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Managing Health in All the Helpers: A Survey of Mental Health Services for Humanitarian Aid Workers

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Abstract

Humanitarianism has been a long-standing principle of helping those in need. However, the work of providing such assistance is not an easy feat. Humanitarian work is mentally taxing because of the high daily demands of the job as well as the potential for exposure to direct and secondary traumatization. These mental health risks can manifest into the mental health disorders if the stressors of the job are not well managed by individual aid workers and by the humanitarian organizations. The most common mental health disorders experienced by aid workers are depression, anxiety, burnout, and PTSD. Research into mental health and humanitarian aid workers suggests that discrepancies exist in mental health risks and outcomes for national aid and international aid workers due to their diverse backgrounds. However, current organizational practices indicate that they are not meeting the diverse needs of all their staff members. To bridge the gap between this discrepancy in mental health service provision for national and international aid workers, humanitarian organizations must increase their efforts to include national staff within organizational policies and they must conduct more research into the various needs of the national staff that they employ.

Preface

Switzerland is well known for its humanitarianism. The opportunity to study abroad in this location greatly influenced my independent study topic. I am interested in working in the humanitarianism or development, which spurred my interest into humanitarianism. However, after our lecture about Healthcare in Danger from Dr. Golaz and the general increased danger of the humanitarian workplace, my interested was piqued about PTSD and the mental recovery of aid workers from this trauma. This new knowledge of danger combined with my previous knowledge about the increased prevalence of burnout and compassion fatigue in humanitarian aid workers drew my interest in this topic.

My local case study focused on the psychosocial services that Switzerland humanitarian aid workers received before and after deployment. While I was researching for that paper I discovered a large discrepancy between the services offered to national humanitarian aid workers and the services national (expatriate) humanitarian aid workers. Not only were the services offered to these groups disproportionate, with the majority of the services offered only to expatriate workers, but it seemed that there were many general gaps of knowledge when it came to the mental health needs of national aid workers.

Acknowledgements

I would like to extend my acknowledgements and thanks to the various experts within the humanitarian field, who so graciously took the time to provide me valuable information for this research. They include Dr. Ariel Eytan, Samantha Wakefield. Dr. Barbara Laumont, and Erin Downey. Their expertise helped to clarify important distinctions within my research.

I would also like to thank Dr. Anne Golaz for her valuable guidance throughout the entirety of this research project. Her enthusiasm for mental health and humanitarian aid workers is infectious and one of the largest reasons this project came to fruition.

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Introduction

History of Humanitarian Action

The worldwide humanitarian crisis has continually increased due to the numerous natural disasters and the protracted conflict of many states, thus increasing the demand for more humanitarian organizations and humanitarian workers. When Henry Dunant established the International Committee of the Red Cross (ICRC) he established the foundation of humanitarian work under three guiding principles. Today, organizations such as the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), the United Nations High Commissioner for Refugees, Médecines Sans Frontières, and many more have adapted those ICRC principles into the four humanitarian principles of humanity, neutrality, impartiality, and independence. While all humanitarian organizations possess different methods and practices, they are rooted in their work to these principles. Officially, around 492 global organizations have signed onto the Code of Conduct for the International Red Cross and Red Crescent Movement as well as the Humanitarian Charter and Minimum Standards in Humanitarian Response elaborated by the Sphere project. In 1991, the General Assembly of the UN recognized of OCHA and the Emergency Relief Coordinator (ERC) was created (Bagshaw 2012). Henceforth, the humanitarian field has undergone several reconstructions to be able to provide the best assistance to their target communities. However, the humanitarian workplace is increasingly fraught with overwhelming complications from global politics, military goals, terrorist threats, and simply the overwhelming need from increased crises (McCormack & Joseph 2013). The result of these complications on the psyche of humanitarian aid workers is highly detrimental.

In the early 1990's, distress among humanitarian aid workers began to be researched and increasingly documented (Welton-Mitchell 2013). The mental health risk to humanitarian aid

workers is twofold. First, the various acute stressors of their daily work can easily turn into chronic stressors. An accumulation of chronic stressors throughout time is known to result in mental health disorders (Suzic et. al 2016). Furthermore, exposure to security or traumatic incidents can as effortlessly manifest into a mental health disorder. By the manner of their occupation, humanitarian aid workers are not only at risk from primary exposure that they themselves experience but also secondary traumatization. This is the process of suffering from post-traumatic syndromes due to endured secondary exposure of primary victims (Antares 2012). While the risks to mental health are an inevitable part of the work, the risks can be mitigated, and mental health disorders can be managed effectively so that aid workers can be successful in the field (Cordozo et. al 2012). While the need for humanitarian aid is at an unprecedent ted high, it does not mean that there needs to be an unprecedented risk of mental health problems for humanitarian aid workers.

The Importance of Maintaining Mental Health in Humanitarian Aid Workers

When the mental health of humanitarian aid workers is compromised it can have adverse effects for the individual, the organization, and the beneficiaries. Individuals can develop mental health disorders when they are constantly under duress or when they are exposed to a traumatic incident. When an aid worker continues to work in the field with an unmanaged mental health disorder or when they are extraordinarily stressed it can lead to loss of productivity, high staff turnover, early retirement, and leaving the field of humanitarian work entirely (Welton-Mitchell 2013). This is a costly occupational consequence since mental health problems such as depression, burnout, and anxiety can persist in individuals long after their assignments in the field are complete (Antares 2012). Furthermore, this can manifest into immense monetary lost

for the organization. The UNCHR estimated the total cost of work related depression across the European Union's Member States to be nearly 620 billion euros per annum (Welton-Mitchell 2013). As a humanitarian organization, institutions have agreed to serve their communities and always act in their best interest. When humanitarian aid organizations fail to take care of the mental wellbeing of their employees they also failing their mission. Their double burden of care to their beneficiaries and their employees is closely associated. An important component to humanitarian aid work is the sense of accomplishment that aid workers feel. This purpose to their work is closely tied to the feelings felt by the affected communities. Therefore, when humanitarian aid organizations fail to take care of one, they are failing to take care of the other.

While an important component of the mental wellbeing of an individual are the actions taken by an individual, they must first have the tools and resources to achieve this due responsibility. Self-care is closely tied to physical, social, and other types of wellbeing and is sometimes referred to as 'self-care' (Curling & Simmons 2010), also known as 'staff care' (InterHealth & PeopleInAid 2009) and 'mental and psychosocial support services' or MHPSS (IASC 2007). When humanitarian aid organizations fail to provide these tools and resources, individuals can take legal action. This legal liability is a protected right of staff members working in humanitarian organizations under a statute called 'duty of care' (Williamson, *Duty of Care*, 2017). Further repercussions in the failure of an organization in their duty of care is the negative media attention brought onto the organization with the occurrence of a legal scandal (Kemp & Merkelbach 2011). These repercussions for the failure to provide staff care and thus duty of care, can all be avoided by providing humanitarian aid workers with the tools and resources to be successful at their jobs.

Literature Review

In recent years, the knowledge and acknowledgement of the mental health and psychosocial support needs of humanitarian aid workers has increased. This is in part due to the independent investigations of researchers interested in this field, to the investigations funded by humanitarian organizations to evaluate their policies, as well as to the special taskforces and organizations specifically aimed at deepening the understanding of the interplay of mental health and humanitarian aid workers. These key organization include the Antares Foundation who works closely with the United Sates' Center for Disease Control (CDC), the CHS Alliance, the Inter-Agency Standing Committee (IASC), and more (Wakefield, personal interview, November 15, 2017). These special organizations work to research and compile resources for humanitarian organizations. Each has their own research area and specialty. For example, organizations such the CHS Alliance focus most on helping humanitarian organizations establish a holistic and effective organizations policies and standards to best support employees (Wakefield, personal interview, November 15, 2017). They published the 'Core Humanitarian Standard on Quality and Accountability' with the eight-commitment focusing specifically on all areas of staff support, which includes mental health (CHS Alliance 2012). Other organizations like the Antares Foundation and the CDC are most focused on helping organizations establish comprehensive policies for the mental wellbeing of their employees. They published a guidebook called 'Managing Stress in Humanitarian Workers – Guidelines for Good Practice, which even outlines the steps necessary to provide adequate care for national and international aid workers (2012). Although the existence of these special organizations is a commendable stride in mental health for the humanitarian aid sector, the actual investigations into the practices of humanitarian organizations are not as assuring. People in Aid and InterHealth found that the staff care, and

thus mental health services of organizations appear to be inconsistent or lacking in many organizational policies. Furthermore, they concluded the implementation of existing policies to be dismal (Curling and Simmons 2010). This highlights the need for more research into the organizational practices and policies of humanitarian aid organizations. The literature exists about the relationship between mental health and humanitarian aid workers. The caveat exists only in the limited literature for the relationship between mental health services and national aid workers. The literate exists to prove that national aid workers suffer from equal and sometimes additional mental health burdens than their expatriate counterparts, but there is little information on the services provided to them to alleviate these burdens.

Research Question

The term 'humanitarian aid worker' is used broadly during this paper to simply imply any worker employed by an organization who operates under the provision of humanitarian assistance to affected communities. The specific context of humanitarian aid workers studied in this research are those who are employed in field offices in active missions around the world. These types of staff members are further clarified into national aid workers and international aid workers. In this context, national aid workers are those who come from the local community and work to serve their own community while international aid workers, or expatriates are those who come from a different country to serve a community different from their own. These definitions are important to clarify because the purpose of this research is to study the potential differences in the mental health of local and international aid workers. Ultimately, this research is interested in how humanitarian organizations address these different needs when it comes to the provision of mental health services.

Methodology

This research project was conducted utilizing a qualitative analysis framework. To best understand the mental health problems of aid workers, it was important to use a broad research method to discern the full scope of the risks and problems. Research into this topic began with the use of secondary resources to create a foundational knowledge of all mental health risks that could develop when involved with humanitarian aid work. These secondary resources utilized in this research comprised of investigations conducted by independent researchers as well as humanitarian aid organizations interested in learning more about the mental risks and consequences of their workplace. The findings from these studies were supplemented with formal definitions of mental health disorders and formal definitions of certain organizational standards acquired from the guidelines published by the Antares Foundation, CHS Alliance, and the Inter-Agency Standing Committee. Before investigation into the mental health nuances of international and national aid workers could occur, an understanding was first needed about the most effective methods to combat mental health problems and risks. Secondary research articles were able to provide good management theories for mental health disorders for both individuals and organizations. Other resources from organizations specializing in humanitarian management and mental health needs were further able to provide substantial evaluation of these management theories and to provided recommendations about the most effective method to turn these theories into sound organizational policies. To gain insight into the current mental health practices employed by humanitarian organizations, primary and secondary resources were utilized. Interviews with experts in the field and experts from humanitarian organizations provided valuable information about the practices of some of the largest organizations within the field such as the ICRC and MSF. Other humanitarian organizations could not be contacted for

interviews so information about their organizational practices were gathered from their psychosocial support documents for their staff members. An exhaustive investigation into the research question was conducted utilizing a plethora of primary and secondary resources with information about international and national aid workers. The earlier findings were later combined with the discoveries of the nuances between the two groups for a thorough analysis.

Due to the difficult nature of this research topic, there was a deliberate attempt made by the researcher to not harm or put vulnerable populations at risk. This study was conducted simply to gain insight into the intricate issue of mental health in the humanitarian sector. It does not aim to go beyond its scope or responsibility or capability by delving into the specifics. The term 'humanitarian aid worker' is intentionally deliberate to capture any worker employed in the sector because the researcher has no special knowledge about specific humanitarian aid workers. Additionally, no interviews were conducted with current humanitarian aid workers or referenced in interviews to protect confidentiality and to respect the imminent and prevailing needs of all. All quotes observed in this paper were gathered from interviews conducted by mental health professionals, and were gathered from secondary resources.

Analysis

Mental Health Dangers of the Humanitarian Workplace

The mental health risks for humanitarian aid workers who work in the field is twofold and complex. Mental risks are difficult to assess because everyone has a different predisposal to these risks. On the one hand working in the field, is arduous work that no one can prepared to endure. The list below describes the possible daily hardships for humanitarian aid workers (Welton-Mitchell 2013):

- Exposure to suffering of persons of concern
- Exposure to incidents when you were seriously injured, or your life was threatened
- Political situation in the country where you are presently working
- Relationship with supervisors
- Relationship with work colleagues
- Family concerns
- Financial concerns
- Feeling undervalued
- Feeling unable to contribute to decision making
- Status of employment contract
- Workload
- Working hours
- Ability to achieve work goals and objectives

While the list above is biased to the work of UN aid workers, it still representative of the struggles faced by all humanitarian aid work as exemplified in studies conducted by other researchers. In fact, studies conducted by Cardozo et. al found the same trends in mental health risks but also found there to be an exacerbated risk for aid workers with previous history of mental health risks (2012).

Humanitarian work is demanding because aid workers are under constant pressure to perform perfectly in an unstable environment. This is a volatile combination because there are times where the work of the aid worker is sometimes not enough to completely alleviate the problems of the community in which they serve. The paradigm with field work is that aid workers interact with their communities daily, and thus they can see the results of these

shortcomings daily. These perceived shortcomings are often due to matters outside of the control of an aid worker, yet they continue to elevate frustration and anger within aid workers. This can mean that manageable stressors as those mentioned above can easily become exacerbated into something more. Daily stressors can often accumulate into chronic stressors which can progress into a mental health disorder (Curling & Simmons 2010). There are abundant triggers and pathways to the unfortunate road of mental health disorders for humanitarian aid workers. The only guarantee from recent research is that chronic stress because of work or other environmental stressors can be just as problematic as exposure to acute traumatic stressors such as direct trauma (Welton-Mitchell, 2013). The other guarantee, is that the daily stressors of humanitarian aid work most often lead down the pathway of exhaustion and burnout (MacGregor 2008).

The other side to the mental health risks of humanitarian aid work is the increasing presence of danger within various humanitarian settings. Unfortunately, the year of 1998 marked the first time that more UN aid workers than peacekeeping soldiers were killed. In 2000, it was found that within the humanitarian sector there were 375 reported deaths, 69% were due to violence and 17% were motor vehicle related. New York University and other research teams have documented an unpresented amount of violence against humanitarian aid workers (Connorton et. al 2012). Figure 1 lists the potential acute traumatic stressors that can be experienced by humanitarian aid workers, as well as the percentage of their likelihood. When aid workers experience acute traumatic stressors, they can experience a variety of symptoms which can affect their physical and mental wellbeing, negatively change behaviors, and many others. Physical symptoms include overtiredness, diarrhea, constipation, and headaches. Emotional symptoms include anxiety, frustration, and poor concentration. Unhealthy behavioral changes include increased intakes of alcohol, caffeine, drugs, tobacco, and addictions. Other potential

symptoms include tested interpersonal relations, isolation, resentfulness or intolerance of others, burnout, compassion fatigue, and secondary traumatization. Some of the less discussed symptoms of acute traumatic stressors include impactful changes and challenges to one's spirituality or core beliefs about God, humans, and life (O'Donnell 2017).

Figure 1. Nature of Direct Trauma Experienced by Relief Workers (Connorton et. al 2012)

Type of Trauma	**Percentage of Respondents**
Frightening situation	55-78
Threats or being chased	16-47
Forced separation from family	40
Shelling/Bombing of office or home	13-43
Hostility of local population	10-37
Life in danger	19-33
Sniper fire/direct range of gunfire	19-32
Life-threatening illness	27
Handling dead bodies	24-25
Road accidents	25
Torture	1-25
Murder of friend/family member	5-21
Robbery, armed attack	15-19
Imprisonment	1-3
Murder of coworker	6-14
Held hostage/kidnapped	0.9-10
Being beaten or mugged	8
Landmine injuries	2-6
Rape/sexual assault	0.6-3

The interesting aspect of acute traumatic stressors is that the direct trauma is not necessary for the development of these symptoms. Secondary traumatization is defined as the onset of post traumatic syndrome symptoms from prolonged exposure to victims of direct trauma (Antares 2012). The secondary traumatization experienced by MSF staff to victims of violence, including women who had been repeatedly raped caused the entire West African team to be pulled from the mission (O'Donnell 2017). The working environment of humanitarian aid workers is mentally and physically demanding, and prone to violence and danger –yet another

complexity to add to humanitarian aid work is the work itself. A UNCHR employee was quoted saying the following:

> "It seemed as if I was reliving the trauma experienced by my clients. I thought about my work with clients when I didn't intend to, memories of my work with clients upset me. I had trouble sleeping. I was easily annoyed. I had trouble concentrating." (Welton-Mitchell 2013 pg. 29)

Furthermore, humanitarian aid work is not only taxing while in the field but also outside of it as well. During follow-up interviews 3-6 months after the completing of an assignment, Cardozo et. al found that rates of depression and burnout did not diminish as compared to level immediately post-assignment. In fact, they found all post-assignment mental health levels to be elevated compared to pre-deployment levels (2012). This signifies that humanitarian aid work changes people. Sometimes that change is not for the better as explained by Kathleen Cravero who worked for the UN RC:

> "The most overwhelming gut-wrenching challenge for me was far more insidious: each day became a relentless series of life-and-death decisions. Decisions, for example, on where food and supplied could be delivered, which in turn determined who would eat, who would freeze, who would get shelter from the rain… I am convinced there is no way to prepare oneself for this level of responsibility. From the day I arrived in Burundi until the day I left, these decisions bore down on me – and never got easier. They haunt me still." (MacGregor 2008 pg. 16)

The following statistics are the manifestation of mental health problems for humanitarian aid workers. Unfortunately, the discrepancy that exists between the lifetime prevalence of mental health risks and outcomes for the worldwide general population and humanitarian aid workers is

enormous. General adults face only a 3-8% risk of generalized anxiety disorders (GAD), a 12% risk for depression, an 8% risk for PTSD, and a 10-20% risk of hazardous alcohol use. Humanitarian aid workers face a 31% risk for GAD, a 25% risk for depression, a 36% risk for PTSD, and a 25% risk for hazardous alcohol use. Furthermore, humanitarian aid workers face additional mental health challenges that are usually not experienced by the general population such as burnout and secondary traumatization (Suzic et. al 2016). The Suzic et. al study further distinguished burnout into three categories based on the source of distress and eventual outcome. They found that humanitarian aid workers were at a 43% risk for a type of burnout leading to diminished personal accomplishment, at a 31% risk for ta type of burnout leading to emotional exhaustion, and at a 9% risk for a type of burnout leading to depersonalization (2016).

The statistical outcomes of mental health disorders can be further aggregated into specific statistics about international and national aid workers. Expatriate staff demonstrated clinically significant levels of the following mental health disorders: depression (20%) anxiety (12%). Few expatriates reported clinically significant cases of PTSD, but 20% did report feeling ‘emotionally exhausted’ due to their work and nearly half reported that they ‘felt a lack of personal accomplishment throughout their work’. Overall, for international aid workers their level of depression and anxiety did not return to pre-deployment rates, and many reported ‘reduced life satisfaction’ (Antares 2012). National staff demonstrated clinically significant levels of the following mental health disorders: depression (50-66%), anxiety (50%), and PTSD (20-25%) (Antares 2012). The Antares Guidelines for Good Practice exemplified the rates of mental health disorders in national staff to be greater than that of international staff (2012).

Health Management

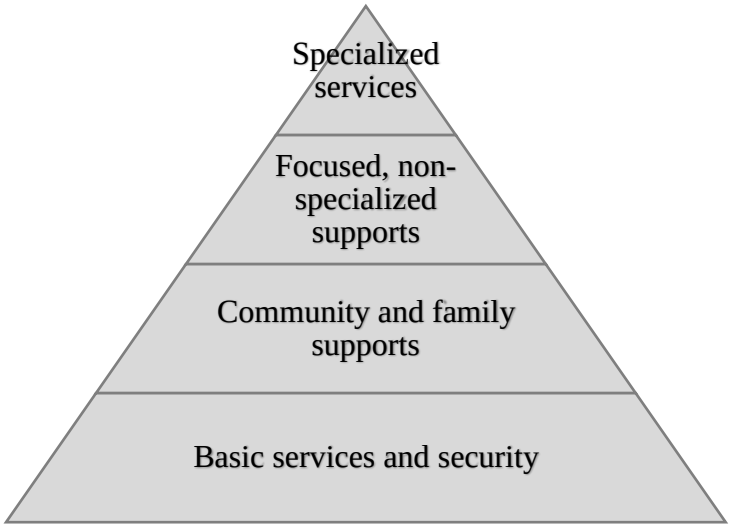

Figure 2. Intervention Period for mental health and psychosocial support as suggested by the Inter-Agency Standing Committee in their *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC 2007 pg. 12).

The manifestation of the stressors discussed previously turning into a clinically diagnosable mental health disorder is distinct path for all. It was found in Cardozo et. al's research that individuals with mental health disorders are more likely to have experienced chronic stressors for a prolonged time or a traumatic incident. Yet, it does not mean that everyone who experiences these situations will be liable to develop a mental health disorder (2012). The onset of a mental health disorder is dependent on the adequate on the management of daily stressors as well as acute traumatic stressors. Figure 2 shows hierarchical management of stressors starting with the bottom two levels being individual coping mechanisms and the top two levels as possible organizational coping mechanisms (IASC 2007).

Health Management – Individual level

A UN worker by the name of Yasmine Sherif is quoted talking about the difficult mental situations she faced and the overwhelming feelings of disbelief that she often encountered:

> "For 7 years, I lived among those whose lives had been torn to pieces by rockets, mines, executions, rape, torture, and an unspeakable climate for fear that could shatter the sanity

> of any human mind. As I worked in the wars and post-war situations in Afghanistan, the Balkans, Cambodia, and the Democratic Republic of Congo, I found myself in the environment for which no human being is prepared." (MacGregor 2008 pg. 9)

Is Yasmine right in believing that no one can ever be prepared to encounter the situations they will find in the humanitarian workplace? There is truth in Yasmine's assumption. No one can truly prepare themselves for the humanitarian difficulties and tragedies that they will encounter, unless they are incapable of feeling. The number one motivation for entering the humanitarian field is a desire to help and the belief that the world can be a better place – which means that they have an abundance of empathy (Erikkson et. al 2012). Empathy is both the greatest tool and the biggest area of weakness for humanitarian aid workers. Although preparation and training are important for aid workers before they begin their assignments, the best way to mitigate mental health risks and manage mental health disorders are to constantly engage in health behaviors and seek support through various avenues. As Figure 1 demonstrates, treatment begins at the individual level. An individual must be willing to seek help and they must be dedicated to the pursuit of their mental and physical wellbeing.

At the individual level, various researchers have described the following as coping mechanisms that humanitarian aid workers have used to mitigate and manage their mental health. For UNCHR employees the statistics on their coping behaviors are positive because it has been documented that the degree to which aid workers rely on positive coping mechanisms to manage their stress was on average more than five times greater than their use of negative coping mechanisms. The most popular positive coping mechanisms include: making time for social activities (91%) and physical activities (89%) or engaging in spiritual or religious practices (68%). Negative coping mechanisms have included alcohol abuse, overworking, cynicism, and

no sleep (Welton-Mitchell 2013). In her study with her colleagues, Erikkson et. al found that the most commonly used 'humanitarian specific' coping strategies were humor (30.7%) and writing letters (26.3%) (2012). Humor and letter writing are both verified positive coping mechanisms by other researchers. Gardner and Vergara have shown that high cognitive hardiness is positively supplemented by humor and adaptive beliefs (2009); while Dr. Ariel Eytan has suggested that the power of social networks to provide support for humanitarian aid workers should not be underestimated (Eytan, personal interview, October 13, 2017). As previously mentioned, humanitarian aid work is complex and difficult but what matters is how they cope with these situations and their resilience to the prolonged exposure to these situations.

Health Management – Organizational Level

While individual coping mechanisms are essential to the management of stressors and the treatment of mental health disorders, an organization is still responsible for the overall wellbeing of their employees. Humanitarian organizations must be willing to provide resources and tools to their employees. Many organizations call this responsibility 'staff care' (IASC 2007). The provision of mental health services may often fall under the responsibility of the human resource department as well as the legal department within humanitarian organizations. Human resource departments will often call it MHPSS, or mental health and psychosocial social support services (Porter and Emmens 2009). Legal departments will often call it the 'duty of care' (Williamson 2017). Organizations have many names for this practice of care for their employees because its implementation is complex and requires the collaboration of diverse organizational sectors. The Antares Foundation has compiled the best organizational practices into a guiding document called 'Managing Stress in Humanitarian Workers: Guidelines for Good Practice' (2012). This

practical guidebook is a convenient tool for humanitarian organizations who wish to review their current practices because the booklet contains eight principles supplemented with measurable indicator action steps. A visual representation of the guidelines as well as a short description is provided in Figure 3.

Figure 3. Visual Representation of the Guidelines (Antares 2012 pg. 4)

The comprehensive guidelines and indicators recommended by the Antares Foundation is provided in Figure 4. While their recommendations are important considerations for any organization, the O'Donnell also suggests five more considerations for organizations (2017). These added considerations were obtained from the first module of 'Confronting Stress and Trauma: A Resource Kit for Personnel Dealing with Violent Conflicts and Natural Disasters', a resource produced by the University of Worcester in association with UNITAR, Geneva (O'Donnell 2017). O'Donnell spoke of the importance of sharing the responsibility, modeling

health, defusing stigma, cultivating resilience in five areas, and most importantly, staying aware and helping staff members grow (2017).

Figure 4. Principles and Indicators suggested by the Antares Foundation in the guidebook 'Managing Stress in Humanitarian Workers – Guidelines for Good Practice' (Antares 2012 p.4)

Principle 1: Policy	The agency has a written and active policy to prevent or mitigate the effects of stress.	1. Integrates staff support into is operational framework. 2. Stress management policy is contextually and culturally appropriate. 3. Plans both for response to routine sources of stress and to unexpected stressful circumstances that affect both national and international staff. 4. Various support needs of staff are likely to be different. Stress management policies and supportive practices are designed to respond to the distinct needs of different types of staff. 5. Promote a culture of stress awareness throughout the organization, and un understanding that it will respond supportively to staff concerns about stress. 6. Specific strategies exist for reducing risks for each individual project. 7. Policy is regularly evaluated and updated. 8. All potential staff members are educated about the general risks of their work they will be assigned to and any individual risks they may face because of their gender, sexual orientation, race, ethnicity, or other predisposing factors. 9. Staff members are asked to comply with agency policy and procedures aimed at reducing stress. Agencies encourage individual staff members to hold the agency to its commitment to actively mitigate the effects of stress.
Principle 2: Screening & Assessing	The agency systematically screens and/or assesses the capacity of staff to respond to and cope with anticipated stresses of a position or contract.	1. Agencies and its managers understand the minimum health and resiliency requirements for high risk and high stress assignments. 2. Both prospective staff and continuing staff seeking new assignments are screened and/or assessed both with respect to their strengths and to the likelihood of negative responses to the risks and stresses of work with the

		agency. Appropriately trained interviewers are used for screening and assessing staff. The results of such screenings/assessments are used to suitably match staff members to specific assignments and to ensure that they have the support they need. 3. The individual seeking employment or assignment is held responsible for disclosing information that may be relevant to assessing the risks involved in an assignment. The agency is held responsible for maintaining the confidentiality of the results of screenings and assessments.
Principle 3: Preparation & Training	The agency ensures that all staff have appropriate pre-assignment preparation and training in managing stress.	1. All staff members received training on: • The sources of stress that can be anticipated in humanitarian work at individual, team, and organizational levels; • How to recognize the signs and effects of stress on themselves, their colleagues, and their teams; • Skills in working with a team; • How to manage and cope with stress 2. All staff receive updated briefing and training in stress management and in any necessary operational skills before a new assignment and when an assignment changes. 3. Managers are adequately trained and evaluated in stress management skills and capacities. They are able: • To recognize and monitor signs of stress in themselves and in those working under them; • To recognize the signs of stress at the team level; • To promote activities that help reduce stress in individuals, manage conflict in teams, and promote team cohesion; to arrange support for individual staff as and when required. 4. Managers receive any necessary training in managerial and leadership skills and that they have available mentoring and a system of peer support.
Principle 4: Monitoring	The agency ensures that staff response to stress is monitored on an ongoing	1. Individual staff members are monitoring (and, if appropriate, reporting) signs of stress in themselves.

	basis.	2. Team managers are monitoring staff members for signs of stress on a regular, routine basis. 3. Team managers are monitoring staff members closely for signs of stress during and after a critical incident or traumatic event. 4. Team managers are monitoring the functioning of their team for signs of conflict, scapegoating, or other evidence of stress. 5. Team managers are report back to the agency on a regular basis with respect to stress-related issues.
Principle 5: Ongoing Support	The agency provides training and support on an ongoing basis to help its staff deal with their daily stress.	1. Staff members and managers are encouraged to engage in good practices of self-care and collegial support with respect to their own health, to safety and security, and to stress reduction. Staff members are encouraged to use existing community and family sources of support. 2. Ongoing training and support is provided for staff with respect to safety and security and with respect to physical and emotional self-care. 3. Organization-wide and local management practices are periodically reviewed with respect to their impact on staff stress, including their likelihood of reducing stress and strengthening team cohesion. The agency seeks feedback from staff as to the overall performance of their managers, both in general and with respect to stress management. 4. Agencies provide support for managers at all levels in dealing with their own stress.
Principle 6: Crisis Support & Management	The agency provides staff with specific and culturally appropriate support in the wake of critical or traumatic incidents and other unusual and unexpected sources of stress.	1. All staff members are provided with explicit guidelines as to the kinds of traumatic, critical, or potentially severely stressful incidents that must be reported to management. 2. All team managers and supervisors are trained in appropriate immediate responses to traumatic incidents, including when to seek back-up support and specialized resources. 3. The agency has arranged for staff with specific training in psychological first aid to

		be available on an 'as needed' basis to consult with staff members after traumatic incidents or other sources of acute stress in staff. 4. The agency has standing arrangements with local, regional, or international specialists during a crisis period to provide culturally relevant trauma assistance as required. 5. The agency has standing evacuation plans, which include their obligations to national staff if evacuations are required.
Principle 7: End of Assignment Support	The agency provides practical, emotional, and culturally appropriate support for staff at the end of an assignment or contract.	1. The agency has a program for assisting staff members who are completing an assignment, leaving a project, or leaving the agency for any reason to prepare for the stresses involved. 2. All staff members are offered an exit operational debriefing at the end of their assignment or contract or project. 3. All staff members have access to personal stress assessment and review at the end of their assignment or contract or on an annual basis. 4. The agency provides opportunities for ongoing staff, including non-professional staff to evaluate projects when they end and to address feelings that may have been aroused. 5. The agency provides adequate notice to staff when a project or assignment will end for reasons other than emergencies. 6. The agency has standing arrangements to make psychosocial services available for staff members in the wake o an evacuation or other premature or unexpected termination of a project or contract or job. It has an explicit commitment to provide staff with practical support to make necessary arrangements associated with the evacuation or termination.
Principle 8: Post Assignment Support	The agency has clear written policies with respect to the ongoing support they will provide staff members who have been adversely impacted by exposure to stress and	1. A clear policy exists aimed at supporting staff who have job stress-related disabilities such as burnout, severe stress, depression, anxiety, compassion fatigue or post-trauma symptoms. 2. The agency has developed policies for dealing with staff who are unable to continue

	trauma during their assignment.	working for the agency due to job-related stress or injury. Policies address issues such as continuation of salary and benefits and provision of medical and/or psychosocial support services. 3. Policy for follow-up exists with respect to on-going adjustment or emotional or family problems several weeks after the end of an assignment or contract and offers services or referrals to services if needed.

Evaluation of Current Practices: MSF, ICRC, and UNHCR

Figure 4. Eight Principles of Good Practices: Comparison of UNCHR, ICRC and MSF (Welton-Mitchell 2013 p.35)

Good Practice Principle (Antares)	**UNCHR**	**ICRC**	**MSF**
1. Policy – *8 indicators*	(50%) 4/8	(63%) 5/8	(63% 5/8
2. Screening & Assessing – *3 indicators*	(20%) 1/5	(60%) 3/5	(0%) 0/5
3. Preparation and Training – *3 indicators*	(3%) 1/3	(67%) 2/3	(67%) 2/3
4. Monitoring – *4 indicators*	(25%) 1/4	(50%) 2/4	(0%) 0/4
5. Ongoing Support – *3 indicators*	(33%) 1/3	(67%) 2/3	(67%) 2/3
6. Crisis Support – *4 indicators*	(50%) 2/4	(50%) 2/4	(25%) 1/4
7. End of Assignment Support – *5 indicators*	(40%) 2/5	(100%) 5/5	(60%) 3/5
8. Post Assignment Support – *2 indicators*	(0%) 0/2	(100%) 2/2	(0%) 0/2
9. Total (*8 principles & 34 indicators*)	2 out of 8 (12/34 = 35%)	8 out 8 (23/34 = 68%)	4 out of 8 (13/34 = 38%)

Using the Antares Guidelines, Figure 4 is the representative evaluation of three large humanitarian organizations against the eight principles and subsequent indicators. Evaluation was conducted by the UNCHR, who was interested in evaluating their current policies and policy implementation against the set standard as well as comparing their practices to other humanitarian organizations (Welton-Mitchell 2013). The consensus that this study demonstrates is that humanitarian aid organizations are lacking in their provision of mental health services for their staff members. No humanitarian organization is completely fulfilling the measures outlined by the indicators, which means that they are failing to meet all eight principles. Although the

ICRC is the closest, they still have areas of growth within several principles where they are not meeting all the indicators.

While humanitarian aid organizations may not be meeting all the standard of the Antares guidelines, studies such as the UNCHR study referenced above mark a crucial advancement for the humanitarian sector in addressing the mental health needs of their workers. Not only does it prove that organizations are prioritizing the mental health needs of their staff members, it also demonstrates that they are willing to turn to others for help. Admittedly, one the largest reasons are failing to provide mental health services is due to their lack of resources. This is derived from their lack of funding, which puts humanitarian aid organizations at a difficult spot to choose between caring for their beneficiaries or their staff members (Welton-Mitchell 2013). The reality with this situation is that humanitarian organizations need not choose between this difficult choice, if they can manage to utilize their limited resources effectively. Whereas humanitarian aid organizations may not be meeting all possible indicators and principles, there are no organizations that are doing nothing. Humanitarian organizations may even be exceeding the criteria of the indicators for specific principles. For example, Médecines Sans Frontières excels at ensuring staff confidentiality with all their mental health services (Laumont, personal interview, November 10, 2017). They value staff empowerment, so their mental health services are available to everyone, but it is left to individual decisions whether those services are utilized. In addition, it is left to individual decisions whether an individual chooses to leave field missions early or whether they choose to return to agency and humanitarian work in general following the completion of a mission – unless they are diagnosed with a severe mental health disorder by a medical doctor. The mental health services that MSF utilizes are not given the power to make decisions for staff members. Within the organization, this breeds trust and more willingness to

utilize mental health services because staff members understand that seeking help will not result in any negative repercussions. The ICRC, on the other hand, excels at utilizing local partnerships. They can meet the minimum standards within all eight principles because they rely on local resources from their red crescent societies to provide easily accessible mental health services always. They focus intentionally on strengthening health systems so that local capacity for mental health services is increased and so that resilience to traumatic incidents within the community is strengthened (Downey, Skype interview, November 17, 2017). Furthermore, the ICRC utilizes innovative screening tools before new staff members are deployed to the field. All new hires within the ICRC are required to undergo simulations and trainings, which have a twofold function to vet new candidates as well as screen them (Welton-Mitchell 2013). The strengths of UNCHR can be found within their willingness to evaluate their practices and compare them to other humanitarian organizations, as previously mentioned. Their provision of mental health is found within the Staff Welfare Section (SWS) which lies underneath the umbrella of the UNCHR Human Resource Management. The entirety of the SWS staff is comprised of seven people which puts their ratios at around 1 SWS staff for every 1,116 staff (Welton-Mitchell 2013). This evaluative study is beneficial for UNCHR because it enables them to provide the most necessary services. Not only do they understand their capacities, they also understand the most effective usage of those capacities.

Background on International and National Aid Workers

In 2010, of the 274,000 aid workers worldwide approximately ninety percent were national staff (Lansky 2014). This means that national humanitarian aid workers are a vital component to humanitarian work. It is important to understand that stressors for national and

international aid workers differ due to their different backgrounds. International aid workers are expatriates because their usual place of residence is outside of the local community in which they work. The most common stressors for them include restrictions on movement due to security concerns, housing problems, conflicts with team members, lack of direction from management and excessive workload (Antares 2012). Expatriate workers often live away from their normal social support network in their new humanitarian work environment. Their greatest mental health risk for them is burnout because they are unable to escape their jobs. They work daily with the affected community and they live within compounds provided by the organization with their work colleagues. For international aid workers, the separation of work-life balance does not exist and within a high stress environment that can quickly tire a person which can result in serious mental health problems. National aid workers can leave the job because their homes are nearby, and they have a more structured work schedule. In their research, agar et. al described the most frequent stressors for national staff to be financial and economic problems (86%) high workload (65%), and tensions in disparity of treatment between international and national staff (59%) (2012). National aid workers tend to have more financial worries because on average they are paid less than their expatriate counterparts and when humanitarian missions pull out of certain locations they are not guaranteed a financial source of income. Contracts for expatriate aid workers is much easier to renew because of the ample resources available to them, while national aid workers have no access to such resources (Lanksy 2016). More than the existence of job differences, separate national and international aid workers. Between the two groups there are often differences of authority, benefits, training, and evacuation plans (Ehrenreich and Elliot 2004). National aid workers can often experience high workload in their daily occupation, but this stressor can be exacerbated when international staff are evacuated from areas of intense

insecurity and conflict while national aid workers are expected to stay and continue providing services to the beneficiaries. 25% of international aid organizations have no exiting unified system when it comes to national staff policies (Kemp and Merkelbach 2011).

While these trends of stressors for national staff exist do exist and are proved with statistical data, it is meaningful to discuss the diversity within affected communities. Each affected community will differ greatly as will the people within each community. In the Bonnen-White and Issa study of local Palestine aid workers, they discovered that gender-based differences in self-reported resiliency and aspects of workplace saliency (2016). Furthermore, the conflict in the Palestinian setting often limited the employment goals of many aid workers due to the military, economic and political barriers (Bonnen-White & Issa 2016). Meanwhile, Agar. Et al found different concerns for national aid workers in Gulu, Northern Uganda (2012). Their researched discovered that fifty-one percent of all aid workers were exposed to at least five or more traumatic events. Moreover, Acholi staff experienced a significantly higher number of traumatic events as compared to non-Acholi staff. International aid workers within this setting were significantly more likely to have experienced no traumatic event (Agar et. al 2012). The Aid Worker Security Report published by Humanitarian Outcomes, states the only certainty of national aid workers to be their likeliness of incurring violence. Unfortunately, national aid workers make up the majority of victims in attacks on aid operations (Stoddard et. al 2011).

Resolution

The majority of studies utilized for this research examined a bias between national and international aid workers – within mental health and humanitarian aid workers the bias of focus exists for international aid workers (Agar et. al 2012). This is disproportionate to the findings

that humanitarian organizations are employing more national staff. Within humanitarian organizations it is considered more ethical to employ more national staff because they are viewed as local experts and community input is a vital part of the successful aid work (Lansky 2014). These contradicting statistics are dangerous not only for national aid workers, but also to humanitarian organizations. It is an unsustainable organizational practice to continue hiring an increased number of national aid workers their care and overall mental and physical wellbeing is not ensured. The research indicates that humanitarian aid work is strenuous both physically and mentally, the fact that national aid workers come from the local community does not make them exempt from these hardships. A bias may exist in the literature about mental health and humanitarian aid workers, but some knowledge exists about the special difficulties faced by national aid workers in this line of work. The only area where national aid workers fail to exist are within the organizational practices. The failure in the lack of provision for mental health services to national aid workers is nothing but the perpetuation of Western savior ideals. All aid workers should be guaranteed equal staff care and equal rights to duty of care, especially when such privileges are assured to international aid workers. This is supported by the research findings of Kemp and Merkelbach, who claim that funding is not the root or main cause of the deficiencies. The lack of staff care is due to the absence of a 'culture of security', of understanding/knowledge, and of institutional willingness, decisions and mechanisms (2011).

Conclusion

Summary

Due to the complexity of mental health problems and risks, the solution to providing support and care for aid workers is complex. Mental health risks are found within the daily high-

stress environment of the job as well as within acute traumatic stressors. However, constant exposure that aid workers must face to these stressors does not automatically guarantee the inception of a mental health disorder. What aid workers do to manage these stressors and the symptoms of acute traumatic stressors is indicative of their predisposal to mental health disorders. The more often an aid worker engages in negative coping mechanisms and the less supportive their social support networks are, the more likely they are to experience clinical depression, anxiety, burnout, and PTSD. Furthermore, direct trauma is not necessary for aid workers to experience post traumatic syndrome symptoms. They can also have the same effects of exposure to direct trauma from exposure to the secondary traumatization from the community in this they work. The solution to mental health spans in responsibility from the humanitarian aid worker to the organization. Humanitarian aid workers need to be willing to seek help before they benefit from help, but it is also important for organizations to have holistic practices and policies that promote a culture of wellbeing and of seeking for help. The Antares Foundation along with the CDC has created an entire document filled with principles and indicators that humanitarian organizations can utilize to better or evaluate their current practices. From the evaluations considered within this research, it is clear that humanitarian organizations can do more to promote mental wellbeing and staff care overall. The greatest area of concern within this topic area is the lack of mental health resources and staff care provided to national aid workers, despite their growing numbers. Humanitarian aid organizations must be held accountable for the wellbeing of all their staff members, if they wish to ensure the wellbeing of their organization. The critical steps to providing more staff care and ensuring the mental wellbeing of national aid workers are to write-in national aid workers into organizational policies and to fund more research about the different needs of each local community.

The Future of Humanitarianism

Although this research was interested in studying the mental health discrepancies between national and international aid workers and the subsequent strategies used to compensate for these differences, it was also interested in understanding the overall sustainability of humanitarian work. If there were inherent dangers within humanitarian work in the form of daily stressors and secondary traumatization as well as present dangers with traumatic events, would humanitarian aid workers be able to continue working if faced with one or both stressors? The short answer is yes. Humanitarian aid workers display a great amount of resilience. Armed with all the resources and tools, and an easily accessible and supportive social network, humanitarian aid workers can encounter any number of situations and survive. Yet, their survival may come at a steep mental prize if humanitarian organizations do not take responsibility for the wellbeing of their staff. With the increase of natural disasters as well a States in protracted conflict, the need for humanitarian aid is at an all-time high (Agar et. al 2012). Staff care is obligatory for all humanitarian aid workers, if organizations want to meet increased humanitarian needs of the world. The future of humanitarianism is unquestionable from the high need, but the sustainability of current organizational practices does put immense doubt into the practical future of humanitarianism.

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Appendix

Definition List from the Antares Foundation (2012; 34-35):

- *Burnout*: An emotional state resulting from long-lasting exposure to work, characterized by emotional exhaustion, tiredness, and a lack of energy (even when you have had enough sleep), little enthusiasm and motivation to work, decreasing work efficiency, a reduced sense of personal accomplishment, and pessimism and cynicism.
- *Compassion Fatigue*: Fatigue, emotional distress, or apathy resulting from constant exposure to miseries of others or from constant demands to care for others.
- *Coping*: The thoughts and actions used to deal with stressful situations. Coping may include acting to solve the problem that is creating stress or it may involve acting to protect oneself from adverse emotional or physical consequences of stress.
- *Humanitarian organization:* Includes organizations employing or deploying staff who provide rescue and relief after natural and man-made disasters, provide humanitarian aid, monitor human rights, assist in development, or provide a wide range of other human services.
- *Monitor*: Repeated observation of staff over a period of time, using informal observation and conversation and possibly more formal questioning or questionnaires to determine levels of stress and to identify support needs.
- *Operational debriefing*: A formal process focusing on what the staff member did, observed, experienced, and learned during their assignment and how the organization could potentially benefit from this experience.

- *Policy*: An explicit set of principles (usually written) intended to guide decision making. Typically, a policy describes actions of responses within an organization and assigns responsibility for carrying them out.
- *Post-traumatic syndromes*: People do not respond in a uniform way to traumatic events and symptoms of distress may last for a long time after the vents. Responses may include flashbacks, nightmares, an exaggerated startle response, difficulty sleeping, feelings of numbness, depression, anxiety, guilt, protracted grief, dissociative disorders, irritability, and interpersonal conflict, and somatic disorders
- *Psychosocial services*: Services addressing both psychological and social needs which help staff to manage stress (e.g. referral to housing providers, debt counseling, psychological counseling).
- *Resilience*: The capacity of people to cope positively with stress and catastrophe.
- *Secondary traumatization*: Repeatedly hearing first hand accounts about traumatization may itself cause effects much like direct exposure to the events. Also sometimes referred to as vicarious traumatization.
- *Self-care*: Taking care of oneself physically and emotionally, for example getting enough sleep, eating properly, getting exercise, taking care of one's health, making time for self-reflection, engaging in spiritual rituals.
- *Somatic (or psychosomatic) disorders*: Disorders of the body (e.g. colds, stomach aches, headaches, dizziness), as opposed to disorders of the mind (e.g. depression, anxiety).
- *Social Support*: The physical and emotional comfort and support given us by our family, friends, and co-workers. Many studies show that social support protects against the negative effects of stress, and the lack of social support can itself be a source of stress.

- *Traumatic Event*: An event that is extremely threatening to the life or physical wellbeing of those involved and is accompanied by feelings of powerlessness, horror, or terror.
- *Vicarious Traumatization*: The cumulative effect of responding with empathy to those who have directly experienced traumatic events may lead to symptoms much like those of the primary victims. Symptoms may include depression, anxiety, irritability, somatic complaints like those of PTSD. Also, sometimes referred to as secondary traumatization.

Abbreviations List

- CDC – Center for Disease Control
- ERC – Emergency Relief Coordinator
- IASC – Inter-Agency Standing Committee
- ICRC – International Committee of the Red Cross
- MHPSS – Mental and psychosocial support services
- MSF - Médecines Sans Frontières
- OCHA – UN Office for the Coordination of Humanitarian Affairs
- SWS – Staff Welfare Section
- UN – United Nations
- UNCHR – United Nations High Commissioner for Refugees