InterHealth

PEOPLE IN AID

Approaches to Staff Care in International NGOs

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Disclaimer
This publication is specifically addressing the psychological needs of those working internationally and does not address the wider medical needs of aid workers including their preparation before departure, care when in the field, medical screening and their support care on return. InterHealth and People in Aid consider this to also be of prime importance. Some areas relating to medical care are included in the previously published joint People in Aid InterHealth booklet entitled 'Staff Health and Welfare Guidelines'. This important topic will be addressed in more detail through future joint publications.

Considerable care has been taken to ensure this report is both accurate and relevant. However, People In Aid and Interhealth are unable to provide any warranty concerning the accuracy, completeness or relevance to your organisation relating to any information contained herein.

Foreword

As the reach of humanitarian aid organisations expands into increasingly insecure and dangerous environments we hear and read reports of elevated rates of injuries and death. From kidnappings, to vehicle accidents, to targeted killings, to disease, aid workers ranging from short-term missions to long-term development projects are at risk in several locations around the world. For People In Aid and InterHealth the importance of staff care is undeniable, more so now than ever before. In this research, organisations acknowledged their clear role to care for their workers in these unpredictable environments, yet many felt unsure how to build a holistic system of support amidst the new and complex situations in which aid workers find themselves today.

For the past ten years, People In Aid has been supporting NGOs around the world through advising, consulting, networking, training, and through its internationally recognised Code of Good Practice in the Management and Support of Aid Personnel (2003). For the past 20 years, InterHealth has been supporting organisations and churches sending workers to some of the most treacherous places in the world through research, writing, and professional clinical services in the areas of occupational, psychological, and physical/travel health services. In recent strategic reviews, both organisations affirmed their commitment to international outreach as core to their ongoing service delivery. We are very pleased with the partnership between People In Aid and InterHealth and the new opportunities for synergising key initiatives and maximising our potential through separate skills but similar goals and values.

The effects of working in the humanitarian and development sector have been well documented, but there is little research into how organisations mitigate the negative consequences and enhance staff care practice. This review is the first step in a process of discovery which will ultimately include separate reviews of staff care practice, and approaches to in-country staff care provision for national, or locally hired staff. The 20 organisations interviewed (19 international non-governmental organisations, and one international organisation), cover a broad spectrum, with some working exclusively in emergency / insecure contexts, and others exclusively in a non-emergency context. Some work through advocacy or consulting, others through partnership, secondments or direct implementation. As such this research should be read as **indicative** of the diverse and innovative approaches to staff care that exists, and not necessarily a representative comparison between organisations.

We are extremely grateful to the organisations and individuals that have participated in this research. Our work is based on the needs of our subscriber and member organisations, and we rely on your feedback. Your contribution shows commitment to helping us understand those needs and especially to the wellbeing of your staff around the world.

We hope that this report will prompt every humanitarian and development organisation to ask searching questions about their staff care provision, based on their peers' experience and practice. Along the way, you will encounter "questions for consideration": ask these questions for *your* organisation. This report can be read as stand-alone chapters and a resource on a particular area of staff care or as a whole. Our commitment remains to supporting your organisation in achieving its mission. Please feel free to contact us in response to this report. We look forward to your engagement and reaction.

Signed

Jonathan Potter Kevin Belcher

Special thanks

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Executive Summary

Background to this research

Increasingly, humanitarian and development work is undertaken in insecure, and sometimes treacherous environments. With a deeper understanding of human vulnerabilities, and a growing appreciation of the risks associated with the work they do, humanitarian and development organisations are realising the growing extent of their duty of care towards the people that deliver their projects and programmes, whether they be full time or part time staff, volunteers or consultants, international or local.

In recent years many International NGOs (INGOs) have strengthened the extent and nature of their staff care support. Spurred on by greater awareness and recognition of the benefits, and in the context of various Codes and Guidelines, there has been a marked increase in investment in staff wellness programmes, counsellors and specialist staff.

There is plenty of anecdotal evidence to suggest this investment is bringing dividends, but organisational approaches vary dramatically, from the *ad hoc* to the consistently high quality. The diversity of staff care practice identified by this brief report alone demonstrates the high levels of creativity and the depth of critical thinking within organisations as they respond to the unique stressors of humanitarian and development workers in unfamiliar environments. Yet at the same time, little has been formally documented regarding the nature and extent of staff care practices across the sector. Through sharing these organisations' experiences of staff care, it is our hope that this piece of research will contribute towards a deeper overall understanding of the current approaches to staff care within the humanitarian and development sector, and encourage organisations to network and take tangible steps towards improving their provision. Several disciplines and factors are involved in developing a comprehensive staff care systems (e.g. health and travel medicine, occupational health and employment law, human resource and management systems), and while several of these disciplines are interwoven in this report, the research focused on mechanisms for emotional and psychological wellbeing of staff.

In early 2009, People In Aid and InterHealth came together to research the provision of psychological and medical care for international staff and frequent travellers. The focus of this report is on psychological care.

Key Findings

1. **Staff care practices appear to be inconsistent, and existing guidelines (or minimum standards) tend not to be adhered to.**
   The questionnaire for this study is based on existing sector guidelines and standards. However, more specific guidelines for staff care are needed to comprehensively guide staff care practice.

2. **All organisations have some policies in place covering aspects of staff care, but only one third of the organisations interviewed had a distinct and specific staff care policy.**
   Several organisations are in the process of developing country/programme-specific staff care policy (See Chapter One).

3. **There are no consistent definitions relating to staff care practices in the humanitarian and development sector, and the scope of staff care provision within agencies is also inconsistent.**

Organisations expressed interest in determining staff care according to: staff types, duration of contract, and context, yet clear definitions for these categories have not been developed (See Chapter Two).

4. **Significant progress has been made with respect to the standardisation of induction.**
   60% of organisations have a standardised induction process and 30% are actively revamping their induction system (See Chapter Three).

5. **Several organisations have developed robust peer support programmes.**
   The embedded nature of support provides continuity and access to on-the-ground crisis response, but organisations warn that it is not a quick fix (See Chapter Four).

6. **Almost half of the organisations do not have a standard procedure for staff to receive a medical check-up at a travel clinic/hospital and only one-quarter of those interviewed require (or strongly encourage) a post-assignment psychological review or debriefing upon return.**
   End-of-assignment is a period of rapid transition for the organisation and the staff. A thorough re-entry process assists in a smooth transition of organisational knowledge, ensures that continuing or leaving staff are healthy, provides closure, and protects the organisation in the event of subsequent illness (See Chapter 5).

7. **In the current economic environment, staff care is at risk for further cuts and face-to-face interaction may decrease (See Chapter Six).**

8. **Less than one-third of the organisations interviewed evaluate their staff care practice. No organisations have conducted research (publicly available) on staff care.**
   Highly developed monitoring and evaluation systems have been developed across the INGO sector to capture the impact of implementation with beneficiaries. Yet, the same rigour has not been applied to the evaluation of staff care practices. By providing scientific evidence on the effects of staff care, organisations can determine the effects of the intervention on the staff (positive or negative), as well as the return on investment (See Chapter Seven).

Conclusion

The humanitarian and development sector has made considerable progress with respect to staff care in the last 10-15 years. Organisations are taking a posture of curiosity and experimentation that is centred in concern for the wellbeing of staff. Diverse operational models, stemming from diverse organisational missions and visions, have made staff care development an organisation-by-organisation endeavour.

Throughout an individual's life with the organisation, there are three distinct opportunities to offer support: pre-departure, on-assignment, and post-assignment.

Of the organisations interviewed, there has been significant effort in preparing staff to enter the field. The majority of organisations have implemented standardized inductions, and linkages between the regional/headquarters and the field are strengthening, and this is to be commended.

The on-assignment period continues to be extremely diverse. This is primarily due to various models of operation, but this research shows that many organisations continue to engage with staff illness and distress on an *ad hoc* basis, which is unsatisfactory. There is opportunity for learning and experience to be shared more systematically at a local level, through networking and collaboration. And coordination within and between organisations in country programmes could be more fully explored.

The area where most improvements can be made is that of post-assignment/re-entry. In a sector where one assignment/deployment flows into another, and international staff return to massively different contexts without systematic regional or headquarter debriefings, some international staff

may “fall through the cracks”, risking their personal health and wellbeing, and putting the organisation at risk of liability.

In addition to taking tangible steps to improve staff care at all stages of an employee’s relationship with the organisation, an important next step for the sector is to gain a clear understanding of the impact and effectiveness of staff care initiatives. Evaluations based on outcomes, and measuring indicators such as wellness / sickness absence, productivity, satisfaction, retention, will guide organisations in building a healthy workforce, and will also clearly articulate the return on investment and justify any need for further funding.

A framework for action

The report raises many questions relating to staff care; we conclude this summary by highlighting a few of the key questions which we hope will catalyse valuable discussion and thus help any organisation embarking on a review of their approach to staff care:

1. Who is responsible for staff care? Where is the balance between individual and corporate responsibility? To what extent should any policy be proactive or reactive?

2. Who falls under the scope of a staff care policy? What are the differences (if any) in your policy for full time staff, consultants, volunteers, and how do they vary by context or location?

3. How can specific staff care practices be developed for the variety of types of staff, duration of contract, and context of work?

4. What are the benefits and limitations of in-house medical or psychological staff care personnel?

5. Which aspects, if any can be ‘outsourced’? Has your organisation investigated the appropriate insurance providers, taking into account the specific needs of international aid workers?

6. In what ways can your organisation coordinate or collaborate with other actors in sharing the costs of staff care?

7. Should your organisation consider developing a monitoring and evaluation system for current staff care practice, or joining with another organisation in producing an efficacy study?

London, September 2009

Chapter 1 – Introduction

Chapter summary

This chapter sets out the background to this research, and in addition to offering a definition for staff care, it presents a brief overview of the participating organisations and the networks and information working in this area.

Defining staff care

First, we need to define what we mean by the term 'staff'. In this report we will assume a broad and un-technical definition of staff, taking it to refer primarily to the people that directly deliver an organisation's projects and programmes, and to whom an organisation has a clear duty of care. Staff could be full time or part time workers, internationally or locally hired; they could be on volunteer contracts, again, whether international or local. Occasionally they may have alternative contractual arrangements such as consultants, however we recognise the legal distinction of consultants, and would encourage the reader to consider how much of their 'staff care provision' should extend to non-staff, i.e. consultants.

Staff *care* is a joint effort between several departments, each playing crucial roles in the wellbeing of their staff. Where it exists, the Human Resource Department typically "hosts" staff care, but other departments such as: Benefits/Compensation, Business Development, Health and Safety/Occupational Health, Finance, Communications, Facilities, and others, participate in supporting staff. Care of staff involves relationship within the hierarchy of line management as well horizontally, that is to say via peers or colleagues. Many interviewees said that staff wellbeing was largely influenced by the extent of dialogue and coordination between departments.

The purpose of staff care is to create a healthy and productive workforce; to create wellbeing among staff and improve the quality of their work. Wellbeing is influenced by internal and external factors, and refers to emotional, cognitive, spiritual, and physical health. Each organisation, and indeed each individual, has different staff care needs.

For InterAction, "Staff care refers to self-care and institutional responses to stress among humanitarian workers in particularly difficult and stressful environments."

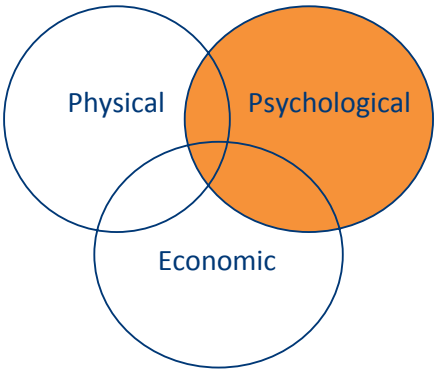
www.imteraction.org

For US AID's Staff Care Task Force, "Staff care includes broad issues ranging from personal emergency preparedness and response to staff wellness on a day-to-day basis, including physical and psychological wellbeing in the workplace."

www.usaid.gov

For People In Aid, there are three dimensions to staff care and these relate to the psychological, physical and economic wellbeing of an individual.

Figure 1: Dimensions to Staff Care



For the purpose of this research, we will follow US AID's emphasis on the physical and psychological wellbeing, as the third area referred to by People In Aid (economic wellbeing) is covered by other research on topics such as recruitment, retention, staff turnover, reward strategy and executive compensation, much of which has been published by People In Aid and is available to download free of charge from www.peopleinaid.org.

In chapter two we will present a framework that presents the dynamic interplay between environmental influences, the organisation, and the individual that comprises the practical manifestation of staff care.

Background to this research

The humanitarian and development sector continues to grow rapidly and increasing attention has been given to the wellbeing of the international aid worker. Several researchers and policy planners in the field of relief and development have given attention to the treacherous life and work of aid personnel, and management of major INGOs have been quickly responding to the growing concerns. In April 2009, the Humanitarian Policy Group, Oversees Development Institute and the Centre on International Cooperation wrote an update on the status of humanitarian worker. Their report "*Providing aid in insecure environments: 2009 Update: Trends in violence against aid workers and the operational response*" indicated that 2008 experienced the highest levels of attacks, kidnappings, and deaths yet recorded. "The absolute number of attacks against aid workers has risen steeply over the past three years, with an annual average almost three times higher than the previous nine years." (Stoddard, et. al., 2009)

Aid workers continue to work in some of the most insecure environments in the world. They witness atrocities, handle dead bodies, encounter destitute poverty, receive threats, among others. "There was a time when the aid worker was sacrosanct, when the work was seen as detached from political agenda. This is ancient history and the truth of the matter is that we are more and more vulnerable either because we are seen as more easily available targets representing our governments or because we are now confused with a military insistent on doing 'development' work…" Donna Read, Devex.com, 2009)

James Guy of the Headington Institute said, "Aid workers are repeatedly confronted with the suffering of victims and the apparent meaninglessness of catastrophic events. To go on with their work, they must find answers to the same questions of meaning and purpose that confront the victims they serve."

Lovgren, 2003

Personnel working in more stable environments may not face the same 'traumatic' experiences, but issues of work-related stress, foreign culture, harsh climate, isolation, illness/disease, professional stagnation, poor management, and dilapidated infrastructures can easily lead to distress, burn-out, and mental and physical deterioration. Whether chronic or acute, staff in humanitarian and development organisations work in emotionally demanding environments and need appropriate support in reaching their potential.

As the risk to staff rises, so does the risk to organisations. Clearly organisations have ethical, moral, and legal responsibilities when it comes to staff care, but what policies and procedures can they concretely put into place to mitigate the risks? This research begins to answer that question by highlighting the steps taken by a number of organisations to date.

Research objectives

In early 2009, People In Aid and InterHealth came together to review the provision of psychological and medical care for international staff and frequent travellers.

We set out with the purpose of:

1. **Identifying current approaches to staff care for international aid workers and frequent travellers**
2. **Stimulating networking and learning, with the aim of encouraging agencies to take tangible steps towards improving their provision**

This review is the first step on a process of discovery which will ultimately include separate reviews of staff care practice, and approaches to in-country staff care provision for national, or locally hired staff. We interviewed 20 organisations (19 international non-governmental organisations, and one international organisation), and they cover a broad spectrum, with some working exclusively in emergency / insecure contexts, and others exclusively in a non-emergency context. Some worked through advocacy or consulting, others through partnership, secondments or direct implementation. As such this review is less comparative / representative and more indicative of the diverse and innovative approaches to staff care that exist.

The impetus of this study is derived from staff care specialists, consultants, service providers, and human resource managers wanting to know what other organisations are

doing for staff care, how they approached similar challenges and how they resource the care.

This study does not purport to present best practice, evaluate, or benchmark staff care practice. Rather, it presents a broad-brush picture of what organisations are currently doing with respect to medical and psychological support. It is our hope the presentation of current data, combined with a new theoretical model of staff care (Chapter Two) will assist organisations in making strategic decisions that enhance the wellbeing of their staff, protect the organisation, and ultimately build a healthy workforce that can fulfil the goals of the organisation and wider sector.

*"It's difficult to **recruit** staff, but it's even harder to **keep** them. Our organisational review of staff care is going to help in our staff retention"*

HR Manager

"We want to learn from this report. There isn't a lot of information out there on staff care. We have tried calling a few organisations to find out what they are doing for staff care, but getting information this way has been difficult. That's why we have decided to participate in this research."

HR Manager

Overview of participating organisations

We are grateful to all those that participated in this research; the sample consisted of well-established American and European INGOs. Interviewees were primarily Human Resource Directors or Staff Care Specialists in major regional or headquarter offices.

Nine offices were based in England, seven offices in the U.S.A., and others in Ireland, France, Norway, and Cyprus. The average age of the organisation was 54 years old (with a median of 59 years old). The youngest organisation was founded in 1989 and the oldest was founded in 1914. The total combined income for the organisations surveyed was USD15 billion. Excluding the International Organisation, the average annual income for the organisations being USD423,115,000 with the lowest annual income at USD25,000,000 and the highest at USD1,600,000,000. [1]

- **The average number of international field-based staff was 324** (Lowest:11, Highest 2,631, Median, 170). (Based from headquarter offices: Data from 20 organisations)
- **The average number of in-country national staff was 3,327** (Lowest: 258, Highest: 8,192, Median: 3,095) (Data from 16 organisations)
- **The average number of countries that these organisations worked in is 44** (Lowest: 10, Highest: 139, Median: 40). (Data from 19 organisations)
- **The average organisation had an international staff made up of 31 nationalities.** (Smallest: 6, Largest: 99, Median: 21). (Data from 15 organisation)
- **Regional or headquarter offices had an average of 42 frequent travellers** (i.e. those that travel 15-20% of their time or more) (Lowest: 2, Highest: 100, Median: 40) (Data from 17 organisations)

Key reflections

In summary we can say that in this research:

> the approximate ratio of international field based staff to in-country national staff was 10% / 90%.

> 42 was the average number of frequent travellers (i.e. those that travel 15-20% of their time or more). This constitutes a tiny percentage of overall staff numbers (approximately 1%, based on an average workforce size of approx 3,600 plus HQ based staff).

[1] The following statistics refer to the specific office contacted and staff within their care (i.e. French Red Cross, not the entire Federation, or Save the Children in the UK, not the Alliance). Questions were aimed at understanding the staff care services available to these specific international staff. So if large decentralized organisations provided support to staff across other regional offices, this was included in the collection of services available to them. Where organisations did not have data, they were excluded from calculations.

> the high average number of countries of operation (44) and nationalities within the international staff contingent (31) presents huge cross-cultural challenges.

What information on staff care is out there?

Much of the most useful information on staff care of international aid workers can be found via a handful of websites, staff care networks, and conferences.

Two notable storehouses for information, literature, guidelines, and links to organisations writing about, assessing, or networking on staff care issues are the Headington Institute (www.headington-institute.org) and Mental Health Workers Without Borders (www.psychosocial.org).

Other important staff care networks include: People In Aid's 'Emergency Personnel Network' www.epn.peopleinaid.org, Helper's Fire www.helpersfire.org, Devex, Member Care Network, Aidworkers Network www.aidworkers.net, and InterAction's Staff Care page www.interaction.org/staffcare. Some of these networks also have working groups or regular conferences.

A number of well known organisations (or inter-agency groups) have also developed standards or guidelines for staff care. The main standards include:

- **People In Aid: Code of good practice in the management and support of aid personnel**
- **Antares Foundation: Guidelines for managing stress in humanitarian workers**
- **Interagency Standing Committee on Mental Health and Psychosocial Support in Complex Emergencies (Minimum standards: section 4.4)**
- **The Sphere Project: Humanitarian charter and minimum standards in disaster response (Sections 7 & 8 of chapter One)**
- **InterAction Private Voluntary Organisations Standards (Section 6)**
- **UNHCR: Managing the Stress of Humanitarian Emergencies (Developed by the Staff Welfare Unit, Career and Staff Support)**
- **Global Connections: Guidelines for Good Practice in Member Care (Faith Based)**
- **British Standards Institute/Royal Geographical Society: BS 8848 2007 +A1 2009: Specification for the Provision of Visits, Fieldwork, Expeditions, and Adventurous Activities, Outside of the United Kingdom**

Apart from the above, published reports are relatively scarce. The Headington Institute published a seminal report on staff care in Darfur in 2007, and organisations such as ECHO and the Humanitarian Practice Network have published on staff security, but aside from that, writing and research on the specific topic of staff care has generally been undertaken by students and has revolved around a few key areas, notably: stress (accumulative and traumatic), safety/security, mental health, travel health, and management practice.

Sectoral staff care interventions (or programmes) at a field have also been relatively scarce, with specific initiatives being undertaken by organisations such as the Antares Foundation and the Headington Institute in various locations throughout Europe, Africa and Asia, and by RedR in Darfur.

Chapter 2 - Approaches to staff care

Chapter summary

This chapter highlights several components of staff care, explores the way in which the different facets of staff care interrelate, and presents a model for understanding staff care in the humanitarian and development sector. Additionally, the chapter discusses the extent of in-house and outsourced medical and psychological support among INGOs. Appendix 1 contains a basic template for a written staff care policy.

Approaches to staff care

"Prepare, support, and debrief: a simple proven model that is still not applied after ten years of hard knocks and errors clearly paid for"

Jean-Guy Morisset (U.N. Secretariat, Headington website)

At each stage of an employee's life within an organisation, there is an opportunity to build institutional and individual resilience to accomplish the demanding tasks set before them. In 2005, the Headington Institute developed a framework of minimum operational procedures for psychosocial support of relief and development workers. Here too, the overarching, holistic nature of support is evident. ***Pick*** suitable candidates, ***Prepare*** team members adequately, ***Provide*** ongoing support during assignments, ***Process*** their experiences afterwards, and ***Plan*** for transition to other career opportunities. Many organisations found this helpful, and some, such as World Vision International, used it to shape their staff care provision.

The Antares Foundation (2006) presents another cyclical model of care involving: Screening and Assessing Staff, Preparation and Training of Staff, Monitoring Staff in the Field, Ongoing Support in the Field, Crisis Support, And of Assignment Support, and Post-assignment support.

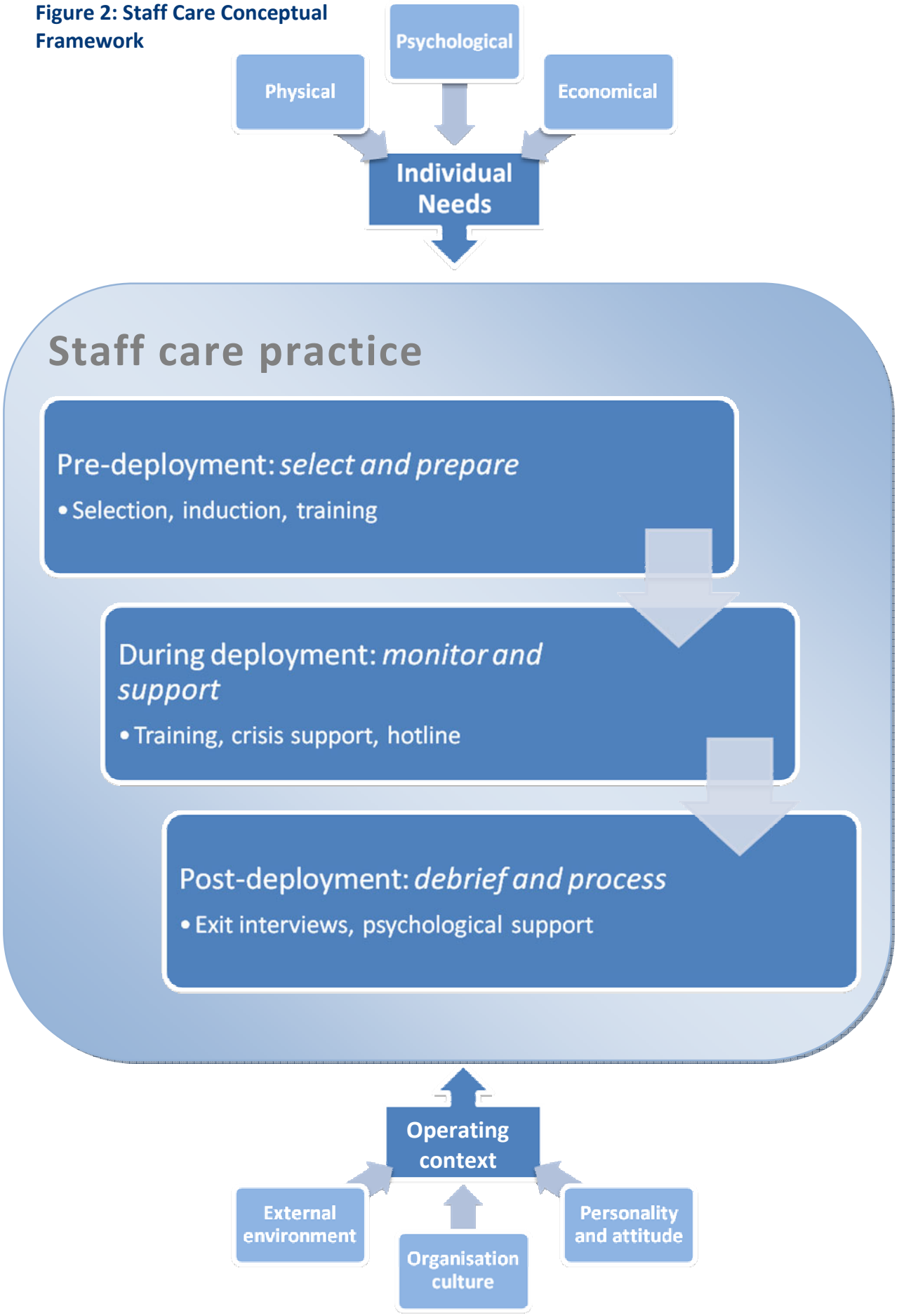
In line with this cyclical perspective, this research will examine two questions in each of the pre-assignment (chapter 3), on-assignment (chapter 4), and post/continuing-assignment (chapter 5) phases. Case studies of innovative practice will be presented in each of these sections

Understanding staff care – a conceptual framework

Several steps have been taken in developing good practice in staff care among aid workers. However, it was evident from our research that while some organisations have well-developed and nuanced staff care systems, while others are still beginning to implement their systems, and others do not believe that much staff care is needed. Why does this disparity exist across the sector?

Most staff care programmes lack systems to determine the nature and extent of support needed in *specific* situations. Understanding the environmental influences of staff care, as well as the parameters for specific staff care interventions, will assist organisations in determining appropriate support in a complex sector

Figure 2: Staff Care Conceptual Framework



Environmental Influences

Economic climate: Economic environment. Donor awareness. Availability of funds for staff care activities. Can return on investment be proven?

Legal climate: Is staff care driven by legal (duty-of-care, due diligence) or moral issues? Is it driven by a business model or a model of compassion?

Social discourse and current trends: Over time, various trends in staff care emerge. How is staff care driven by: conferences, new best practices, media coverage, and development theory.

The Organisation

Organisational Culture

There are many aspects of organisational culture which impact staff care, and the priority an organisation places on staff care. For example the extent to which it is :

- relational or clinical;
- linked to motivation and retention;
- influenced by financial constraints; cost/benefits;
- influenced by the individuals doing the work (emergency responders vs. long-term development workers)

Attitude towards staff care

A variety of attitudes may exist towards staff care. These are often constructed from socio-cultural perspectives and personality (i.e. we're "tough" and don't need expensive staff care). A clash of attitude towards staff care may cause serious distress. Some organisations strive to develop a collective attitude towards staff care.

Senior management buy-in

Is there buy-in from a strategic level, for example among senior managers, Directors and trustees?

Operational Model

As noted above, the humanitarian and development sector is extremely diverse, and an organisation's operational model is developed from the organisation's vision and goals. The operational model has direct implications for supporting staff. Here are some considerations:

Contractual status: for example, contracted, International, European/American, In-country National, Regional, Expatriate local hire, incentive refugee staff, emergency responders, volunteers, employed at will, consultants
Duration of contract: for example development (usually long term i.e. 1-3 years or more), emergency relief (usually short term), frequent travellers (15-20% of contracted time or more),
Location and role of staff: Manager, Field workers, Office workers, remote managers.
Context of work: for example stable (high stress), stable (low stress), Rural, Urban, Insecure, Emergency type (likelihood of assault, death, abduction, vehicle accident, natural disaster, etc…), climate and terrain considerations, infrastructure/development considerations, proximity to more stable / secure destination
Nature of the role: managerial, advisory, office based, field based, isolated, remote team

Phases of the contract

Taking into account the frameworks proposed by the Headington Institute and the Antares Foundation, in this report we will consider staff care in three main phases of an employee's relationship with an organisation, and we will do so primarily from the perspective of psychological provision:

1) Pre-assignment: this includes planning, recruitment, selection, screening, preparation
2) On-assignment: this includes on-going support, training, and post-incident crisis support
3) Post-assignment/continued employment: this includes organisational debriefing, medical and psychological reviews, re-entry.

The Individual

Each individual comes to an organisation with a different history and set of personal attributes. Just like organisations, individual have their own attitude towards staff care; some are heavily reliant on comprehensive support, while others will not accept support unless it is mandated. Whether a person will

require extensive support or not depends on: their previous experience, ability to self-care, pre-existing medical or psychological illnesses or disability, level of personal resilience, external support networks (in country and at home), ability to maintain a healthy work/life balance, capacity to adapt to unfamiliar environments, ability to assess risk, interpersonal skills, and many others. Consistently, human resource managers maintain that the wellbeing of staff depends on the "goodness of fit" of the assignment/location.

Monitor and evaluate

Finally, there is an obvious need to monitor, evaluate, and where appropriate create new support systems and this touches on all sections of the framework. A monitoring framework identifies crucial points to gather indicators of wellbeing for staff, management, and stakeholders. Evaluation examines the efficacy of specific interventions, over time, according to determined indicators. And ultimately, the output from monitoring and evaluation activity provides the basis for funding staff care.

Observations, and applying the model

What has become clear from this research is that organisations are struggling to decide upon the specific staff care practices that should apply to their diverse workforce. Minimum standards and frameworks offer principles but lack concrete steps and objectively verifiable indicators to guide organisations in developing operational-specific staff care plan. Workforces are often so diverse that staff care plans should relate the need of the particular **individual**, their **contract length**, and **operating context**. For example, one Human Resource Manager had not received a single notice of psychological distress in the past two years, while another organisation had recently responded to staff killings. Another organisation regularly sends staff on month-long missions to intensely insecure areas, while the other operates through 4 year contracts in secure areas only. How can organisations be prepared for contingencies, while maintaining an appropriate level of support for staff facing very different contexts and stressors?

One respondent raised this question: "What is the definition of post-assignment? Is it after a 3 month assignment, a year-long contract, two-weeks in a war zone? We haven't had a problem in making staff care services available. Figuring out what constitutes an assignment that requires a post-medical check-up has been the challenge. We are developing a matrix that looks at a combination time and threat-level, using security ratings and in-country or programme context data."

While staff care needs vary and no "one-size fits all", minimum standards continue to play an important role in creating a baseline services and guiding humanitarian aid organisations. Existing minimum standards are a starting point, and organisations are left with the decision of additional support in extenuating circumstances.

Creating the ideal framework begins with an understanding of the environmental influences of staff care, then analyses the organisation's culture, modes of operation, and an application to the three phases of the employee's lifespan combined with individual staff care considerations. This produces a nuanced and strategic approach to staff care and is likely to satisfy the various departments involved with the different types of staff. Monitoring and evaluation is central to this framework. On-going monitoring and periodic evaluation helps the organisation enhance effective practice and eliminating unhelpful and cost-ineffective practice.

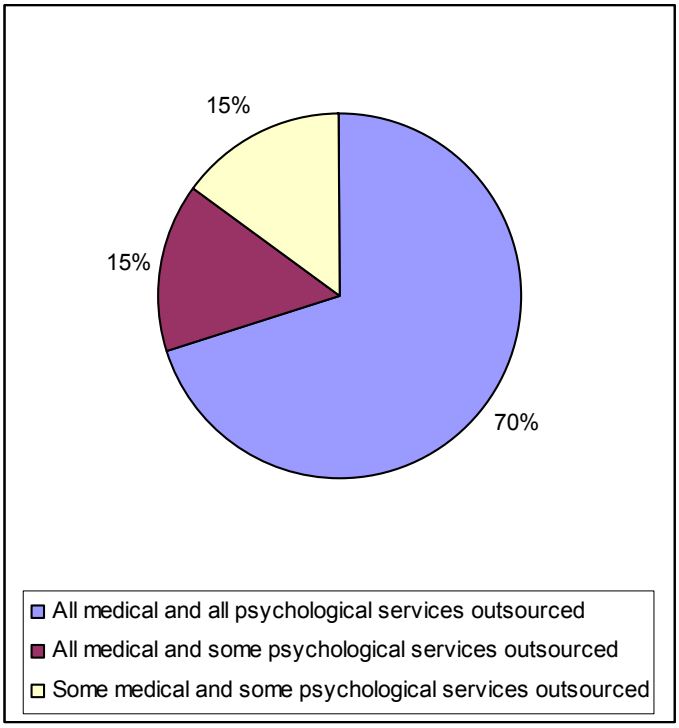
Who provides the service?

A major question facing organisations in recent years is whether to out-source staff care practice or to have the in-house capacity. This research examined the current extent of INGOs use of both in-house and out-sourced personnel in place for the medical, psychological and general care of staff. We found that the answer is not typically 'binary', that is to say either / or, rather the question is how much should be in-house or out-sourced, and which aspects lend themselves to either?

The majority of organisations out-source medical, psychological, and often other types of staff care. Commonly, organisations to have close relationships and contracts with trusted doctors and psychologists. In fact, many organisations answered that they had an in-house psychological professional, when

it later became clear that the specialist was not actually on staff, but worked very closely with the organisation.[2]

Figure 3. Outsourcing Medical and Psychological Services



- All medical and some psychological services outsourced: 3 (15%)
- Some medical and some psychological services outsourced: 3 (15%)
- All medical and all psychological services outsourced: 14 (70%)

The in-house psychological specialists mentioned above are typically based at headquarters or regional offices. They are involved with developing staff care policy and systems, identifying appropriate external support, pre-departure preparation and post-assignment debriefings, as well as in-country activities such as training, psychological support in the aftermath of a crisis, and very occasional *ad hoc* trips to country programmes for severe cases of mental breakdown and/or evacuation. It was common for the in-house psychological professionals to be involved with psychosocial programme implementation as well. Of the six organisations that had some kind of in-house psychological staff, the centralized organisations had one or two psychological staff person, whereas decentralized organisations typically had six or seven. There was little correlation between size of organisations and medical or psychological professionals, but a stronger correlation between medical or psychological professionals and agencies working in insecure contexts.

One organisation has fulltime doctors in several countries, and two organisations have doctors who dedicate a proportion of their time to staff of the organisation. Three organisations had a dedicated "staff care specialist" (whose role is devoted solely to the wellbeing of staff, and may include advocacy, direct psychological support, monitoring and evaluation of staff care practice, training, debriefing, referring), and 8 additional organisations reported that staff care was part of non-specialist in-house role.

Advantages and disadvantages to in-house support:

Advantages:

- Institutional capacity is built when the specialist trains others in the organisation. Counsellors and/or psychologist often train in peer support, crisis management, conflict resolution, good communication, team dynamics and cohesion. They can train in countries of operation, or during regional or headquarter inductions.
- In-house specialists in countries of operation are often involved in programme implementation, but may be utilized by the organisation when necessary. Preventative methods such as monitoring and tracking are cost-effective.
- In-house specialists provide consistency through the staff person's lifespan.

[2] Specialists were included in the total, even if they were not hired via HQ or a main office, if they were available to the international staff

- In-house specialists can advocate for funding for staff care provision, having a detailed understanding of the needs.
- In-house specialists can build a framework of staff care practice and develop policy in line in organisational values and context of operation.
- Staff care is more consistent and thorough when a staff person has this sole responsibility, rather than adding on top of a busy workload.

Disadvantages:

- Staff may be unwilling to share psychological or medical issues with another member of staff. Staff may feel that they lack objectivity, and worry about information being leaked to colleagues/management.
- In-house staff care specialists are usually not available in person when the need presents. Organisations interviewed worked in an average of 44 countries. Covering this wide geographic area with in-house specialists may cost prohibitive
- In-house specialists may or may not understanding the context in which the staff live and work, and an in-country specialists might be more useful

A combined effort between in-house and outsourced staff care specialist provide the most comprehensive and cost-effective support. Examples of combined efforts are presented in the body of this report.

Staff care policy

While all guidelines and standards on staff care and wellbeing recommend the development of specific written policies, **only 35% of the organisations interviewed for this research have a distinct section for staff care in their policy.** Most organisations have policies that relate to staff care (i.e. health and safety, leave allowance, R&R, substance abuse, occupational health, security, housing, work-life balance, flexitime, etc…), but only one-third had designated staff care/wellness sections or chapters within their wider organisational policy. One organisation notably reported having a three year strategic plan on staff care which was unique.

This research shows that organisations are in very different places when it comes to developing their staff care policies. Several organisations have a centralized staff care policy and are now requiring each country programme to develop context-specific staff care policies and practice. Interestingly, our findings were consistent with a 2007 study of aid organisations working in Eastern Chad and the Darfur region of Sudan.

"Relatively few organisations have clearly articulated a commitment to staff wellbeing in organisational handbooks and other policy documents, or proactive plans for staff support."

Headington Institute, 2007

Key observations

Staff care is a cyclical process that is influenced by a number of variables. It involves the whole organisation, and personnel from both regional/headquarter offices and in-country offices. Staff care practice has been developed based on minimum standards and guidelines. Still lacking, however, are nuanced systems that take into account the dynamic relationship between environmental influences, the organisation's culture, operational model and contractual phases, and the individual.

Almost three-quarters of the organisations interviewed out-sourced all psychological and medical support. The main advantages of in-house support are the consistency of care and increased institutional capacity, while the main disadvantages are concerns of confidentiality, cost effectiveness, and proximity to in-country locations.

Organisations have to choose their path when it comes to deciding whether their staff care policy should be integrated or in the form of a discrete, stand alone policy (or selection of policies).

Key questions for consideration

- Could your organisation use this conceptual framework for a strategic review of staff care practice? Who would be a part of the review?

- Would your organisation benefit from a multi-faceted set of staff care guidelines?
- Would your organisation benefit from a stand-alone staff care policy?
- How could you integrate a staff care policy with other HR management policies?

Chapter 3 – Preparedness – Psychological Screening and Induction

Chapter summary

This chapter examines two pre-assignment staff care practices in detail: psychological screening, and induction. A few figures are presented to show the extent of these practices, followed by some observations and questions, and ends with a summary of key messages. Other key components of an effective preparation phase (such as: recruitment processes, interviewing/hiring, training, and medical health screenings) were not examined in detail in this research as comparatively, they were much better systematised.

Psychological screening

"With psychological ill health being the most common reason for premature departure from overseas assignment, there is a strong business, moral, and legal case for assessing the psychological health of new and ongoing staff. This is especially true for humanitarian aid workers planning to work in high pressure situations."

Angus Murray, InterHealth, citing research by Dr Dipti Patel from Occupational Health [at Work] Journal. December/January 2008 /2009 (vol. 05/4)

"Attention to the psychological needs of the field staff during the pre-deployment phase helps develop a stable workforce by curbing the potential for illness, psychological distress (including 'anticipatory anxiety'), security lapses, poor performance, and the high expenses associated with turnover"

Idealist.org, 2009

The purpose of pre-assignment screening is to mitigate potential adverse reactions to typical aid work challenges and potential traumatic events. Psychologists assess the type of mental illness, the context of deployment and type of work, recent losses, history of the mental illness, internal resources/resilience and coping ability, and availability of treatment in country. Screening psychologists have experience with the international humanitarian and development sector and can provide guidance on appropriate management supports, identify coping mechanisms, promote protective factors and an individual's resilience capacity. It is a risk management practice and is conducted by a qualified mental health practitioner to meet legal and/or ethical obligations. Psychological screenings have been a routine practice for military deployments. As the humanitarian and development sector send staff to increasingly insecure areas, there is much to learn from the military's practice.

Principle 2 of the Antares Foundation Guidelines on *Managing Stress in Humanitarian Workers*:
"The agency systematically screens and / or assesses the current capacity of staff members to respond to and cope with the anticipated stressors of an assignment: Screening of staff members is recommended prior to general hiring. A more thorough assessment should be made prior to a specific project."

Our research found that only 15% of organisations require a psychological screening for their international staff prior to departure. Another 15% of organisations reported using a non-clinical behavioural screening or personality assessment.

CASE STUDY

French Red Cross: Consultation with external psychological support

"Consultation with external psychological professionals helps us determine where and how to invest in staff care." -FRC Psychosocial Coordinator. Often times, there is little or no confidential feedback to organisations sending their staff for pre-deployment counselling or screening sessions.

The French Red Cross requires all international staff to receive psychological and medical screenings prior to departure, as well as medical check-ups and a post-assignment appointment with a psychologist. The external psychological support is conducted by mental health professionals who are familiar with the context in which staff are deployed, and they are able to process past and upcoming experiences with the staff in a supportive manner. In the event that a psycho-social issue needs to be addressed prior to deployment, then, with the staff member's consent, the external psychologist is able to discuss the issue with the Red Cross's Psychosocial Coordinator in order to safeguard both the individual and the organisation.

By engaging external psychological professionals and maintaining a regular dialogue with them, the Psychological Coordinator for the Red Cross and the person in charge of delegate HR, is able to objectively assess whether there are any recurring issues for workers in specific locations, and influence the timing of deployment for those returning from 'hardship locations'.

Interdepartmental meetings are held monthly between the psychological professionals and relevant Red Cross management to identify trends in returning workers which can be raised and dealt with sensitively. This process ensures that the French Red Cross is able to make informed and robust decisions about an individual's suitability for deployment as well as the level of staff care required in different geographic locations. In the words of a senior Red Cross manager, "We talk about what's going well, where there's a potential problem, conflict, or area of tension. It takes all of these actors, to put the whole picture together, and this kind of open exchange of information is very important." Action points from the meeting are developed and followed-up systematically.

The objective and confidential feedback helps the organisation gain maximum benefit from the learning and prepared staff to manage risk. An added advantage is that the process is much less threatening to an individual or department. According the Psychosocial Coordinator, this practice has been invaluable in helping make decisions about timing and the level of staff care needed in different geographic locations paired with the individual staff person's internal resources and natural resilience.

Induction Processes

"We have devised a standardized orientation because of experiences we have had during disaster response. People who were deployed quickly and did not have a thorough orientation to the organisation performed terribly compared to those who had."

HR Manager, INGO

Induction and/or orientation are the processes through which organisational knowledge is transferred and new employees are prepared to work to their potential. The process has been summarised in the publication "Induction, Briefing, and Handovers" by People In Aid (2005). In this research we sought to understand whether the induction/orientation process was in any way standardised across organisations. In this research we shall refer to the whole process as "induction" and clarify the different stages.

Organisations interviewed held between 2 and 4 distinct induction processes. [3] Inductions ranged in duration from a half day, to 3 weeks, to a "rolling" 18 month process. There are three main types of induction: the organisational induction, the technical induction, and the in-country induction.

[3] Distinct sections of a rolling induction scheme have been counted as one induction process each. For example, if the new hire has a schedule of meetings, a series of readings and introductions during the first week, this is counted as one process.

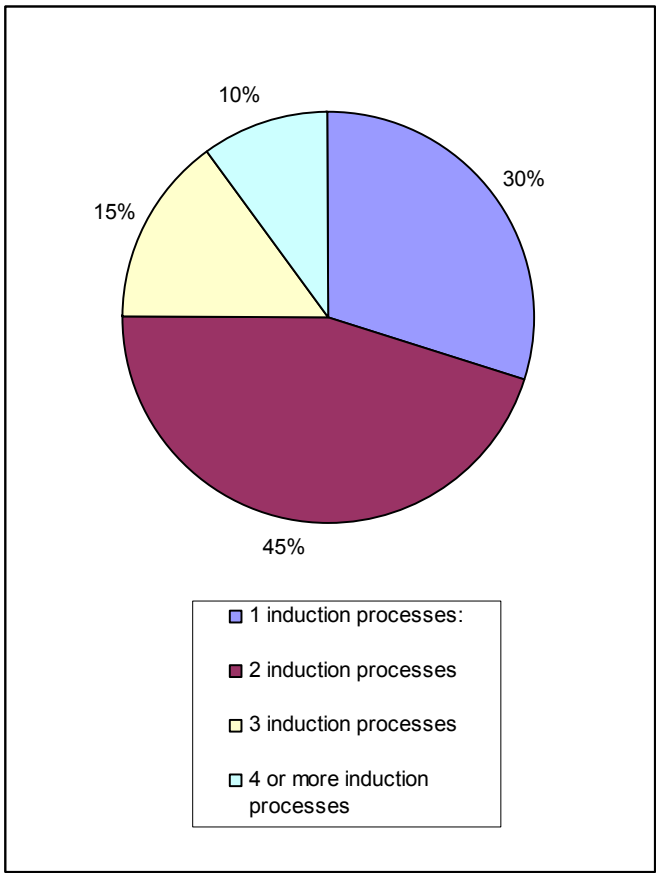
1. **Organisational induction / "Corporate" induction:** If any induction occurs at regional or headquarters office it is the organisational induction. Topics typically include: organisational structure, culture/history, protocols/procedures, values, terms of employment, and policy. Human resources departments usually take the lead on the organisational induction and link with other departments such as benefits/compensation, communication, finance, IT, and others. For organisations that have de-centralized the organisational induction, this is increasingly conducted through informational material sent in the mail, intranet or DVD, and videos.

2. **Technical induction**: This induction has a wide variety of formats and venues. It may be conducted at HQ or regional offices, but is often conducted in-country by members of pertinent departments or by phone with the head of the department in HQ. If new staff are replacing an existing position, the technical induction includes a handover. This induction focuses on: detailed job description and specific tasks, logistical arrangements, technical protocols, and perhaps an additional training.

3. **In-country induction.** This induction makes new hires aware of the living and working environment. It is usually conducted by the new hire's line manager in country and/or a peer. Organisations that use 4 inductions typically have an in-country induction at the capital city and one in the field site. It covers issues such as: security, health and safety, cultural norms, working and living environment, equipment, logistics, line management and performance appraisals, internal and external introductions, and in-country specific policy.

In our research, we found that 60% of organisations used a standardized orientation/induction process for all international staff. Many organisations use their intranet to run a modular induction process, and there are therefore a number of orientation processes available to ***all*** levels of international staff; additional induction processes occur with senior management and certain technical staff.

Figure 4: Number of Induction Processes



- 1 induction processes: 6 organisations (30%)
- 2 induction processes: 9 organisations (45%)
- 3 induction processes: 3 organisations (15%)
- 4 or more induction processes: 2 organisations (10%)

CASE STUDY

Save the Children-USA: OnBoarding for new hires

According to a senior manager at Save the Children, "new employees provide an opportunity for the organisation to cultivate and propel its growing workforce to a higher level". Save the Children believes that a robust OnBoarding programme will help them meet their goals by strengthening the engagement of its workforce. Engaged employees are defined as "employees who know what is expected of them, have the materials and support needed to perform, understand the importance of their work, and believe they have opportunities to learn and grow at Save the Children and receive recognition and praise for their results".

Rather than a single "orientation" event, the OnBoarding programme is designed to promote the induction, assimilation, familiarization and knowledge sharing of new employees into the organisation over an extended period of time. This process improves retention and raises the level of engagement of new employees into Save the Children, with the ultimate goal of enhancing the impact and performance of each employee.

The OnBoarding programme primarily consists of three components.

1. Peer Sponsor – A peer sponsor from the new hire's department is assigned to help the new employee get acquainted with their new work associates and surroundings.

2. New Employee Orientation Program (NEO) - This is a one day session that provides an overview of the role, mission and structure of the organization.

3. New Employee Lunch and Learn Sessions – Additional modular sessions provide a closer look at the specific divisions, business units and initiatives of the organisation which supplements the one day New Hire Orientation Program.

An important aspect for success of OnBoarding is the participation of the Senior Management Team in both the introduction and implementation of the programme. Senior managers need to regularly participate in and sponsor OnBoarding events as a part of the New Employee Orientation or Lunch and Learns to demonstrate the importance of OnBoarding and their commitment to it.

The process requires that all stakeholders play an active role in the process. The OnBoarding programme has 4 key stakeholders: the new hire, the peer sponsor, the hiring manager and human resources. Each has a set of responsibilities to accomplish in the OnBoarding process.

Another important part of the program is the concept of colleague affiliation. The OnBoarding Program is designed to encourage new employees to meet each other and forge relationships. Participants have several opportunities to connect with other new hires including the one day New Employee Orientation programme and at the regularly scheduled learning sessions held over the first twelve to eighteen months of the new employee's tenure. The modular learning sessions take place in synchronous on-line classrooms and new hires participate from their countries of operation.

Save the Children is beginning to see how the programme achieves improvement in: reduced turnover; reduced hiring costs; quickened internalization of cultural attributes; standardized content and process; enhanced new hire's navigation of the organisation; and, accelerated contribution of new staff to the organisation.

Key observations

Organisations that undertake psychological screening found them very useful. Rarely, were staff asked to delay their assignment or take a different assignment. After a period of support (i.e. private counselling through bereavement, depression, drug and alcohol rehabilitation) the organisation and staff person felt much more comfortable about working in the high pressure environment.

The main dilemma facing psychological screening is one of confidentiality and discrimination. Some organisations believe that mental health or illness should not factor into a staff person's ability to work abroad. Or, if there is an issue of mental illness (past or present), there is no mechanism in place to determine its severity in relation to the job description.

Another challenge that organisations noted is the length of time that it takes to conduct a psychological screening. It usually takes a few days to attend an appointment with the psychologist, and often, organisations are trying to deploy staff to emergencies within a couple of days.

With ongoing budget cuts, organisations reported having fewer centralized inductions this year than previous years. The high cost of airfare has convinced several organisations to decentralize inductions. It is too early to know whether there is a long-term cost-benefit from decentralizing induction processes. One respondent from an organisation that is decentralizing induction commented, "We are starting to monitor and evaluated the effectiveness of inductions of staff that are not inducted at regional or headquarter offices. There is some feeling that staff may not get a hands-on view of the organisational structures and operation if they only get inducted at the local level."

Questions for consideration

- How do organisations determine that a physical or mental condition will put a staff member at risk or inhibit the effectiveness of a programme?
- What procedures can be established to ensure timely screenings?
- What information should be confidentially shared between out-sourced psychologists and the organisation?
- How can regional or headquarter offices assess the quality of in-country inductions?
- Does your organisation use an intranet system for information dissemination and guidance of line managers?
- Does stress management and self care form part of the induction process?
- How does your organisation monitor in-country contexts/heightened risk factor? Are these risk factors taken into consideration when developing the induction process?

Chapter 3 – Summary points

The preparation to departure phase for a staff member is being re-thought and overhauled more than any other phase of the employment cycle. A wide variety of induction methods and practices exist, and more could be done to share learning.

Although standardisation of induction has become much wide spread, decentralised inductions should be monitored and evaluated to weigh its benefit.

In this research, five organisations were actively modifying their induction procedures, and three of them were currently piloting a new system.

Very few organisations use psychological screening. Scepticism and issues of confidentiality prevent some organisations from using pre-assignment screening to inform the agency on a staff person's ability to work.

The lack of confidential communication between external psychological professionals and staff members who influence staff care practice should be reviewed as an opportunity exists to improve overall staff care. The French Red Cross provides a good example of how organisations can pre-empt future problems by openly discussing areas of tension/conflict and specific hardship locations.

Chapter 4 –Ongoing Psychological Support, Crisis Support, and Peer Support Systems

Chapter summary

This chapter examines the on-going provision of psychological support, crisis support, and peer support systems in countries of operation. A brief summary of these areas is provided, followed by the data presentation and some observations and questions for consideration and ending with key messages and a summary. As we found procedures for medical provision (i.e. institutional and practitioner identification, evacuation, first aid protocols, etc…) to be well systematized, this study examines the psychological/psychiatric components of care in countries of operation. However, one case study presents a model that applies for both medical and psychological support. The peer support section is based on four organisations with robust systems and examines the models as well as key constraints.

Ongoing psychological support

"50% of field staff indicated that they did not know where to go or whom to contact to find good resources on stress and trauma support if they wanted them"

Headington Institute study in Darfur and Eastern Chad, 2007

"There can be no health without mental health"
WHO motto

Identifying and providing appropriate psychological and psychiatric support has been a major dilemma of INGOs in the recent past. The number of nationalities on INGO staff is growing, increasing the level of cultural and ethnographic complexity, and organisations are working in more and more areas that span the spectrum of health infrastructure. Some organisations have found creative ways of addressing these issues, others are searching for viable solutions, and others are satisfied with responding to psychological crisis reactively rather than preventatively.

Organisations use a variety of mechanisms in offering psychological support to their field staff. Listed below are the most common elements; most organisations a combination of these elements in their psychological care system:

1. **Employee Assistance Programmes (EAP**): EAPs are organisations that provide 24 hour telephone support (among other services) by trained counsellors. When staff call an EAP there will be no history and the conversation is confidential, with the client organisation typically receiving a summary report of activities and issues identified. Some organisations have an EAP, but the service is not available to staff based internationally, i.e. outside the country where the organisation has its HQ.
2. **Telephone and email support by out-sourced psychologists.** In some cases, email support is also offered. These are psychological professionals known to the organisation, either independently contracted or through an agency, and potentially known to the field-staff needing support. Long-term relationships make some of these mental health professionals an intricate part of the organisation's staff care. They are often more involved in the pre and post assignment phases than on-assignment phase.
3. **Out-sourced "Western-based" psychological support going to the field.** These are independently contracted psychologists or organisations offering psychological support that can go to the field when needed. They are practitioners with which organisations have regular contact and typically have an ongoing role of supporting staff.
4. **Psychological support by in-house psychological professionals.** Some organisations have in-house psychologists who can support staff by telephone phone as a first line of support and subsequently decide if a field intervention is necessary. In-house psychologists can also play the important role in: vetting in-country psychological professionals, developing appropriate referral lists, training and advising non-clinical

managers, and offering continuity for staff.

5. **In-house, field-based psychological support:** These are psychological professionals that are based in-countries of operation or regional programmes.
6. **Databases/Referral lists of qualified psychologists/counsellors:** Referrals/databases may be personal contacts known by organisation, or generic lists of practitioners across the world. Frequently, this is how many organisations identify and use out-sourced psychologists from the country or region of operation.

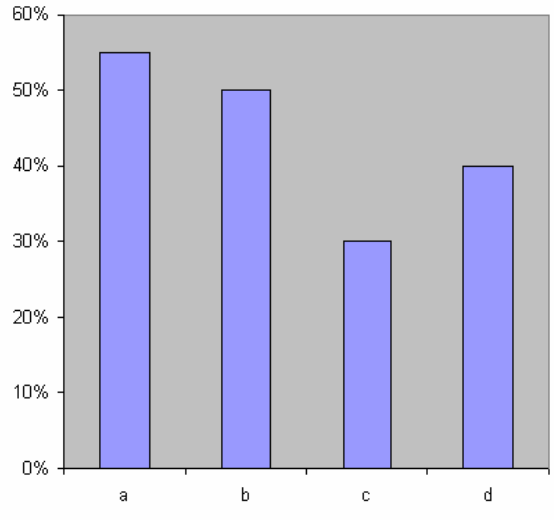
When we investigated whether every international staff member in the field had access to psychological support by a trained/professional counsellor or psychologist, we obtained some interesting results:

Note: The "Low", "Average" and "High" levels of psychological support presented below is not a value judgement of the support mechanism. Rather it presents, from least to most, the extent of support by means of: availability of professional support, number of possible interventions, and availability of both in-house and out-sourced psychological support while on-assignment.

Figure 5: Extent of Psychological Support While on Assignment

Low level of Psychological support in countries of operation (6 orgs)	Reasonable level of Psychological support in countries of operation (11 orgs)	High level of Psychological support in countries of operation (3 orgs)
➢ 6 organisations had no system for psychological support of their field staff: These organisations work on an ad hoc basis. Some of them offer non-clinical telephone support (i.e. there desk officer or HR manager). Some replied, "We have medical insurance if the need arises" but had no implementation plan for receiving psychological support for their staff while on assignment.	➢ 3 organisations use a non-EAP outsourced psychological support telephone line; ➢ 2 organisations use an EAP as their sole source of psychological support; ➢ 2 organisation use in-house psychological telephone support (able to go to the field) **+** database/referral system; ➢ 2 organisations use an EAP **+** outsourced psychological telephone support (not able to go to the field) **+** a database/referral system; ➢ 1 organisation uses an EAP **+** a database/referral system; ➢ 1 organisation uses an EAP **+** in-house psychological telephone support (able to go to the field) **+** database/referral system	➢ 1 organisation uses out-sourced psychological telephone support **+** in-house psychological telephone support (able to go to the field) **+** out-sourced psychologists (able to go to the field); ➢ 1 organisation uses out-sourced telephone support **+** out-sourced psychologist (able to go to the field) **+** in-house psychological telephone support (able to go to the field) **+** database/referrals; ➢ 1 organisation uses an in-house psychologists and counsellors based in the field **+** in-house telephone support **+** database/referral system

Figure 6: In-house / Outsource statistical summary



a.) 55% of organisations have no system or contingency plan for staff to receive face-to-face psychological support (5 use clinical phone support, 6 have offer ad hoc support)
b.) 50% of organisations have an EAP. Of that 50%, 30% use an EAP as a source of psychological support for staff based abroad.
c.) 30% of organisations have in-house psychological professionals
d.) 40% of organisations have developed a referral list of qualified professionals or use a number of different generic databases.

Case study - In-house tracking of psychological and physical wellbeing

At the consent of the staff member, some organisations request medical and psychological records (or self-reported medical/psychological questionnaire) be made available to one team member in-country, so that they are able to make regular follow ups. Organisations have long-since used standards and lists of clearly defined medical conditions that must be disclosed to work abroad, yet no such standards exist for psychological illnesses. One organisation interviewed uses a "Medical Coordinator" to support and monitor medical or psychological issues among staff in the field. The Medical Coordinators are based at the country offices and, with consent, communicate pertinent medical or psychological issues to in-house doctors on field teams. The doctors are primarily implementing programmes with beneficiaries, but remain available for needs that surface within field staff. Each international field staff member completes a self-reported medical form that indicates a number of medical and psychological conditions. The field based doctors are the "go-to" people for medical or psychological complaints in the field. If the staff member is uncomfortable discussing psychological issues with the doctor in their programme, they are encouraged to call the psychologist at their regional office or headquarters, or request external psychological support.

Referrals

Using existing referral lists combined with personal relationships and past experiences of working with specific practitioners or institutions can assist in the ongoing, confidential support to staff, and provide expedited and cost effective ways of mitigating incidents of crisis. The following were identified as key referral mechanisms:

- **Personal contacts** can be developed by in-country team and in-house psychological staff persons when in-country
- **CARD Directory** (Counsellors Assisting Relief and Development by the Headington Institute)
- **In-country research**: This includes developing a system for feedback and vetting from in-house or out-sourced psychological professionals or specialized institutions.
- **Home country embassy referral lists**
- **ICISF:** International Critical Incident Stress Foundation
- **ISTSS:** International Society for Traumatic Stress Studies
- **ESTSS:** European Society for Traumatic Stress Studies
- **Humanitarian Aid networks** (see above)

CASE STUDY

UNICEF: Field-based psychological support

Due to the high stress contexts of many UNICEF staff, a comprehensive system of field-based psychological support ensures that staff have access to internal and external professionals for preventing and mitigating psychological distress on assignment.

UNICEF has a multifaceted system by which staff in the field can access professional psychological support.

Global Staff Counsellor: UNICEF has a Global Staff Counsellor who is available for email and phone consultations and face-to-face counselling when in-country. Additionally, all staff have access to an international EAP.

UN Counsellors: UNICEF links with a global network of other UN agency Counsellors to cover the needs of psychological support to national and international staff. For example, the UNHCR and WFP each have 6 full-time counsellors, and every country with a UN Peacekeeping mission has at least one trained mental health professional who may, on request, be made available for specific psychological issues across all UN agencies. UNICEF also uses local counsellors through the agency-wide Critical Incident Stress Intervention Cells. The Intervention Cells are comprised of in-country professionals who are hired on a contract basis to support staff. Some are contracted on a full-time basis, while the majority are contracted between 30-50% of their time. Each of these mental health practitioners are vetted through the UNDSS (Department of Safety and Security in New York) by reviewing qualifications and credentials and phone interviews. The UNDSS then liaises with the in-country Security Management Team and advises on practitioner and institutional selection. This level of support is particularly useful in high stress, yet secure contexts that do not have UN Peacekeeping missions. The UNDSS has a Staff Counselling Unit that provides technical supervision to the in-country professionals when appropriate. There are around 85 professional counsellors in the UN system globally that can be accessed by UNICEF staff when needed. The UN counsellors have annual meetings to network, share experiences, tools, and much needed support.

Referral system: UNICEF has also identified a large number of private counsellors at the local level. UNICEF staff members, and their direct dependants who require ongoing professional psychological support, are provided with the contact details of these counsellors, where available. UNICEF's medical insurance covers the majority of the cost of consultation with these professionals, with an additional co-pay covered by the staff member.

As seen below, UNICEF also utilizes a robust peer helper methodology to support staff on an informal basis as well as provide crucial support during crisis. Through a combination of internal, external and informal psychological support, UNICEF has found that staff report feeling well-supported in the field. This comprehensive system is the result of coordination across the UN agencies both in the field and at headquarters, and the requirement for all country operations to identify qualified practitioners.

Psychological First Aid (PFA)

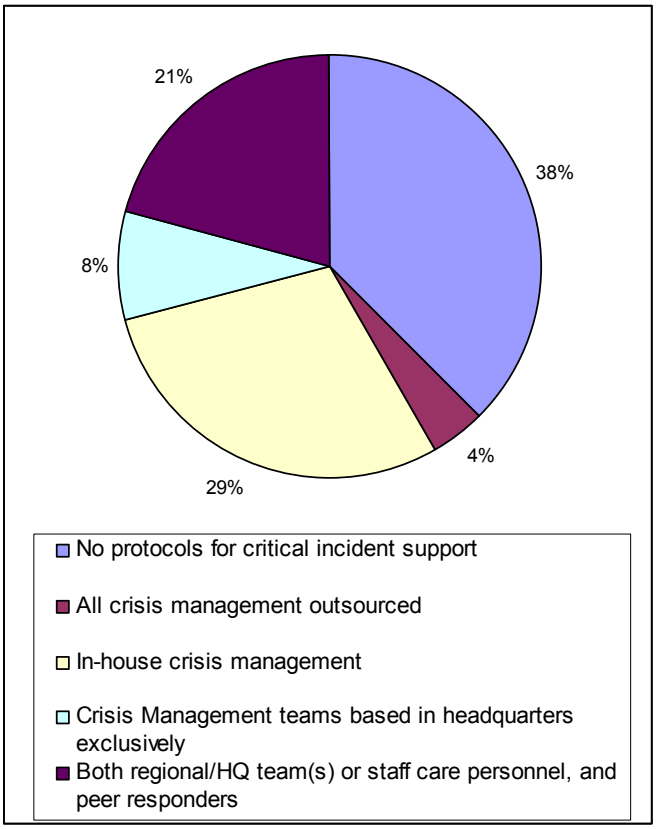
"Most individuals experiencing acute mental distress following exposure to extremely stressful events are best supported without medication. All aid workers, and especially health workers, should be able to provide very basic psychological first aid (PFA). PFA is often mistakenly seen as a clinical or emergency psychiatric intervention. Rather, it is a description of a humane, supportive response to a fellow human being who is suffering and who may need support." IASC guidelines on MHPSS in complex emergencies, section 6.1.

The question on psychological response to an emergency elicited a diverse range of responses. Very few trends can be seen with respect to standard models of crisis management. "It depends on the type of crisis" was a common response. While some organisations had protocols and definitions on the appropriate response to various types of critical incidents/emergencies, many organisations operated on an *ad hoc* basis.

We asked whether organisations offered Psychological First Aid (PFA) for international staff in the aftermath of crisis, and if so, who provided it.[4]

[4] It is beyond the scope of this study to review or assess the various approaches to psychological response to crisis incidents. While there is contention about models of care, there is consensus that untrained or poorly trained lay people should not inquire into traumatic events, the action taken, thoughts or feelings about the traumatic event, and that crisis response models must be trained by a certified trainer, not as a ToT.

Figure 7: Crisis Management Mechanism



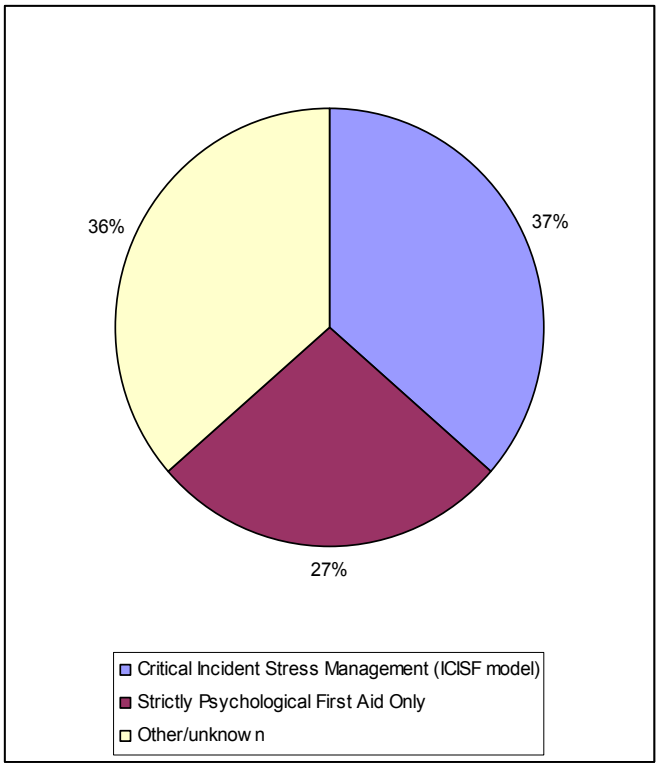
- No protocols for critical incident support[5]: 9
- All crisis management outsourced: 1
- In-house crisis management[6]: 7
- Crisis Management teams based in headquarters exclusively: 2 (one with 7 members, one with 6.)
- Both regional/HQ team(s) or staff care personnel, and peer responders: 5
- Both in-house and out-sourced crisis management[7]: 3

[5] These are organisations that either: have no crisis management protocols, are limited to phone contact with HR, or have mention of crisis management in orientation.

[6] These consist of crisis management teams who have been trained by the organisation and are on-call, or fulltime staff, as well as in-country a peer supporters and emergency responders. Additionally, the in-house component of the crisis management is limited to the initial contact. All peer teams are trained to make referrals to external psychological support when the need has been identified.

[7] This refers to organisations that use their own staff to respond to a crisis event, as well as external organisations and/or consultants. Organisations are not included in this section if they use other organisations exclusively for the training, without a responding component.

Figure 8: Models of Crisis Management



- Critical Incident Stress Management (ICISF model): 4
- Strictly Psychological First Aid Only: 3
- Other/unknown: 4

Outsourcing emergency response can be problematic in that entry clearance for foreigners is difficult to obtain on short notice. It is preferable for in-country peer support put the protocol into action, *provided they have not been affected by the critical incident*, begin the process of psychological first aid, and make referrals while waiting for consultation and further support.

Peer support mechanisms

Over the last few years, peer support mechanisms have grown in their popularity due to proximity to staff needing support, collegiate/informal status with other team members, and potential for preventing chronic and acute post-crisis distress. The advent of the interactive web (Web 2.0) provides opportunities for aid workers to connect with colleagues and there are a number of vibrant online communities (for example aidworkers.net and EPN Online / epn.peopleinaid.org) fulfilling a partial peer support role.

In addition, the peer support networks for psychologists and staff care professionals have also strengthened over the last 3 -4 years, and communities such as 'Helpers' Fire' provide invaluable peer support.

And finally, a number of the federated organisations featured in this research have been able to introduce buddy or peer support systems in response to the challenging working environment and significant operating pressures.

"Peer Helpers are a first line of support. They are proactive in going to colleagues who need to 'vent', or simply show that they care. This contact with a supportive colleague is enough to boost their natural coping mechanisms and prevent the development of a stress disorder."

Organisations with Robust Peer Support Systems

CARE-USA: CARE's Peer Social Support Team (PSST) was developed in 2007 to increase social support to help staff cope with the stresses of life. The team, which now consists of approximately 80 Social Support Advisors (SSAs), is in 13 countries in Anglophone Africa and Asia. SSAs have received training in listening skills, stress and coping strategies, developing referral networks, and in CARE's Critical Incident Protocol. Each SSA devotes an average of three hours per week towards PSST activities outlined in an action plan relevant to their location and context. One agreed upon indicator for the PSST M&E framework is to develop an in-country staff wellness policy for all countries with a PSST.

UNICEF: UNICEF's Global Staff Counsellor has trained over 200 Peer Helpers, based in 88 countries. The initial 5-day training covers a broad range of topics including: recognizing mental distress, listening and communication skills, empathy, being pro-active in identifying colleagues who need additional support, psychological first aid, stress management, as well as an introduction to the impact of trauma and bereavement.

Peer Helpers receive an advanced level training one year after the initial training. The advanced training is an opportunity for Peer Helpers to refresh their knowledge and share their experience as a Peer Helper and includes additional training modules such as HIV in the workplace. The Global Staff Counsellor facilitates the advanced level workshop and technical supervision and advice is provided with respect to common dilemmas faced by the Peer Helpers and the staff they support. The Peer Helpers are mandated to create a referral list of professional mental health practitioners in their area, so they can be prepared to refer when encountering serious cases. Peer Helpers are sent a standardized form which the selected professionals must complete and UNICEF maintains a database of appropriate practitioners in each location. Peer Helper duties require an average of 2 hours per week time commitment. UNICEF coordinates their Peer Helper programme with that of other UN Agencies, and their training programme was drawn from the experiences of other Agencies, particularly that of WFP.

Organisations with Robust Peer Support Systems

World Vision International (WVI): 90 Peer Supporters, working in 50 countries, are trained in Critical Incident Stress Management (International Critical Incident Stress Foundation model), Stress Management Education, and Appreciative Inquiry. WVI uses two in-house psychological professionals and the Staff Wellbeing Manager to train the "CISM (Critical Incident Stress Management) Peer Supporters" quarterly, in one of 4 regional locations. Each training has an average of 15 WVI staff members in attendance. "Culture, Language, and Context Matters", as WVI's Director of Staff Care says. The assessment technique used for community-based programme design (i.e. participatory appraisal and appreciate inquiry) is the same model that WVI uses in determining new areas of intervention for staff care. In addition to CISM Peer Supporters, the Global Rapid Response Team (GRRT) members of WVI use a "buddy" system whereby HR members maintain regular phone contact with the GRRT members on and off assignment.

SAVE-USA Has trained 50 field staff in a comprehensive staff wellness training. Twenty of them have received an intensive 12 day certification course (with the Antares Foundation) in psychological support, including training in PFA, debriefing, referrals, and assessment processes. After the training, the Antares Foundation worked with the trainees to co-develop a year long work plan consisting of several key activities such as conducting workshops, designing referral systems, and holding 360 peer reviews. All 50 involved in the staff wellness training return to their field site and are developing "staff wellness strategies" for their country programmes. The strategic document will include areas where the national offices need to build the capacity for staff support and subsequent trainings/consultancies will be offered in those areas.

All of these organisations with significant peer support programmes warn that these systems cannot be adopted haphazardly. Providing peer support, especially during post-incident management, requires a high degree of sensitivity, competence and commitment. Listed below are a summary of some key considerations in establishing a peer support system:

Key considerations when establishing a peer support system

- Good selection criteria is crucial. "Sometimes managers send the only person available to attend a five-day training rather than carefully considering the most appropriate individual." (UNICEF is willing to share guidelines on selecting the peer helper)
- The model of peer support in the aftermath of a crisis incident should not be implemented as a training of trainers, and only well-trained supporters, using specific protocols, should endeavour to intervene in post-incident interventions.
- At the regional or HQ level, there should be an in-house counsellor/psychologist to oversee the programme.
- The in-house counsellor/psychologist should conduct all peer support trainings. This fosters a sense of continuity and builds a strong team of Helpers
- The involvement of the in-country management team is essential. Without buy-in from the management, the system will likely fail.
- In the past, peer support has been seen as an add-on. Now, the tasks of a peer supporter should be written into job description or annual operating plan.
- Work colleagues should be made aware of the peer support process, its usefulness, and its limitations.

"A decision to use Peer Helpers must be taken seriously, it is not easy and I have seen it fail in many situations due to a lack of commitment and poor understanding on the side of managers in knowing how much a Peer Helper can offer."

Staff Care Specialist

"Country office management, including the country manager, has to be supportive and must to be involved and be aware of how the system works. This has traditionally been an add-on to the staff incredibility busy schedule, so it should be written into their job description or annual operating plan. Also, buy-in from other staff is essential to the success of the system."

Senior HR advisor

Organisations that train in post-incident management: Antares Foundation (Australia/Holland), People In Aid (UK), Centre for Humanitarian Psychology (Switzerland), Trauma Risk Management-TRiM, March on Stress (UK), ICISF (USA) RedR UK (UK), Centre for Trauma Psychology (Norway), Eastern Mennonite University and The KonTerra Group (USA)

Key observations

Respondents highlighted the importance of staff having more than one option available to them when it comes to their psychological wellbeing. Some may choose to talk with an internal person in the field or someone at the regional or headquarters office, while others choose to talk with an external person, either in country or in their home country. The notion of "they [psychologists] can't relate" surfaced several times, but from different perspectives. Some respondents criticized the notion of receiving psychological support from someone in their home country, while others maintained that even if psychological professionals existed in the country of operation, they may not offer appropriate/culturally sensitive support. There is a general consensus that psychological support should come from someone who has experience in the field of humanitarian support.

The usefulness of EAPs is heavily debated: some organisations are pleased that 24/7, confidential support is available and it is clearly used by staff, while others believe that an EAP cannot truly relate with international staff:

"The EAP isn't really effective for the international staff in the field. EAPs are geared for the USA. So you're talking to someone in Iowa who doesn't even know where Burundi is, and can't really relate to them. You're alone,

you're in a foreign country, you miss your family, you're dealing with starving people….they just don't get it."

Several organisations indicated that "pin-pointing" areas that were entrenched with interpersonal conflict or high levels of distress and offering regular external support to individuals and the team has been tremendously helpful in re-developing team cohesion and individual wellbeing.

Mini-Case study:
One organisation uses an external local psychologist in specific countries of operation where high levels of stress are common. As part of the in-country orientation, all new staff persons meet with the psychologist for an intake interview. This is an informal meeting when the psychologist gets to know the staff person and sets the foundation for future sessions, if needed. This provides an opportunity for the incoming staff to talk about any psychological history and potential issues that may arise while on assignment. The psychologist remains available for phone or face-to-face sessions in case a situation arises where the staff member needs additional support. The psychologist also provides an exit interview/debriefing at the end of the assignment. This is all kept confidential. Often, psychologists are willing to charge minimal, charity rates, for these procedures, and the organisation has found it cost-effective in preventing psychological deterioration.

Insurance companies also play a role in the psychological support of aid workers. One organisation is currently investigating a practice of the corporate sector in using medical insurance companies that provide lists of pre-qualified institutions and practitioners to corporations with high percentages of international staff. The organisations interviewed reported a wide range of psychological coverage from 4, to 6, to 16, to 30 counselling sessions per year. One organisation said that their insurance company covered all costs for response to a critical incident stress, including airfare and accommodation for three specialists.

Several organisations reported the dilemma of not knowing what constitutes a "critical incident". Team managers respond differently to crisis events, and regional/headquarter psychological professionals have found it useful to contact each of the team members involved in the event to get an in-depth understand of the impact of the event on different team members.

Questions for Consideration

- Has your organisation considered coordinating or collaborating with other organisations where pooled resources can provide regional psychological or medical support or training for staff on assignment? (e.g. staff care could be assigned to a UN cluster and willing organisations could contribute)
- Has your organisation defined the types of medical or psychological issues that require monitoring in the field?
- Should organisations with databases of qualified practitioners send their names and qualifications to an overarching/existing database?
- How does your organisation track trends in the field that influence staff care needs (security, team dynamics/conflict, availability of psychosocial and/or medical support, etc…)
- Should your organisation extend the EAP service to international staff, or is its usefulness limited to US/UK based office staff?
- Should your organisation use focal people in-country who can (with consent of the staff) monitor the medical or psychological?

Chapter 4 - Summary points

More than half of the organisations we interviewed had no provision or contingency for face-to-face psychological support in the field.

There is an extremely wide range of practice for field-based psychological support and it is inconsistent across the sector. The rapid changes in field-based staff support indicate that the sector is moving from a reactive, ad hoc, stance to one of preparedness and prevention.

Using a database or developing a referral list of pre-qualified practitioners has minimal costs and maximum benefit in times of urgent psychological support. Advantages include socio-cultural understanding of the context and confidentiality.

Almost half of the organisations interviewed do not have a staff care protocol in place in the event of a critical incident. Additionally, while this research did not inquire specifically into on-going medical support, organisations often commented the medical evacuation protocols are regularly reviewed and clear while psychological evacuation procedures tend to be ad hoc.

For most organisations, it is unclear as to what events constitute a "Critical Incident". Subsequently, protocols have not been developed for specific categories of incidents. Peer supports can play a vital role in the wellbeing of field-based staff, but the design of a peer support system should be carefully thought through.

Many organisations have creatively developed formal and informal mechanisms for on-going/chronic and critical incident psychological support for international staff in countries of operation. **Of the organisations interviewed, however, it is clear that the on-assignment phase of a staff person's lifespan is the most inconsistent.** Finding viable solutions to address psychological distress in this diverse workforce remains a challenge. Many opportunities exist to network/coordinate, collaborate, and share costs of staff care that would provide more than one option to any staff person seeking support.

Chapter 5 – Medical Checks and Psychological Debriefing Post-assignment

Chapter summary

This chapter examines the processes for post-assignment medical checks and psychological debriefing. It outlines some issues relating to re-entry, presents some observations and questions for consideration, and concludes with the key messages and a summary. A number of case studies are included in this section, illustrating good or noteworthy practices.

Post–assignment medical checks

People In Aid Code: Principle 7, indicator 7

"At the end of a contract or assignment, all staff should have health checks, personal counselling and career advice."

Post-assignment medical checks are considered to be minimum standard and a good practice. Post-assignment medicals allow organisations to determine if a staff person has contracted any diseases that will need long-term support, as well as discern medical issues that existed prior to the assignment.

When we asked, 'Does your organisation offer a post-assignment medical check up through a specialist travel clinic?' we found that 55% of organisations require or strongly encourage a medical check-up/screening during the post-assignment period. Some organisations require staff to sign a waiver should they choose to opt-out of receiving a medical check-up, while others absolutely insisted that every staff person receive a medical. We found that 9 organisations had established relationships with travel health clinics that provide tropical screenings.

However, 45% of organisations do not have a specific procedure in place for a post-assignment medical, with respondents adding that it was not a standard procedure or necessarily recommended. Three of these organisations knew of an appropriate travel clinic while the rest leave the identification of a clinic to the returned staff. One organisation said that no medical check-up was available, and another said that the staff could get transitional insurance (i.e. Cobra). In most cases, returning staff have medical insurance for a period of time post-assignment (1-3 months), which several organisations deemed sufficient.

CASE STUDY

Tearfund: Mandatory post-assignment medical and Opt-out policy for psychological debriefing

Tearfund requires all returning field-based staff to attend a returner's medical check-up at a pre-approved travel health clinic and has an opt-out policy for a post-assignment psychological debriefing with one of three psychologists or three professional counsellors: all of whom have received additional training by Tearfund to provide an appropriate debriefing experience.

Tearfund's psychological debriefing began as critical incident stress group debriefing but soon developed into individual debriefing for all emergency personnel. A Tearfund manager says, "It became a normal end-of-assignment protocol for our relief teams, developing it as an opt-out model rather than an opt-in one, so that it became accepted as a normal post-assignment appointment rather than pinpointing anyone as 'needing a debrief'." Because staff must sign a disclaimer should they choose not to receive the debriefing, the opt-out policy encourages staff to receive a psychological check-up. The procedure also provides legal protection if psychological issues present after staff have left the organisation.

Tearfund subsequently decided to offer the post-assignment psychological debriefing to non-relief international staff and frequent travellers based in London, due to the inherent challenges and accumulative stress that all workers encounter. "We felt that staff would benefit from this type of individual and confidential support whether or not they felt, or others perceived them as being 'high risk'. Staff share valuable insight on the positive and challenging aspects of their assignment. This insight needs to be woven back into the fabric of the organisation so that it can adapt and grow."

Tearfund has found that almost all eligible staff (approximately 90%) voluntarily attend a post assignment psychological debriefing. They have created a culture that acknowledges the inherent stress of aid work. Currently, a small number of international staff are debriefed in Nairobi and Tearfund is in the process of identifying and working with psychologists and doctors in Nairobi who can offer services in line with those provided in London. Finding high quality medical and psychological services for staff that do not return through regional or headquarter offices was identified as a challenge for several organisations.

Post-assignment psychological review

The intense stressors of work in the humanitarian and development sector mentioned in the introduction have a taxing effect on aid workers. While responses to stress vary from one staff person to the next, a psychological review provides an opportunity to process the assignment (and perhaps vent a little, if required), whether the stressors were internal team issues, external contextual issues or both.

Re-entry

The process of re-entry can be so disorienting for staff returning to their home country, that many have adopted the term "re-entry syndrome" or "reverse culture shock". While extensive measures are taken to prepare staff to enter an extremely different context upon deployment, much less is done to prepare staff for coming home—an experience that may feel equally or even more shocking as entering the country of operation. As friends and family may not be able to identify with the staff person's experience or understand their motivations, returning home may feel isolating unless support can be offered by someone who can help the staff person navigate the common pitfalls of re-entry. Returned staff feel the loss of friends and colleagues and may also feel guilty for leaving them behind. Often times, feelings of disillusionment and hopelessness overwhelm a newly returned staff person and organisations risk losing valuable staff without providing opportunities for review.

Post-assignment psychological review sessions present opportunities for the organisation to receive feedback on ways of improving support to staff throughout the span of their assignment. Organisations can plan and prevent on-going or future problems by listening to those who have just returned from assignment.

In other literature, this process may be called a "debriefing". People In Aid have described several types of debriefing including: operational debriefing, personal debriefing, technical debriefing and the exit interview. In this study, the term psychological review is most similar to "Personal debriefing", which has been described as "asking how the experience was for the individual (high points/low points/readjustment). [Personal debriefing aims to help them integrate experience into their life as a whole, perceive the experience more meaningfully and bring a sense of closure." (People In Aid, 2004). In this study, however, we asked whether a psychological professional was involved in the psychological review.

"Staff members should obtain an overall health check-up, including a stress review and assessment"

IASC guidelines

The Antares Foundation recommends that all staff have access to a personal stress assessment, by someone not associated with human resource management within the agency.

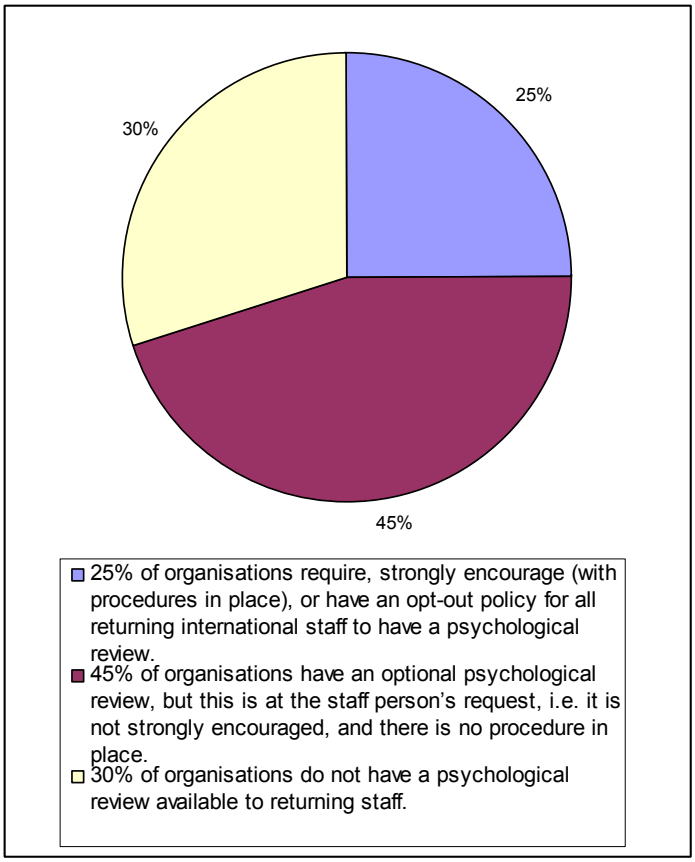
"In 1992 McConnan found that 72% of aid workers reported feeling inadequately debriefed and supported on their return, while in 2003 Foyle found that 43% reported that debriefing was inadequate."

(People in Aid 'Information Note': Effective Debriefing, 2004)

In response to our question, 'Does your organisation offer a post-assignment psychological review or counselling session by a trained mental health practitioner?'[8], we found that:

[8] This question does not refer to general exit-interviews, critical incident debriefing, technical debriefings, or operational debriefing. This psychological review is akin to a personal debriefing, it is confidential, and is conducted by a professional psychologist or counsellor.

Figure 10: Extent of Psychological Reviews



25% of organisations require, strongly encourage (with procedures in place), or have an opt-out policy for all returning international staff to have a psychological review.

45% of organisations have an *optional* psychological review, but this is at the staff person's request, i.e. it is not strongly encouraged, and there is no procedure in place.

30% of organisations do not have a psychological review available to returning staff.

CASE STUDY

Medecins Sans Frontières-UK: Returners' Talk and Volunteer Link

MSF-UK has between 180 and 200 International staff returning from areas of acute crisis annually. There are formal and informal opportunities for returning staff to talk about their experience in the field and decide whether additional support is needed.

At the end of their assignment, each staff member is required to return through one of 5 Operational Centres for a "returners' talk", offered by a qualified psychological practitioner who understands the specific pressures of working in unstable environments. Each of the 19 offices worldwide feed into the operational centres. In rare cases where field staff do not pass through an operational centre, MSF-UK uses a consultant psychotherapist to ensure that all staff have received the returners' talk. The consultant psychotherapist is also available for confidential sessions for returning staff when the staff person requests clinical counselling.

When the worker returns to the UK, they receive a debriefing/exit interview in the office and are subsequently followed up through a system called "Volunteer Link". This system includes a Volunteer Link Coordinator and ten Volunteer Link Representatives. All of the Representatives have previously worked with MSF and are selected by the Coordinator for their sensitivity to the emotional needs of returning staff. The Volunteer Link Coordinator is a staff member of MSF that arranges for all returned workers to receive a telephone call from a Representative six to eight weeks after return. The Representatives are not clinical but receive training by the Volunteer Link Coordinator and the consultant psychotherapist in supporting returning staff.

A senior HR manager said, "In terms of psychological health, the availability of an external and confidential follow-up phone call by Volunteer Link is one of the most helpful practices. Initiating conversation with the returning staff gives them an opportunity to talk about the re-entry experience and provides an avenue for professional psychological support though referral to a psychologist that they may not pursue otherwise".

CASE STUDY

Mennonite Central Committee: Debriefing and Re-entry Retreat

The Mennonite Central Committee believes that a thorough post-assignment experience is crucial in ensuring that staff continue into their next assignment or leave the organisation healthy. Medical and psychological check-ups and debriefings are strongly encouraged, yet most importantly are the "relationship-oriented" procedures for moving on.

Debriefing at headquarters: All staff are strongly encouraged to return through regional or headquarter offices. Debriefing involves several opportunities for returning workers to tell their stories and receive appreciation. Opportunities for storytelling and asking questions are created through a series of short meetings with various departments, the area desk, and brown bag lunches. Identifying workers who need additional psychological support, devising financial interventions, career counselling, and strengthening the alumni network are all key elements of the post-assignment procedure.

Re-entry retreat: MCC has three re-entry retreats annually and encourages all returning staff to attend the four-day "decompression and processing experience" with fellow returning staff. Guided by MCC's in-house staff care worker and at least one psychologist, workers are encouraged to talk about their experiences abroad. "This sets a standard for understanding a normal process that people go through, it may raise some issues that need follow up, and it heightens people's awareness about their own process, and helps them feel less isolated" (MCC staff care specialist). The psychologist leads returning staff through a guided release of experiences that may be burdening the staff and helps them gain understanding and perspective in reflecting on their assignment. It is seen by MCC as a process that re-commissions workers for their next job.

"We have found that a thorough re-entry experience is incredibly valuable, both for *our* learning *and* for the returning staff."

Key observations

There was no clear sense from organisations whether the post-assignment medical was given high priority or simply fulfilling a duty-of-care checklist. Organisations either went out of their way to encourage the medical checks (i.e. scheduling the medical during exit-interviews, providing information on tropical screening clinics and procedures for making an appointment, signing a disclaimer if they chose not to have a medical) while other organisations may have medical insurance to cover costs, but opportunities to raise awareness or encourage staff to see a doctor do not exist. Organisations that strongly encouraged post-assignment medicals reported high levels of uptake, while others said that it was too difficult to make any practice mandatory post-contract.

Many organisations require a medical check-up before the assignment and after the assignment to ensure the wellbeing of their staff, as well as for liability reasons. With pre and post check-ups, organisations can clearly identify medical issues that existed prior to deployment and medical issues that arose during assignment.

Some organisations bring all international workers through a central location, conduct exit interviews, meet with pertinent departments, attend a mandatory tropical health screening, and a mandatory psychological review, while other organisations lose contact with the staff after they leave the field; no follow-up support is provided.

The legal perspective

Increasingly, organisational policy is taking into account the risk, or potential risk, of litigation from returning staff. We did not explore this in detail in this research, but are aware that there is a trend towards insisting on a comprehensive debriefing process as part of a due-diligence process, primarily as a response to several significant insurance claims from ex- staff who believed they were not adequately or properly supported by their INGO employer. Clearly there are moral and legal obligations when it comes to post-assignment responsibilities, and these responsibilities extend back to the planning, recruitment and induction stage of employment as well. This is a topic we will return to at another time.

Questions for consideration

- At what point does your organisation require a post-assignment medical or psychological check-up? Does the decision consider duration and threat level of the assignment?

- Is there a mechanism for confidentially feeding back information from the medicals or psychological reviews that could assist in designing staff care plans? For example:
  - 30% of workers returning from country “A” have bilharzia, what can your organisation do to educate staff on avoiding the disease? Or
  - 60% of staff returning from country “B” report poor boundaries in work/life balance.

- Is there something about the management culture or modelled behaviour in your organisation that fosters a workaholic culture?

- What are the advantages of using a staff person’s general practitioner versus a travel clinic offering tropical screening?

- If your organisation requires medicals or psychological reviews, have you evaluated the procedures? Does your policy impact worker satisfaction levels, or improve retention, or future employment prospects?

- How can de-centralized organisations ensure that staff have a thorough “re-entry” experience if they do not return through an office that organises post-assignment staff care interventions (debriefing, medical, psychological, retreats, etc…)?

- Should a different set of post-assignment procedures be in place to care for “career aid workers” vs. the large number of entry-level workers or volunteers who engage in a short

"exposure" assignments with no plan of long-term investment in the sector?

- What additional procedures should be in place to support staff returning from a critical incident, evacuation, or other pre-mature termination?

Chapter 5 – Summary points

Just over half of the organisations have a standard procedure for staff to receive a medical check-up at a travel clinic/hospital and one-quarter require a post-assignment psychological review or debriefing upon return.

Organisations that strongly encouraged staff to receive a medical or psychological review had high levels of uptake.

The end of an assignment or contract period is an ideal time for staff members to "take stock" of their physical and psychological state. Tropical screenings at travel clinics identify diseases or parasites contracted in the field, and psychological reviews enable staff to process their experience, receive advice on dealing with reverse culture shock, learn and give meaning to their time abroad, as well as prepare for the next assignment.

Our findings suggest that many organisations believe that their responsibility for staff care ends with the end of the contract. However, recent litigation suggests that the responsibility may extend a little further. Setting up a system, such as the "Volunteer Link" provides an opportunity for staff to be followed-up in an informal way, helps identify when additional support is needed, and assists in the staff member's re-entry.

Post-assignment staff care is the weakest phase during the employee's life cycle. We found that organisations often do not have procedures in place to ensure the healthy exit of staff, as they transit through new country programme offices or leave the organisation. High percentages of staff do not pass through regional or headquarter offices and return to countries where health services are neither readily accessible or available.

Chapter 6 - Resourcing Staff Care

Chapter summary

This chapter highlights the major issues related to resourcing staff care, namely funding, and highlights the challenge of demonstrating 'return on investment' as well as questions that need to be addressed before staff care programming becomes mainstream and widely accepted.

Funding

When we asked, 'Does you organisation have a designated funding scheme for staff care', we found that: **40% of organisations have a designated funding scheme for staff care.**

"The availability of funding and other resources for staff care support services" was a key issue identified by field based staff in the Headington Institute's study in Darfur and E. Chad. And our discussions with staff care specialists suggested that funding for staff care is still an issue.

"Convincing senior management that investing in staff care initiatives is a cost-effective business practice continues to be a challenge for most organisations". Sharon Forrence, 2008"

Monday Developments

Funding for staff care is essentially derived in two ways: either as one-off stand alone funding, usually for a specific initiative or staff care programme, or alternatively it is integrated within programme budgets on an ongoing basis and considered a running cost. The second method is common in a country or region where an institutional donor has recognised a need, or the agency themselves has recognised the need. The first method was more common in the immediate period following the south Asian Tsunami of December 2006.

Whichever way staff care funding is derived, unlocking the investment or ongoing budgets required still appears to be a major challenge. Funding clearly impacts whether or not a staff care post even exists, and in the relatively few organisations which employ one or more dedicated staff care specialists, they themselves often struggle to convince senior management of the necessity for adequate staff care funding. Donors have also been known on occasion to push the issue back to organisations for them to decide an appropriate level of staff care. One respondent said, "our budgets are bare-bones after being reviewed by donors. There's usually no space for staff care." Some exceptions among the donor community have been noteworthy, though it could be argued that this is due to the individuals concerned rather than a donor policy: "Staff care is one of our top priorities. The best thing we can provide our beneficiaries are our relief workers." (Ky Luu, Director of OFDA, during his speech at Helpers Fire II)

When staff care is funded by integrating the costs with planned programme expenditure, it is typically done so by adding a modest percentage to the staff cost, in a similar way to which a training budget is typically calculated, i.e. a percentage of payroll. That way a certain percentage of salary goes into an accrual account that is set aside specifically for staff care. Organisations that do this often designated various components of their staff care and gave it different labels. Some organisations put all staff care funding into the same pot, while others calculate specific amounts for out-source medical and psychological professionals.

Whatever the method adopted though, resourcing remains a key constraint in the provision of staff care. In the current economic climate, staff care faces the very real risk of being cut-back. Organisations are introducing new ways of offering more cost-effective staff care by using different models (i.e. in-country inductions only, in-country post-assignment debriefing, outsourced medical support). However, other organisations face very real dilemmas: "With the current financial climate challenging the need for staff to transit via the UK, we are struggling to know how we can best continue and expand debriefing in formats other than face to face."

Return on investment

Calculating a return on investment is not straightforward, and each agency will have different sums to process.
"Ultimately, the calculus is simple: Any money saved by ignoring stress in the workplace is lost tenfold in employee-

efficiency, ineffectiveness, and turnover" Joshua Levin, Mercy Corps, Monday Developments, 2008).
However, unequivocally, organisations do need to understand this return, and combine it with legal, ethical, and moral considerations which need to be taken into account.

Work is underway to demonstrate clearly the value of effective staff care programmes, but evaluation (the subject of chapter seven), and the need for cost-benefit analysis vocabulary, investment vs. expenditure calculations, is greater than ever (Helper's Fire II, Ager, 2008). We consider return on investment in chapter 7, 'Evaluating staff care', as it is clear that without the necessary evaluation proving the financial benefits of staff care, the sector will be unable to justify the expense of holistic staff care initiatives.

Key observations

Less than half of the organisations we interviewed have a designated funding scheme for staff care, meaning that many are struggling to mainstream their staff care programmes.

Donors are formulating their position on the issue with some being more proactive than others. However, sustainability in terms of staff care programming comes in the form of integrated staff care programmes, for which funding is seen as an operating cost, and therefore integrated with other programme expenditure lines.

Key questions for consideration

- What are the advantages and disadvantages of having in-country programmes cover costs of staff care interventions vs. sending designated funding for staff care from central offices?
- What new staff care issues do organisations need to deal with in the economic downturn? (One organisation is offering out-placement counselling another is offering career counselling)
- Does staff care feature in all external funding applications?
- Should staff care appear on the agenda or workplans of the Good Humanitarian Donorship Initiative? Of the 23 principles in the "Principles and Good Practice of Humanitarian Donorship", none refer to building a healthy workforce with which to implement the important activities of relief and development.
- How can macro-level humanitarian policy and practice initiatives become aware of the importance of staff care? Should staff care funding be integrated into the UN consolidated appeals processes (CAP) and common humanitarian assistance action plans (CHAPS)?
- What processes should move toward an E-learning/decentralized methodology for staff care, and what practices should be face-to-face? What are the implications for a less personalized staff care system?

Chapter 7 – Evaluating Staff Care

Chapter summary

This chapter addresses issues of monitoring and evaluating staff wellbeing and interventions aimed at enhancing staff wellbeing. Some examples are provided, and our key observations, and questions for discussion, are put forward.

A Case for Evaluation

"We don't evaluate our staff care interventions. I have recently taken notice of this issue. How do we know if we're doing a good job? We could be mucking people up as well."

Monitoring and evaluation activities facilitate learning. An evaluation process shows the strengths and weaknesses of the programme and allows organisations to make informed decisions on where to invest and where to cut. Without monitoring and evaluating staff care interventions, organisations cannot prove whether their interventions are cost beneficial or even helping the staff. Each discipline within humanitarian sector has its own, unique monitoring and evaluation system. Agencies are accountable to donors by ensuring that funds are well-placed, resulting in maximum return on investment. Participatory approaches, review meetings, audit procedures, impact assessments, outcome measures, logframes, are only a few of the methods to assess the efficacy of programmes, yet these procedures are not being applied with regards to staff care programmes.

Indicators and outcomes of a successful staff care programme are interrelated to the organisation's culture and will depend on the values and attitude towards staff wellbeing. Through participatory approaches, organisations can reach their staff care goals by consistently measuring progress and making adaptations.

When we asked whether organisations evaluated staff care, only 30% said they did.[9]

[9] Included in the 30% were organisations that reported using staff data (i.e. self-reported stress checklists, surveys, and health statistics) to inform staff care programme design. This practice is not evaluation in a strict sense, as the data was not linked to a specific intervention. In other words, this 30% includes organisations that "monitored" wellbeing. Only one organisation collected data on a specific intervention and made comparison over time.

Some examples of staff care evaluation/monitoring

One organisation has conducted a 6 year long longitudinal study evaluating their staff care programme (based on statistics of the peer supporters, surveys, and measurement according to indicator), and also examined: types of stress, reactions to stress, and reactions to different types of critical incidents.

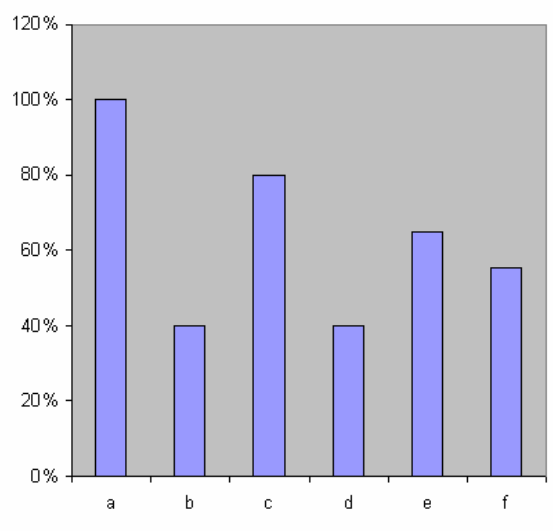
Another organisation regularly collects information on staff wellbeing as well as measures the efficacy of staff care interventions. This is done through on-line surveys, peer support data, and by the in-house psychologist who analyses various country contexts and specific interventions. Additionally, staff are sent a survey one month post-assignment to assess the re-entry experience. About 50% of staff complete the post-assignment survey. Using this information, a staff care report is developed annually.

Another organisation sends a regular wellbeing survey to all staff. The information is analysed and used to inform staff care programme design decisions. They also outsourced a staff care audit. (People In Aid and the Antares Foundation were mentioned as organisations that conduct comprehensive staff care evaluations/audits)

Collecting and tracking data

We were aware that organisations may already be collecting various data to help evaluate staff care, and we prompted this by asking them to indicate from a brief list, which data they collected:

Figure 11: Data Collected by Organisations



a.) 100% Staff turnover
b.) 40% Employee engagement (This was a problematic question as the terminology was unfamiliar to many respondents)
c.) 80% uptake of EAP-Of those organisations that used an EAP
d.) 40% of staff using any optional staff care interventions (i.e. debriefing)
e.) 65% # of Medical complaints
f.) 55% # of Psychological complaints

Key observations

Highly developed monitoring and evaluation systems have been developed across the INGO sector to capture the impact of implementation with beneficiaries. Yet, the same rigour has not been applied to the evaluation of staff care practice. In the same way that organisations must prove their effectiveness to donors with respect to outputs and impact with beneficiaries, organisations should measure the wellbeing of their staff.

Of the 30 percent listed above, only one organisation was conducting ***evaluation***, while the others were engaged in ***monitoring*** staff wellbeing. For evaluation to be effective, organisations would need a set of indicators and make comparisons of interventions across time, and ideally, across other industry sectors. While most organisations collect information on the wellbeing of their staff, it is not linked with specific interventions or measured periodically. Generally, organisations collect data through performance appraisals, job satisfaction surveys, EAP reports, exit interview questions, and anecdotal evidence.

While organisations reported high percentages of data collection, very few reported using this data to inform their staff care programme; only rarely did the information reach Human Resources or those in charge of staff care. Out-sourced medical and psychological care information is anonymised and sent to benefits or financial departments for invoicing, but many of the staff care personnel we spoke to did not appear to use this information to track the overall wellbeing of their staff. Frequency of medical or psychological referrals in the field and post-assignment can be used to identify challenging context and the appropriate extent of staff care. For example, one respondent said that they become concerned when psychological referrals climb over 5% for any particular country programme (While this statistic could indicate that more staff are aware of the value of psychological support, it could also be understood as relative to other country programmes). For organisations with fewer international staff, these figures could be reviewed bi-annually so that it is not clear who went for a session with a counsellor or psychologist.

Questions for consideration

- How can your organisation apply its knowledge of M&E to the discipline of staff care and guide investment decisions?
- What are the staff care key performance indicators (KPIs) that need tracking, how can the data be collected consistently, and how can a meaningful benchmarking process be facilitated?
- It has been posited that self care and good management ultimately contributes to an aid worker's ability to deliver high quality services in the field. How can your organisation prove that its staff care practice is doing this?
- Given that no organisation we interviewed has produced or

published research on staff care that is available to the public in the last five years, would a staff care efficacy study be useful to the sector?

- Would it be easier, or equally valuable to research the cost and impact of **inadequate** staff care, as some have done in the past, including the ODI and Headington Institute.

- Is there opportunity for staff care workers to access all types of data that inform staff wellbeing (frequency of medical or psychological complaints, % EAP uptake, turnover, engagement/satisfaction, etc…)?

Chapter 7 - Summary points

Less that one-third of organisations evaluate their staff care. Even though INGOs have the internal capacity to develop effective monitoring and evaluation procedures, this knowledge has not been utilized to examine staff care practice. By developing a staff care monitoring and evaluation system, organisations can learn from one another and begin to determine good practice based on scientific evidence

Evaluation of staff care initiatives is lacking, both in practice and in general guidelines. Monitoring and evaluation is rarely mentioned in the literature or guidelines on staff care. This lack of guidance may be one reason for its general absence.

Organisations collect significant amounts of data that can be used for tracking wellbeing of staff. However, the confidential data may not reach the person in charge of staff care.

No organisations have conducted research on staff care within the past five years. Three organisations had on-going studies. While several studies have been dedicated to the study of wellbeing of staff of INGOs (and even more on military personnel returning from deployment), research studies on the effectiveness of specific staff care is lacking

Monitoring and evaluating is an intricate part of the staff care conceptual framework. Evaluation should occur across the types of staff, duration of contract, and context, as it relates to the lifespan of employment. Good monitoring and evaluation can impact the environmental influences of staff care.

Chapter 8 - Conclusion

Our brief research has shown that staff care across the humanitarian and development sector remains inconsistent and diverse. This is largely due to the various operational models and contexts that INGOs are working in today - each of the organisations we interviewed has developed a different approach to care for staff, and these range from the extensive and comprehensive to the patchy and *ad hoc*.

Our interviews also lead us to conclude that an organisation's approach to staff care is largely a reflection of its culture: some organisations consistently achieve minimum standards and go beyond what is required, while others fall below acceptable levels of duty-of-care. This prompts the question: how can organisations create, and sustain a culture of wellbeing?

In our research we heard how some organisations are moving away from their 'problems focus' and 'sticking plaster' approach that is at best reactive, to a philosophy that acknowledges the variety of supportive needs of all staff from a perspective of prevention and addresses underlying or root issues. Clearly a number of organisations continue to operate on an *ad hoc* basis, with high rates of staff turnover, and weak systems of support. But we see that in this era of litigation and insurance pay-outs, staff care practice is becoming increasingly important. Furthermore, some organisations and staff care specialists we interviewed report success from proactive staff care programmes aimed at increasing the engagement of aid workers and enhancing their work life balance.

It is clear that many organisations refer to and use staff care guidelines, and a number have implemented a range of recommended staff care practices. Existing guidelines, however, offer general staff care considerations and lack specificity with respect to types of staff, duration of contract, and context. While some tools of the "Western" workplace may be appropriate, INGOs and their staff are well placed to further develop benchmarks and inform the sector on best practice for staff care. Monitoring and evaluation of interventions relating to a variety of situations can guide the community of practice in effective care for aid workers: this responsibility should be owned by the whole sector.

"The provision of support to mitigate the possible psychosocial consequences within crisis situations is a moral obligation and a responsibility of organisations exposing staff to extremes"

(IASC MHPSS in complex emergencies-2007)

Where could we go from here?

Our research leads us to identify several opportunities for organisations to explore:

1. **Coordination and collaboration**
   Better coordination within organisations (i.e. across decentralized organisations) as well as between organisations (i.e. different INGOs/NGOs working in the same local geographic area) could potentially reduce costs and enhance staff care provision. It would be worth exploring the idea of coordinating service provision locally through existing working groups or consortia / membership organisations to pool resources.

2. **Cyclical feedback**
   Some organisations have devised ways of identifying risk to health, conflict, and high levels of stress, by tracking the experience of workers in specific locations. Often, data on various wellbeing indicators (turn-over, medical/psychological health, information from exit interviews, satisfaction/engagement,) is collected, but it is not fed back when developing new staff care initiatives. Exploring a way of harvesting this data to inform policy development is essential.

3. **Strategic decision making and investment**
   The conceptual framework and statistics presented in this study may help you position your organisation's staff care practice within the wider sector, and assist you in making some

strategic and concrete decisions on the most needed area of support for your staff. This could be less investment in one area with new investment in another.

4. **Staff care task force**
   Research undertaken by the Headington Institute recommended the formation of a Minimum Standards for Staff Care (MSSC) Task Force to advocate for funding, and to develop and widely disseminated agreed upon staff care standards to a major INGOs and INGO consortiums. (Page 61) http://www.headington-institute.org/Portals/32/resources/InterAction_Report_Final_November_28_2007.pdf Clearly a number of minimum standards or operating principles already exist, but perhaps there is an opportunity to mobilise a sector wide task force that could further develop specific operating standards for staff care where necessary.

Areas for further study

"Provide funding for a longitudinal study to assess the effectiveness of various staff-care programs and interventions, leading to a revised set of data-based recommendations for future staff-care programs"

Recommendation of the Headington Institute, 2007.

Our conclusions also lead us to suggest some further areas of study which may be of interest to participating organisations:

i) **Current practice of staff care for national aid workers.**
Many organisations expressed the importance of examining staff care practice of INGOs for in-country national staff. The difference in practice between international and national staff has been noted in guidelines, conferences, articles and other writing. Some lessons learned from care of international staff care can be applied to national staff care, but new frameworks must be developed for the distinct needs of national staff.

ii) **Evidence-based staff care practice:**
Efficacy of staff care interventions must be proved to convince donors and senior management of its value. A business model for staff care gives clout to advocacy activities and cost/benefit analysis presents staff care as essential and not an add-on: this is essential for the survival of staff care in lean programme budgets. Running pilot projects and developing logistical frameworks with specific indicators and outcomes that are compared over time, increases organisational learning and effectiveness. Where is it cost-effective to be preventative, where is it cost-effective to act *ad hoc*?

iii) **Building a resilience model**
Negative psychological consequences (i.e. depression, PTSD, acute stress) of aid workers have been well documented. More attention however, should be given to identifying the resilience, growth, and adversity-activated development (Papadopolous, 2007), that is equally common in the sector. By sharing practices, and developing effective monitoring and evaluation of those practices, organisations can transform dysfunction into coping, and coping into individual and organisational thriving.

iv) **Management's involvement in staff wellbeing**
Managers and management systems may play one of the largest roles in the wellbeing of staff. Many organisations, including People In Aid and InterHealth have turned their interest to strengthening leadership and management capacity to prevent and mitigate severe distress in the field, but research in this area is limited. One respondent said, "Our greatest success in supporting staff will be determined by the extent to which managers and team leaders effectively manage their team. We have had a very strong operation

and technical skills process, but like many other organisations, we have had a very weak people management capacity process. The greatest return for our investment is where we can significantly enhance our ability to lead our teams, and manage our people. Our focus now is on capacity building at a leadership and team cohesion level, rather than using the language of stress, distress and disability. Team cohesion and leadership quality and are the strongest protective factors that can be built in a program."

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UNDP (2007) UNDP Staff Wellbeing Guide.

Appendix 1

Common practice in staff care in the humanitarian and development sector – Aspects of staff care to consider[10]

Pre-deployment

Selection:

- Reference and background checks, face-to-face interviews, behavioural interviewing, language considerations, group or multi-day interviews
- Assessment: psychological, vocational, interpersonal, personality, cultural competency (standardized and/or adapted).
- Medical check and clearance (relating to specific assignment)
- Psychological screening and/or clearance by trained psychological or occupational health professional
- Policy on re-deployment on staff that have recently experienced a critical incident

Preparation:

- Thorough Inductions: Organisational Induction and Technical Induction
- Field-based managers training in personnel management (team cohesion, interpersonal, leadership, stress management, conflict management, PFA)
- Provision of travel health advice, vaccinations, and medical supplies/first aid kit.
- Detailed briefing on prevalent environmental and security conditions, including possible future changes in these conditions.
- Briefing with staff on in-country social, historical, cultural, and political information.
- Personal safety and security training
- Training in stress management, coping skills, and preparation for typical hardships on assignment
- Designated funding scheme for staff care and emergency contingency

On-Assignment

On-going

- Thorough In-country Induction
- Regular staff appraisals, including indicators of wellness, with feedback.
- One designated staff member per team in charge of well-being, and who is trained in psychological first aid. Or, staff have access to an independent counsellor.
- Mid-assignment psychological consultation (for assignments > 2 years)
- Organisations make workshops and trainings available to staff (Stress management, team building, conflict resolution, compassion fatigue/vicarious trauma, security, peer support, leadership, self-care, spiritual rejuvenation, etc…)
- Identified specialist for urgent psychiatric complaints.
- Optional or required annual medical check-ups (general, eyes, dental)
- For dispersed team members, manager or staff-care worker visits remote site at least once per quarter and hold regular team meetings.
- Annual regional retreats that include components of staff care, recreational and social opportunities
- Area-specific benefits: vacation time, hardship compensation, access to transportation,
- Mechanisms in place for receiving support from home (annual leave, phone calls home, internet access, etc…)
- Non-financial incentives:
  - Continuing education/career development

[10] Selected through a review of guidelines and standards mentioned above, responses from organisations interviewed, and the authors' experience. These are not guidelines, but examples of common types of staff care to consider as organisations determine appropriate levels of care for specific staff types, duration, and context.

Technical supervision
Journal subscriptions
Trainings/workshops
Secondments/changes in role

- Programme specific policy on staff wellbeing. Potential sections: stress management, self-care, work/life balance, living arrangements, building resilience, HIV/AIDS, whistle-blowing procedures, substance use/abuse, domestic violence, conflict resolution, interpersonal skills,
- Regular country team meetings or “away days”
- Peer Support system
- Develop a system that monitors and evaluates staff care interventions and overall staff wellbeing

Critical Incidents:

- Established protocols for specific emergencies (including training staff and identifying local, regional, and international specialists)
- Concrete procedures are in place for medical (including mental health) evacuation including appropriate medically trained staff to accompany evacuees and are reviewed regularly.
- Culturally appropriate support, including Psychological First Aid (PFA) immediately available for staff that have experienced or witnessed extreme events. Referral system in place for staff with traumatic reactions, receive evidence-based treatment by qualified professional
- Staff that have witnessed or experienced a crisis incident are systematically screened for mental health problems, 3 and 12 months following the event and appropriate services are arranged

Post assignment:

- Technical briefing, 360° review, and job evaluation by senior office staff (incl. financial/benefits debriefing, with time scale and expectations)
- Medical check-up and treatment by a tropical screening travel clinic
- Practical support with relocation, transitional coaching and career planning
- Re-entry retreats, alumni groups
- Psychological briefing/support by a professional mental health clinician, including a stress review assessment and reverse culture shock lessons. Sessions should be with a practitioner who understands the challenges of aid work.
- For critical incidents and/or evacuations, psychological follow up 3 to 6 months after return
- Availability of continued mental health support upon request

Appendix 2

Participating organisations and Useful Codes / Standards

Action Against Hunger-UK,
Amnesty International-International Secretariat,
ARD. Inc.,
CARE-USA,
Catholic Relief Services,
Concern Worldwide,
French Red Cross,
Help Age International,
International Rescue Committee,
Marie Stopes International,
Medecins Sans Frontières-UK,
Mennonite Central Committee,
Mines Advisory Group,
Norwegian Refugee Council,
Save the Children-UK,
Save the Children-US,
Tearfund,
UNICEF,
WaterAid,
World Vision International

Useful Codes / Standards

1) People in Aid: www.peopleinaid.org/Code
2) Antares Foundation:
   Managing stress in humanitarian aid workers:
   Guidelines for good practice www.antaresfoundation.org/Guidelines
3) Sphere www.sphereproject.org
4) HAP www.hapinternational.org
5) IASC www.humanitarianinfo.org/iasc/
   Headington Institute
   (Training material in a variety of staff care topics): www.headington-institute.org
6) Center For Humanitarian Psychology:
   CHP website (CHP provides Peer
   Support trainings. However, they also still use
   terminology of Defusing and Debriefing) www.humanitarian-psy.org

Useful Networks

1. Action without borders: www.psychosocial.org
2. People In Aid - Emergency Personnel Network: www.epn.peopleinaid.org
3. Global Connections: www.globalconnections.co.uk
4. Lingos / NGO Learning: www.lingos.org
5. Aid workers network: www.aidworkersnetwork.net

Other useful resources

1. Doing member care well, 2002, Kelly O'Donnell, William Carey Library Publishing, Pasadena CA
2. Preventing Accidents, 2003, People In Aid, London
3. Traveller's Good Health Guide, 2002, Ted Lankester, Sheldon
4. Travel Health Berlitz Pocket Guide, 2008, Ted Lankester, Berlitz
5. Staying alive, 2006, ICRC, Geneva

Appendix 3: Research methodology & Questionnaire

All of the organisations involved in this research are members/subscribers or known by People In Aid or InterHealth. The only defining criterion was that the INGO needed to have an annual income of more than 50 million US dollars. An email research invitation was sent to 35 organisations and 20 responded positively.

All participants received a research brief and the 21 question survey ahead of the interview. Semi-structured interviews were conducted by telephone (with exception to one submitted by email) in the months of April and May, 2009. All interviews were audio recorded and sections of the interview were transcribed. Each participant was informed of the purpose of the research and made aware of their confidentiality. Permission has been obtained where organisations are named.

The questionnaire comprised of a brief quantitative section on organisational profile and types of data collected, followed by a semi-structured section of 6 staff care practices, one open ended question on an effective practice, one question on outsourcing, one question on evaluation, and one question on funding for staff care. These questions were decided upon with three basic considerations: a focus of emotional and psychological care, the extent to which the issues surfaced in current staff care literature, and time constraint (40 minute interviews). The average length of the telephone interview was 45 minutes.

Limitations

The research does not explore certain important staff care practices such as: recruitment, personnel management capacity, team cohesion, leadership, legal issues, occupational health, benefits, etc… Because of the diverse sample for this study, direct comparisons between organisations cannot be made. Equally, resource constraints mean that the detail of specific staff care practices was not researched. Rather than receiving in-depth information from a very small sample, the objective of this study is to present some overarching trends across the sector.

Questionnaire for Staff Care Research

A) Basic organisational data

1) Name of interviewee:
2) Job title:
3) Email address:
4) Name of organisation:
5) Approx total annual income (and currency), if known for your office. For the wider Organisation?)
6) Location of your office

B) Quantitative data including staff care personnel mapping

7) Total # of staff
    - # of international field-based staff from your offices.
    - How many offices recruit and hire your international staff?
    - Total # of international field-based staff for the wider organisation (# of nationalities, if known)
    - # of nationalities
    - # of countries of operation
    - # of frequent travellers (>4x per year) based at your offices.
    - # of emergency response staff (dedicated team / unit) based at your offices
    - # of In-country national staff that your international staff work with.
    - # of in-country staff for wider organisation

8) Staff Care Personnel:
    a) # of In-house Psychological (counsellors, psychologists, psychiatrists, mental health trainers) staff care workers available to your international staff.
    b) If known, total number of in-house psychological staff care workers for wider organisation (Locations)
    c) # of In-house Medical (doctors, nurses, public health trainers) staff care workers available to your staff.
    d) If known, total number of medical staff care workers. (Locations)
    e) # of in-house Staff Care Specialists (whose role is devoted solely to wellbeing of staff) available to your international staff.
    f) In known, total number of in-house staff care specialists for wider organisation
    g) Does your organisation use an EAP? YES/NO

9) Has your organisation conducted any research on the benefits of staff care? i.e. reports based on data, available to the public. YES/NO (If Yes, how many in the past five years)

10) Does your organisation collect data on any of the following? (Here, we are simply asking whether or not it is collected, not the figures. YES/NO):
    a) Staff turnover
    b) Employee engagement
    c) % uptake of EAP
    d) % of staff using any optional staff care interventions (i.e. debriefing,)
    e) # of Medical complaints
    f) # of Psychological complaints

11) Does your organisation have specific written policies for staff care/staff wellness? YES/NO

C) Qualitative data

Please answer the following questions according to the practices at your offices, rather than for the wider/international organisation, unless you represent the wider organisation.

Pre-assignment:

12) Does your organisation use psychological screening for international staff? Follow-up: Before hiring, Before Deployment?

13) Is there a standardized orientation or induction for all international staff? Follow-up: # or % of international staff coming through your office for an induction/orientation. How long is the orientation?

On-assignment:

14) Does every international staff in the field have access to psychological support by a trained/professional counsellor or psychologist?

15) Does your organisation offer Psychological First Aid (PFA) for international staff in the aftermath of crisis? Who provides the PFA? Have any staff been trained in PFA?

Post-assignment:

16) Does your organisation offer a post-assignment medical check up through a specialist travel clinic? Mandatory/Optional/Not available?

17) Does your organisation offer a post-assignment psychological review or counselling session by a trained mental health practitioner? Mandatory/Optional/Not Available?

18) Can you describe one way in which your organisation has developed a creative or innovative solution to a staff care challenge? In other words, tell me a success story.

19) In what circumstance, if any, does your organisation outsource psychological and/or medical staff care? (i.e. training, debriefing after crisis, consultant, doctor, psychologist,) All, Some, or None. Who provides that service?

20) Do you evaluate staff care? YES/NO
Follow-up, if time allows
- What is the mechanism for M&E staff care activities
- Who does it?

21) How do you typically fund staff care?
- Is there a designated funded staff care scheme? YES/NO
- Can you give me a specific example of how you funded activities related to staff care within the last year

People In Aid

People In Aid is a **global network** of development and humanitarian assistance organisations. We help those organisations, whose goal is the relief of poverty and suffering, to enhance the impact they make through better management and support of staff and volunteers.

The impact and effectiveness of relief and development operations depends upon the quality of staff and volunteers and the support given by an organisation. People In Aid's very practical output can help organisations enhance that quality.

Our Vision, Mission and Values

People In Aid's **vision** is of a world in which organisations work effectively to eradicate poverty and reduce suffering.

Our **mission** is to advocate, support and recognise good practice in the management of people in the humanitarian and development sector worldwide.

We achieve this principally by:

- Engaging and developing good relationships with our members
- Advocating good people management practice - gathering and presenting the evidence that good people management enhances organisational effectiveness through research and publications
- Stimulating and facilitating learning - creating opportunities for members to learn from us and others through conferences workshops and special interest groups worldwide
- Strengthening people management capacity - providing members with access to HR services including diagnostic support from the HR Services Team in People In Aid
- Recognising good practice and certifying achievement – guided by the People In Aid Code of Good Practice and its principles, providing an audit and certification framework, with the aid of the necessary tools and skills, for members to use and be committed to, together with publicly acknowledging the improvements and commitments organisations have made to their people management practices.

We work towards the **values** which reflect those of our members and focus on people. These values inspire us to be open and fair, to encourage creativity and effectiveness and to work with integrity and compassion.

InterHealth

InterHealth is a specialist London-based medical charity, providing Medical, Psychological, Occupational and Travel Health support to many of the major international agencies involved in humanitarian relief and poverty reduction across the world.

By working with UK charities, relief, development and mission agencies we work to maximize the health and wellbeing of their staff to help them fulfil their purpose more effectively. Our multi-disciplined clinical teams support dedicated staff and volunteers to be physically and psychologically fit, resilient, and prepared for tough environments and demanding work in the UK and internationally.

For organisations working/travelling internationally, tailored medicals, work-life balance and stress management support, vaccinations and travel health advice are available to support workers physically and psychologically before, during and after travel.

For organisations working in the UK, InterHealth's Occupational Health service helps manage the health and welfare of staff through pre-employment screening, managing sickness absence referrals, and workstation assessments.

For all of our clients, InterHealth's holistic support helps to achieve best practice in staff care, meet relevant employment legislation, maximise the effectiveness of their people, and ensure that costs related to ill-health are minimised.

Global Health Initiatives

InterHealth facilitates selected networks and initiatives that help to provide healthcare to vulnerable communities, individuals and organisations. Affirm and Community Health Global Network (CHGN) continue to be a strategic focus of their support. CHGN links and strengthens community based health programmes worldwide. Affirm specialises in community responses to HIV and other health issues that overwhelm poor neighbourhoods.

As InterHealth's focus on vulnerable communities develops, they are able to harness the experience and passion of team members in leading these initiatives and create opportunities to collaborate with clients in a new capacity.

Research

InterHealth is actively involved in a number of research projects, recently becoming the fifth largest worldwide contributor to GeoSentinel, a worldwide database on health problems in travellers. Since joining the network, InterHealth has contributed anonymous data from 1359 returned long-term travellers by collecting travel histories and recording outcomes following screening.

Findings recently presented to the International Society of Travel Medicine (ISTM) conference in Budapest communicated the demographics, travel patterns, and region-specific morbidity of mission/volunteer/humanitarian aid (MVHA) workers. Information collected from travellers seen at InterHealth plays a vital role in furthering the understanding of the causes of illness experienced by clients. This knowledge allows InterHealth clinicians to provide evidence-based, tailored and preventative advice.

Workshops

An exciting programme of training events is on offer at InterHealth, including a successful one-day workshop 'Building Resilience Under Pressure and Managing Others in High Stress Environments', developed in association with The Management Centre (=mc). Bespoke courses can be developed for in-house delivery upon request. http://www.interhealth.org.uk/workshops.html

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