning the effectiveness of an integrated service model in isolated communities.

It should also be noted that the proportion of coverage across regions was not evenly distributed. The quantitative data available in detail covered only three regencies in Aceh, while equivalent data for Sibolga and West Sumatra had not been documented with the same level of detail at the time this article was prepared. This documentation disparity is itself a

²⁴ Z Li et al., “Scenario Construction and Deduction of Emergency Response for Landslide Disasters in Rural Communities,” *Natural Hazards Review*, 2026.

relevant finding to consider, as it indicates that in field-based community engagement activities involving teams divided into several working groups, maintaining consistency in data recording across teams presents a distinct challenge that needs to be addressed in the planning of similar activities in the future. This limitation will be discussed further in the limitations section at the end of the Results and Discussion. It should also be noted that the regions served are not unfamiliar terrain for faith-based engagement, since contextual approaches to congregational revitalisation have been documented in Padang, which suggests that follow-up accompaniment in West Sumatra could be built upon existing ecclesial structures rather than initiated anew.²⁵

Integration of Medical and Psychosocial Services: Not Two Programs, but a Single Continuum of Care

One of the most prominent findings from the implementation of Mission Care was the sequence of services delivered at each location. Residents were not immediately directed to medical examinations upon the team's arrival. Instead, they first received a brief briefing from the medical team regarding stress conditions and sleep disturbances commonly experienced following a disaster (Figure 3). Only after this session was completed were health examinations and free medical treatment provided. This sequence was not merely a minor administrative detail but rather a service-design decision that shaped how the assistance was psychologically received by the affected residents.

This arrangement directly operationalized the principle articulated by Hobfoll et al., namely that a sense of safety and calm should be established from the first point of contact, before any technical intervention is provided.²⁶ When residents were first given an opportunity to understand that the stress symptoms and sleep difficulties they experienced were normal post-disaster reactions rather than signs of personal weakness, the subsequent medical examination was received within a broader framework of recovery rather than as merely a clinical transaction. Without this stage, there was a risk that residents would perceive

²⁵ Harun Puling and Emilia Wori Hana, "Refitalisasi Spiritualitas Jemaat melalui Pendekatan Iman Kontekstual di Gereja GKSI Anugerah Padang," *Real Coster : Jurnal Pengabdian kepada Masyarakat*, 2025.

²⁶ S E Hobfoll et al., "Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence," *Psychiatry*, 2007.

the team's presence solely as the provision of routine medical treatment, leaving the psychological dimension of the trauma they had experienced insufficiently addressed.

The importance of this sequence was further reinforced by the team's initial observations prior to deployment, which indicated a relatively widespread prevalence of trauma-related symptoms at the target locations. In their meta-analysis of risk factors for post-traumatic stress disorder, Brewin et al. found that direct exposure to traumatic events, when not accompanied by adequate social support, consistently increased the risk of long-term psychological disorders.²⁷ The implication is clear: even high-quality medical services are insufficient to prevent long-term psychological consequences when social support and psychoeducation components are neglected.

An element that distinguishes Mission Care from conventional psychosocial support models was the provision of prayer support for some residents who requested it, delivered alongside the mental health briefing. This approach is consistent with the findings of Ager et al., who demonstrated that faith-based community support can facilitate the acceptance of psychosocial interventions among populations with strong religious backgrounds, because trust in aid providers may already be established through shared religious identity.²⁸ In the context of Acehese communities, where religiosity is highly significant, such an approach



Figure 4, 5 & 6. Brief Briefing by the Medical Team and Health Examinations

²⁷ C R Brewin, B Andrews, and J D Valentine, "Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults," *Journal of Consulting and Clinical Psychology*, 2000.

²⁸ J Ager, E Fiddian-Qasimiyeh, and A Ager, "Local faith communities and the promotion of resilience in contexts of humanitarian crisis," *Journal of Refugee Studies*, 2015.

may reduce resistance to psychological interventions, an obstacle that can arise in secular-based MHPSS programs when implemented in areas with strong religious and social structures. At the same time, the place of prayer in such a programme requires theological precision. Discussions of the tension between divine sovereignty and human agency within Pentecostal theologies of healing caution against framings in which divine intervention is set against ordinary means, and this caution is directly relevant to a programme in which prayer accompanies, rather than substitutes for, medical treatment.²⁹

Thus, the integration referred to in this article does not simply involve two services scheduled sequentially on the same day. Rather, it represents a single continuum of intervention in which the effectiveness of the medical component is partly shaped by the psychological readiness established during the preceding stage.

Alignment of Assistance with Local Vulnerability Characteristics

The types of medication transported by the medical team from Batam indicate that Mission Care did not provide generic assistance but instead responded to specific patterns of health needs in the post-disaster context. The medications included antihypertensive drugs, blood glucose medication, antipyretics, ophthalmic medication, as well as five hundred pairs of reading glasses distributed to residents with visual impairments (Figure 4). This selection is important because it addressed chronic health conditions rather than focusing exclusively on acute injuries resulting from the disaster. Residents with hypertension or diabetes who lost regular access to community health centers during the emergency period faced risks of complications that could be comparable to, or even more serious than, physical injuries caused by the disaster itself. Nevertheless, such conditions are often overlooked in conventional emergency assistance, which generally prioritizes the management of acute trauma.

The large-scale distribution of reading glasses also reflects sensitivity to needs that are rarely considered in conventional disaster assistance schemes. Visual impairment may not constitute a life-threatening emergency, but it directly affects residents' ability, particularly

²⁹ Upa Silaen, Ibiang O. Okoi, and Foret Nicholson, "The Tension between Divine Sovereignty and Human Agency in Pentecostal Theology: Miracles, Healing, and the 'Word of Faith' Movement," *DIEGESIS: Jurnal Teologi Kharismatika*, 2025.

among older adults, to carry out routine recovery activities, such as reading assistance documents or managing post-disaster administrative requirements. Such details indicate that Mission Care's medical logistics planning considered the demographic characteristics of the beneficiary population rather than merely providing medications within broad, general categories. Sensitivity of this kind reflects a wider principle in Christian service, namely that managerial, pedagogical, and theological considerations converge in the obligation to design provision around the specific limitations of those being served rather than around an undifferentiated average.³⁰

A similar pattern can be observed in the distribution of basic necessities. Each location received between 75 and 250 assistance packages containing staple food items and comprehensive cooking equipment, including stoves, cooking pots, frying pans, plates, and drinking glasses, with 30 dozen units of each item, in addition to 350 blanket packages (Figure 5). This composition extended beyond immediate daily emergency needs and was oriented toward the medium-term restoration of household functioning. The provision of complete cooking equipment suggests that the planning process assumed that residents' household kitchens had been damaged or completely lost as a result of the disaster, rather than merely experiencing a temporary shortage of food that could be addressed through the distribution of staple food packages alone.



Figure 7. Medical Examinations and Eye Screening by Physicians

³⁰ Yusuf Elpontus Tanaem et al., "Manajemen Pembelajaran Pendidikan Agama Kristen Bagi Anak Berkebutuhan Khusus di Di Sekolah Luar Biasa Negeri (SLBN) Pembina Kota Kupang," *REAL DIDACHE: Journal of Christian Education*, 2026.

This approach is consistent with the argument of Lu et al. in their study of rural disaster resilience programs in developing countries, which emphasizes that effective post-disaster interventions should take into account the comprehensive restoration of household functions rather than stopping at the distribution of food supplies alone.³¹ Households that have lost cooking equipment and sleeping facilities continue to face barriers to sustained recovery even when their daily food needs have been met, because basic household functions have not yet been restored.

The alignment between the types of assistance provided and the characteristics of local vulnerabilities strengthens the argument that the effectiveness of Mission Care lies not merely in the amount of assistance distributed, but in the appropriateness of the assistance to the actual needs of residents in areas where follow-up assistance may be difficult to deliver in the near term.



Figure 8, 9 & 10. Distribution of Aid and Staple Food Packages to Disaster-Affected Communities

³¹ Y Lu, Y Wang, and C Zhan, “Building rural community disaster resilience in developing countries: insights from a Chinese NGO’s Safe Rural Community programme,” *Disasters*, 2023.

Contribution of Cross-Institutional Collaboration

The ability to reach three regencies in Aceh, as well as areas in Sibolga and West Sumatra, within a twelve-day period was closely associated with the collaborative structure involving Real Care, Sekolah Tinggi Teologi Real Batam, and GBI Rayon Misi 20. These three institutions contributed different yet complementary types of resources. Real Care provided humanitarian networks and field experience, STT Real Batam contributed academic personnel and the institutional legitimacy of a higher education institution, while GBI Rayon Misi 20 provided a broad congregation-based volunteer network. This combination enabled the twenty-four personnel to be divided into two parallel working groups without compromising the core operational capacity of either group, an arrangement that would have been difficult to achieve if the activity had been driven by a single institution with limited resources. Comparable arrangements have been documented in church-centred models of community service directed at hard-to-reach populations, in which the congregational network supplies the access and continuity that a single academic institution could not provide on its own.³²

This pattern of rapid mobilization reinforces the findings of Kreutziger et al. in their documentation of the role of faith-based organizations in post-Hurricane Katrina recovery,³³ which demonstrates that faith-based institutions can mobilize volunteers more rapidly than formal bureaucratic channels because networks of trust among members have already been established well before a crisis occurs. The membership structure of GBI Rayon Misi 20, with an established congregation and interregional relationships prior to the disaster, provided a similar advantage for Mission Care, namely coordination that did not have to be built from scratch during the emergency. Studies of Christian leadership patterns likewise indicate that the readiness of a congregation to be mobilised for service depends less on the urgency of a

³² Fredy Simanjuntak et al., “Penerjemahan Alkitab Berbasis Church-Centric Bible Translation sebagai Model Pengabdian kepada Masyarakat pada Komunitas Suku Laut,” *Real Coster : Jurnal Pengabdian kepada Masyarakat*, 2026.

³³ S Kreutziger, E Blue, and M J Zakour, “Faith-based organizations in Katrina: The United Methodist Church,” *Creating Katrina, Rebuilding Resilience: Lessons from New Orleans on Vulnerability and Resiliency*, 2018.

given appeal than on leadership practices that sustain the motivation of members over time.³⁴

The involvement of STT Real Batam as a theological higher education institution added a dimension that is less commonly found in conventional humanitarian programs, namely the incorporation of academic perspectives into field-level decision-making. The participation of lecturers and institutional leaders was not merely symbolic but positioned the activity as a concrete implementation of community service, one of the components of the *Tri Dharma Perguruan Tinggi* that higher education institutions in Indonesia are expected to undertake. This position is consistent with the argument of Borkowska et al. concerning the third mission of universities in humanitarian crisis response, based on their case study of the University of Duhok's involvement in addressing the health needs of internally displaced persons.³⁵ The similarity between these two cases, despite differences in scale and national context, suggests that the concrete contribution of higher education institutions to humanitarian emergencies is not limited to large universities in developed countries but may also be replicated by smaller higher education institutions when their collaborative structures are appropriately designed.

The theological dimension of this involvement also provided a framework of meaning for the activity's implementers, as reflected in the team leadership's emphasis that their presence represented a form of moral responsibility rather than merely an organizational routine. Such a framework is relevant to Ferris's argument that faith-based humanitarian organizations tend to view their engagement as an obligation embedded in their institutional identity rather than as a programmatic option that can be postponed or reduced solely on the basis of cost considerations.³⁶ This orientation also helps explain why the team continued to reach areas with the greatest accessibility challenges rather than selecting locations that were easier to access and could potentially yield a larger numerical coverage of beneficiaries.

Overall, the cross-institutional collaboration within Mission Care demonstrates that

³⁴ Imelda Marcos Simbolon and Fransiskus Irwan Widjaja, "Pola Kepemimpinan Kristen Yang Menginspirasi: Strategi Meningkatkan Motivasi Jemaat Dalam Pelayanan," *REAL DIDACHE: Journal of Christian Education*, 2025.

³⁵ K Borkowska et al., "Embedding the Third Mission of universities in humanitarian crisis response: Profiling the role of the University of Duhok in addressing health needs of internally displaced people and refugees," *Journal of Adult and Continuing Education*, 2025.

³⁶ E Ferris, "Faith-based and secular humanitarian organizations," *International Review of the Red Cross*, 2005.

the effectiveness of humanitarian responses in isolated communities depends not solely on the size of the budget or the number of personnel but also on the alignment between the types of resources available from each partner institution and the characteristics of the challenges encountered in the field.

CONCLUSION

The Mission Care program demonstrates that an integrated model of medical services and psychosocial support can be implemented in post-disaster isolated communities, reaching 240 households across three regencies in Aceh, as well as areas in Sibolga and West Sumatra, within a twelve-day implementation period. Positioning psychosocial support as a stage preceding medical services, rather than as an additional program, is consistent with the principles of mass trauma intervention, which emphasize the importance of establishing safety and calm from the first point of contact with disaster survivors. The alignment of medical and logistical assistance with local vulnerability characteristics, particularly the management of chronic health conditions and the restoration of household functions, further indicates that the effectiveness of humanitarian response is more closely related to the appropriateness of interventions to residents' actual needs than to numerical coverage alone.

The collaboration among Real Care, Sekolah Tinggi Teologi Real Batam, and GBI Rayon Misi 20 was an important factor in the rapid mobilization of cross-disciplinary resources. The involvement of a theological higher education institution in this activity further supports the argument that community service based on the *Tri Dharma Perguruan Tinggi* can be implemented concretely by smaller institutions when collaborative structures are designed to complement the respective resources of each partner.

Several limitations should be considered in similar activities in the future. The evaluation of this program relied primarily on field observations without standardized instruments; consequently, the long-term effects of psychosocial support on residents' psychological conditions cannot yet be established. Quantitative data documentation was also uneven across locations, with more complete data available for Aceh than for Sibolga and West Sumatra. Therefore, future collaborative disaster-oriented community engagement activities should incorporate standardized evaluation instruments from the planning stage,

together with consistent data-recording mechanisms across field teams, so that lessons from each activity can be documented more systematically and provide a stronger basis for developing disaster-oriented community engagement models in Indonesia.

Declaration of Generative AI and AI-Assisted Technologies

During the preparation of this manuscript, the authors used Claude (Anthropic) to assist in mapping the conceptual structure of the argument and in developing the schematic outlines and diagrams presented in this article; ChatGPT (OpenAI) to check sentence-level accuracy and identify errors in formulation; and Grammarly and QuillBot for language refinement and for assistance in translating the manuscript into English. After using these tools, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication. All data, field documentation, analysis, and conclusions presented in this article are the work of the authors.

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