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_____ _____

Leslie Leonard *Date*

Approval Sheet

Understanding Staff Burnout and Wellbeing Resources in Faith-based Humanitarian Organizations and Hilton Humanitarian Prize Laureates

By

Leslie Leonard

Master of Public Health

Global Health

_____

Mimi Kiser, DMin, MPH

Committee Chair

_____

David Addiss, MD, MPH

Committee Member

Abstract Cover Page

Understanding Staff Burnout and Wellbeing Resources in Faith-based Humanitarian Organizations and Hilton Humanitarian Prize Laureates

By

Leslie Leonard

Bachelor of Arts
Austin College
2011

Thesis Committee Chair: Mimi Kiser, DMin, MPH

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Abstract

Understanding Staff Burnout and Wellbeing Resources in Faith-based Humanitarian Organizations and Hilton Humanitarian Prize Laureates
By Leslie Leonard

The Hilton Humanitarian Prize Laureate organizations (HHPLs) and international faith-based humanitarian organizations (FBHOs) have been internationally recognized for their achievements, and the positive impacts of their collective work have reached billions of people around the world. However, while burnout is extensively documented in health care professions, little is known about the negative impacts on humanitarian staff from chronic exposure to work-related stress. Further gaps exist in knowledge about the existence and effectiveness of resources at these organizations for addressing burnout and supporting wellbeing.

The purpose of this project is to (1) identify the various factors in the work lives of HHPL and FBHO employees that contribute to burnout, (2) understand how HHPLs and FBHOs differ in their staff experience of burnout and their provision of staff resources related to wellbeing, and (3) inventory resources and discuss strategies that support staff wellbeing in all its forms.

Respondents from 14 HHPLs and 9 FBHOs completed an online survey answering questions about their staff's experience of burnout and their organizations' wellbeing resources.

The most common contributing factors to burnout among both HHPLs and FBHOs were related to organizational culture and other internal workplace factors, with supervisors and/or other leaders cited by 85.7% of HHPLs (n=12) and 66.7% of FBHOs (n=6). The differences between the two groups differed in terms of wellbeing resources and support staff – namely, the employment of chaplains or other religious/spiritual advisors (66.7% of FBHOs [n=6] and 7.1% of HHPLs [n=1]). Similarly, 42.9% of HHPLs (n=6) indicated that they employ none of the types of support staff listed, compared to 22.2% of FBHOs (n=2).

If they are interested in confronting the issue of burnout, humanitarian organizations should make staff wellbeing a priority, by improving existing organizational resources and policies and/or implementing new strategies to address burnout. This study highlights an opportunity for further research into the possible spiritual dimensions of burnout, including the particular benefits of staff chaplains at secular organizations.

Cover Page

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Chapter 1: Introduction

People who work in the fields of humanitarian aid, development, relief, and global health are motivated by many of the same altruistic values as those who work in clinical healthcare: compassion, service, and social justice to name a few. The sense of calling and passion that drives these two groups of professionals typically correlates with intense commitment to and strong self-identification with their work. Combined with the heavy workloads and challenging work environments (often characterized by stress, conflict, and attending to intense human suffering) that accompanies these kinds of work, these qualities can interfere with humanitarians' and healthcare practitioners' ability to practice self-care and attend to their own needs for wellbeing. It is now clear that chronic exposure to these kinds of stressors can lead to burnout (characterized by exhaustion, cynicism, depersonalization, feelings of ineffectiveness), depression, anxiety, even post-traumatic stress disorder (PTSD). Researchers have studied and documented this phenomenon extensively among healthcare practitioners, but much less among humanitarian workers who experience many of the same working conditions and challenges.

In the world of humanitarian organizations, be they related to health, development, and/or emergency relief, faith-based organizations (FBOs) represent a significant portion of the effort to alleviate human suffering around the world. The term 'faith-based organization' comprehends a whole spectrum of commitment to religiosity, but at its core it signifies a foundation and some set of values in some form of religious or spiritual faith. If the compassionate values and passion for service that motivate secular humanitarians lead to a strong self-identification with their work, how might this attachment differ for people who feel theologically called to be in the humanitarian profession? How might the faith-based nature of their motivations, priorities, and values lead them to approach wellbeing for their staff in the face of chronic stress and burnout?

There may be something distinctive about FBOs in the context of facilitators and barriers to wellbeing – that is, factors contributing to burnout and resources in place that address stress and support employee flourishing.

Background and Rationale

Humanitarian organizations working in global health, development, and relief conduct projects in challenging environments all over the world, often in places with very limited resources and infrastructure, widespread poverty and disease, sometimes even war and other violent conflict or physical danger. Their employees typically have heavy workloads and demanding schedules, operate under strict deadlines and time-limited contracts, with restrictions imposed upon their projects by supervisors, external funding sources, and collaborating organizations or departments. They often face challenges related to pay and benefits (non-profit employment is not known for being lucrative), various types of discrimination in the workplace, or other struggles with organizational culture. What is known about the long-term impact of these sustained experiences, which is primarily based on research of healthcare professionals, is that it can lead people to feel physically and mentally exhausted, demotivated, ineffective, and cynical – in short, burned-out.

This is also the case for faith-based humanitarian organizations (FBHOs), which comprise a significant sector of the humanitarian aid field and share much in common with secular humanitarian organizations. One distinguishing quality about FBHOs is that while their motivations for alleviating human suffering arguably stem from the same basic values as those of secular humanitarian organizations, their religious/spiritual foundations may offer unique and important qualities to their organizational culture and their work in communities. However, the particularities of these qualities are under-researched. There is an even greater paucity of data

related to staff burnout and wellbeing in faith-based health and development organizations than for their secular counterparts.

The Conrad N. Hilton Humanitarian Prize, established in 1996, is the largest annual humanitarian prize awarded to a non-profit organization (Conrad N. Hilton Foundation, 2019a). Each year, the prize committee selects a nominated organization that has demonstrated the utmost excellence in alleviating human suffering and presents it with an award of $2 million. To date, the award has been presented to 23 non-profit humanitarian organizations around the world (Conrad N. Hilton Foundation, 2019c). These laureate organizations make up an independent alliance known as the Hilton Prize Coalition, which is led by an executive committee, comprised of some of the leaders of the organizations, as well as a Secretariat, Global Impact, an organization based in Washington, D.C. (Hilton Prize Coalition, 2016a).

In Spring 2018, the Hilton Prize Coalition awarded a project grant to The Task Force for Global Health (TFGH) and Heifer International as part of the Coalition's Collaborative Models Program, which promotes collaboration among laureate organizations to maximize collective impact. Through this project, known as the Humanitarian Wellbeing Project, "The Task Force for Global Health and Heifer International will inventory, analyze, and better understand employee wellbeing policies of other Coalition member organizations. By identifying challenges to human flourishing, they will develop a program to improve resilience, emotional health, and psychological wellbeing of employees" (Hilton Prize Coalition, 2016b). The project lead at TFGH is David Addiss, MD, MPH, who serves as the head of the Task Force's newly established Focus Area for Compassion and Ethics (FACE). Addiss recruited anthropologist Deirdre Guthrie, PhD, from the Keough School of International Affairs at University of Notre Dame (UND), to assist with the implementation of the project. Dr. Guthrie has been researching

wellbeing in international development and humanitarian staff through UND's Well Being at Work project since 2015. Leslie Leonard, author of this thesis and MPH candidate at the Rollins School of Public Health, Emory University, served in a graduate assistant capacity as the project coordinator.

The Hilton Coalition Humanitarian Wellbeing Project was launched in June 2018 and consisted of three phases: (1) interviews with the CEO/President of each participating laureate organizations; (2) interviews with the member of their staff in charge of employee wellbeing (i.e. director of human resources, operations, diversity & inclusion, or related position), supplemented by an online survey; and (3) interviews with up to three of each participating organization's field/frontlines staff. The focus of this thesis study is on the survey results from the second phase of the Hilton Wellbeing Project, which have been analyzed in conjunction with survey responses from a comparable sample of faith-based humanitarian organizations (FBHOs) – most of which do not enjoy the same international notoriety and attendant sizeable budgets as HHPLs, but whose positive impacts are similarly far-reaching.

Problem statement

The experience of burnout and compassion fatigue in healthcare professionals (physicians, nurses, emergency response teams, etc.) has been well-documented in scientific literature and popular media for many years, and is considered by some a public health crisis (Health Affairs, 2017; Lacy & Chan, 2018). This kind of intense exhaustion is a very common and understandable byproduct of the sustained and acute stress, the chronic exposure to intense suffering, and the extreme emotional burden of care that healthcare practitioners experience in their daily work. However, much less is known about how the phenomena of burnout and

compassion fatigue are experienced in the fields of global health, humanitarian aid, and international development.

HHPLs have been internationally recognized for their achievements, and the positive impacts of their employees' collective work have reached hundreds of millions, if not billions, of people around the world. The same can be said for many international FBHOs. While these positive results are well-documented and easy to identify, little is known about the negative impacts on their staff – the actual lived experience – of the work that they perform, and/or the contexts in which they work. Further gaps exist in knowledge about the existence and effectiveness of institutional resources at these organizations for addressing burnout and supporting staff wellbeing.

Purpose statement

The purpose of this project is to (1) identify the various factors in the work lives of HHPL and FBHO employees that contribute to burnout, (2) understand how HHPLs and FBHOs differ in their staff experience of burnout and their provision of staff resources related to wellbeing, and (3) inventory resources and discuss strategies that support staff wellbeing in all its forms.

Research questions

The research questions are:

1. What are the factors at Hilton Prize Laureate organizations and faith-based humanitarian organizations that contribute to staff burnout and otherwise challenge staff wellbeing?

2. What types of resources are available at both types of organizations that address burnout and support wellbeing, and how effective are they?
3. To what extent do stress and burnout (in terms of reported intensity, stressors, and contributing factors) and the resources, structures, and processes available to support staff wellbeing differ between the secular Hilton Prize Laureate organizations and the faith-based humanitarian organizations?

Significance statement

This study will contribute to the body of information around staff wellbeing for secular and faith-based humanitarian organizations and the various factors that contribute to stress and burnout in this sector. This information can be used to make a case for the prioritization of employee wellbeing and to promote organizational efforts to address burnout and support the flourishing of their staff. Not only is this a worthwhile endeavor for improving morale and stemming turnover, it is a matter of equity and ethical significance in the process of alleviating human suffering of all kinds.

Global health, development, and emergency relief efforts have seen great successes in solving problems and helping people, but they have also created some problems and suffering of their own in the process – analogous to taking buckets of water out of their neighbor's sinking boat and dumping them into their own. In its guidelines for managing stress in humanitarian workers, the Antares Foundation came to the conclusion that "Stress fundamentally interferes with the ability of the agency to provide services to its supposed beneficiaries" (Antares Foundation, 2012). This statement accurately represents the crux of the problem with burnout: it prevents professionals from doing their best work, and doing mediocre work is a waste of valuable time, finances, and human resources. To acknowledge this is to confront the ethical

importance of minimizing harm and prioritizing wellbeing in all its forms – not only for the beneficiaries of humanitarian aid interventions, but also for those conducting them.

Understanding the phenomenon of burnout and compassion fatigue in humanitarian workers will help enable a needed investment in the wellbeing of the workforce. This wellbeing will bring about more efficient employees, which will further the value of the resources spent on the organization's programs. More effective and successful programs will not only solve problems more quickly and efficiently, but will also increase morale, resulting in a positive feedback loop that will continually maximize the investments made in it. In short, staff wellbeing is a practical and ethical priority that humanitarian organizations must not overlook.

Definition of terms

For the purposes of this thesis project, I define the following terms as such:

> **Burnout** - the state of physical and/or mental exhaustion or collapse caused by chronic overwork and cumulative stress. It often results from a combination of feeling increasingly ineffective (a reduced sense of personal accomplishment, competence or overall job effectiveness), exhausted (feeling depleted, overextended), and/or cynical (holding depersonalized, callous attitudes towards work and others, feeling detached).[1]
>
> **Compassion Fatigue** - "a state of exhaustion and dysfunction biologically, psychologically, and socially as a result of prolonged exposure to compassion stress and all it invokes" (Figley, 1995, p.253, as cited in Cocker & Joss, 2016).

[1] This definition was established and agreed upon by the Humanitarian Wellbeing Project team at the Task Force for Global Health, based on Dr. Deirdre Guthrie's research and experience.

Moral distress - "Moral distress refers to the anguish experienced when an individual makes a clear moral judgement about what action he/she should take but is unable to act accordingly due to constraints (societal, institutional or contextual)." (Prentice, Janvier, Gillam, & Davis, 2016).

Organizational culture - the "values, norms, rites, rituals, symbols, and shared beliefs that make up an organization" (Champoux, 1996).

Wellbeing – The Hilton Wellbeing Project's unpublished report to the Hilton Prize Coalition Members (Guthrie, Addiss, & Leonard, 2019) presents the following definition for the concept of wellbeing:

> In the literature, "wellbeing" or "flourishing" has two often strongly correlated components that are distinguished as "hedonic" (pleasant feelings and positive assessments of satisfaction and engagement) and "eudemonic" (doing what is virtuous, morally right, true to one's self, meaningful, and self-actualizing and results in learning and growth of one's talents and capacities) (Ryan & Deci, 2001; Ryff & Singer, 2008; Seligman, 2002; Sheldon & Elliot, 1999). A related hedonic concept is "vigor" defined as a positive affective experience involving feelings of physical strength, emotional energy, and cognitive liveliness (Shirom, 2003, 2007).
>
> Using these definitions, an organizational culture that supports wellbeing refers to one where individuals experience more "positive" (engaged, vigorous, satisfying, pleasant) work days than "negative" (disengaged, cynical, ineffective, depleted) ones and feel their work has meaning and purpose because it is aligned with their core capacities and values. A wellbeing culture also creates a "sanctuary" of social support and mentorship when needed and provides ample opportunities to learn and grow.

Humanitarian assistance – "Aid that seeks to save lives and alleviate suffering of a crisis-affected population. Humanitarian assistance must be provided in accordance with the basic humanitarian principles of humanity, impartiality and neutrality, as stated in General Assembly Resolution 46/182. In addition, the UN seeks to provide humanitarian assistance with full respect for the sovereignty of States. Assistance may be divided into

three categories - direct assistance, indirect assistance and infrastructure support - which have diminishing degrees of contact with the affected population. (OCHA)" (ReliefWeb, 2008).

Humanitarian organization – An organization that provides humanitarian assistance (see above) as part of its central mission and operations.

> **Faith-based organization (FBO) –** "…one that shares many if not all of the following characteristics: it was started by a temple, church, or other religious institution or a religiously inspired individual; it works closely with other religious institutions in its community; and it raises most of its funds from individuals and institutions of the same faith. At the same time, these faith-based organizations do not limit their benefits or services to those of the same faith as the founders and at least some of the staff may also be of a different faith" (Harper, M., Rao, D.S.K., and Sahu, A.K., 2008, as cited in Idler, 2014, p. 325).

Chapter 2: Comprehensive Review of the Literature

Introduction

The issue of burnout has been well-documented in health care providers, but is demonstrably lacking in the fields of humanitarian relief, development, and global health; even less is known about its particular impact within faith-based organizations. The current body of literature reveals that burnout negatively impacts humanitarian workers around the world, often resulting in severe mental health problems. However, there is a need to understand the various factors that cause burnout, what its effects are on the humanitarian workforce, and what can be done to mitigate its deleterious effects.

In the field of humanitarian assistance, faith-based organizations (FBOs) play a central and indispensable role in the delivery of services. For example, it is estimated that FBOs provide around 40% of health care services in sub-Saharan Africa (Bandy et al, 2008, as cited in U.S. President's Emergency Plan for AIDS Relief, 2012). What are the unique and diverse qualities of FBOs that set them apart from secular ones in terms of staff burnout and organizational resources that support wellbeing? What might be learned from the experiences of employees and the organizational culture in predominantly secular humanitarian organizations (such as the HHPLs) as compared to their religiously-motivated counterparts? Why should non-profit organizations prioritize internally-facing initiatives like staff wellbeing in the face of limited budgets and external pressures to maximize results in target populations?

This chapter will provide an overview of the relevant body of literature around this topic, as it relates to the health impact and ethical implications of burnout on humanitarian workers, as

well as some of the distinctions and overlap between secular and faith-based humanitarian aid organizations.

Burnout

A Background on Burnout

The term "burnout," as we understand and use it today, was first used by psychologist Herbert Freudenberger. Working in a free clinic, he and his colleagues were quite familiar with the experience of burnout, but didn't necessarily have the terminology to describe what it was or why it was happening. His 1974 article in the *Journal of Social Issues* described the phenomenon: its symptoms and causes, the kinds of people who are most prone to experiencing it, ways of preventing or mitigating it, and ways of helping the burned-out. According to Freudenberger, the most at-risk population for burnout is "[t]he dedicated and the committed" – more specifically, those who are "seeking to respond to the recognized needs of people" (Freudenberger, 1974). He describes the pressures from within and without that drive such humanitarians to help and to give intensely of themselves, the guilt that can push them even further, the whole dangerous process of "depleting" that leads to total exhaustion (Freudenberger, 1974).

General causes and symptoms of burnout

Burnout is typically associated with some combination of symptoms related to physical and emotional exhaustion, such as general signs and symptoms of depression, quick-fused irritability, paranoia, inflexibility, and extreme negativity (Freudenberger, 1974). While these effects tend to dissipate fairly quickly with the recovery of physical and emotional strength, they are sometimes long-lasting manifestations of the deeper effects of burnout: those that often indicate moderate to severe mental health damage. The potential long-term impacts of burnout

on emotional, psychological, and even physical health are far-reaching. Scientific literature has shown evidence that burnout can cause feelings of powerlessness, depersonalization, cynicism, and apathy, and has been correlated with diagnoses of clinical depression, anxiety, and post-traumatic stress disorder (PTSD) (Aronsson et al., 2017; Chatzea, Sifaki-Pistolla, Vlachaki, Melidoniotis, & Pistolla, 2018; Chemali, Smati, Johnson, Borba, & Fricchione, 2018; Freudenberger, 1974). Burnout may also be a significant predictor of negative physical health outcomes such as: type 2 diabetes; hypercholesterolemia; heart disease; cardiovascular, gastrointestinal, respiratory, and musculoskeletal issues; and premature mortality (Salvagioni et al., 2017).

Burnout in Healthcare Practitioners

The global impact of burnout on healthcare professionals (primarily physicians, nurses, and emergency medical services) has been well-documented in scientific literature in recent decades, representing nearly every continent (Al-Sareai, Al-Khaldi, Mostafa, & Abdel-Fattah, 2013; Cathébras, Begon, Laporte, Bois, & Truchot, 2004; Deckard, Meterko, & Field, 1994; Kavukcu & Altıntaş; Kushnir, Levhar, & Cohen, 2004; Martin, 1999; Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012; Pines, 1981; Rothenberger, 2017; Schooley, Hikmet, Tarcan, & Yorgancioglu, 2016; Squiers, Lobdell, Fann, & DiMaio, 2017; Tironi et al., 2009). It is, understandably, a very common byproduct of the sustained stress, exposure to intense suffering, and emotional burden of care for the sick and dying that characterize the daily work of these professionals. However, there is *much* less formal examination and documentation of the toll that these very same working conditions have on humanitarian aid and global health practitioners.

Moral Distress, Moral Disempowerment, and Moral Injury

Leo Eisenstein, a fourth-year student at Harvard Medical School, describes a main source of burnout as "the experience of caring for patients when you know that their socioeconomic and structural circumstances are actively causing harm in ways no medicines can touch" (Eisenstein, 2018, p. 509). This also touches on the concept of moral distress, which occurs when one acknowledges a moral responsibility and determines a course of moral action, but is unable to act upon it due to actual or perceived constraints (Prentice et al., 2016; Rushton, Kaszniak, & Halifax, 2013). Alisa Carse describes further: "When the sense of moral failure is compounded by feelings of frustration or impotence, of being constrained or impeded in one's ability to act as one believes one ought, one experiences *moral disempowerment* [emphasis added]" (Carse, 2013, p. 147). Similarly, *moral injury* is the act of "perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009, p. 697). This term was first used in the context of combat veterans, but the effects of moral injury have also been observed in physicians (Currier, Holland, & Malott, 2015; Litz et al., 2009; Meador & Nieuwsma, 2018; Talbot & Dean, 2018).

In these working conditions, it is understandably difficult to avoid the acute sense of powerlessness, defeat, guilt, and even shame that many clinical healthcare practitioners experience. So how does this dynamic affect practitioners in fields like global health and development, human rights, and humanitarian relief, who tackle systematic oppression, legacies of colonialism and genocide, corrupt officials, and countless other obstacles, on a day to day basis?

Burnout in Humanitarian Workers

Very recently, researchers have begun to investigate the extent to which the stressful nature of global health and humanitarian work affects the physical, emotional, and mental wellbeing of professionals in these occupations. A wide range of study methodologies, combined with systematic reviews of the literature and meta-analyses, constitute the sparse but growing body of research pointing to the burden of trauma-related mental health problems and overall burnout on humanitarian workers. In places like Syria, Jordan, Kosovo, Sri Lanka, and Uganda, this research has shown that aid workers experience high rates of burnout and staff turnover, and are likely at disproportionate risk of clinical depression, anxiety, and PTSD (Ager et al., 2012; Antares Foundation, 2012; B. L. Cardozo et al., 2013; Barbara Lopes Cardozo et al., 2005; Eriksson et al., 2013; Holtz, Salama, Cardozo, & Gotway, 2002; Lopes Cardozo et al., 2012; Strohmeier & Scholte, 2015).

Workplace factors that contribute to burnout

Many of these studies indicate that the chronic stressors leading to burnout and poor mental health stem not only from factors outside of the workers' organizations (e.g. violence, disease, extreme poverty, death) but also from internal workplace factors as well – such as organizational culture, lack of resources (financial capital and/or organizational support structures), excessive demands, lack of recognition for work, etc. (Ager et al., 2012; Aronsson et al., 2017; B. L. Cardozo et al., 2013; Chemali et al., 2018; Eriksson et al., 2013; Strohmeier & Scholte, 2015). These findings held true for national staff as well as expatriate staff[2], although most of the research has focused on the latter – despite national/local staff comprising (rather surprisingly) around 90% of the

[2] For this study, expatriate staff is understood as staff who works in a country in which they are not a citizen.

humanitarian relief workforce (Ager et al., 2012). It has also become clear that organizational and experiential inequities between national and expatriate staff – in terms of entitlement to support resources and other benefits, as well as team cohesion and prior exposure to trauma – pose a significant differential risk of burnout to national staff (Ager et al., 2012; Antares Foundation, 2012; B. L. Cardozo et al., 2013; Barbara Lopes Cardozo et al., 2005; Eriksson et al., 2013).

The Antares Foundation (2012) further describes the differences between expatriate and national humanitarian aid workers illuminated in their research with the CDC:

> The expatriate staff participants reported the following chronic sources of substantial to extreme stress: restrictions on movement due to security concerns; housing problems; conflicts with team members; lack of direction from management; and an excessive workload. The typical expatriate also experienced at least one or two traumatic events. […] While national staff also reported stresses resulting from their work assignments, they reported important additional sources of stress. These stemmed from living in highly stressed societies and often from themselves being survivors of the events that led to the humanitarian intervention (p.10).

This information supports the findings from previously mentioned studies that national humanitarian aid workers typically experience many of the same stressors as expatriate workers, as well as a great deal of *additional* sources of stress and trauma.

Impact of Burnout on Work

While we now know that these professionals are negatively impacted by the nature of their work, we have much less evidence of how the quality of their work might be negatively impacted as a result. Some published research supports a great deal of anecdotal evidence of very high staff turnover rates and decreased job performance as a result of burnout and compromised mental health (Antares Foundation, 2012; Aronsson

et al., 2017; Chemali et al., 2018). The Antares Foundation (2012) points to chronic stress as a contributor to poor/risky decision-making and decreased efficiency and effectiveness, which have been linked to increased rates of workplace accidents and staff illness, absenteeism, and turnover, and ultimately "a loss of skilled, experienced staff in the field and increased recruitment and training costs."

Faith-based Organizations

Typology for understanding faith-based organizations

To capture the complexities, nuance, and extensive variety represented within the world of faith-based organizations (FBOs), I present the three-dimensional typology for describing FBOs presented in Laurie Occhipinti's chapter in the *Routledge Handbook of Religions and Global Development* (Tomalin (ed.), 2015). The three facets of a faith-based organization are: "(1) the ways in which they are faith-based; (2) their activities (or the kinds of work in which they are engaged); and (3) the way they are organized in terms of their degree of formality and relationships with other faith and non-faith structures" (Occhipinti, 2015, p. 336).

First, Occhipinti presents an adapted version of the typologies set forth by Sider and Unruh (2004) and Hefferan et al. (2009) in terms of faith orientation as a spectrum across the various dimensions of the organization's structure, mission, and activities. This spectrum is described as follows:

- faith-permeated – faith is an integral component and is openly and explicitly expressed;
- faith-centered – faith is important and taken for granted, but may be implicit rather than explicit;
- faith-affiliated – a faith background is important, and the organization draws on a faith community for some aspects of its support, but this may be more implicit or structural than explicit or embedded in discourses;

- faith background – more loosely tied to a faith tradition, whether this is through historical ties or faith-based values, but with few overt references to faith otherwise;
- faith–secular partnership – few references to faith, an attitude of respect and tolerance towards varying faith perspectives, or a completely secular perspective;
- secular – no faith content or overt faith references (Occhipinti, 2015, pp. 337-338).

This faith orientation can be expressed in any of the organization's structural dimensions, which include but are not limited to:

- self-identification – mission statements, organizational ties, organized faith practices, use of faith symbols;
- staff and leadership – including founders, paid staff, volunteers, board members;
- financial support – degree of reliance on religious or secular funding sources; discourses that are used to raise money or obtain funding;
- programming – how faith is integrated into services and programs, expectations of beneficiaries, connections between faith and expected outcomes of programs (Occhipinti, 2015, p. 338).

The second part of Occhipinti's typology consists of describing the types of activities the organization engages in. For the purposes of this project, which targets humanitarian aid, global health, and development organizations, I focused on the second activity listed (charitable and development work) in the selection process, but did not exclude organizations that also included any of the other three.

- Religious policy, networking, and cooperation – this constitutes providing rulings on doctrine, governance of the faithful, and representing the faith. I include here ecumenical work, or networking and outreach between faiths, as well as representing a faith and its members to other organizations (such as the UN).
- Charitable and development work – this includes a range of activities that provide services to the poor or other marginalized groups, which can include health care, education, economic development, community development, and so on.
- Political activism and lobbying – this involves the political mobilization of social groups based on a shared faith identity. […]
- Proselytizing and recruitment (Occhipinti, 2015, p. 340).

Third, this typology describes the range of organizational structures of FBOs, as it concerns other faith (and non-faith) structures:

> - initiatives within a larger faith organization that are volunteer-based, informal, and directed at members of the faith community [A];
> - an organization that has formal structure within a denomination or faith that is oriented towards service provision, but is still subsidiary to a parent religious organization in terms of legal status, membership, and/or financing [B];
> - a formal, independent NGO with ties to a particular religious community, such as a congregation, but with an independent organizational structure and identity [C];
> - a formal NGO with loose ties to a parent faith, with ties to multiple faith communities, or autonomous from any particular faith [D] (Occhipinti, 2015, p. 341).

The faith-based organizations involved in this study represent a wide range of forms, activities, and interagency relationships, as described in this typology. In terms of structure, the participants in this study's survey are categorized as follows:

- ADRA International (Adventist Development and Relief Agency) is a global humanitarian organization of the Seventh-day Adventist Church [structure B];
- Buddhist Tzu Chi Foundation is a Taiwanese international humanitarian NGO centered around the principles of Buddhism [structure D];
- Catholic Medical Mission Board (CMMB) is an international health service NGO with religious foundations in the Catholic faith [structure D];
- Episcopal Relief & Development was originally founded by the Episcopal Church (and still receives funding from the Church, among other sources) but is now an independent non-profit organization [structure C];
- IMA World Health is a Christian ecumenical health service organization, founded as a coalition of a number of different faith-based agencies [structure D];

- New Life Home Trust is a children's home organization inspired by principles of the Christian faith [structure D];
- Nyumbani is an independent, non-profit HIV/AIDS service organization founded by a Jesuit priest [structure D];
- Water4, Inc. is a Christian faith-inspired humanitarian non-profit organization [structure D];
- World Concern is an independent Christian development and relief organization [structure D].

Secular vs. Faith-Based Humanitarian Aid

> The fields of humanitarian aid and global health are motivated by an unshakeable belief in the interconnectedness of the human family and a commitment to the values of social justice, solidarity, equity, and compassion. The fields attract – and depend on – idealistic, highly-skilled individuals who bear witness to intense, and at times, overwhelming human suffering. They often enter the field out of a sense of calling, which is fostered by intense personal encounters or by an experience of suffering in their own lives. (Guthrie et al., 2019, p. 1).

This paragraph from the Hilton Wellbeing Project's report to the Hilton Prize Coalition Members represents the values and qualities that motivate those who work in the fields of humanitarian relief, development, and global health, and it applies as well both to secular and faith-based organizations (FBOs). But this thesis project is predicated on the idea that there might be something distinctive about FBOs in the context of facilitators and barriers to wellbeing – that is, factors contributing to burnout and resources in place that mitigate burnout and support employee flourishing. What might be different about the motivations, priorities, and values of FBO staff and their employers that may have an effect – either positive or negative – on workplace burnout?

When Kaler and Parkins interviewed expatriate Christian humanitarian workers based in South Sudan, they found that the humanitarians' unconventional understandings of time (temporality) had significant implications for the ways they "conceptualize[d] success, progress, and failure" (Kaler & Parkins, 2018, p. 1315). Their sense of time in the context of the divine was that God works and executes God's plan for each of them in the past, present, and future, which is what enables them to cope with the intense challenges of their work. Notably, the participants communicated a sense of their own agency in their work, not fully subject to predestination and divine will, at the same time that they asserted their part in serving a much larger purpose. The authors state the importance of this realization as such:

> The generative power of this trajectory, blending God's will with individual agency, became apparent when our participants talked about the dangers of South Sudan. The belief that God had placed them there enabled them to cope with discouragement, fear, and the nagging doubt that they had made a mistake. The same people who told their histories of coming to South Sudan as a series of choices they had made also relied on the idea that God's providence had brought them there, even if they could not see evidence of a good future (Kaler & Parkins, 2018, p. 1334).

This piece of research is illuminating but unfortunately rather singular in what it reveals about burnout and wellbeing in faith-based humanitarian aid. This is an under-researched topic, which makes it difficult to come to meaningful conclusions or make meaningful generalizations. Kaler and Parkins' article is especially limited in that it only discusses the perceptions of international (expatriate) humanitarian workers and not of those working in their own countries. The findings in this article represent one small strand in the large and complex web of secular and faith-based humanitarianism to which this study intends to contribute.

Religious/spiritual wellbeing as protective against burnout in health care settings

While there is a lack of published research on the occurrence of burnout in humanitarian workers within faith-based organizations, there is some literature about the role that religious

and/or spiritual wellbeing may play in mitigating the effects of burnout on healthcare practitioners, such as physicians, nurses, and other hospital employees.

Quantitative and qualitative studies have found some evidence of a protective effect of religion and/or spirituality[3] against burnout in hospital employees in Brazil, Hong Kong, and South Korea. Specifically, the data indicated varying degrees of correlation between higher levels of religious/spiritual (R/S) belief and practice and lower levels of burnout due to a greater sense of resilience and spiritual wellbeing (Carneiro, Navinchandra, Vento, Timóteo, & de Fátima Borges, 2019; Ho et al., 2016; Kim & Yeom, 2018). The concept of spiritual wellbeing was defined as "a peaceful state characterized by fulfillment of spiritual needs, life stability, and balanced relationships with self, others and the environment, without spiritual suffering and conflicts" and was measured by self-reported degrees of both religious and existential wellbeing (Kim & Yeom, 2018, p. 93). According to one study looking at daily spiritual experience (DSE), which refers to "the emotional perception of an individual toward the transcendent in daily life," spiritual practice and DSE may also be protective against depression and anxiety in healthcare workers, in addition to mitigating burnout (Ho et al., 2016, p. 67).

A qualitative study of nurses in faith-based and secular hospitals in Uganda found that religion/spirituality, and, more specifically, "faith in God," helped nurses better cope with the stresses and challenges of their daily work (Bakibinga, Vinje, & Mittelmark, 2014). Prayer (either individually or in groups), meditation, and social support connected to religious faith, were cited in the interviews with the nurses as the factors that helped them carry on with their

[3] Most of the researchers involved in these studies took care to differentiate between religion and spirituality, but for the purposes of this literature review, I will not make such a distinction in their definitions. In general, spirituality was considered more broadly and included religious belief among other concepts like "existentialism" and "the transcendent." In the Uganda study, religion and spirituality were considered synonymous.

work despite immense difficulties (2014, p. 1349). The authors noted that the experiences of the nurses from the faith-based hospitals did not differ from those working in public (secular) institutions, and hypothesized that this was because "public expressions of spirituality are not frowned upon in Uganda" (Bakibinga et al., 2014, p. 1350).

A study of emergency medicine physicians in Massachusetts found no significant association between R/S measures and burnout, but did discover a possible protective association between certain R/S measures and maladaptive behaviors (smoking, drinking, substance use) and medical malpractice (Salmoirago-Blotcher et al., 2016).

Kumar & Kumar (2014) found in their research on managerial personnel in India that workplace spirituality mitigated the negative impact of stress on health and wellbeing and was, overall, positively correlated with health. (Workplace spirituality was measured by self-reported degree of "engaging work, sense of community, spiritual connection, and mystical experience" (Kumar & Kumar, 2014, p. 348).)

These findings indicate an opportunity for exploration in the benefits of R/S belief and practice for preventing and addressing burnout in humanitarian workers, whether in a formal, organizational capacity (in the form of institutional resources and/or professionals such as staff chaplains) or on a personal, individual level.

Ethical considerations

An Ethical Dilemma Amidst Competing Priorities

The chronic strain that the humanitarian aid industry puts on its workers, which is often not counterbalanced with sufficient psychosocial support from individual organizations, presents a significant ethical dilemma. The Inter-Agency Standing Committee (IASC) Guidelines on

Mental Health and Psychosocial Support in Emergency Settings states: "The provision of support to mitigate the possible psychosocial consequences of work in crisis situations is a *moral obligation* [emphasis added] and a responsibility of organisations exposing staff to extremes" (IASC, 2007). This internally-facing concern for wellbeing is an exigent need for any organization that serves a humanitarian purpose. However, with a variety of pressing, and often conflicting, demands it is difficult for many organizations to make it a true priority. Of these demands that organizations must meet, the increased pressure from funders for low overhead and administrative costs is perhaps the most notable because of its effect on staff wellbeing.

In 2009, the Stanford Social Innovation Review (SSIR) presented the idea of the 'Nonprofit Starvation Cycle,' in which unrealistic donor expectations and demands lead to organizations' underinvestment in their own critical operations and eventually severely limited results and unmet goals (Gregory & Howard, 2009). This phenomenon reveals what the BBB Wise Giving Alliance, GuideStar, and Charity Navigator described in their open letters to American donors and nonprofits as the 'Overhead Myth': "the false conception that financial ratios are a proxy for overall nonprofit performance" (Taylor, Harold, & Berger, 2013, 2014). The three groups called for a continued prioritization of transparency and ethical practice with an informed understanding of the true costs of running a nonprofit as well as the value of administrative, training, evaluation, and other overhead costs to the organization's effectiveness (Taylor et al., 2013, 2014).

The considerable benefits of a happy, healthy, successful staff are well worth the costs of supporting employee wellbeing. Taken another way, the costs of staff burnout are not only financial losses due to decreased productivity, turnover, and a failure to maximize donor investments. They also represent an organization's failure to prioritize the wellbeing of its

employees – the most valuable operating components of their philanthropically-motivated endeavors.

A Matter of Moral Obligation

Humanitarian organizations should devote more of their resources to inward-facing efforts to support human flourishing, as a matter of moral obligation (Antares Foundation, 2012; IASC, 2007). These entities assert that the principle of 'Do no harm,' in medicine as well as humanitarianism, should include not only the beneficiaries of the work but also the practitioners. This principle has protective implications for the individual employee's mental health as well as the overall efficiency and effectiveness of the organization as a whole.

The IASC's guidelines for emergency settings focus on 'Do no harm' in terms of unintended negative impact on the beneficiaries of humanitarian aid (IASC, 2007). While this is undoubtedly imperative to good humanitarian practice, the Antares Foundation suggests that it is insufficient and invokes this same principle for an internal target population: the staff. In *Managing stress in humanitarian workers: Guidelines for good practice* (3rd ed.), Antares indicates the harm posed by "discriminatory policies, policies that place unnecessary burdens on staff, and inept management practices," as well as the necessity of "appropriately trained and experienced professionals" in the provision of psychosocial support (Antares Foundation, 2012, p. 11). The idea is to minimize this harm as much as possible by identifying these policies and practices and revising them so that they support staff wellbeing rather than diminish it.

Addressing Burnout

Herbert Freudenberger's original recommendations to combat burnout are somewhat intuitive, and the sentiment behind them has been carried through in further recommendations since. He suggests:

- utilizing screening/selection processes to identify and potentially mitigate risks,
- limiting work hours,
- building in vacation time and allowing additional time off periodically when needed,
- rotating functions as much as possible to avoid monotony and frustration,
- supporting group cohesion,
- sharing experiences together,
- sending staff to workshops or hosting workshops at your institution,
- recruiting volunteers when possible, and
- encouraging intense physical exercise (as opposed to meditation or yoga, which Freudenberger says further strain the mind and emotions) (Freudenberger, 1974).

Other research on the issue of burnout and trauma-related mental health similarly promotes strong peer/social support networks; improved working conditions (and safe and comfortable living conditions for deployed staff); management strategies such as conflict resolution, appreciation for job performance, and creating avenues for mental health support resources; and providing staff development trainings for stress management and mental health awareness (Ager et al., 2012; B. L. Cardozo et al., 2013; Barbara Lopes Cardozo et al., 2005; Chemali et al., 2018; Eriksson et al., 2013; Lopes Cardozo et al., 2012).

The Antares Foundation's *Managing stress in humanitarian workers: Guidelines for good practice* manual offers eight specific guidelines that can help humanitarian agencies, teams, and individual employees in mitigating staff stress and burnout (Figure 1).

Figure 1. Visual representation of Antares Foundation's guidelines for managing stress in humanitarian workers

The guidelines are as follows:

1. Policy – The agency has a written and active policy to prevent or mitigate the effects of stress.
2. Screening and Assessing – The agency systematically screens and/or assesses the capacity of staff to respond to and cope with the anticipated stresses of a position or contract.
3. Preparation and Training – The agency ensures that all staff have appropriate pre-assignment preparation and training in managing stress.
4. Monitoring – The agency ensures that staff response to stress is monitored on an ongoing basis.
5. Ongoing Support – The agency provides training and support on an ongoing basis to help its staff deal with their daily stresses.
6. Crisis Support and Management – The agency provides staff and teams with specific culturally appropriate support in the wake of critical or traumatic incidents and other unusual and unexpected sources of severe stress.
7. End of Assignment Support – The agency provides practical, emotional, and culturally-appropriate support for staff at the end of an assignment or contract.
8. Post Assignment Support – The agency has clear written policies with respect to the ongoing support it will offer to staff who have been adversely impacted by exposure to stress and trauma during their assignment. (Antares Foundation, 2012)

The Discussion and Recommendations sections of this thesis provide further detail about what organizations can do to address burnout, and the Appendix offers a number of resources about programs and policies that some HHPLs are currently implementing.

Summary of current problem & study relevance

Current Status of Humanitarian Burnout Problem

What's clear about burnout among humanitarian workers is that it is widespread and has many sources. Chronic stress and the burnout that often results pose a burden on the psychological, emotional, physical, and even spiritual wellbeing of many global health, development, and relief professionals around the world. In turn, there is a logistical and financial toll on the organizations that employ them, which is seen in elevated rates of staff turnover, minimized efficiency and impact, and valuable resources spent on treating the symptoms of the problem rather than on prevention. However, there is still much to be learned and understood about the experience and impact of burnout among humanitarian workers, especially among those working for faith-based organizations.

Although burnout is pervasive in the international humanitarian aid sector, there are strategies and resources that can be effective in preventing and mitigating its effects. Many organizations, including some of those that participated in this study, have implemented such strategies and have seen success in improving their staff wellbeing. These organizations and the resources they utilize can potentially serve as role models for other organizations who are struggling with employee burnout. Sources consistently report that the initial step for leaders of any humanitarian organization, whether secular or faith-based, should be to properly assess the presence and effect of burnout among their staff. After this, they will be able to make informed decisions about how to respond and ensure staff wellbeing in all its forms.

Public Health Impact

Burnout in humanitarian workers impacts public health in two ways: (1) it can harm the physical and mental health of those personally affected by it, potentially long-term, and (2) it prevents the burned-out humanitarians from performing their best work, which by default directly impacts the health and wellbeing of the communities they serve. In sheer numbers of individual people affected by burnout, whether directly or indirectly, this impact is vast but incalculable. Just as burnout in physicians is considered by many a public health crisis (Health Affairs, 2017; Lacy & Chan, 2018), burnout among humanitarian workers – which is comprised of professionals working in public health, development, agriculture, economic empowerment, disaster relief, victim assistance, and many more areas, which *all* directly impact the health of individuals and communities – should be considered a crisis in its own right.

Taking legitimate measures to prioritize staff wellbeing – for example, by improving existing organizational resources and policies, and/or implementing new strategies to screen for, prevent, and mitigate burnout – will allow humanitarian organizations of all kinds to maximize their positive impact through their programs, projects, and initiatives. This, in turn, has the potential to result in better health outcomes and overall quality of life for millions more.

Chapter 3: Methods

Introduction

The purpose of this project is to (1) identify the various factors in the work lives of HHPL and FBHO employees that contribute to burnout, (2) understand how HHPLs and FBHOs differ in their staff experience of burnout and their provision of staff resources related to wellbeing, and (3) inventory resources and develop strategies that support staff wellbeing in all its forms.

This is a hypothesis-generating project which draws upon data from two sources: survey results from the Hilton Wellbeing Project (via the Task Force for Global Health) and a comparable sample of international FBHOs, most of whom have a relationship with the Interfaith Health Program (IHP) at Emory University. The Hilton Wellbeing Project used interviews and survey to identify sources of burnout and other challenges to wellbeing, inventory resources, and make recommendations to HHLPs regarding staff wellbeing. The focus of this thesis study was on the survey data that stemmed from that overarching project, complemented by additional survey data from FBHOs as a point of comparison to serve the research questions.

Population and sample

The study population was made up of two groups: HHPLs and FBHOs. The primary sampling criteria for the former was that they received the Hilton Humanitarian Prize before the year 2018 (when the project began). We initially invited 23 organizations[4] to participate in the Humanitarian Wellbeing Project (sponsored by the Hilton Coalition) and we solicited survey

[4] There are officially 22 prize recipients from 1996 to 2017, but one organization is comprised of two distinct initiatives with different headquarters and leadership teams.

responses from 15 HHPLs – only the ones from whom we had received a response to either the preliminary project invitation, which involved interviews with CEOs and other staff, or to our follow-up invitation for this thesis project, which involved only the survey. In the end, we received 14 completed surveys.

For the FBHOs, the sampling criteria was that they have a similar distribution of characteristics as the laureate respondents, with priority given to the organizations with which the Interfaith Health Program (namely, my thesis committee chair) had a personal relationship, to encourage participation. I considered the following characteristics: type of work (health, relief, or development); staff size (small [10-200], medium [201-500], large [501-1000], or extra-large [1000+]); scope (domestic or international); and location of main headquarters (USA, Europe, or Africa/Asia). To compensate for the expected low response rate, I planned to solicit three times the number of FBHOs than the number of HHPLs in our sample – that is to say, 42 FBHOs, compared to 14 HHPLs. For the appropriate distribution of characteristics, I also multiplied each category of organizational characteristic (type, staff size, scope, location of main office) by three, and aimed to include at least that many organizations meeting those characteristics. I selected FBHOs meeting these criteria from the Emory University Interfaith Health Program's partnership database and identified additional organizations through those partner networks.

In the end, I sent survey invitation emails to 37 FBHOs instead of the desired 42, due to time constraints and obstacles finding appropriate contact information. Tables with the characteristics of each of the organizations that participated in this study can be found in Appendices A and B. For information about the Hilton Humanitarian Prize, see Appendix C. For the sample population of FBHOs solicited for surveys, see Appendix D.

Procedures

For the survey component of the Hilton Wellbeing Project, the researchers targeted "staff in charge of employee wellbeing" at each participating organization: Human Resources (HR) directors; mental health professionals (staff psychologists, counselors, life coaches, etc.); Directors of Diversity & Inclusion, etc., depending on the type of staff available. (These various staff members will hence be referred to as "HR staff" for the sake of simplicity.) The project team only contacted the HR staff at the organizations whose CEOs or presidents had already consented to participating in the project. If the HR staff responded to the invitation letter with agreement to participate, the researcher presented them with a personalized link to an online survey, a notice about the confidentiality of the data, and instructions for scheduling their interview with the other researcher.

After the FBHO sample was selected, I reached out via e-mail to the available contacts at each organization to request that they either (a) identify the appropriate staff in charge of employee wellbeing and ask them to complete the survey (via the link provided in the invitation letter), or (b) complete the survey themselves if they were the most appropriate and available staff member.

Instruments

I developed the survey tool using Qualtrics survey software (Version XM, 2018-2019) (Qualtrics, Provo, UT). The HHPL survey was comprised of 29 questions (see Appendix E). The FBHO survey had 32 questions: the same 29 questions in the HHPL survey, with 3 supplemental questions related to faith's impact on their organization and employees (see Appendix F). The survey asked respondents for their name, organization, and job title so that we could keep track

of the participating organizations, but all findings are reported anonymously. For both groups, the survey typically took respondents no more than 30 minutes to complete.

The survey aims to identify (1) various factors that contribute to cumulative stress and burnout in the organization's employees, and (2) the availability and quality of various resources for employees that support their psychological, emotional, and physical wellbeing.

Data analysis

I analyzed the quantitative survey data using the Qualtrics software, which identifies the frequency and means of the responses. For the open text questions, I pulled together the responses from both samples and grouped them together based on similar answers, identifying any unique answers that arose, as well as comparing and contrasting the two samples.

Ethical considerations

I submitted a summary of the project and its intended use to the Emory IRB for its determination as to whether the project qualified as human subjects research. This included information about the confidentiality of survey responses and anonymity of the reporting of findings, the size of the samples, and our intent to use the data for investigation of wellbeing challenges and inventory/evaluation of resources within the organizations surveyed – not to generalize the findings to a larger population.

The IRB determined that this study qualified as non-human subjects research, and no review by the full IRB would be required.

Limitations and delimitations

Limitations

First, the convenience sample greatly limits the generalizability of the data – as does the small sample size of both secular and faith-based humanitarian organizations (n=14 and n=9, respectively). There was a low response rate among FBHOs (25%), which also affects the quality and generalizability of the data. Despite prioritizing organizations with whom the Interfaith Health Program (IHP) had a strong relationship, there were still many "cold call" survey invitations. Not only that, but many of the FBHO contacts in the Interfaith Health Program database were outdated, and 8 emails bounced back as a result. Both of these factors had a negative impact on the response rate.

Based on the structure and nature of this study, is not possible to use the survey data to come to conclusions about the lived experience of individual employees, as the respondents were directors of human resources or related positions, answering on behalf of the rest of the staff as a whole. Similarly, it is also not possible to pinpoint or confirm specific causal relationships between (a) various workplace factors and their impact on burnout, or (b) organizational resources and their impact on physical and mental wellbeing; or to isolate specific aspects of faith-based organizations that facilitate or hinder wellbeing any more or less than secular humanitarian organizations (or vice versa).

There were some challenges related to infrastructure (e.g. computer/Internet access) for respondents from organizations based in low-resource settings, and some user error and other flaws with the Qualtrics software, which likely impacted the quality of the data as well as the response rate. Qualtrics does not allow respondents to save their

answers as they go, or to complete the survey in more than one session. The precise impact of this characteristic of the software is unknown, but I suspect it was inconvenient for some.

Many respondents did not go into great detail in the open text responses, or they left them blank. Whether this is because of time constraints or other barriers is unclear, but this limits the depth and breadth of the information obtained. Additionally, in the FBHO sample, there were 4 recorded surveys that were submitted entirely blank. It is not clear how or why this occurred, but it was not possible to follow up with those respondents due to the blank data fields.

Delimitations

The purpose of the study is to describe the experience of burnout and the resources at only the organizations sampled, which greatly limits the scope of the data obtained. We chose to survey HR staff at each organization for the sake of time and simplicity, and the survey itself provides an organizational, high-level perspective, so it does not necessarily reflect the lived experience of individual employees. The data are intended to be hypothesis-generating, not to be extrapolated to any greater population.

Chapter 4: Results

Introduction

The purpose of this project is to (1) identify the various factors in the work lives of HHPL and FBHO employees that contribute to burnout, (2) understand how HHPLs and FBHOs differ in their staff experience of burnout and their provision of staff resources related to wellbeing, and (3) inventory resources and develop strategies that support staff wellbeing in all its forms. To this end, we obtained survey responses from appropriate staff (those who are most responsible for employee wellbeing – in this case, primarily Human Resources directors) at a sample of HHPLs and comparable international FBHOs.

Overall, the results indicate that a number of different factors, which are inherent to the nature of the work of these humanitarian professionals, are a consistent source of stress and sometimes burnout among the organizations' staff. Moreover, there is room for improvement in the resources that these organizations provide for their staff to mitigate their stress and support overall wellbeing. In order to achieve this improvement in support resources, however, there are several internal and external barriers that must be addressed.

Respondents

Of the 15 HHPLs from which we solicited surveys (only the ones from whom we had received a response to our initial project invitation or follow-up) 14 completed surveys (response rate: 93%). The HHPLs that completed the survey are as follows:

- Aravind Eye Care System
- BRAC USA
- ECPAT International (End Child Prostitution and Trafficking)
- Heifer International
- Humanity & Inclusion
- icddr,b (International Centre for Diarrhoeal Disease Research, Bangladesh)

- International Rescue Committee (IRC)
- IRCT (International Rehabilitation Council for Torture Victims)
- Operation Smile
- PATH
- Partners in Health (PIH)
- St Christopher's Hospice
- The Task Force for Global Health
- Women for Women International (WFW)

Of 37 FBHOs from which we solicited responses, 9 completed and returned surveys (response rate: 24.3%). The FBHOs that completed the survey are as follows:

- ADRA International (Adventist Development and Relief Agency)
- Catholic Medical Mission Board (CMMB)
- Episcopal Relief & Development
- IMA World Health
- New Life Home Trust
- Nyumbani
- Buddhist Tzu Chi Foundation
- Water4, Inc.
- World Concern

Tables with the organizational characteristics (type, staff size, location, countries in which they conduct work, etc.) of each of these organizations can be found in the Appendix. Regarding the distribution of organizational characteristics, the final sample of FBHOs represented half the number of desired extra-large organizations (9 instead of 18), and one-third the number of large organizations (2 instead of 6). In contrast, there were 2.3 times the desired number of small organizations (21 instead of 9). The desired proportion of international to national organizations was 33 to 9; in the end, however, I ended up with 26 international organizations to 11 nationals. There were proportionally more Africa- and Asia-based organizations than desired, and as a result, the distribution of Europe- and USA-based organizations was lowered. These discrepancies were primarily due to the convenience sampling procedure and time constraints.

Overview of Findings

- The factors most commonly associated with burnout for HHPLs were: supervisors and/or other leaders (n=12, 85.7%); long, unpredictable working hours (n=10, 71.4%); problems with communication (n=9, 64.3%); and job expectations, roles, responsibilities (n=9, 64.3%). The most common contributing factors for FBHOs were almost the same – 'supervisors and/or other leaders,' 'problems with communication,' and 'job expectations, roles, responsibilities' were each reported by 6 FBHOs (66.7%), and 5 (55.6%) indicated 'surrounding poverty.'
- In a question unique to their own survey, 3 FBHOs (33.3%) indicated a stressor related to faith/religiosity, which was generally related to working in religious minority contexts or where the local government was "anti-religion."
- Ten (71.4%) HHPLs and eight (88.9%) FBHOs distinguish between (1) main office/headquarters staff and remote/field staff *and* (2) national/local staff and foreign/expatriate staff. Overall, these respondents expressed that the two types of staff in both categories experience different stressors due to the nature of their work, and these are relatively similar between the secular and faith-based organizations.
    - In general, field staff experience the same stressors related to workload as the main office staff, with the added challenges of extreme working conditions (e.g. poverty, lack of infrastructure, sometimes conflict zones or other dangers) and inequity of resources and benefits compared to headquarters staff.
    - The stressors experienced by the foreign/expatriate staff generally have to do with travel-related challenges (e.g. being away from home and family, visas and other documents/bureaucracy, language and cultural barriers, etc.) and overall feelings

of isolation and lack of cohesion with the rest of the organization. Most respondents, in both HHPLs and FBHOs, indicated through their open text responses that the challenges for foreign staff are generally worse than for national staff.

- For resources available to staff to support wellbeing, rated from 1 (low) to 10 (high) in terms of availability, quality, and effectiveness, both groups reported very similar results:
    - The resource rated highest among HHPLs was Crisis Support & Management (mean score: 6.1), followed closely by HR policies (mean score: 5.9). The resource rated lowest among HHPLs was Screening/Assessing for Stress or Burnout (mean score: 3.4).
    - The highest rated resource among FBHOs was HR policies (mean score: 6.1), followed closely by Crisis Support & Management (mean score: 5.7); the lowest was Screening/Assessing for Stress or Burnout (mean score: 3.4).
- Regarding available support staff at the organizations, mental health professionals are most common among HHPLs (50%), followed by 'none of the above.' Chaplains/spiritual advisors are most common for FBHOs (66.7% of respondents), followed by mental health professionals (55.6%). Only 22.2% had none of the types of support staff listed (compared with 42.9% of HHPLs).
- Both groups generally gave positive ratings of both the perceived accessibility of the available resources and the receptivity of the staff to using those resources. However, HHPLs were less confident overall that the resources meet their staff's needs well. (57.1% of HHPLs [n=8] selected 'moderately well' and 35.7% [n=5] selected 'slightly well' or 'not well at all.' 55.6% of FBHOs [n=5] selected 'moderately well' and 44.4%

[n=4] selected ‘very well’ or ‘extremely well.’ None of the FBHOs selected a rating lower than ‘moderately well.’).

- Both HHPLs and FBHOs indicated that the two most common barriers to wellbeing resources at their organizations are lack of funding (85.7% and 66.7%, respectively) and lack of time (64.3% and 77.8%, respectively). Lack of expertise was the third most common barrier to resources for both groups.

Specific Findings

This section will describe in detail the findings of both surveys, categorized by research question.

Research Question #1: What are the factors at Hilton Prize Laureate organizations and faith-based humanitarian organizations that contribute to staff burnout and otherwise challenge staff wellbeing?

Turnover

Proportion: Respondents were asked to approximate their organization’s annual turnover, averaged over the last five years. For both HHPLs and FBHOs, the vast majority of organizations cited annual turnover between 0-20%, with most respondents selecting the 11-20% range (42.9% of HHPLs and 55.6% of FBHOs).

Reasons: Participants were prompted to select their organization’s top three reasons for turnover, in no particular order (Table 1). Among the HHPLs, the most common responses were ‘funding restraints’ (n=8, 57.1%) and ‘other’ (n=8), for which the written-in responses included ones related to pursuing further education and better career opportunities, as well as retirement, marriage, migration, and time-limited contracts. For the FBHOs, the most common reasons for turnover were ‘pay and/or benefits’ (n=4, 44.4%); ‘other’ (n=4), with written-in responses

related to relocation or migration to other countries, as well as young professionals seeking "constant career advancement," and pursuit of other opportunities. Related to this, 3 FBHO participants selected 'barriers to career advancement.'

Table 1. Top reasons for staff turnover among HHPLs and FBHOs.

	HHPLs		FBHOs	
Reason	**Count**	**Percent**	**Count**	**Percent**
Funding restraints	8	57.1%	2	22.2%
Other (specify)	8	57.1%	4	44.4%
Pay and/or benefits	6	42.9%	4	44.4%
Burnout (a combination of feeling exhausted, ineffective, and/or cynical due to cumulative stress)	5	35.7%	2	22.2%
Barriers to career advancement	5	35.7%	3	33.3%
Problems with manager/supervisor	4	28.6%	2	22.2%
Workload	1	7.1%	2	22.2%
Interpersonal conflict	0	0%	1	11.1%
Lack of fit to the job	0	0%	2	22.2%
Medical reasons	0	0%	0	0%
Work environment	0	0%	0	0%

Note: Cells highlighted in yellow indicate the most common responses for each sample.

Burnout

Respondents were asked to consider a list of factors that contribute to staff burnout in the following categories: organizational culture and management, relationships, other aspects of the job, and contextual factors (which are more external to the organization). Respondents were encouraged to select as many options as apply to their organization and staff experience, to the best of their knowledge.

1. *Organizational Culture and Management*

   For the HHPLs, the most common contributing factor to burnout in this category was 'problems with communication' (n=9, 64.3%), followed closely by 'barriers to individual growth and contribution' (n=8, 57.1%). Six organizations selected 'unrealistic or

ambiguous job roles / program objectives,' and five selected 'challenging decision-making processes' and 'lack of transparency.'

The FBHOs reported the same top four factors as the HHPLs – first, 'problems with communication' (n=6, 66.7%), followed by 'barriers to individual growth and contribution' (n=4, 44.4%). 'Unrealistic or ambiguous job roles / program objectives' and 'challenging decision-making processes' were selected by 3 respondents each.

2. *Relationships*

The most common response in this category for HHPLs was 'supervisors,' which 8 organizations (57.1%) selected. Six indicated 'other leadership.' A combined 12 out of 14 organizations (85.7%) indicated that supervisors and/or other leadership were a source of burnout. 'Funders' was selected by 4 organizations, and 3 participants selected 'collaborating organizations.'

For FBHOs, the most common relationships contributing to burnout were 'supervisors,' 'other leadership,' and 'funders' with 4 selections each. (These were the top three choices for the HHPLs as well.) A combined 6 of the 9 organizations (66.7%) indicated that supervisors and/or other leadership were a source of burnout. Three participants selected each of 'peers' and 'project teams.'

3. *Other Aspects of the Job*

By far the most common burnout factors in this category for the HHPL respondents were 'long and/or unpredictable working hours' (n=10, 71.4%) and 'job expectations, roles, responsibilities' (n=9, 64.3%). Less frequent were 'uncertain program funding' (n=6, 42.9%) and 'pay or benefits' (n=5, 35.7%). The FBHOs responded similarly, with their most common selection being 'job expectations, roles, responsibilities' (n=6, 66.7%).

Below that were ‘long and/or unpredictable working hours’ and ‘lack of job fit’ (both with n=4, 44.4%), then ‘pay or benefits’ and ‘uncertain program funding’ (both with n=3, 33.3%).

4. *Contextual Factors*

Interestingly, 6 of the HHPL respondents (42.9%) indicated that none of the contextual factors listed were main sources of burnout for their staff. The next most common selections were ‘surrounding poverty’ (n=5), ‘witnessing suffering / moral distress’ (n=5), and ‘surrounding violence’ (n=4). Six organizations indicated various forms of discrimination: based on race, ethnicity, or national origin (n=2); gender (n=2); and sexual orientation or gender identity/expression (n=2).

Five respondents in the FBHO sample (55.6%) reported that surrounding poverty is a main source of burnout for their staff; and four (44.4%) indicated that none of the contextual factors we listed were an issue. The rest of the long list of options were not commonly selected – all were indicated by between zero and two participants.

5. *FBHOs only – Stressors based in Faith/Religiosity*

Participants in the FBHO sample were asked if their staff experience stressors that have their origins in or are in some way exacerbated by faith/religiosity (e.g. inter-religious tensions, crises of faith, etc.), and if so, to briefly describe them.

Six of the nine responses (66.7%) were either “No” or were left blank. Two respondents indicated religious persecution as a source of high stress – particularly persecution targeted towards Christians, either because it is a minority religion in those settings or because the government there is “oppressive toward religion” in general. One respondent

stated that the effects of faith/religiosity are mild and are caused by "different beliefs that affect work schedules" or "lack of corporate cohesiveness in religious practices."

As shown in Table 2 (below), the factors most commonly contributing to staff burnout among HHPLs had to do with organizational culture, relationships, and other aspects of the job itself. Specifically, the factors selected by more than 50% of HHPLs were: relationships with supervisors and/or other leaders (n=12); long, unpredictable working hours (n=10); problems with communication (n=9); job expectations, roles, responsibilities (n=9); and barriers to individual growth and contribution (n=8). Contextual factors such as surrounding poverty, violence, and health risks were chosen by 36% of HHPLs or less (with 43% indicating that none of them were a burnout factor for their staff). Relationships with all others in the workplace, excluding supervisors and other leadership, were selected by 29% of HHPLs or less.

Next, Table 3 reveals that among a majority of FBHOs, there were several contributing factors to burnout in their staff (namely, 5 factors were selected by more than 50% of FBHOs). Interestingly, all the contextual factors except for 'surrounding poverty' were selected by 22% of FBHOs or less. (As mentioned above, 44% of FBHOs indicated that none of the contextual factors were a source of staff burnout.) Specifically, the most common burnout factors for more than 50% of FBHOs were: relationships with supervisors and/or other leaders (n=6); problems with communication (n=6); job expectations, roles, responsibilities (n=6); and surrounding poverty (n=5). (Note: Tables 2 and 3 do not include the options for "Other (specify)" and "None of the above.")

Table 2. All factors contributing to burnout among HHPLs, by category

Factor	Category	Count	Percent (%)
Supervisors and/or other leaders	Relationships	12	86%
Long, unpredictable working hours	Other aspects of the job	10	71%
Problems with communication	Org. culture	9	64%
Job expectations, roles, responsibilities	Other aspects of the job	9	64%
Barriers to individual growth & contribution	Org. culture	8	57%
Unrealistic or ambiguous job roles / program objectives	Org. culture	6	43%
Uncertain program funding	Other aspects of the job	6	43%
Lack of transparency	Org. culture	5	36%
Challenging decision-making processes	Org. culture	5	36%
Pay and/or benefits	Other aspects of the job	5	36%
Surrounding poverty	Contextual	5	36%
Witnessing suffering / moral distress	Contextual	5	36%
Funders	Relationships	4	29%
Deployment length & timing	Other aspects of the job	4	29%
Surrounding violence	Contextual	4	29%
Collaborating organizations	Relationships	3	21%
Travel	Other aspects of the job	3	21%
Paperwork/bureaucracy	Other aspects of the job	3	21%
Microaggressions	Org. culture	2	14%
Structural/institutional discrimination or bias	Org. culture	2	14%
Peers	Relationships	2	14%
Stakeholders	Relationships	2	14%
Job insecurity	Other aspects of the job	2	14%
Discrimination, insecurity, or threat based on race, ethnicity, or national origin	Contextual	2	14%
Discrimination, insecurity, or threat based on gender	Contextual	2	14%
Discrimination, insecurity, or threat based on sexual orientation, gender identity, or gender expression	Contextual	2	14%
“Macho” or “heroic” organizational culture	Org. culture	1	7%
Stigma around self-care	Org. culture	1	7%
Project teams	Relationships	1	7%
Health risks (due to lack of infrastructure, etc.)	Contextual	1	7%
Community or affected persons	Relationships	0	0%
Lack of job fit	Other aspects of the job	0	0%
Barriers to keeping up with research / policies & recommendations	Other aspects of the job	0	0%

Discrimination, insecurity, or threat based on class or socioeconomic status	Contextual	0	0%
Unsafe or dangerous working conditions	Contextual	0	0%
Relationships with authorities (e.g. police, political officials, etc.)	Contextual	0	0%

Table 3. All factors contributing to burnout among FBHOs, by category

Factor	Category	Count	Percent (%)
Supervisors and/or other leaders	Relationships	6	67%
Problems with communication	Org. culture	6	67%
Job expectations, roles, responsibilities	Other aspects of the job	6	67%
Surrounding poverty	Contextual	5	56%
Barriers to individual growth & contribution	Org. culture	4	44%
Funders	Relationships	4	44%
Long and/or unpredictable working hours	Other aspects of the job	4	44%
Lack of job fit	Other aspects of the job	4	44%
Stressors related to faith/religiosity	*Org. culture (FBHO only)*	*3*	*33%*
Unrealistic or ambiguous job roles / program objectives	Org. culture	3	33%
Challenging decision-making processes	Org. culture	3	33%
Peers	Relationships	3	33%
Project teams	Relationships	3	33%
Uncertain program funding	Other aspects of the job	3	33%
Pay and/or benefits	Other aspects of the job	3	33%
Microaggressions	Org. culture	2	22%
Community or affected persons	Relationships	2	22%
Travel	Other aspects of the job	2	22%
Witnessing suffering / moral distress	Contextual	2	22%
Surrounding violence	Contextual	2	22%
Discrimination, insecurity, or threat based on gender	Contextual	2	22%
“Macho” or “heroic” organizational culture	Org. culture	1	11%
Stigma around self-care	Org. culture	1	11%
Collaborating organizations	Relationships	1	11%
Stakeholders	Relationships	1	11%
Deployment length & timing	Other aspects of the job	1	11%
Paperwork/bureaucracy	Other aspects of the job	1	11%
Barriers to keeping up with research / policies & recommendations	Other aspects of the job	1	11%

Discrimination, insecurity, or threat based on sexual orientation, gender identity, or gender expression	Contextual	1	11%
Discrimination, insecurity, or threat based on religion	Contextual	1	11%
Unsafe or dangerous working conditions	Contextual	1	11%
Relationships with authorities (e.g. police, political officials, etc.)	Contextual	1	11%
Lack of transparency	Org. culture	0	0%
Structural/institutional discrimination or bias	Org. culture	0	0%
Job insecurity	Other aspects of the job	0	0%
Discrimination, insecurity, or threat based on race, ethnicity, or national origin	Contextual	0	0%
Health risks (due to lack of infrastructure, etc.)	Contextual	0	0%
Discrimination, insecurity, or threat based on class or socioeconomic status	Contextual	0	0%

Burnout for Headquarters/Main office staff vs. Remote/Field staff

After the questions about the various internal and external factors that contribute to general staff burnout, we sought to discover the extent to which different types of staff experienced different stressors due to the nature of their work. First, we asked participants if their organization distinguishes between staff at the main office (headquarters or HQ) and those in the "field" (i.e. close to the community and the programs). The respondents who do differentiate between main office and field staff were then asked if the types of stressors faced by both types of staff differed, and if so, to what extent (in their own words).

Of the 10 HHPL organizations who make this distinction, almost all respondents indicated a difference in the nature of the work of the two types of staff, as far as working conditions and the resources at their disposal. These open-text responses indicated that field staff travel more, work more hours, work more closely with the communities, and travel and

work in more difficult areas (whether in isolation, in conflict zones or other danger, in low-resource settings, etc.).

Among their answers, most HHPL survey participants indicated that these working conditions led field staff to feel disconnected from the decisions being made at the main office, to manage everything alone as opposed to being able to rely on a team for support, or to make do with extremely limited resources and poor infrastructure, which has an impact on efficiency. One respondent summarized the distinction between field staff and main office staff by saying that the stressors for the HQ staff were deadlines and workload, whereas the field staff's stressors involved "service delivery, vicarious trauma, security," *in addition to* deadlines and workload.

One HHPL respondent mentioned another important type of resource inequity, indicating that the benefit package and overall compensation for field staff were much lower in quality and quantity than for HQ staff. This participant cited "personal economic stresses created by fluctuations in the cost of living" as a significant one for their organization's field staff, along with the fact that their compensation and benefits are based on the local standard in their area of work, while the HQ staff – based in the U.S. in this case – received their local standard (which, although the respondent didn't explicitly state it, in most cases amounts to much more than the field staff's compensation).

In the FBHO sample, 8 respondents stated that their organizations distinguish between main office and field staff. Of these, the responses indicated in general that the field staff experience more challenges and stressors than the main office staff, although they provided less detail than the HHPL respondents. Challenges faced by FBHO field staff include job insecurity; remote working locations; unfavorable working hours; more decision-making responsibilities;

"more stigma"; more exposure to extreme poverty, violence, and persecution; and fewer resources for coping with stress (as well as scarcity of resources overall).

Burnout for National/Local vs. Foreign/Expatriate staff

In this section, we asked respondents if their organization distinguishes between national staff and foreign staff (i.e. employees working in a country in which they are not a citizen). Then, as above, they were asked if the types of stressors faced by both types of staff differed, and if so, to what extent (in their own words).

Ten HHPL organizations do distinguish between national and foreign staff – the same number that distinguish between HQ and field staff, but not necessarily the same organizations. Responses indicated that the difficulties for foreign/expat staff are centered around being away from their homes and families. Specifically, one respondent listed the following stressors: "being relocated, including being away from family, maintaining the requirements for work permits, limited movement, and navigating language/cultural issues in the work place." Discrimination and currency fluctuation were also mentioned, as well as the lesser benefit package for national staff discussed in the previous section.

Eight FBHOs make the distinction between national and foreign staff, again the same number as the previous section (and, again, not necessarily the same organizations). For the open text follow-up question, there was a wide variety of responses. Challenges for international/foreign staff included feelings of isolation and lack of cohesion with the rest of the organization; raising their own funding; government bureaucracy associated with traveling and working internationally; cultural barriers; and communication challenges. One respondent specified that non-U.S. staff experience different travel/visa restrictions. One respondent indicated that national/local staff are not as trusted by the public as foreign staff are. Another

respondent stated that while the foreign staff face different stresses than the national staff, their organization has "adequate support mechanisms in place" to address them; however, they did not provide additional details about these support mechanisms.

Research Question #2: What types of resources are available at both types of organizations that address burnout and support wellbeing, and how effective are they?

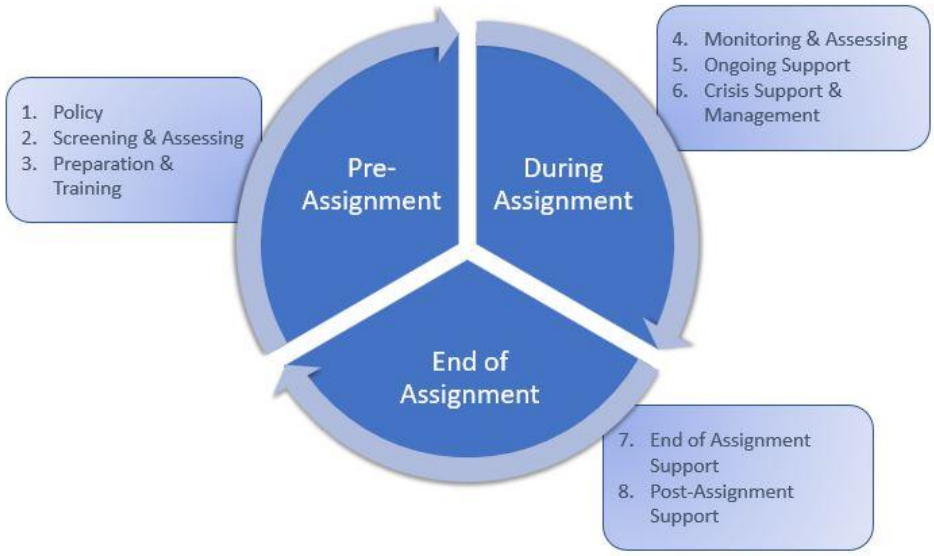
Quality & Effectiveness of Existing Resources

Respondents were asked to indicate, on a sliding scale from 0 to 10, their opinion of the quality and effectiveness of specific resources available in their organization to manage employee stress. A zero indicates not available, not accessed, or completely ineffective. A 10 indicates available, accessed as often as needed, and highly effective. Only whole numbers were possible.[5]

The resources listed in this question are based on a conceptual framework in Antares Foundation's *Managing Stress in Humanitarian Workers: Guidelines for Good Practice* (Antares Foundation, 2012), which we have adapted for clarity and flexibility according to the context of our project (Figure 2, below).

[5] Note: If the respondent did not indicate any number, the slider remained at the default position of zero but registered as a non-response. This explains the response counts that are less than 14, and may represent a source of bias in our data collection. Only one participant registered a zero for one of their resources – and they also left the remaining choices blank (non-response).

Figure 2. Adaptation of Antares Foundation's framework of organizational components for employee wellbeing.

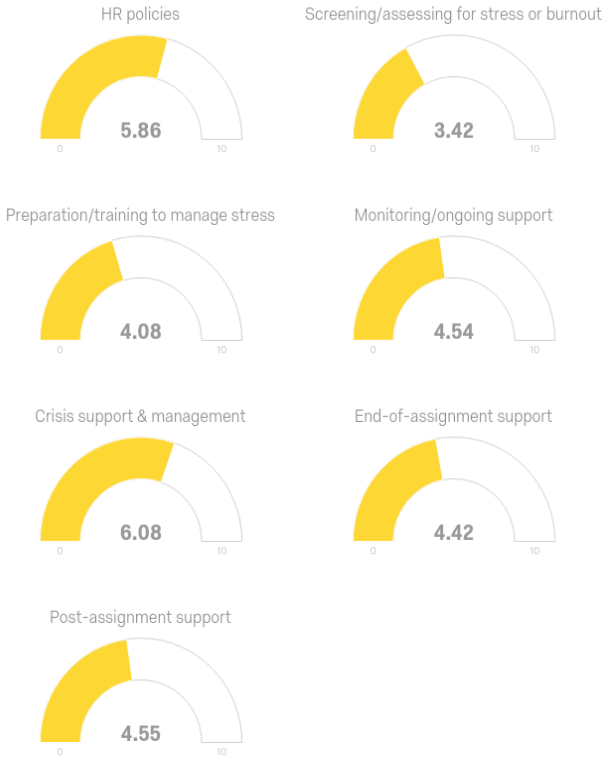


There was a wide variety of responses among HHPLs regarding the quality and effectiveness of their institutional resources, as shown in Table 4 (below). Figure 3 illustrates the positions of the mean scores of each type of support on the gauge from 1 to 10. In a later question, we asked for additional details about the specific resources that these organizations provide to their staff.

Table 4. Frequency table for evaluation of resources among HHPLs.

Resource	**Minimum**	**Maximum**	**Mean**	**Count**
Crisis support & management	2	10	6.1	13
HR policies	0	8	5.9	14
Post-assignment support	2	7	4.6	11
Monitoring / ongoing support	1	10	4.5	13
End-of-assignment support	1	7	4.4	12
Preparation / training to manage stress	2	8	4.1	13
Screening / assessing for stress or burnout	1	6	3.4	12

Figure 3. Mean scores for evaluation of resources among HHPLs.



For the same section, the respondents from the FBHO sample rated their resources remarkably similar to the HHPL participants. Ranked from highest to lowest in order of mean score (Table 5), the evaluation of resources is in almost exactly the same order for the FBOs as for the HHPLs. The average scores for each resource were also remarkably similar (Figure 4).

Table 5. Frequency table for evaluation of resources among FBHOs.

Resource	**Minimum**	**Maximum**	**Mean**	**Count**
HR policies	3	8	6.1	9
Crisis support & management	1	9	5.7	9
Post-assignment support	2	9	5.2	9
Monitoring / ongoing support	1	9	5.1	9
End-of-assignment support	2	7	4.8	6
Preparation / training to manage stress	1	9	4.4	9
Screening / assessing for stress or burnout	0	6	3.4	9

Figure 4. Mean scores for evaluation of resources among FBHOs.

Support Staff

Seven HHPL organizations indicated that they employed some type of mental health professional (e.g. psychologist, counselor, social worker, etc.); this was the most common selection, representing 50% of responses (Table 6). Six organizations (42.9%) selected 'none of the above.' Five HHPLs employ stress reduction professionals (specializing in mindfulness, meditation, etc.), four employ physical health professionals, three employ professional/life coaches, and one employs chaplains or other spiritual advisors.

Among the FBHOs, six respondents (66.7%) indicated that their organizations employ chaplains or spiritual advisors, and five of the nine organizations (55.6%) employ some type of mental health professional. Two (22.2%) FBHOs do not employ any of the support staff that we listed (compared to the aforementioned 6 HHPLs [42.9%] who do not provide any support staff);

two others employ stress reduction professionals. One FBHO respondent selected 'other' and wrote in "Outsourced – motivation speakers, health professionals."

Table 6. Frequency table for HHPL and FBHO support staff.

	HHPLs		FBHOs	
Staff	**Count**	**Percent**	**Count**	**Percent**
Mental health professional (psychologist, counselor, social worker, etc.)	7	50%	5	55.6%
None	6	42.9%	2	22.2%
Stress reduction professionals (mindfulness, meditation, etc.)	5	35.7%	2	22.2%
Physical health professionals (nutrition, fitness, etc.)	4	28.6%	1	11.1%
Professional (life) coaches	3	21.4%	1	11.1%
Chaplains / spiritual advisors	1	7.1%	6	66.7%
Other (specify)	0	0%	1	11.1%

Note: Cells highlighted in yellow indicate the most common responses for each sample.

Resources that Address Wellbeing

When prompted to select all resources on a checklist that their organization provides for its staff, all 14 HHPL respondents indicated that their organizations provide health insurance for their staff (Table 7). The next most common selection was 'Employee Assistance Program (EAP)' (n=8, 57.1%), followed by 'partner/spousal benefits' (n=7, 50%). Six respondents selected 'counseling/therapy (for individuals or families)' and 'trainings.' Five organizations offer wellness programs offered on a permanent basis, workshops or seminars, and/or childcare/nanny support. One organization indicated under 'other' that depending on where their staff is based, they either provide health insurance or they pay a health insurance allowance, and certain international staff are eligible for restoration time (e.g. post-assignment).

Table 7. Frequency table for staff wellbeing resources among HHPLs.

Resource	**Count**	**Percent**
Health insurance	14	100%
Employee Assistance Program (EAP)	8	57.1%
Partner/spousal benefits	7	50%

Counseling/therapy (for individuals or families)	6	42.9%
Trainings	6	42.9%
Wellness programs (offered on a permanent basis)	5	35.7%
Workshops or seminars	5	35.7%
Childcare/nanny support	5	35.7%
Speaker series	4	28.6%
Educational stipends for children	3	21.4%
Support groups	2	14.3%
Wellness programs (offered on a temporary basis)	2	14.3%
Spiritual or religious support	2	14.3%
Restoration time post-travel or post-assignment	2	14.3%
Mentorship program	1	7.1%
Other (specify)	1	7.1%
None of the above	0	0%

Details: Many respondents simply listed the types of resources that their organizations offer, which were previously indicated in the checklist.

Two respondents indicated that the wellbeing resources their organizations offer are restricted to headquarters/main office staff (with the exception of health insurance, which is provided to all). Some offer staff and family psychosocial support for their employees in the field, and/or are looking to expand their resources to include or improve this.

There were two responses of note, which provided detail about a wide array of resources that the organizations offer their staff:

- We offer remote counseling in local languages to all [organization] staff and their families. We offer management counseling for struggling managers. We are weeks away from launching a website with resources in all official languages on psychosocial wellbeing, including screening tools, self-study resources, and videos. We have a mandatory online training on stress and resilience for all staff. A specific online training on Staff Care for Managers will be offered [soon] and will be mandatory for all supervisors. We also have a variety of staff led groups--employee resource groups, personnel committees, and staff welfare groups.

- We have an additional private health insurance for all employees that covers therapies and interventions to counter and address stress, such as psychological support, physiotherapy, work aids, acupuncture etc. We also have an agreement with another larger NGO for specialized post-travel/assignment de-briefing and counseling in case staff had a traumatic experience during the mission. Due the the [sic] small size of our organisation we do not have specialized counseling staff on our team.

The most common selection for the faith-based organizations was, unsurprisingly, 'spiritual or religious support,' with 7 of 9 organizations (77.7%), followed by the Employee Assistance Program (EAP) and health insurance with 6 organizations each (Table 8). Four participants selected each of 'workshops or seminars' and 'restoration time post-travel or post-assignment.'

Table 8. Frequency table for staff wellbeing resources among FBHOs.

Resource	**Count**	**Percent**
Spiritual or religious support	7	77.8%
Employee Assistance Program (EAP)	6	66.7%
Health insurance	6	66.7%
Workshops or seminars	4	44.4%
Restoration time post-travel or post-assignment	4	44.4%
Counseling therapy (for individuals or families)	2	22.2%
Trainings	2	22.2%
Educational stipends for children	2	22.2%
Other (specify)	2	22.2%
Support groups	1	11.1%
Wellness programs (offered on a permanent basis)	1	11.1%
Wellness programs (offered on a temporary basis)	1	11.1%
Mentorship program	1	11.1%
Speaker series	1	11.1%
Partner/spousal benefits	1	11.1%
Childcare/nanny support	0	0%
None of the above	0	0%

Details: Again, respondents primarily listed their organizations' available resources with a small amount of additional detail. The resources listed (that weren't already explicitly covered in the previous question) include:

- Generous paid time off (PTO) and health insurance policies
- Flexible post-assignment/deployment recovery time
- Sabbatical and long-term training opportunities
- "Stay" interviews and exit interviews for all staff
- Organization-wide devotions and prayer teams; frequent prayers for the needs of the staff
- Daily meditation and chanting

There was one response of note, which provided great detail about a wide array of resources that the organization offers various groups of their staff. [Formatted as a bulleted list for clarity]:

- Seminars and workshop - this is especially done for leadership but sometimes includes participation of all staff.
- Religious support - weekly prayer and devotional times amongst groups of staff.
- Care Teams - committees formed amongst our staff to intentionally look into the welfare of the children.
- Nurses - employed by the organisation assist in advisory of health related issues with the staff.
- Doctors - are consulted when staff require extensive medical intervention that they cannot afford.
- Donations - in-kind usually given towards staff welfare.
- Open door policy that helps in keeping the management informed on staff welfare.
- Compassionate leave and tokens given especially when a staff member is bereaved or in crisis.

Staff Use & Need

Respondents were asked to answer questions, using open text boxes, regarding which staff (e.g. entry-level vs. high-level, headquarters vs. remote/field, male vs. female, etc.) utilize their organization's resources the most, which staff utilize them the least, and which staff need the resources the most.

1. *Use Most*

Among the HHPLs, many respondents indicated that entry-level, HQ/main office, and female staff members were the types or levels of staff that used the resources the most. Some also observed that management used the resources because they "have family dependents" or because "they have been around enough to know that they benefit from these resources." One respondent noted that their staff is 75% female, which probably reflects the approximate gender make-up of many other humanitarian organizations in our sample, and would partially explain the higher use of resources among female staff. A few respondents indicated that they did not have the data to support an answer, that

there was no determinable use pattern among their staff, or that all their staff use the resources equally.

For the FBHOs, the most common response (n=4, 44.4%) was that "all staff" use the resources the most, which is to say that all their employees use the resources equally. One respondent indicated that the field staff uses the resources the most because they experience more stress in their work. Another respondent stated that the HQ staff use the resources the most "because there are gaps in figuring out how to best include/disseminate info to overseas staff." Two respondents indicated that they did not have the data to support an answer.

2. Use Least

Responses for this question varied in the HHPL sample, but included high-level/executive staff, mid-level staff, remote/field staff, corporate services staff (who are "not exposed to" the organization's target population), and male staff.

One respondent indicated that their entry-level staff do not utilize the resources because they perceive their work at the organization "as a great and fun opportunity," eagerly accepting unpaid internships and other junior positions, which means they generally do not need (and/or do not qualify for) available resources. Two other respondents stated that they did not have the data to support an answer or that there was no determinable pattern of use among their staff.

Within the FBHO group, three respondents (33.3%) stated that the entry-level staff use the resources the least. One respondent clarified that this is because they are "still acclimatizing to the new environment and tend to be extra cautious before feeling

comfortable enough to utilize the resources fully." Also listed were new staff, regional office staff, field staff ("due to inaccessibility"), and high-level staff. A few respondents indicated that they did not have the data to support an answer.

3. Need Most

About half of the HHPL respondents indicated that all of their staff need the resources the most, "due to the stress and limitation in resources," "to help manage work life issues and challenges," "for different reasons," or to "not assume that there are sections of staff that my [sic] need it less."

The other respondents listed entry-level, HQ, and female staff; international missions program team; front line staff, who deal directly and daily with the community; field office staff who are closer to violence (terrorist attacks and ethnic conflicts); local nationals, who are often seen as more "resilient" and therefore perceived as not able to directly benefit from resources; remote field and foreign nationals; and "particular attention to staff who travel heavily and those staff with heavy and sustained workloads."

Among FBHOs, three respondents indicated that the field staff needs the resources the most; one of these elaborated on the reasoning, saying this is "due to environmental, political and physical circumstances under which they work." (A different participant listed levels of staff that presumably have similarly strenuous responsibilities: front workers, case managers, and disaster response teams.) Three other respondents stated that all employees need the resources.

In addition to these groupings, there were two relatively unique responses. One participant speculated that mid-level managers and directors have the highest rate of

burnout, and highest need for resources, due to the level of stress inherent in their jobs. Another participant described the responsibilities and challenges faced by their operations staff, who are tasked with the slow work of finding replacements in the event of turnover, in the face of a "competitive market and funding limitations."

General Evaluation

Note: Table 9, at the end of this sub-section, summarizes the overall evaluation of resource accessibility, staff receptivity, and need fulfillment among both HHPLs and FBHOs.

1. *Accessibility*

Most HHPL respondents (n=8, 57.1%) indicated that their organization's resources were 'somewhat accessible' (Figure 5). One respondent selected 'not accessible.' The remainder (n=5, 35.7%) selected 'very accessible.'

For the FBHOs, most respondents indicated that their organization's resources were either 'very accessible' (n=4) or 'somewhat accessible' (n=4) (Figure 6). One respondent selected 'not very accessible.'

Figure 5. Frequency distribution of HHPL resource accessibility.

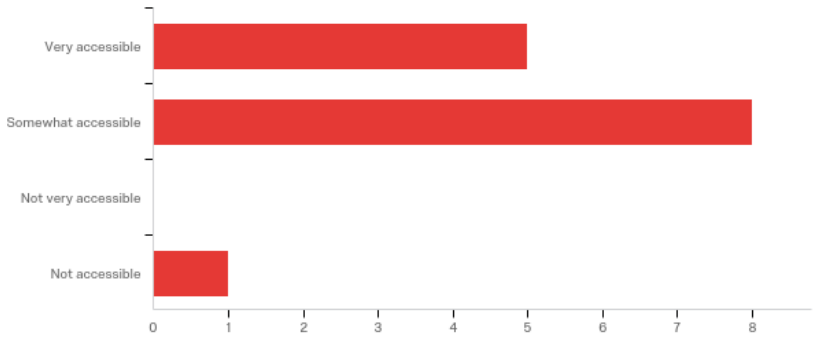
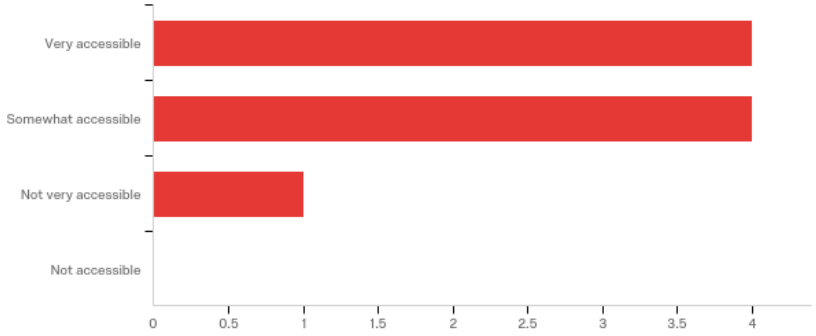


Figure 6. Frequency distribution of FBHO resource accessibility.



2. Staff Receptivity

The majority of HHPLs (n=10, 71.4%) indicated that the staff at their organization were 'somewhat receptive' to the resources offered (Figure 7). The remainder (n=4, 28.6%) selected 'very receptive.'

Four FBHO respondents (44.4%) indicated that the staff at their organization were 'very receptive' to the resources offered (Figure 8). Three participants selected 'somewhat receptive.' Two respondents selected 'not very receptive.'

Figure 7. Frequency distribution of HHPL staff receptivity to resources.

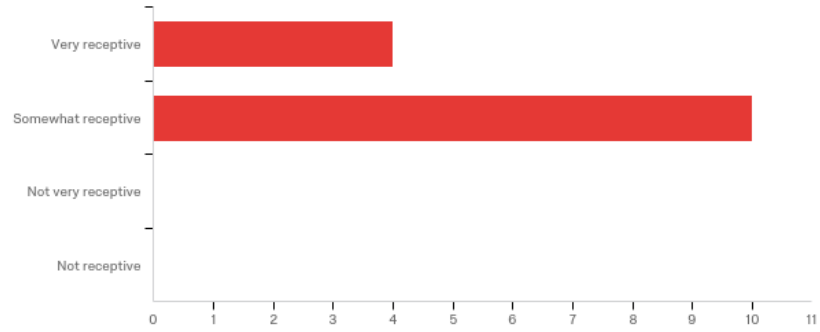
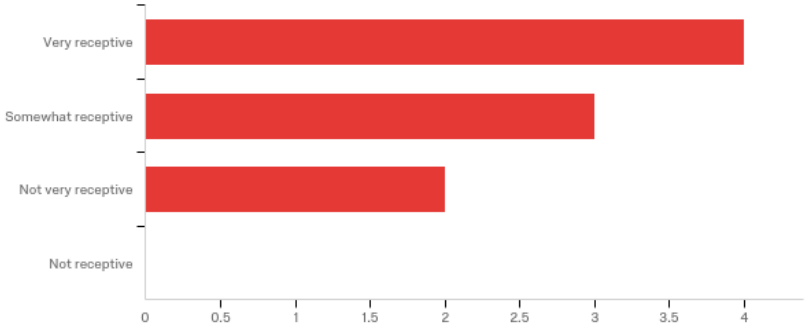


Figure 8. Frequency distribution of FBHO staff receptivity to resources.



3. *Fulfill Employees' Needs*

Note: For this question, we clarified that 'needs' referred to emotional, mental, psychological, and physical needs.

Among the HHPLs, most respondents (n=8, 57.1%) indicated that their existing resources met the staff's needs 'moderately well' (Figure 9). Three respondents (21.4%) selected 'slightly well.' Two respondents selected 'not well at all.' One respondent selected 'very well.'

As for the FBHOs most respondents (n=5, 55.6%) indicated that their existing resources met the staff's needs 'moderately well' (Figure 10). Three respondents (33.3%) selected 'very well.' One participant selected 'extremely well.'

Figure 9. Frequency distribution of HHPL resource staff need fulfillment

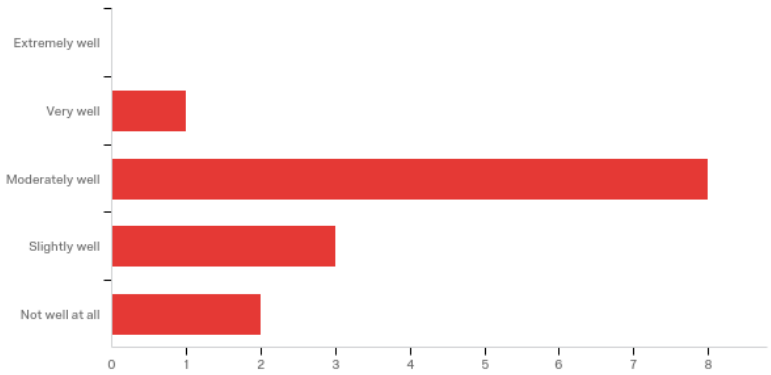


Figure 10. Frequency distribution of FBHO resource staff need fulfillment

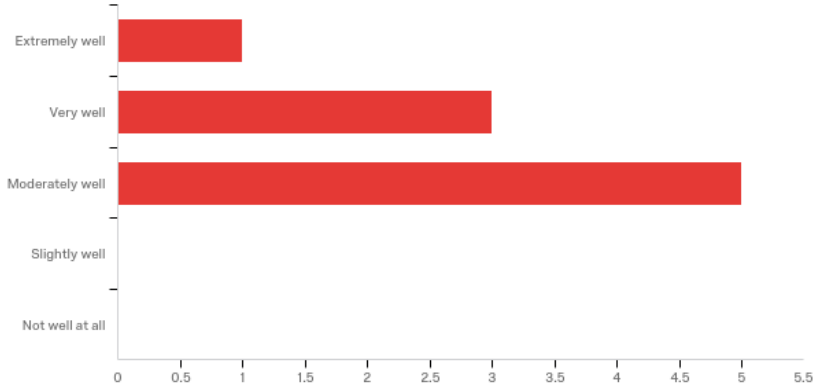


Table 9. Frequency table for resource accessibility, staff receptivity, and need fulfillment among HHPLs and FBHOs

		Very	Somewhat	Not very	Not
Accessible					
FBHOs		4 (44.4%)	4 (44.4%)	1 (11.1%)	0 (0%)
HHPLs		5 (35.7%)	8 (57.1%)	0 (0%)	1 (7.1%)
Receptive					
FBHOs		4 (44.4%)	3 (33.3%)	2 (22.2%)	0 (0%)
HHPLs		4 (28.6%)	10 (71.4%)	0 (0%)	0 (0%)
	Extremely well	**Very well**	**Moderately well**	**Slightly well**	**Not well at all**
Fulfill needs					
FBHOs	1 (11.1%)	3 (33.3%)	5 (55.6%)	0 (0%)	0 (0%)
HHPLs	0 (0%)	1 (7.1%)	8 (57.1%)	3 (21.4%)	2 (14.3%)

Note: Cells highlighted in yellow indicate the most common responses for each sample.

Barriers

When asked which organizational barrier(s), if any, are preventing their organization from sufficiently addressing staff stress, burnout, and mental health (Table 10), 12 HHPL respondents (85.7%) selected ‘lack of funding.’ The next most common responses were ‘lack of time’ (n=9, 64,3%) and ‘lack of expertise’ (n=8, 57.1%).

In the FBHO group, seven respondents (77.8%) selected 'lack of time,' followed closely by 'lack of funding' (n=6, 66.7%) Two organizations selected 'lack of expertise.' One participant selected 'other' and wrote in "lack of perceived need."

Table 10. Frequency table of barriers to resources among HHPLs and FBHOs.

	HHPLs		FBHOs	
Barrier	**Count**	**Percent**	**Count**	**Percent**
Lack of funding	12	85.7%	6	66.7%
Lack of time	9	64.3%	7	77.8%
Lack of expertise	8	57.1%	2	22.2%
Lack of support from leadership or board	2	14.3%	1	11.1%
None	1	7.1%	1	11.1%
Lack of interest	0	0%	1	11.1%
Other (specify)	0	0%	1	11.1%

Note: Cells highlighted in yellow indicate the most common responses for each sample.

Resource Wish List

This question asked participants what resources they wish their organization could add to its "wellbeing tool-kit or culture." The most common responses among HHPLs were various forms of psychosocial counseling/support and stress management resources. Some other examples include:

- "…regular counseling for staff in protection fields to guard against vicarious trauma… [and] more help around facilitating culture change around gender biases in our field sites."
- "Funding for institutional time (mentoring, training, reflection, etc.)"
- "Occupational health infrastructure; Staff safety and security infrastructure…"
- "Pre and post psycho-social counseling; crisis management; stress management training for managers and staff; cultural sensitivity, safety and security trainings."

For FBHOs, the most common response to this wish list question was mentoring support or one-on-one coaching (n=4, 44.4%). One participant elaborated on this need, saying: "We are a relatively small organization with limited paths for advancement - personal and career coaching could empower staff to find their niche and explore their options."

Some other responses from this sample included:

- Funding that is designated to staff benefits and welfare; a dedicated staff care team
- Greater support for spouses and families
- Access to medical and education support for employees and their families.
- More HR officers
- Support in developing and implementing an exhaustive HR Policy and Employee Handbook
- Staff retreat outside of the office

Research Question #3: To what extent do stress and burnout (in terms of reported intensity, stressors, and contributing factors) and the resources, structures, and processes available to support staff wellbeing differ between the secular Hilton Prize Laureate organizations and the faith-based humanitarian organizations?

The final two questions in the survey for the FBHOs were intended to investigate the extent to which the religious foundations of the organizations had an effect on (1) the quantity, severity, and/or type of stressors experienced by staff, and (2) the support/resources offered to staff to cultivate wellbeing and mitigate burnout. (These questions were not presented to the HHPLs.)

Stress

There was a fairly wide variety of responses to the question about staff stress. Among the challenges listed were:

- Difficulty saying ‘no’ to various high-level figures in the organization (due to the relationship with the larger church);

- Chronic over-work and obstacles to self-care, caused by "urgency to the problems and a strong commitment to accompany our partners";
- Pressure from and accountability to donors; and
- Sensitivity to criticism from the Church (possibly related to the above point).

One respondent stated that they believe there is a positive effect related to religion: the "higher level of resilience with staff of faith." They offered the caveat that this resilience should not be "assumed or taken advantage of."

Three respondents indicated that they do not believe the religious nature of their organization has an effect on the stressors experience by their staff.

Aside from these responses, there were two of note that are best quoted in their entirety:

- "The day to day mission is to serve the underserved. In carrying out this mission, there can be a sense of there is not enough of me, there is not enough time, to accomplish what we have set out to do. In those times, it is important for staff to recognize we are the instruments and God is in control."
- "Our organization's mission is to go to the 'end of the road' when deciding where to work and who to work with; we go to the places that no other organization wants to go to because of conditions/poverty/dangerous environments. Therefore, these stressors are inherently part of our work."

Support/Resources

Respondents indicated the following faith-related factors that affect the support that their organizations provide for their staff:

- Weekly faith- and connection-building sessions for employees, which the participant stated is "useful in building a level of resilience"
- "Spiritual cultivation" trips

- Compassion; profound care and support from senior leadership for staff wellbeing and benefits packages

Two participants did not perceive faith or religion as affecting their organization's staff support. One participant indicated that there is a desire to support staff but it is "hindered by a lack of resources." Another respondent stated eloquently: "We see each person as a reflection of God and it is our duty and privilege to support them in all ways possible. We are founded on the belief that in service to others we are fulfilled ourselves."

Summary

These results indicate, while many of these organizations are not yet naming burnout as a main reason for their staff turnover, their employees do experience burnout and chronic exposure to stress, due to a number of factors related to the nature of their work. The impact of this stress is difficult to pinpoint and is beyond the scope of this project, but warrants further attention and investigation. Most of the participants indicated a need and a desire for additional resources to support their staff, but in the face of various barriers are currently unable to provide them.

Despite the small sample sizes in both groups, the breadth and depth of information provided by these survey results represents an important opportunity for additional research and further investigation of these issues facing humanitarian organizations of all kinds. The organizations who took the time to respond to our surveys are widely considered among the best and most successful health, development, and relief organizations in the world. Likely the experiences of their staff are comparable to those of countless other humanitarian professionals, and surely the insights gained from this small project can be beneficial to any number of other efforts to mitigate burnout and support staff wellbeing.

Chapter 5: Discussion and Recommendations

Discussion

As a hypothesis-generating project, with a very small convenience sample that cannot be generalized to a larger population, the outcome of the surveys and the following discussion represent an ingress to future investigation of the issue of burnout and wellbeing resources for secular and faith-based humanitarian organizations. The survey results stand on their own as answers to the research questions at the foundation of this study, regarding the major factors contributing to burnout in HHPLs and FBHOs and their available resources to support staff wellbeing. Beyond that, this study can contribute to the existing body of research about burnout in humanitarian organizations, and can be used to create many more questions and identify further areas of exploration.

Most of the responses from the HHPLs and the FBHOs were very similar to each other, in terms of sources and experience of burnout; their organizational structures regarding both main office and field staff as well as local/national staff and expatriate staff, and their respective work-related stressors; the accessibility of their resources and the receptivity of their staff to using them; and the barriers to providing wellbeing resources. Within a few sections, such as the categories of factors contributing to burnout, the two groups sometimes even had the same top two or three answers, in the same order.

Among all the categories of factors contributing to burnout (organizational culture, relationships, contextual factors, etc.), the 4 most common responses for HHPLs were: supervisors and/or other leaders; long, unpredictable working hours; problems with communication; and job expectations, roles, responsibilities. The 4 most common for FBHOs

were almost the same, with 'long, unpredictable working hours' substituted by 'surrounding poverty.' Six (42.9%) HHPLs and four (44.4%) FBHOs said none of the contextual factors listed were main sources of burnout. These findings reflect the literature that indicates that the chronic stressors leading to burnout arise not only from factors outside of the workers' organizations but also – and potentially to an even greater degree – from internal workplace factors as well (Ager et al., 2012; Aronsson et al., 2017; B. L. Cardozo et al., 2013; Chemali et al., 2018; Eriksson et al., 2013; Strohmeier & Scholte, 2015).

Findings from this survey related to the experiences of field/frontlines staff versus main office/headquarters staff also reflect the literature, in that field staff in both HHPLs and FBHOs typically experience the same stressors related to workload as the main office staff, with the added challenges of extreme working conditions and inequity of resources and benefits compared to headquarters staff. However, the conclusion that the challenges for foreign staff in both HHPLs and FBHOs are generally worse than for their national staff is a departure from the literature. Most of the research on this subject points overwhelmingly to a differential risk of burnout to national staff, due to organizational and experiential inequities between national and expatriate staff, both in terms of entitlement to support resources and other benefits, as well as team cohesion and prior exposure to trauma (Ager et al., 2012; Antares Foundation, 2012; B. L. Cardozo et al., 2013; Barbara Lopes Cardozo et al., 2005; Eriksson et al., 2013).

The fact that there was so much overlap between the two samples make the differences between them stand out even more. The two groups differed when it came to the types of resources that they offer their staff; the types of support staff they employ; and how well they feel their wellbeing resources meet their employees' needs (the FBHOs' responses for this question were more positive overall than those of the HHPLs). Perhaps the starkest among these

differences, albeit not surprising, was the number of FBHOs who employ chaplains or other religious/spiritual advisors as compared to the HHPLs who do: n=6 (66.7%) and n=1 (7.1%), respectively. The only HHPL who indicated that they employ a chaplain or chaplains is not expressly faith-based, but is a hospital setting, which would explain why they have this type of professional on their staff. This difference points to a divergence in the two humanitarian groups' approach to and understanding of wellbeing in the workplace.

Because there is little published research on specific organizational wellbeing resources and their direct impact on reducing burnout in humanitarian workers, it is difficult to determine the extent to which these survey findings reflect the literature. However, the survey results suggest that the FBHOs reported overall effectiveness of and higher satisfaction with their wellbeing resources compared to HHPLs. Since their employment of chaplains is the main difference in wellbeing resources compared to the HHPLs, this *may* serve as another piece of evidence of the possible protective effect of religious/spiritual belief and practice against burnout, as found in recent studies (Carneiro et al., 2019; Ho et al., 2016; Kim & Yeom, 2018).

Despite the lack of generalizability of these survey results to the greater humanitarian population, this study still represents the experience of 23 reputable and impactful organizations working with hundreds of countries around the world in the fields of health, development, and relief. The rich information that the respondents shared with me can be used to further understand the sources of burnout in such organizations and inform recommendations for resources that support staff wellbeing.

Recommendations

In its contributions to the limited body of research on burnout in humanitarian workers, this study is particularly illuminating in its comparison of these two groups of organizations and

what they may be able to learn from each other. In this section, I recommend some areas of further research in light of the hypotheses generated by this project. I also propose some practical resources that HHPLs and FBHOs can use to internally foster their staff wellbeing, as well as some ways they can help each other in the struggle against burnout, for the benefit of their employees and the communities in which they work. There are plenty of advantages to interdisciplinary work in the fields of global health and humanitarian aid, so there are likely other benefits to breaking down the silos between secular and faith-based organizations and sharing the knowledge and perspective that each has gained from their experiences.

Recommendations for Further Research

The survey findings related to staff chaplains evokes a number of questions that, again, are beyond the scope and purpose of this study to answer, but which offer a variety of opportunities for enriched understanding of the role that faith can play in the humanitarian field. Why do so many FBOs, including 6 of the 9 FBHOs surveyed in this study, employ chaplains? I propose that perhaps there is some spiritual dimension to burnout that is being overlooked and that could be well served by different untapped resources or professionals. Chaplains may serve a role in addressing burnout that isn't met by other types of support staff and resources, and there may be needs that are unaddressed in secular organizations that chaplains are supporting in FBOs. For example, chaplains may be uniquely beneficial in addressing moral distress, moral disempowerment, and moral injury in humanitarian workers.

The United States military, whose members confront moral distress and innumerable other stressors regularly, employs psychologists as well as chaplains (U.S. Army, n.d.; Zieger, 2009). As a branch of the U.S. government, the military is obviously a secular entity, but

apparently this is not an obstacle to providing religiously-based staff. Even in the private sector, secular mid-sized companies and even large corporations, such as Tyson Foods, have started employing chaplains as a workplace benefit – not only in the United States, but in Europe and Hong Kong as well (Green, 2016). So why don't more secular non-profit and non-governmental organizations employ chaplains or other religious professionals – especially global health, relief, and development organizations who are struggling with burnout? I recommend this as another area for investigation, to further the humanitarian community's understanding about what chaplains contribute to burnout prevention and inform secular organizations' decisions in hiring support staff.

The surveys in this study sought to understand more about the sources of burnout than its effects. This leaves additional questions about the measured impact of chronic work-related stress and burnout on individual employees and on the effectiveness of the organizations they work for in achieving their programmatic goals and overall mission. Another gap in knowledge following this study is how these organizations can overcome the various barriers that they identified to providing wellbeing resources for their staff.

Recommendations for Action

First and foremost, if they are interested in addressing this issue, humanitarian organizations should make staff wellbeing a priority, as formally and officially as possible – in their conversations with their boards and other governing bodies, in their budgets, in their internally-facing programmatic agendas, by improving existing organizational resources and policies and/or implementing new strategies to address burnout. They should institute processes such as those recommended by the Antares Foundation (see Chapter 2: Literature Review):

1. Policy – The agency has a written and active policy to prevent or mitigate the effects of stress.
2. Screening and Assessing – The agency systematically screens and/or assesses the capacity of staff to respond to and cope with the anticipated stresses of a position or contract.
3. Preparation and Training – The agency ensures that all staff have appropriate pre-assignment preparation and training in managing stress.
4. Monitoring – The agency ensures that staff response to stress is monitored on an ongoing basis.
5. Ongoing Support – The agency provides training and support on an ongoing basis to help its staff deal with their daily stresses.
6. Crisis Support and Management – The agency provides staff and teams with specific culturally appropriate support in the wake of critical or traumatic incidents and other unusual and unexpected sources of severe stress.
7. End of Assignment Support – The agency provides practical, emotional, and culturally-appropriate support for staff at the end of an assignment or contract.
8. Post Assignment Support – The agency has clear written policies with respect to the ongoing support it will offer to staff who have been adversely impacted by exposure to stress and trauma during their assignment. (Antares Foundation, 2012)

Furthermore, the various parallels found in these surveys suggest that HHPLs and FBHOs share similar challenges with burnout and similar interests in wellbeing. This would allow for a collective effort in advocating for wellbeing among secular and faith-based humanitarian workers. This advocacy could include (1) promoting the widespread consideration of the gravity of the public health problem that burnout poses, and (2) the prioritization of formal organizational wellbeing resources among all those dedicated to global health, development, relief, and other forms of humanitarian aid. This includes dispelling the 'Overhead Myth' and dismantling the 'Nonprofit Starvation Cycle' (see Chapter 2: Literature Review) by joining forces with the BBB Wise Giving Alliance, GuideStar, Charity Navigator, and other institutions to encourage donors to acknowledge the importance of administrative costs and other internally-facing resources to the vitality of every non-profit organization (Gregory & Howard, 2009; Taylor et al., 2013, 2014).

The Appendix contains a list of accessible resources (Appendix G) as well as several additional strategies for wellbeing (Appendix H), which participating organizations provided to the Hilton Coalition Humanitarian Wellbeing Project team to be disseminated.

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APPENDICES

Appendix A. Organizational Characteristics of HHPL Respondents

Organization	**Type** **(Categories of work & target population)**	**Staff Size**	**Location of main office(s)**	**Where they work**	**Differentiate between Field & HQ staff?**	**Differentiate between national & foreign staff?**
Aravind Eye Care System	Global health / Social medicine (Clinical)	4,500	India	India	No	No
BRAC USA	Children / youth; Refugees / IDPs; Women; Agriculture; Economic empowerment / micro-lending; Global health / social medicine; Poverty; Sustainable development; Victim assistance; War / conflict zones	8,000	USA	11 countries; Asia and Africa	Yes	Yes
ECPAT International	Children / youth; Sustainable development; Trafficking / exploitation; Victim assistance	25	Thailand	90+ countries; all continents except Australia	No	Yes
Humanity & Inclusion	People with disabilities; Refugees / IDPs; Victim assistance; War / conflict zones	15 (US); 300 (France HQ); 3000+ field	8 national offices (Europe & North America)	59 countries; Africa, Asia, and South America	Yes	Yes
Heifer International	Women; Agriculture; Poverty; Sustainable development	960	USA	23 countries; Africa, Asia, and North & South America	Yes	Yes

icddr,b	Global health / Social medicine (Research)	4,000	Bangladesh	Bangladesh	Yes	Yes
International Rescue Committee (IRC)	Refugees / IDPs; War / conflict zones	13,000	USA	41 countries; all continents except Australia	Yes	Yes
IRCT	Victim assistance	13	Denmark	35-70 countries; all continents	No	No
Operation Smile	Global health / social medicine	450	USA	45 countries; all continents except Australia	Yes	Yes
Partners in Health	Global health / social medicine	15,000	USA	9 countries; Africa and North & South America	Yes	Yes
PATH	Global health / social medicine	1,700	USA	70 countries; Africa, Asia, Europe, North America	No	Yes
St. Christopher's Hospice	Elderly / seniors; Global health / social medicine	600	England	England	Yes	-
Task Force for Global Health	Global health / social medicine	152 (doesn't include field staff)	USA	157 countries; all continents	Yes	No
Women for Women International	Women; Economic empowerment / micro-lending; Poverty	400	USA	10 countries; Africa and Asia	Yes	Yes

Appendix B. Organizational Characteristics of FBHO Respondents

Organization	Type (Categories of work & target population)	Staff Size	Location of main office(s)	Where they work	Differentiate between Field & HQ staff?	Differentiate between national & foreign staff?
ADRA International (Adventist Development and Relief Agency)	Refugees/IDPs; Sustainable development; Women; Agriculture; Children/youth	110	USA	131 countries (Africa, Asia, Australia, Europe, North America, South America)	Yes	Yes
Buddhist Tzu Chi Foundation	Poverty; Refugees/IDPs; Sustainable development; Victim assistance; Women; Agriculture; Children/youth; Elderly/ seniors; Global health/ Social medicine; Homelessness; Mental health; People with disabilities	500+	Taiwan	87 countries (Africa, Asia, Australia, Europe, North America, South America)	Yes	Yes
Catholic Medical Mission Board (CMMB)	Poverty; Sustainable development; Women; Agriculture; Children/youth; Economic empowerment / micro-lending; Elderly/seniors; Global health/ Social medicine; People with disabilities	250	USA	5 countries (Africa, North America, South America)	Yes	Yes
Episcopal Relief & Development	Poverty; Sustainable development; Women; Agriculture; Children/youth; Economic empowerment /	55	USA	31 countries (Africa, Asia, North America, South America)	No	Yes

	micro-lending					
IMA World Health	Global health/ Social medicine	300	USA	5 countries (Africa, South America)	Yes	Yes
New Life Home Trust	Children/youth; Global health/ Social medicine; Mental health; People with disabilities	138	Kenya	Approx. 20 countries (Africa)	Yes	Yes
Nyumbani	Poverty; Children/youth; Economic empowerment / micro-lending; Homelessness	310	Kenya	5 countries (Africa)	Yes	Yes
Water4, Inc.	Sustainable development; Economic empowerment / micro-lending	30	USA	16 countries (Africa, South America)	Yes	No
World Concern	Poverty; Refugees/IDPs; Sustainable development; Trafficking/ exploitation (sex/labor); War/conflict zones; Women; Agriculture; Children/youth; Economic empowerment / micro-lending	633	USA	16 countries (Africa, Asia, North America)	Yes	Yes

Appendix C. The Hilton Humanitarian Prize

Background

The Conrad N. Hilton Humanitarian Prize began in 1996 as a way of paying tribute to its namesake's international philanthropic efforts. Since then, it has doubled its award from $1 million to $2 million and has made a name for itself as the world's largest annual humanitarian prize awarded to a non-profit organization (rather than to an individual) (Conrad N. Hilton Foundation, 2019a).

Qualifications / evaluation criteria

The prize selection committee is made up of seven jurors who each serve at least one four-year term. Five of the committee spots are for prominent individuals in the international field of humanitarianism, and the remaining two are filled by a Hilton Foundation Board member and a member of the Hilton family (Conrad N. Hilton Foundation, 2019a). The jurors review nominations from around 200 organizations in more than 100 countries every year and present the award to the organization deemed to have made the most "exemplary and extraordinary contributions toward alleviating human suffering" that year (Conrad N. Hilton Foundation, 2019a, 2019b).

The selection committee considers the following elements in their selection of each laurate:

- Extraordinary contributions toward alleviating human suffering
- Established record of achievement
- Demonstration of impact
- Ability to serve as a model for other nonprofits
- Demonstration of effective partnerships
- Innovation in program design
- Organizational capacity and administrative efficiency (Conrad N. Hilton Foundation, 2019d).

There are currently 23 Hilton Humanitarian Prize laureate organizations:

2018 SHOFCO (Shining Hope for Communities)[6]
2017 icddr,b
2016 The Task Force for Global Health
2015 Landesa
2014 Fountain House / Clubhouse International
2013 ECPAT International
2012 HelpAge International
2011 Humanity & Inclusion (formerly Handicap International)
2010 Aravind Eye Care System
2009 PATH
2008 BRAC
2007 Tostan
2006 Women for Women International
2005 Partners In Health
2004 Heifer International
2003 International Rehabilitation Council for Torture Victims
2002 SOS Children's Villages
2001 St Christopher's Hospice
2000 Casa Alianza
1999 Amref Health Africa
1998 Doctors Without Borders
1997 International Rescue Committee
1996 Operation Smile
(Conrad N. Hilton Foundation, 2018)

[6] This is the only organization that was not included in the Hilton Coalition's Humanitarian Wellbeing Project, as it received its award after the project began.

Appendix D. Sample Population of Faith-based Humanitarian Organizations.

The following FBHOs were solicited via email for survey responses.

- ADAMS Center
- American Friends Service Committee (AFSC)
- American Jewish World Service (AJWS)
- Buddhism and Social Development Action
- Caritas Internationalis
- Catholic Medical Mission Board (CMMB)
- Catholic Relief Services
- Christian Commission for Development in Bangladesh (CCDB)
- Christian Health Association of Kenya (CHAK)
- Christian Health Association of Zambia (CHAZ)
- Christian Social Services Commission of Tanzania (CSSC)
- Church World Service
- Convoy of Hope
- Coptic Mission
- Cornerstone International
- Diakon Lutheran Social Ministries
- DIFAEM (German Institute for Medical Mission)
- Episcopal Relief & Development
- Global Ministries (UCC) – Council for Health & Human Services Ministries
- IMA World Health
- INERELA+
- Islamic Relief Worldwide
- Islamic Society of North America (ISNA)
- JAMKHED – CRHP (Comprehensive Rural Health Program)
- Jesuit Refugee Service
- Lutheran World Federation
- New Life Home Trust
- Nyumbani
- PACANET (Pan-African Christian AIDS Network)
- Rahma Relief Foundation
- Salvation Army
- The Adventist Development and Relief Agency (ADRA)
- Tzu Chi Foundation
- United Methodist General Board of Global Ministries
- Water4
- World Concern
- World Vision

Appendix E. The Hilton Wellbeing Project Survey

Hilton Wellbeing Project

Start of Block: Section 1: Organizational Background Information

Welcome to the Hilton Prize Coalition Wellbeing Project survey.

We appreciate you taking the time to answer our questions about your organization. This survey is part of a Hilton Prize Coalition project addressing wellbeing in the workplace. It is intended to identify challenges to employee wellbeing, inventory existing resources and policies, and provide recommendations to Hilton Humanitarian Prize laureates to further address those challenges.

This survey should take approximately 25-30 minutes to complete. You will not be able to save your answers and leave the survey to complete at a later time, so please ensure that you have plenty of time before you begin. The progress bar at the top of your screen will indicate how much you have left to fill out.

Your responses will not be viewed by anyone outside of our project team at the Task Force for Global Health and the University of Notre Dame. For all reports and presentations related to the project, responses to the survey will be presented in the aggregate: unassociated with your name, your organization's name, or any other identifying information.

Thank you so much for your time and your participation in our project.

Q1 What is your name?

_____

Q2 What organization do you work with?

_____

Q3 What is your job title/position at that organization?

_____

To begin, we would like to ask you some general background questions about your organization. This will help us understand the size, scope, and impact of your organization and its work, for categorization purposes.

Q4 Which of these categories best describe the affected populations and/or programs that constitute your organization's main focus of work? (Select all that apply.)

- ☐ Children/youth
- ☐ Elderly/seniors
- ☐ People with disabilities
- ☐ Refugees / internally displaced persons
- ☐ Women
- ☐ Agriculture
- ☐ Economic empowerment / micro-lending
- ☐ Global health/Social medicine
- ☐ Homelessness
- ☐ Mental health
- ☐ Poverty
- ☐ Sustainable development
- ☐ Trafficking / exploitation (sex/labor)
- ☐ Victim assistance
- ☐ War / conflict zones

Q5 Approximately how many staff are employed at your organization, including any field staff?

_____

Q6 How many countries, including your own, does your organization currently work in?
(By "work" we mean managing projects, collaborating with partners, or supporting work financially or with staff.)

_____

Q7 Where does your organization work? (Select all that apply.)

- ☐ Africa
- ☐ Asia
- ☐ Australia
- ☐ Europe
- ☐ North America
- ☐ South America

Q8 What has been the annual employee turnover rate (%) at your organization, averaged over the last 5 years?

- ○ 0-10%
- ○ 11-20%
- ○ 21-30%
- ○ 31-40%
- ○ 41-50%
- ○ 51% or more

Q9 Please select the 3 most common reasons for employee turnover in your organization.

Note: You can select no more than 3 boxes.

- ☐ Burnout (a combination of feeling exhausted, ineffective, and/or cynical due to cumulative stress)
- ☐ Interpersonal conflict
- ☐ Pay and/or benefits
- ☐ Workload
- ☐ Barriers to career advancement
- ☐ Lack of fit to the job
- ☐ Problems with manager/supervisor
- ☐ Other (specify) _____
- ☐ Funding restraints
- ☐ Medical reasons
- ☐ Work environment

End of Block: Section 1: Organizational Background Information

---

Start of Block: Section 2: Stressors in the Workplace

Now we would like to ask you about your perception of factors in your organization that may contribute to burnout.

***Burnout** is the state of physical and/or mental exhaustion or collapse caused by chronic overwork and cumulative stress. It often results from a combination of feeling increasingly **ineffective** (a reduced sense of personal accomplishment, competence or overall job effectiveness), **exhausted** (feeling depleted, overextended), and/or **cynical** (holding depersonalized, callous attitudes towards work and others, feeling detached).*

The next three questions address potential contributors to burnout in the following categories:
(1) organizational culture and management, (2) relationships, and (3) other aspects of the job.

Q10
Organizational Culture and Management

We define organizational culture as "values, norms, rites, rituals, symbols, and shared beliefs that make up an organization" (Champoux 1996).
Please indicate which of the following aspects of organizational culture & management contribute to burnout and/or compromise worker wellbeing in your organization. (Select all that apply.)

- ☐ Barriers to individual growth and contribution
- ☐ Challenging decision-making processes
- ☐ Lack of transparency
- ☐ "Macho" or "heroic" organizational culture
- ☐ Micro-aggressions (communications or encounters, whether intentional or unintentional, which communicate negative messages against members of a marginalized group)
- ☐ Problems with communication
- ☐ Stigma around self-care
- ☐ Structural/institutional discrimination or bias
- ☐ Unrealistic or ambiguous job roles / program objectives
- ☐ Other (specify) _____
- ☐ ⊗ None of the above

Q11
Relationships

Please indicate which of the following workplace relationships contribute to burnout or compromise worker wellbeing in your organization's employees. (Select all that apply.)

- ☐ Peers
- ☐ Project teams
- ☐ Supervisors
- ☐ Other leadership
- ☐ Community or affected persons
- ☐ Stakeholders
- ☐ Funders
- ☐ Collaborating organizations
- ☐ Other (specify) _____
- ☐ ⊗ None of the above

Q12
Other Aspects of the Job

Please indicate which of the following job-related aspects contribute to burnout or compromise worker wellbeing in your organization's employees. (Select all that apply.)

- ☐ Long and/or unpredictable working hours
- ☐ Job expectations, roles, responsibilities
- ☐ Travel
- ☐ Deployment length and timing
- ☐ Lack of job fit
- ☐ Job insecurity
- ☐ Uncertain program funding
- ☐ Pay or benefits
- ☐ Paperwork/bureaucracy
- ☐ Barriers to keeping up with current research / policies & recommendations
- ☐ Other (specify) _____
- ☐ ⊗ None of the above

In addition to these three major contributors to burnout, some of your staff may work in challenging contexts and experience additional stressors that contribute to burnout.

Q13 Please indicate which of the following *contextual* factors contribute to burnout or compromise worker wellbeing in your organization's employees. (Select all that apply.)

- ☐ Discrimination, insecurity, or threat based on class / socioeconomic status
- ☐ Discrimination, insecurity, or threat based on race, ethnicity, or national origin
- ☐ Discrimination, insecurity, or threat based on religion
- ☐ Discrimination, insecurity, or threat based on gender
- ☐ Discrimination, insecurity, or threat based on sexual orientation, gender identity, or gender expression
- ☐ Health risks (due to lack of infrastructure, etc.)
- ☐ Surrounding poverty
- ☐ Surrounding violence
- ☐ Unsafe or dangerous working conditions
- ☐ Witnessing suffering/ moral distress
- ☐ Relationships with authorities (e.g. police, political officials, etc.)
- ☐ Other acute stressor (specify) _____
- ☐ ⊗ None of the above

Q14 In your organization, do you distinguish between staff at the main office (headquarters) and those in the "field," i.e. close to the community and the programs?

- ○ Yes
- ○ No

Skip To: Q16 If In your organization, do you distinguish between staff at the main office (headquarters) and thos... = No

---

Q15 Do the types of stressors faced by staff in the field differ from those faced by staff at the main office? If so, please briefly describe.

_____

_____

_____

Q16 In your organization, do you distinguish between foreign staff (i.e. employees working in a country in which they are not a citizen) and national staff?

- ○ Yes
- ○ No

Skip To: Q17 In your organization, do you distinguish between foreign staff (i.e. employees working in a count... = No

Q17 Do the types of stressors faced by foreign staff differ from those faced by national staff? If so, please briefly describe.

_____

_____

_____

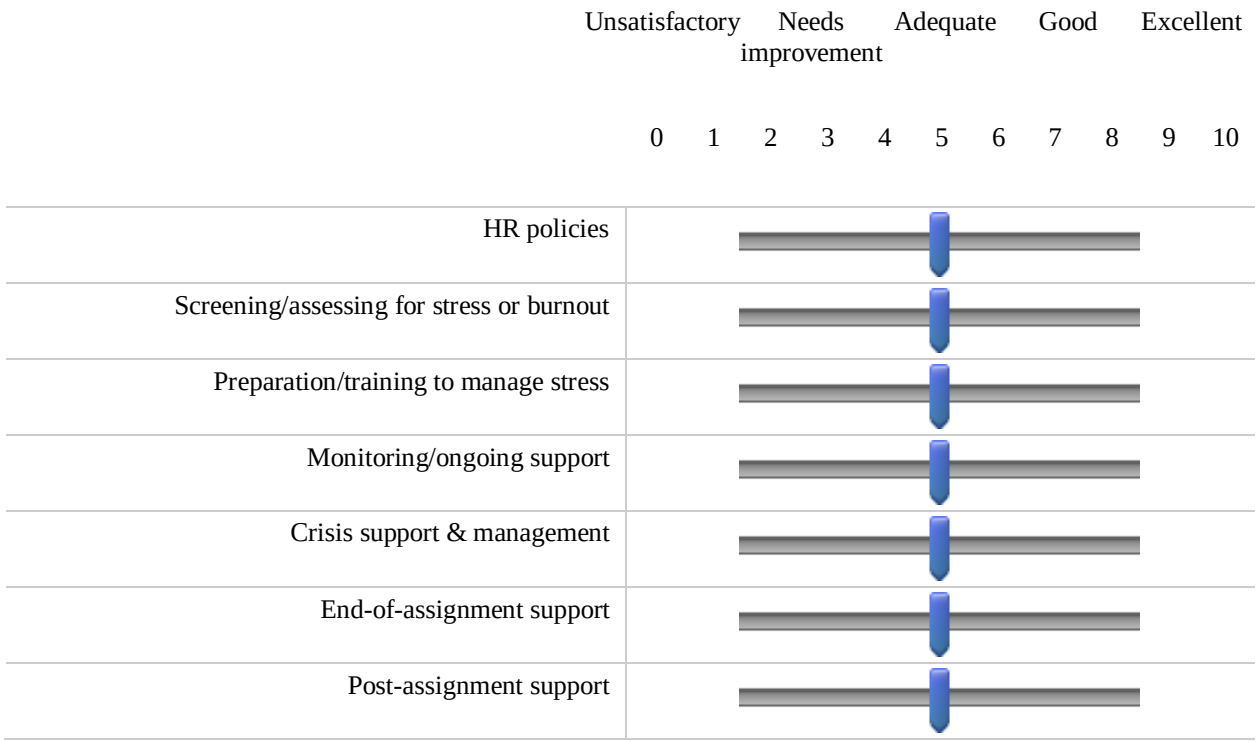
End of Block: Section 2: Stressors in the Workplace

Start of Block: Section 3: Resources to Support Well-being & Address Distress

For this next section, we would like to ask you questions about the availability and quality of various resources for your organization's employees, specifically those that address employees' physical, emotional, and psychological wellbeing.

Q18 Please drag each slider below to indicate your opinion of the quality and effectiveness of specific resources available in your organization to *manage employee stress*.

Note: A zero would indicate not available, not accessed, or completely ineffective. A 10 would indicate available, accessed as often as needed, and highly effective.



Q19 Which of the following types of support staff, if any, does your organization employ for the benefit of your employees? (Select all that apply.)

- ☐ Mental health professionals (psychologists, counselors, social workers, etc.)
- ☐ Physical health professionals (nutrition, fitness, etc.)
- ☐ Stress reduction professionals (mindfulness, meditation, etc.)
- ☐ Chaplains / spiritual advisors
- ☐ Professional (life) coaches
- ☐ Other (specify) _____
- ☐ ⊗ None of the above

Q20 Does your organization offer any of the following types of resources that address wellbeing, resilience, burnout, trauma, and/or mental health? (Select all that apply.)

- ☐ Employee Assistance Program (EAP)
- ☐ Counseling/therapy (for individuals or families)
- ☐ Support groups
- ☐ Wellness programs (offered on a permanent basis)
- ☐ Wellness programs (offered on a temporary basis)
- ☐ Spiritual or religious support
- ☐ Mentorship program
- ☐ Speaker series
- ☐ Trainings
- ☐ Workshops or seminars
- ☐ Health insurance
- ☐ Restoration time post-travel or post-assignment
- ☐ Partner/spousal benefits
- ☐ Childcare/nanny support
- ☐ Educational stipends for children
- ☐ ⊗ None of the above
- ☐ Other (specify) _____

Skip To: Q28 If Does your organization offer any of the following types of resources that address wellbeing, resi... = None of the above

Q21 Please describe in more detail the resources available at your organization that you selected in the previous question, particularly the ones that have been the most successful in addressing worker wellbeing/burnout.

_____

_____

_____

Q22 Which staff do you believe utilize these resources the most, and why? (e.g. entry-level vs. high-level, headquarters vs. remote/field, male vs. female, etc.)

_____

_____

_____

Q23 Which staff do you believe utilize these resources the least, and why? (e.g. entry-level vs. high-level, headquarters vs. remote/field, male vs. female, etc.)

_____

_____

_____

Q24 Which staff do you believe need these resources the most, and why? (e.g. entry-level vs. high-level, headquarters vs. remote/field, male vs. female, etc.)

_____

_____

_____

Q25 In your opinion, how accessible to employees are these resources?

- ○ Very accessible
- ○ Somewhat accessible
- ○ Not very accessible
- ○ Not accessible

Q26 In your opinion, how receptive are employees to using these resources, in general?

- ○ Very receptive
- ○ Somewhat receptive
- ○ Not very receptive
- ○ Not receptive

Q27 How well do you feel that these programs/resources fulfill employees' needs?

Note: "Needs" refers to emotional, mental, psychological, and physical needs.

- ○ Extremely well
- ○ Very well
- ○ Moderately well
- ○ Slightly well
- ○ Not well at all

Q28 What resource(s) do you wish your organization could add to its wellbeing tool-kit or culture?

_____

_____

_____

_____

Q29 Please indicate which organizational barrier(s), if any, are preventing your organization from sufficiently addressing staff stress, burnout, and mental health. (Select all that apply.)

- ☐ Lack of funding
- ☐ Lack of time
- ☐ Lack of expertise
- ☐ Lack of interest
- ☐ Lack of support from leadership or board
- ☐ Other (specify) _____
- ☐ ⊗ None

End of Block: Section 3: Resources to Support Well-being & Address Distress

Appendix F. Faith-based Organizations Wellbeing Survey

Faith-Based Organizations Wellbeing Survey

Start of Block: Section 1: Organizational Background Information

Welcome to the FACE/Interfaith Health Program Wellbeing Project survey.

We appreciate you taking the time to answer our questions about your organization. This survey is part of a graduate student thesis project collaboration with the Focus Area for Compassion and Ethics (FACE) at the Task Force for Global Health and the Interfaith Health Program (IHP) at Emory University. It is intended to identify challenges to employee wellbeing, inventory existing resources and policies, and provide recommendations to humanitarian organizations to further address those challenges.

This survey should take approximately 25-30 minutes to complete. You will not be able to save your answers and leave the survey to complete at a later time, so please ensure that you have plenty of time before you begin. The progress bar at the top of your screen will indicate how much you have left to fill out.

Your responses will not be viewed by anyone outside of our project team at FACE and IHP. For all reports and presentations related to the project, responses to the survey will be presented in the aggregate: unassociated with your name, your organization's name, or any other identifying information.

Thank you so much for your time and your participation in our project.

Q1 What is your name?

_____

Q2 What organization do you work with?

_____

Q3 What is your job title/position at that organization?

_____

To begin, we would like to ask you some general background questions about your organization. This will help us understand the size, scope, and impact of your organization and its work, for categorization purposes.

Q4 Which of these categories best describe the affected populations and/or programs that constitute your organization's main focus of work? (Select all that apply.)

- [ ] Children/youth (3)
- [ ] Elderly/seniors (5)
- [ ] People with disabilities (9)
- [ ] Refugees / internally displaced persons (11)
- [ ] Women (16)
- [ ] Agriculture (2)
- [ ] Economic empowerment / micro-lending (4)
- [ ] Global health/Social medicine (6)
- [ ] Homelessness (7)
- [ ] Mental health (8)
- [ ] Poverty (10)
- [ ] Sustainable development (12)
- [ ] Trafficking / exploitation (sex/labor) (13)
- [ ] Victim assistance (14)
- [ ] War / conflict zones (15)

Q5 Approximately how many staff are employed at your organization, including any field staff?

_____

Q6 How many countries, including your own, does your organization currently work in?
(By "work" we mean managing projects, collaborating with partners, or supporting work financially or with staff.)

_____

Q7 Where does your organization work? (Select all that apply.)

- ☐ Africa (1)
- ☐ Asia (2)
- ☐ Australia (3)
- ☐ Europe (4)
- ☐ North America (5)
- ☐ South America (6)

Q8 What has been the annual employee turnover rate (%) at your organization, averaged over the last 5 years?

- ○ 0-10% (6)
- ○ 11-20% (7)
- ○ 21-30% (8)
- ○ 31-40% (9)
- ○ 41-50% (10)
- ○ 51% or more (11)

Q9 Please select the 3 most common reasons for employee turnover in your organization.

Note: You can select no more than 3 boxes.

- ☐ Burnout (a combination of feeling exhausted, ineffective, and/or cynical due to cumulative stress) (6)
- ☐ Interpersonal conflict (4)
- ☐ Pay and/or benefits (7)
- ☐ Workload (2)
- ☐ Barriers to career advancement (1)
- ☐ Lack of fit to the job (3)
- ☐ Problems with manager/supervisor (11)
- ☐ Other (specify) (9) _____
- ☐ Funding restraints (10)
- ☐ Medical reasons (5)
- ☐ Work environment (8)

End of Block: Section 1: Organizational Background Information

---

Start of Block: Section 2: Stressors in the Workplace

Now we would like to ask you about your perception of factors in your organization that may contribute to burnout.

Burnout *is the state of physical and/or mental exhaustion or collapse caused by chronic overwork and cumulative stress. It often results from a combination of feeling increasingly* ***ineffective*** *(a reduced sense of personal accomplishment, competence or overall job effectiveness),* ***exhausted*** *(feeling depleted, overextended), and/or* ***cynical*** *(holding depersonalized, callous attitudes towards work and others, feeling*

detached).

The next three questions address potential contributors to burnout in the following categories: (1) organizational culture and management, (2) relationships, and (3) other aspects of the job.

Q10

Organizational Culture and Management

We define organizational culture as "values, norms, rites, rituals, symbols, and shared beliefs that make up an organization" (Champoux 1996).

Please indicate which of the following aspects of organizational culture & management contribute to burnout and/or compromise worker wellbeing in your organization. (Select all that apply.)

- ☐ Barriers to individual growth and contribution (12)
- ☐ Challenging decision-making processes (3)
- ☐ Lack of transparency (1)
- ☐ "Macho" or "heroic" organizational culture (5)
- ☐ Microaggressions (communications or encounters, whether intentional or unintentional, which communicate negative messages against members of a marginalized group) (11)
- ☐ Problems with communication (2)
- ☐ Stigma around self-care (6)
- ☐ Structural/institutional discrimination or bias (13)
- ☐ Unrealistic or ambiguous job roles / program objectives (4)
- ☐ Other (specify) (7) _____
- ☒ None of the above (8)

Q11
Relationships

Please indicate which of the following workplace relationships contribute to burnout or compromise worker wellbeing in your organization's employees. (Select all that apply.)

- ☐ Peers (1)
- ☐ Project teams (8)
- ☐ Supervisors (4)
- ☐ Other leadership (10)
- ☐ Community or affected persons (13)
- ☐ Stakeholders (6)
- ☐ Funders (12)
- ☐ Collaborating organizations (5)
- ☐ Other (specify) (11) _____
- ☐ ⊗ None of the above (16)

Q12
Other Aspects of the Job

Please indicate which of the following job-related aspects contribute to burnout or compromise worker wellbeing in your organization's employees. (Select all that apply.)

- ☐ Long and/or unpredictable working hours (2)
- ☐ Job expectations, roles, responsibilities (6)
- ☐ Travel (9)
- ☐ Deployment length and timing (11)
- ☐ Lack of job fit (5)
- ☐ Job insecurity (4)
- ☐ Uncertain program funding (12)
- ☐ Pay or benefits (1)
- ☐ Paperwork/bureaucracy (10)
- ☐ Barriers to keeping up with current research / policies & recommendations (7)
- ☐ Other (specify) (8) _____
- ☐ ⊗ None of the above (13)

In addition to these three major contributors to burnout, some of your staff may work in challenging contexts and experience additional stressors that contribute to burnout.

Q13 Please indicate which of the following *contextual* factors contribute to burnout or compromise worker wellbeing in your organization's employees. (Select all that apply.)

- ☐ Discrimination, insecurity, or threat based on class / socioeconomic status (15)
- ☐ Discrimination, insecurity, or threat based on race, ethnicity, or national origin (14)
- ☐ Discrimination, insecurity, or threat based on religion (20)
- ☐ Discrimination, insecurity, or threat based on gender (5)
- ☐ Discrimination, insecurity, or threat based on sexual orientation, gender identity, or gender expression (19)
- ☐ Health risks (due to lack of infrastructure, etc.) (2)
- ☐ Surrounding poverty (3)
- ☐ Surrounding violence (17)
- ☐ Unsafe or dangerous working conditions (1)
- ☐ Witnessing suffering/ moral distress (11)
- ☐ Relationships with authorities (e.g. police, political officials, etc.) (18)
- ☐ Other acute stressor (specify) (9) _____
- ☐ ⊗ None of the above (10)

Q14 Do your staff experience stressors that have their origins in or are in some way exacerbated by faith/religiosity? (e.g. inter-religious tensions, crises of faith, etc.)
If so, please briefly describe.

_____

_____

_____

_____

_____

Q15 In your organization, do you distinguish between staff at the main office (headquarters) and those in the "field," i.e. close to the community and the programs?

- Yes (1)
- No (2)

Skip To: Q17 If In your organization, do you distinguish between staff at the main office (headquarters) and thos... = No

Q16 Do the types of stressors faced by staff in the field differ from those faced by staff at the main office? If so, please briefly describe.

_____

_____

_____

_____

_____

Q17 In your organization, do you distinguish between foreign staff (i.e. employees working in a country in which they are not a citizen) and national staff?

- ○ Yes (1)
- ○ No (2)

Skip To: End of Block If In your organization, do you distinguish between foreign staff (i.e. employees working in a count... = No

Q18 Do the types of stressors faced by foreign staff differ from those faced by national staff? If so, please briefly describe.

_____

_____

_____

_____

_____

End of Block: Section 2: Stressors in the Workplace

Start of Block: Section 3: Resources to Support Well-being & Address Distress

For this next section, we would like to ask you questions about the availability and quality of various resources for your organization's employees, specifically those that address employees' physical, emotional, and psychological wellbeing.

Q19 Please indicate your opinion of the quality and effectiveness of specific resources available in your organization to *manage employee stress* **by entering the corresponding number (from 0 to 10) in the space next to each resource.**

Note: A zero would indicate not available, not accessed, or completely ineffective. A 10 would indicate available, accessed as often as needed, and highly effective.

	Unsatisfactory		Needs improvement		Adequate		Good			Excellent
	0	1	2	3	4	5	6	7	8	9	10
HR policies ()											
Screening/assessing for stress or burnout ()											
Preparation/training to manage stress ()											
Monitoring/ongoing support ()											
Crisis support & management ()											
End-of-assignment support ()											
Post-assignment support ()											

Q20 Which of the following types of support staff, if any, does your organization employ for the benefit of your employees? (Select all that apply.)

- ☐ Mental health professionals (psychologists, counselors, social workers, etc.) (1)
- ☐ Physical health professionals (nutrition, fitness, etc.) (8)
- ☐ Stress reduction professionals (mindfulness, meditation, etc.) (9)
- ☐ Chaplains / spiritual advisors (3)
- ☐ Professional (life) coaches (7)
- ☐ Other (specify) (4) _____
- ☐ ⊗ None of the above (5)

Q21 Does your organization offer any of the following types of resources that address wellbeing, resilience, burnout, trauma, and/or mental health? (Select all that apply.)

- ☐ Employee Assistance Program (EAP) (12)
- ☐ Counseling/therapy (for individuals or families) (9)
- ☐ Support groups (6)
- ☐ Wellness programs (offered on a permanent basis) (4)
- ☐ Wellness programs (offered on a temporary basis) (5)
- ☐ Spiritual or religious support (10)
- ☐ Mentorship program (11)
- ☐ Speaker series (3)
- ☐ Trainings (2)
- ☐ Workshops or seminars (1)
- ☐ Health insurance (17)
- ☐ Restoration time post-travel or post-assignment (16)
- ☐ Partner/spousal benefits (13)
- ☐ Childcare/nanny support (14)
- ☐ Educational stipends for children (15)
- ☒ None of the above (8)
- ☐ Other (specify) (7) _____

Skip To: Q29 If Does your organization offer any of the following types of resources that address wellbeing, resi... = None of the above

Q22 Please describe in more detail the resources available at your organization that you selected in the previous question, particularly the ones that have been the most successful in addressing worker wellbeing/burnout.

_____

_____

_____

_____

_____

Q23 Which staff do you believe utilize these resources the most, and why? (e.g. entry-level vs. high-level, headquarters vs. remote/field, male vs. female, etc.)

_____

_____

_____

_____

_____

Q24 Which staff do you believe utilize these resources the least, and why? (e.g. entry-level vs. high-level, headquarters vs. remote/field, male vs. female, etc.)

_____

_____

_____

_____

_____

Q25 Which staff do you believe need these resources the most, and why? (e.g. entry-level vs. high-level, headquarters vs. remote/field, male vs. female, etc.)

_____

_____

_____

_____

_____

Q26 In your opinion, how accessible to employees are these resources?

- Very accessible (1)
- Somewhat accessible (2)
- Not very accessible (3)
- Not accessible (4)

Q27 In your opinion, how receptive are employees to using these resources, in general?

- Very receptive (1)
- Somewhat receptive (2)
- Not very receptive (3)
- Not receptive (4)

Q28 How well do you feel that these programs/resources fulfill employees' needs?

Note: "Needs" refers to emotional, mental, psychological, and physical needs.

- ○ Extremely well (1)
- ○ Very well (2)
- ○ Moderately well (3)
- ○ Slightly well (4)
- ○ Not well at all (5)

Q29 What resource(s) do you wish your organization could add to its wellbeing tool-kit or culture?

_____

_____

_____

_____

_____

Q30 Please indicate which organizational barrier(s), if any, are preventing your organization from sufficiently addressing staff stress, burnout, and mental health. (Select all that apply.)

- ☐ Lack of funding (1)
- ☐ Lack of time (2)
- ☐ Lack of expertise (3)
- ☐ Lack of interest (4)
- ☐ Lack of support from leadership or board (5)
- ☐ Other (specify) (7) _____
- ☐ ⊗ None (9)

End of Block: Section 3: Resources to Support Well-being & Address Distress

---

Start of Block: Block 3

"FBOs [faith-based organizations] have properties that make them uniquely able to deliver health care, health education, and other services, including well-established health service-delivery networks and infrastructures, histories of clear commitments to local communities, the trust of local communities, and a capacity to mobilize volunteers." - Dr. Peter J. Brown, Emory University. (From Religion as a Social Determinant of Public Health*, 2014, ed. Ellen L. Idler, Ch. 20.)*

We agree with Dr. Brown's statement, and we similarly believe that the **particular motivations and values** of the individuals working within FBOs may have a distinctive influence on the experience of wellbeing and burnout among the staff at those organizations, and on the resources FBOs may offer that provide staff support, **as compared to secular humanitarian organizations**.

Please reflect on this idea for a moment before responding to the final two questions.

Q31 In your opinion, how (if at all) does your organization's foundation in faith/religion affect the quantity, severity, and/or type of stressors that your staff experience in their typical work?

_____

_____

_____

_____

_____

Q32 In your opinion, how (if at all) does your organization's foundation in faith/religion affect the support it offers to its staff (to cultivate wellbeing, mitigate burnout, etc.)?

_____

_____

_____

_____

_____

End of Block: Block 3

Appendix G. Additional Resources for Organizational Wellbeing

Note: This appendix was compiled by Dr. Deirdre Guthrie and was featured in the complete (unpublished) version of the project team's report to the Hilton Coalition (Guthrie et al., 2019).

A note from Dr. Guthrie: These resources are provided in the spirit of information sharing, and their inclusion is not meant to indicate an endorsement of specific tools or products.

ORGANIZATIONAL ASSESSMENTS

Perlo, J., Balik, B., Swensen, S., Kabcenell. A., Landsman, J., & Feeley, D. (2017) IHI Framework for improving joy in work. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement. See Appendix A. "What Matters to You?" Conversation Guide. (Available at ihi.org)

Dik, B. J., Eldridge, B. M., Steger, M. F., & Duffy, R. D. (2012). Development and validation of the Calling and Vocation Questionnaire (CVQ) and Brief Calling Scale (BCS). *Journal of Career Assessment, 20*(3), 242-263. doi:10.1177/1069072711434410

Self-Sacrifice Scale

Bélanger, J. J., Caouette, J., Sharvit, K., & Dugas, M. (2014). The psychology of martyrdom: Making the ultimate sacrifice in the name of a cause. *Journal of Personality and Social Psychology*, *107*(3), 494.

POLICY AND MODELS OF WELLBEING

Welton-Mitchell, C.E. (2013). UNHCR'S Mental health and psychosocial support for staff. , Geneva: United Nations High Commissioner for Refugees Policy Development & Evaluation Service. Retrieved from https://www.unhcr.org/research/evalreports/51f67bdc9/unhcrsmental-health-psychosocial-support-staff.html

Community for Understanding Scale Up working group. (2017). On the CUSP of change: Effective scaling of social norms programming for gender equality. Briefing paper. Retrieved from http://steppingstonesfeedback.org/wpcontent/ uploads/2017/09/CUSP.SVRIpaper.Final_.6sept2017.forWeb.pdf

Fisher, C.D. (2010). Happiness at work. *International journal of management reviews, 12* (4), 384-412.

Perlo, J., Balik, B., Swensen, S., Kabcenell. A., Landsman, J., & Feeley, D. (2017) IHI Framework for improving joy in work. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement. (Available at ihi.org)

Sexton, J.B., Helmreich, R.L., Neilands, T.B., Rowan, K., Vella, K., Boyden, J., et al. (2006). The safety attitudes questionnaire: Psychometric properties, benchmarking data, and emerging

research. *BMC Health Services Research,* 6, 44. doi: 10.1186/1472-6963-6-44

SCREENING AND ASSESSING

The Center for Physician Wellbeing. (2019). Screen your Wellbeing. Retrieved from https://www.thecpw.org/screen-your-wellbeing.

O'Reilly, C. A. III, Chatman, J., & Caldwell, D. F. (1991). People and organizational culture: A profile comparison approach to assessing person-organization fit. *The Academy of Management Journal, 34*(3), 487-516.

Dyrbye, L. N., Meyers, D., Ripp, J., Dalal, N., Bird, S. B., & Sen, S. (2018). A pragmatic approach for organizations to measure health care professional well-being. *NAM Perspectives.* Discussion Paper, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/201810b

Reichheld, F.F. The one number you need to grow. (2003). *Harvard Business Review.* Retrieved from https://hbr.org/2003/12/the-one-number-you-need-to-grow. (Note: contains net promoter score to measure internal team member engagement.)

Stamm, B.H. (2005). The ProQOL manual: The professional quality of life scale: Compassion fatigue/secondary trauma scale. Baltimore: Sidran Press. (Note: an updated (2010) version is available online at http://www.proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf).

Winwood, P. C., Colon, R., & McEwen, K. (2013). A practical measure of workplace resilience: Developing the resilience at work scale. *Journal of Occupational and Environmental Medicine, 55*(10), 1205-1212. doi: 10.1097/JOM.0b013e3182a2a60a

ProQOL.org. (2019, April 6). Bibliography of compassion satisfaction, compassion fatigue, secondary trauma and vicarious trauma. Retrieved from https://proqol.org/Bibliography.html

PREPARATION AND TRAINING

Bloom, S.L. (1997). Creating sanctuary: Toward the evolution of sane societies. New York: Routledge. (Note: includes S.E.L.F.: A Trauma Informed Psychoeducational Group Curriculum)

Eisenman, D., Weine, S., Green, B., de Jong, J., Rayburn, N., Ventevogel, P., et al. (2006). The ISTSS/Rand guidelines on mental health training of primary healthcare providers for trauma exposed populations in conflict-affected countries. *Journal of Traumatic Stress, 19*(1), 5–17.

Ehrenreich, J. H. & Elliot, T. L. (2004). Managing stress in humanitarian aid workers: A survey of humanitarian aid agencies' psychosocial training and support of staff. *Peace and Conflict: Journal of Peace Psychology, 10*(1), 53–66.

Shanafelt, T.D., Gorringe, G., Menaker R., Storz, K. A., Reeves, D., Buskirk, S. J., et al. (2015). Impact of organizational leadership on physician burnout and satisfaction. *Mayo Clinic*

Proceedings, 90(4), 432-440. (Note: Includes Mayo Clinic Leadership Dimensions Assessment)

MONITORING AND ONGOING SUPPORT

Engagement

Montgomery, A., Spânu, F., Băban, A., & Panagopoulou, E. (2015), Job demands, burnout, and engagement among nurses: A multi-level analysis of ORCAB data investigating the moderating effect of teamwork. *Burnout Research, 2,* 71-79.

Nilsson, W. (August 2009). Sustaining engagement in social purpose organizations: An institutional perspective on positive organizational practices (Unpublished doctoral thesis). Montreal: Faculty of Management, McGill University.

Compassion Fatigue

Mathieu, F. (2012). The compassion fatigue workbook: Creative tools for transforming compassion fatigue and vicarious traumatization. New York: Routledge.

Orfi, D. (2013). What doctors feel: How emotions affect the practice of medicine. Boston, MA: Beacon Press.

Pfifferling. J.-H., Gilley, K. (2000). Overcoming compassion fatigue. *Family Practice Management,7*(4), 39-44.

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Teater, M., Ludgate, J. (2012). Overcoming compassion fatigue: A practical resilience workbook. Eau Claire, WI: PESI Publishing.

Burnout

Leiter, M. P., & Maslach, C. (2005). Banishing burnout: Six strategies for improving your relationship with work. San Francisco: Jossey-Bass.

Leiter, M. P., Bakker, A. B., & Maslach, C. (2014). Burnout at work: a psychological perspective. New York: Psychology Press.

Southwick, S. M., & Charney, D. S. (2012). Resilience: The science of mastering life's greatest challenges. New York: Cambridge University Press.

Self/Other Care

Mathieu, F. (2007). Transforming compassion fatigue into compassion satisfaction: Top 12 selfcare tips for helpers. Retrieved from http://www.compassionfatigue.org/pages/Top12SelfCareTips.pdf

Pennebaker, J. W., & Smyth, J. M. (2016). Opening up by writing it down: How expressive writing improves health and eases emotional pain. New York: The Guilford Press.

Van Dernoot Lipsky, L., Burk, C. (2009). Trauma stewardship: An everyday guide in caring for self while caring for others. San Francisco, CA: Berrett-Koehler.

Peer Support

Van Roy, K., Vanheule, S., & Inslegers, R. (2015). Research on Balint groups: A literature review. *Patient Education and Counseling, 98*, 685–694.

Peterson, U., Bergstrom, G. Samuelsson, M., Bergstrosberg, A., & Nygren, A. (2008). Reflecting peer-support groups in the prevention of stress and burnout: Randomized controlled trial. *Journal of Advanced Nursing, 63*(5), 506–516.

Mentoring

Kram, K. E., & Higgins, M. C. (April 5, 2009). A new mindset on mentoring: Creating developmental networks at work. *MIT Sloan Management Review.*

END AND POST-CONTRACT SUPPORT

Brooks, S. K., Dunn, R., Sage, C. A. M., Amlôt, R., Greenberg, N., & Rubin, G. J. (2015). Risk and resilience factors affecting the psychological wellbeing of individuals deployed in humanitarian relief roles after a disaster. *Journal of Mental Health, 24*(6), 385-413. (Note: See Appendix IV).

Australian Red Cross. (May 2016). Needs assessment and psychosocial support after emergencies: a multi-agency framework and guidelines. Retrieved from https://www.redcross.org.au/getmedia/c26d0363-5c38-4348-9bb2-07b4817a27a8/Australian-Red-Cross-Needs-Assessment-and-Psychosocial-Support-After-Emergencies-Guidelines.pdf.aspx

PRACTICES AND PROGRAMS TO PREVENT OR MINIMIZE BURNOUT

Stress management training. Either cognitive-behavioral or mindfulness-based stress reduction programs should be standard training for all staff. The University of Massachusetts (www.umassmed.edu/cfm/stress-reduction) mindfulness-based stress reduction (MBSR) program is regarded as among the very best although many medical schools now offer MBSR programs. The American Medical Association's "STEPS program" for preventing physician burnout may also be very helpful.

Daily contemplative/meditation practices. A wide variety of practices (www.contemplativemind.org/practices/tree) are available, so individuals can select an approach that works best for them. Most religious traditions have practices. There are many on-line training resources that provide a variety of self-guided learning opportunities. The Wellbeing at Work team has also found the Headspace and Stop Breathe Think smart device

apps to be effective training tools.

Personal reflection practices. Again, a wide variety of practices are available—from daily journals and diaries, to semi-structured expressive writing activities, to religious practices. The intervention is to create regular opportunities for individuals to step back from the flow of daily life to examine the positives and negatives of life. These practices create space to identify problems, stresses, and challenges. Individuals can then take remedial actions. See Pennebaker & Smyth (2016) and Wilson (2013) above.
Small group social support. Physician groups have proven to be effective in preventing and treating burnout. Three examples of such approaches are Balint groups, Schwartz Rounds and Resilience Rounds.

ORGANIZATIONAL EXPERTISE IN CULTIVATING WELLBEING, PSYCHOSOCIAL SUPPORT, AND COMPASSIONATE LEADERSHIP

These organizations offer consulting to help organizations build wellbeing into their organizational cultures. Excerpts from their mission statements found on their websites are below.

Antares Foundation https://www.antaresfoundation.org
Antares takes a holistic approach to stress management at every level, and offers trainings for management and individuals, to create a functional and sustainable system of staff support.

Circles International https://www.circlesinternational.org
"Cultivating emotional health, resilience, and wellbeing through leadership programs and consulting services."

Headington Institute https://www.headington-institute.org
"The Headington Institute partners with humanitarian relief and development organizations and emergency responders, before, during, and after deployment in order to ensure the wellbeing of individuals. Our team of psychologists, many with over 30 years of clinical experience, bridge cutting edge academic research with practical application at the field level, in order to strengthen the impact of humanitarian response and promote the long-term wellbeing of humanitarian personnel."

Organization Unbound http://organizationunbound.org/in-depth/
"We are a global community of practice that learns from and supports organizations seeking to deepen their social impact by more consciously aligning their internal practices with their broader social change goals. We believe the best way for our organizations to create deep and lasting change in the world is to embody it."

Center for Physician Wellbeing (CPW) http://www.thecenterforphysicianwellbeing.org
"The CPW provides consultation, coaching, counseling, education, workshops, retreats, and collegial relationship activities that are informed by current research and insight-oriented approaches. Our services aim to help physicians improve outlook, identify choices, and deepen interpersonal relationships. All interventions and initiatives are designed to promote self-care, prevent burnout and assist in the integration of life skills including resiliency, compassion, and

effectiveness."

WorkWell Research https://workwellresearch.com/welcome/
"Take our scientific assessment and unlock your wellbeing profile: with results across four dimensions and twelve sub-dimensions of wellbeing, tailored insights, and suggested practices."

Still Harbor https://www.stillharbor.org
"We are creating a network of fiercely loving and compassionate spiritual leaders for social change."

Appendix H. Components of Organizational Wellbeing, with Examples from Hilton Humanitarian Prize Laureates

Note: This appendix is adapted from the Antares Model[7] and was compiled by Dr. Deirdre Guthrie based on the results of the interview phase of the Hilton Humanitarian Wellbeing Project. It was featured in the complete (unpublished) version of the project team's report to the Hilton Coalition (Guthrie et al., 2019).

Dimension: Policy

Description: Organizations must clearly define a set of "Best Practices" in their approach to staff wellbeing support and integrate it into their daily operations. This approach should be grounded in the knowledge of how stress (both chronic or acute challenges) affects individuals, teams, and organizations and the responsibility organizations have to both reduce/manage stressors as well as optimize staff resiliency and coping capacities. Along these lines, Laureates reported that organizational policies and procedures should address

- Proposal narrative templates that include rationale and budget requests for staff wellbeing support
- The specific staff care needs of various groups; such as ensuring the equity of resources between national and international support mechanisms
- A clear endorsement of self-care by leadership
- Regular communications and trainings to normalize the experience of burnout
- Regular check-ins to alert staff to their early warning signs of burnout
- The duties and responsibilities of supervisors/managers as well as mechanisms to empower them to intervene with staff *before* burnout sets in, possibly relocating field staff to other sites or imposing holiday leave (without restricting salary/pay), for example.
- Performance reviews that include leaders' effectiveness in supporting staff using existing support tools
- Feedback mechanisms to periodically assess if staff are using services and to what degree they are effective
- Caps on time spent away from families (no more than 6 months)
- Yearly incentives such as a salary increase
- Clear enforceable policies for security, code of conduct, and sexual harassment

Examples from Featured Laureates:

Women for Women, ECPAT, Tostan

These organizations have robust feminist and participatory empowerment models that can especially inform discussions within and across offices to assess and define each organization's needs, philosophy,

[7] Antares Foundation. (2012). Managing stress in humanitarian workers: Guidelines for good practice. (3rd edition). The Netherlands. Retrieved from https://www.antaresfoundation.org/filestore/si/1164337/1/1167964/managing_stress_in_humanitarian_aid_workers_guidelines_for_good_practice.pdf?etag=4a88e3afb4f73629c068ee24d9bd30d9

and engagement in staff wellbeing policy and practice, particularly across lines of difference (e.g., gender, nationality, culture). Positive characteristics of these models that can help organizations design inclusive wellbeing policies and practice include

- Having a holistic approach to supporting empowerment with a nuanced understanding that power is multi-directional (power over, power with, power to)
- Empowerment models that address stigma and discrimination—internally, externally and in community throughout the life cycle
- Community problem-solving dialogues involving villages and neighboring communities
- Deliberately partnering with opposing or divergent groups (Hutus and Tutsis, Muslims and Christians, women and men, etc.)
- Understanding the importance of understanding and working within or even against cultural norms
- Having native speakers commit to up to 3 years to facilitate community programs
- Program goals and anticipated outcomes guided by and amenable to the contexts of peoples' lives, not imposed by grants or donors (e.g., education for women about land rights in Nigeria; gender-based violence protection in the Democratic Republic of Congo, and advocate for change and equality in Bosnia)
- All levels of program and practice supported by theoretical models that support mission (theory of change, wellbeing, understanding social norms, capacity to aspire) and a community based participatory methodology
- Ideas of value change that are spread through connected communities or social networks

Dimension: Screening and Assessing

Description: Ensure the assessments of individual resilience to anticipated stressors and person-organization fit are part of candidate selection processes. Understand that with optimal support from organization, peers and managers with a range of personalities can be successful in their work. Evaluate candidate's physical and psychological health, ability to work with diverse teams, toleration for ambiguity, level of self-awareness and coping strategies, as well as risks and contextual factors that surround potential assignment. Continue to assess needs and impact of work stressors throughout assignment/contract. Furthermore, organizations need to

- Train staff for screening roles, including how interviewer bias, projection, personal experience, and risk tolerance can influence assessment of a candidate.
- Train staff to interview using attentive listening and scenario-based approaches to appraise how individual demonstrates self-awareness and resiliency as well as vulnerabilities relative to operating context being considered.
- Standardize recruitment, screening and assessment procedures for interviews at the levels of office and "field"; create culturally and contextually appropriate tools; adapt as needed
- Screen for risk and resilience factors, hardiness, and coping mechanisms related to psychological wellbeing in the sector
- Upon positive assessment, explain potential stressors of job with candidates
- Review and normalize staff care policies with candidates
- Implement internal needs assessments periodically to determine levels of acute and chronic stress in organization, assess candidate's resilience, hardiness, and coping abilities and determine what levels of support are desired/needed
- Initiate practices to help staff feel connected to its mission in everyday practice within an organization

Examples from Featured Laureates: **Aravind, Tostan, Operation Smile**

Aravind

- Prioritizes the creation of psychological safety during their Quality Review process for doctors. The process is never personalized or used for incentivizing. Rather, the emphasis during the review is on how practitioners can improve.
- Centers all aspects of culture around "living the mission" of offering care to all who need it. Staff are screened and trained in compassion.
- Teaches staff through yoga, breathing, and meditation how to handle stressors mindfully and recognize signs of burnout in themselves and each other

Tostan

- Conducts robust risk assessments and in-depth country profile analyses with local experts

Operation Smile

- Holds a debrief of each mission in terms of logistics and outcomes but this is subsequent to the event and does not include discussion of any moral or psychological social distress. Organization is considering bringing in psychosocial counselors from leadership conference to mission training to help prepare students for assignment.

Dimension: Preparation and Training

Description: While many organizations offer training programs for individuals to develop professional skills required for work, Laureates would benefit from more substantive and ongoing training in the qualities needed to understand and recognize stress associated with their work and to develop corresponding emotional resilience. Studies have shown that initial deployments are the most challenging for early career staff who lack experience and may harbor idealistic ideas of work and are therefore more vulnerable to burnout (Adler et al, 2005, Huffman et al., 1999). The job demands-resources model (Demerouti et al., 2001), which classifies working conditions that require effort and skill as demands or resources that help achieve goals and decrease demands, suggests that appropriate training and preparedness and support from colleagues and management are particularly important resources. High demands, particularly when coupled with insufficient resources, have a negative psychosocial impact on wellbeing. Preparation and training mechanisms need to include

- Orientation and onboarding with visual materials for head office, prepared with staff input
- Training in compassion, empathy, resilience/endurance, and emotional regulation as well as vicarious trauma
- Training related to cross-cultural work settings and communications
- Pre-assignment confidential consultations with mental health professionals with humanitarian/development experience to discuss psychological readiness and promote resilience available to all staff; these should be part of standard protocol for those deploying to high conflict zones
- Procedures for accessing confidential counseling and staff care services, clearly communicated at regular intervals to all international and national staff in relevant languages

Examples from Featured Laureates: **Partners In Health (PIH) and International Rescue Committee (IRC)**

PIH is currently writing a curriculum that will include resiliency and wellbeing support tools along with strategies on how to deal with governments, security issues, and finance to offer mid-managers in public health courses. Managers are central to the stress management process as supervisor, educators, and role models to staff. They are also at high risk for burnout and require their own customized supports.

In addition, the clinical supervisors at PIH/CES in Chiapas have completed Dr. Guthrie's "train the trainer" **Compassionate Leadership program,** which was offered, in turn, to the early entry professionals called "pasantes" they supervised. Pasantes provide medical care to highland communities during their service year. As part of the program they kept wellbeing logs to track the best/worst events of each month as well as to describe which strategies they found most helpful to address ongoing work challenges and later shared these findings with their supervisor. Then a designated wellbeing champion located at the main office regularly checked in with supervisors to help determine how to continue to best support staff in the field. Also, PIH staff in the Boston office have been certified in Restorative Justice principles and Peace Circle Process (Greenwood 2005) to help staff there live into and connect with the organization's mission of accompaniment in everyday practice.

IRC has a mandatory online training on stress and resilience for all staff. A specific online training on staff care for managers will be offered [soon] and will be mandatory for all supervisors.

Dimension: Monitoring and Ongoing Support

Description: Organizations need to anticipate that staff will become emotionally involved with their work subjects and colleagues. Drawing from the training and supervision that therapists and counselors receive to help them cope could be helpful. We also know that positive social support at both the inter-agency and intra-team level is vital to wellbeing. "Insider versus outsider" dynamics or rivalries can be minimized when agencies focus on joint goals and "restorative justice" practices that can sensitize teams to power dynamics and opportunities to repair harm and build cohesion (Greenwood 2005).

Monitoring and ongoing support entails building multi-levels of psychologically safe spaces into organizations to ensure staff have continual access to confidential consultations, support, materials and training. These spaces may encompass

- Psychosocial-emotional sanctuary and space for contemplation
- Tracking mechanisms such as through wellbeing logs
- Proactive stress counseling and emotional support from external sources on site
- Continuous one-on-one counseling through phone or video conference (in setting that ensures privacy) or through qualified local networks
- Destigmatizing efforts such as when leaders share their experience with accessing and using counseling
- Continuous support such as training in emotional regulation and processing, mindfulness, cross-cultural sensitivity training in power dynamics
- Ongoing restorative team-building sessions, mentorship programs, peer to peer support groups across network

- Co-designed R&R policies with staff input as what are desirable restorative ways to promote psychological recovery and wellbeing (beyond catharsis)
- Modeling of resilient behavior by leaders taking their vacations and leave from work.
- Advance planning for staff rotation to ensure they get their R&R leave
- Annual training (onsite and online) for managers to assess staff wellbeing
- Internal/external capacity (security and crisis management protocols, duties, accountability, roles) to respond to critical incidents
- Extending capacity to provide direct support to family members of staff adversely affected by stress whenever possible

Examples from Featured Laureates: **IRCT, Heifer International, IRC**

IRCT

- Has 3 levels of psycho-social support.
  1. At site level
     "Some sites have extremely sophisticated resources while others are under-resourced."

  2. At level of network
     Peer-to-peer approaches, such as when a person under prolonged extreme stress working in Argentina can go to Germany, for example, for couple months to get into another environment. Support includes risk management, if there has been a numbing effect and staff member's ability to evaluate risk has eroded.

  3. At level of policy
     Establishment of best practice guidelines around stress management across network, a definition of a minimum standard of what needs to be in place for each member across network to do no harm.

- IRCT Centers in Lebanon, Jordan, Syria, and Iraq are developing their own models for vicarious traumatization, not only dealing with trauma but *facing the limits of what one can achieve*
- In-country models that support staff and caregivers are culturally specific and often involve collective, peer support
- Advocates small group work in four rounds when a "helping" staff member encounters a stressor:
  1. Group asks staff "helper" for details to clarify case
  2. Team puts themselves in role of the helper/therapist, shares their thoughts on what they would feel and think in that situation or relationship
  3. Helpers project themselves into role of client, share their thoughts from this vantage point.
  4. Helper wraps up and responds to team feedback.
- In addition, provides private health insurance for all employees that covers therapies and interventions to counter and address stress, such as psychological support, physiotherapy, work aids, acupuncture etc.

Heifer International

- Offers psychosocial support for staff and their families around "Staff wellbeing and resilience" and "How to manage insecure environments" as well as "Post-traumatic stress"

IRC

- Offers remote counseling in local languages to all [organization] staff and their families.
- Offers management counseling for struggling managers.
- In process of launching a website with resources in all official languages on psychosocial wellbeing, including screening tools, self-study resources, and videos.
- Has a variety of staff led groups--employee resource groups, personnel committees, and staff welfare groups.

Dimension: End and Post Contract/Program Support

Description: After a contract has ended many staff welcome support for reintegration. They may benefit from taking a course, maintaining contact with a community of colleagues, or processing their experience with a counselor who can help them frame their experience in terms of personal and professional growth. Organizations may offer

- Confidential post-assignment resilient consultations as a standard protocol, separate from programmatic or operational debriefing, required particularly for staff concluding an assignment in a high stress context
- Procedures and time frames for accessing counseling and other staff care resources after leaving the organization that are clearly communicated to international and national staff
- Active encouragement to access supports by organizational leaders and managers
- A re-entry ritual or celebration
- Psychosocial support for at least 3 months post-assignment/contract

Examples from Featured Laureates: Task Force for Global Health, IRCT

The Task Force for Global Health is initiating more regular debriefings around moral distress associated with work.

IRCT has an agreement with a larger NGO for specialized post-travel/assignment de-briefing and counseling in case staff had a traumatic experience during the mission.