Summary of the Inter-Agency Roundtable about NGOs' Duty-of-Care for Local Staff

Overview of the Roundtable Discussion

On March 13, 2026, a peer-to-peer roundtable of 24 international aid professionals discussed progress in NGO attention to the "duty of care" of local staff particularly when disasters occur. It was convened and co-hosted by George Washington University, Compassion International and the World Hunger Education Service (WHES). Held over two hours by zoom with each participant able to contribute, it followed the Chatham House rule of non-attribution.

This was one of ten roundtables organized by George Washington University during the past year about the future of foreign aid. One consistent theme in these roundtables has been the push to increase localization: devolving more resources, attention, decision-making, and initiative to national actors. This March roundtable brought together experienced non-governmental experts to examine how aid agencies are defining and implementing Duty of Care (DoC) for their tens of thousands of local staff, including national volunteers, community health workers, and personnel of local CBOs and partner organizations. Because many participants had worked for multiple organizations, experiences from over multiple organizations. Good balance was achieved between development versus emergency relief NGOs and with people joining from Africa and Asia. Some of the NGOs participating operate through complex structures, with federated models, multiple national affiliates, or networks of sub-grantees, which complicates the definition of "local staff."

A framing posed to those attending was: *"To what extent do organizational policies and procedures at the headquarters level acknowledge or address local staff Duty of Care issues?"* Participants were asked to reflect about whether their organizations explicitly recognize local staff in formal policies, whether volunteers and community-based workers are included, and how family members or dependents are considered.

> Duty of care (DoC) is the institutional, legal, and moral obligation of organizations to protect the health, safety, and well-being of their staff. While most international NGOs (INGOs) now have formal policies in place, the sector remains characterized by a persistent shortcoming between policy and practice—particularly for local staff, who make up the overwhelming majority of the workforce yet face the greatest risks.[i]

The ambiguity between which staff or volunteers are included/covered and which may not be covered by organizational policies was a consistent concern by discussants who said that duty of care is only as strong as the clarity of who is covered. Past priorities have been given to international staff.

In most INGOs, security, human resources, and psychosocial care operate in silos, leading to critical information falling through the cracks during crisis management. Kick-off slides that were presented are included at the end of this document.

The Challenges of Duty of Care (DoC)

Across most organizations and NGO networks, different functions for duty of care remained siloed in different offices. There have been gaps between intentions and their fulfillment.

Participants spoke to the rising levels of harm incurred by national colleagues. In 2024, 97% of reported aid worker casualties were national or local staff, representing an extraordinary 35-to-1 ratio relative to international staff, a disparity that has grown more pronounced as INGOs shift implementation to local partners. Documented rates among aid workers include depression (10–39%), anxiety (4–38%), burnout (8–32%), PTSD (up to 25%), and hazardous alcohol use up to 50%. National personnel often carry a "double burden" as both responders and affected community members. Female local staff face a distinct and under-addressed set of risks.

There is no database tracking the needs, harms or problems faced by national colleagues, outside of war zones.[ii] There are data about attacks on humanitarian staff working in conflict zones but not in the majority of countries that are occasionally hit with earthquakes, cyclones, and other disasters which challenge frontline workers in their day-to-day work.

> *"In disasters national staff deployed away from home are exposed to crisis contexts and deserve the same evacuation protections as international staff."*

Internal staff surveys have revealed that well-being and care were not being adequately tracked, prompting remediation efforts. Even development (non-emergency) staff face high burnout; organizations need to identify early warning signs and support healthy coping.

> *"Organizations often lack visibility into the pressures and stress signals of local staff, representing a key gap in early intervention."*

Progress to Date

Participants generally saw a positive evolution of organization-wide policies and procedures for DoC while also noting that the practical implications for field staff remain inadequately implemented. During the last two decades, more NGOs have given attention in procedures, systems, policies and practice to their duty for the care of frontline field staff.

Organizations have made progress—but mostly for expatriates. Policies for expatriate staff are generally well-developed. In contrast, participants explained how local staff:

- Are central to operations but peripheral in policy
- Face the highest risks
- Possess the most contextual knowledge
- Are essential for program continuity
- Yet they remain the least protected.

Governmental donors have been giving more attention to the issue over the last decade, both U.S. government and European Union. Key donors now expect or require safety and security line items, though this doesn't yet extend to softer duty of care areas. Yet, participants said that donors rarely require explicit duty-of-care provisions for country staff which reduces incentives for organizations to

invest in comprehensive systems. However, recent U.S. funding cuts may erode even the basic duty of care protections that aid grants currently fund.

One NGO described a model tailored to the onboarding of nationals — a comprehensive orientation covering staff security, safeguarding, digital safety, and communications channels exemplifies practice-over-policy for national staff.

The discussion revealed that while awareness of duty of care has grown, policies remain inconsistent, fragmented, and often centered on expatriate needs rather than the realities of local staff. The discussion highlighted a gradual evolution of greater attention being paid to locals' Duty of Care:

> *"Over time, throughout my career, I've noticed how much of the evolution we've experienced as the industry... in convincing the donors to bear some of that cost [for Duty of Care]. If before you had to make a case for, for example, safety and security measures to be part of the budget, it's no longer necessarily the case for the critical donors."*

Duty of Care encompasses a range of operational tasks within the parameters of legal compliance with local laws in all jurisdictions where employees operate.[iii]

> *"One of the things that I continue to hear... is a lot about policy. And as you all know, Peter Drucker is famous for saying: culture eats policy for breakfast."*
>
> *"We don't necessarily exercise the implementation of the broader terms …of the duty of care on staff, especially if the office is huge, because it ultimately depends on the resources that are available."*

Contexts facing NGOs continue to evolve, along with very diverse expectations by staff related to culture, generations and individual needs. As well, NGOs have seen changes in their own risk appetite for working in disasters.

> *"I think policy really evolved faster than practice… most of our organization has been good to create templates, guidance, processes around DoC for local staff that protects the organization. I think we still have quite a lot of work to do to really make it relevant for staff."*

Aid groups that are organized around federated structures or extensive sub-granting arrangements face additional challenges. Policies differ across affiliates, and prime awardees often assume partners have adequate duty-of-care systems without verification. Training availability is similarly uneven, with some organizations offering rigorous security and wellness training while others provide little or none.

Organizations with Established Policies

Several organizations were specifically noted for having robust or evolving frameworks:

- One NGO talked about their organizational well-being framework. They are now pushing country and project offices to develop "contextualized" well-being frameworks specifically for national workers.

- Another NGO reported that their DoC policy has evolved faster than practice. They use standardized templates and criteria for duty of care incidents (handling mental health, disability, and injury) in partnership with security teams.
- One federated NGO shared about its highly specialized approach that distinguishes between "Work-Related" incidents (Duty of Care) and "Non-Work-Related" disasters (Solidarity). For work-related cases, they apply a substantive frame with no distinction between local and international staff. "Work-related incidents trigger formal duty of care; non-work disasters trigger a "solidarity" response, a deliberate framing with no distinction between local and international staff for work-related cases."
- A participant talked about having health, safety, and security teams that work closely with local staff, and yet many national workers felt the practical application of evacuation vs. relocation protocols remained unequal.
- One NGO example was of a highly structured "Family Liaison Officer" (FLO) program, though it was admitted this was historically trained and designed for international staff rather than local staff. The Roundtable highlighted one NGOs efforts that offer a two-day virtual family liaison officer training to partner aid groups, filling a gap where smaller NGOs lack in-house capacity. Curricula are expanding beyond kidnapping and medical emergencies to remedy suicide risk.

Emerging Policies

- **Senior Leadership & Board Involvement:** Many NGOs only began defining these systems within the last 4–5 years. Executive leadership often listens when duty of care is framed as "purpose-driven" rather than just "compliance" or "HR-driven".
- **From International to National Focus:** For many years, DoC policies were almost entirely focused on international staff deployed overseas. Participants observed a major "switch" in the last 10–15 years toward including national staff, accelerated by the localization agenda and COVID-19
- **Mental Health Integration:** Mental health has finally entered the policy conversation. However, participants said that simply pointing local staff to an Employee Assistance Program (EAP) is often ineffective due to cultural stigmas. NGOs need to identify what is effective.
- **The "Paper vs. Reality" Gap:** Multiple speakers expressed concern that policies are "great on paper" but lack follow-up or fail to confront the unique risks local staff face, such as being "delocalized" (working in their own country but away from their home network).

Identified Gaps in Current Policies

- **Local Partners & Sub-grantees:** Policies often fail to cover "indirect staff" or local partner aid bodies, effectively "cascading the risk" down to the local level without providing the same protections.

- **Family Inclusion:** There is a lack of structured support for the families of local staff during crises (e.g., kidnappings), unlike the rigorous systems in place for international staff families.
- **Mobility:** Most NGOs lack clear policies on whether local staff can work remotely from outside their home country when a conflict erupts.

An organizational Duty of Care policy is essential for an aid agency's Enterprise Risk calculations and adaptive posture. What is done in one situation may not be appropriate in another, but that opens an organization up to risk associated with human decisions which can be litigated (lawsuits).

Duty of Care Across Complex Organizational Structures

Participants surfaced how federated or multi-affiliate organizations struggle to harmonize duty-of-care policies. Some agencies have separate national entities (e.g., a U.S. branch, a U.K. branch, a European branch), each with its own HR and security frameworks. This leads to inconsistent coverage for local staff depending on which affiliate funds or manages a project.

> *"Duty of care has become a huge, huge* [sic] *topic in [our NGO network] worldwide... The cause of the damage, not the type of the damage. So either the cause is work related and then it's duty of care, And then we would, I believe, we would deploy the same sort of situation... and there would be no distinction between local staff and international staff."*

Another challenge is sub-granting and subcontracting in NGO programs. Groups that serve as prime awardees often pass funds to local partners, who then manage their own staff. Participants flagged that:

- ✓ Prime organizations may assume partners have adequate duty-of-care systems.
- ✓ Local partners may lack resources or expertise to implement such systems.

One participant referenced large global programs where sub-granting is the norm, raising the question of whether the prime organization has any responsibility for the safety and well-being of partner-organization staff. Safety and security provisions in many USG awards require flow-downs of DoC to sub-awardees.

Gaps in Policy: Family Members, Dependents, Psychosocial Support

A major gap identified was the lack of support for family members and dependents of local staff, despite their proximity to risk. Psychosocial support was also described as uneven and often inaccessible, even though local staff routinely experience chronic stress and secondary trauma. Health equity concerns surfaced repeatedly, with participants noting that local staff often receive inferior medical coverage compared to expatriates. Security risk management emerged as another critical area. Local staff, including drivers, field officers, and community workers, tend to possess the best situational awareness as noted above, yet are excluded from formal decision-making. The contrast in family support during a kidnapping crisis revealed that structured family engagement remains an international-staff-only benefit.

> *"We do not have a family liaison officer program for local staff.. we still have a ways to go."*

While some INGOs provide evacuation or medical support for expatriate dependents, few extend similar considerations to local staff families—even though local staff often face equal or greater exposure to risk.

> *"We changed our evacuation policy, given that we do not evacuate local staff. There are some red lines, and some of those red lines are legal requirements of countries for operating legally... We even changed R&R policy for our local staff in South Sudan. They ended up getting the same R&R after we did an after-action review with them."*

Another major blind spot is psychosocial support. We're seeing a good and significant cultural shift from 15 years ago, when mental health was not discussed at all. However, several participants noted that local staff experience chronic stress, exposure to violence and trauma, yet mental-health services are often unavailable or culturally inaccessible. And where psychosocial support systems exist they often go unused due to stigma, cultural norms, and distrust. Off-the-shelf counseling resources were available but underutilized. In one case, a tailored psychological first aid workshop revealed unmet staff support needs and sparked localized solutions.

One participant described wellness ambassadors in a large country program, highlighting the need for peer-support models when professional services are limited. In one case, "*trained community health workers provide local psychosocial support where digital communication is unavailable; but unclear work/non-work distinctions complicate duty of care obligations."*

Participants also wrestled with health equity, noting that local staff often have inferior access to medical care compared to expatriates. A participant referenced hearing "a lot" about health equity concerns in the field. Locals receive lower quality of care, or no care, or do not know how to access care.

Inclusion of Partner Agencies, Volunteers and Indirect Workers

Participants remarked that many organizations rely heavily on categories of workers who fall outside formal HR structures, including volunteers, incentivized workers, community health workers, and staff of sub-grantees. These individuals frequently face the highest exposure to risk yet are the least likely to be covered by insurance, psychosocial support, or security protocols. Transportation contractors and drivers face high risk.

> *"When local CBOs and NGOs are treated as contractors rather than partners, duty of care responsibilities toward their staff get sidelined."*

As one participant put it, *"The boundaries of what is included as your local staff might be a little bit blurry… you have direct staff and indirect staff… volunteers… people working for the government but taking direction from you."*

> *"The bigger INGOs or the bigger UNs, they just hide behind their own bureaucracies and their own rules and regulations to say, oh yeah, we can't do that. Or, our procurement department doesn't allow it. So, in other words, 'you guys do it and take all the legal risks and all the personal risks actually.' And so that kind of cascading down to local networks who are on their own."*

Good programming through adaptive risk management conflicts within our processes with enterprise risk reduction. The need for context-specific, duty of care approaches is increasingly in tension with institutional drives to minimize organizational risk.

A major portion of the discussion focused on whether organizations extend duty of care to volunteers, Community health workers (CHWs or home visitors), Incentivized workers (which may include CHWs, referral networks, agriculture extension workers, trainers who receive stipends or in-kind support), Staff of partner organizations (local CBOs, societies, sub-grantees), Government-employed workers who are effectively supervised by the NGO, etc.

Participants repeatedly observed that many organizations rely heavily on these categories of workers, yet their protection is inconsistently tackled in formal policies.

> *"The reality is they are also more exposed to different contexts. They also need to be evacuated, et cetera. And some of these conversations we were having internally to define what are the minimal responsibilities, but also what is the ethical responsibility when we have colleagues that we send to different contexts that are not their home of record."*

One participant highlighted that community health workers often receive incentives or equipment from NGOs, which creates a *de facto* employment relationship.

Several participants agreed that volunteers and community-based workers are often the most exposed to risk, especially in conflict zones, but are the least likely to be covered by insurance, psychosocial support, or security protocols.

Another issue raised was the lack of standardized definitions across organizations. Some use terms like "direct staff," "indirect staff," or "associated personnel," but these categories rarely map cleanly onto risk exposure or legal responsibility.

> *"Local partners require a different engagement model: Partners are independent entities; good practice means offering advice without coercion, and genuinely listening during insecurity — but gaps in formal duty of care remain."*

Security Risk Management and Local Knowledge

A significant portion of the discussion focused on security risk management and the role of local staff in identifying threats. One participant referenced a study involving several hundred security officers, noting that the most reliable source of threat information was often the drivers. Participants agreed that:

First, local staff possess critical situational awareness, yet are often excluded from formal security decision-making. Second, participants pointed out that local staff are frequently the persons traveling through and to dangerous areas, conducting field visits, or interacting with armed actors. Despite this, many organizations still design security protocols primarily around expatriate risk.

> *" At the end of the day, you're on your own, an unspoken message... we yet depend on their ability to implement the last mile delivery."*

"Local risks push aid agencies away from establishing practices that are designed to ask and answer the more fundamental questions which requires an adaptive posture... because what makes sense one situation is not appropriate in another... and that opens the agency up to risk because action steps are contingent on critical human decisions which can be litigated."

There was broad agreement that security policies may need to be rewritten to center local staff, not treat them as an afterthought.

Training, Preparedness, and Organizational Learning

Participants unpacked the uneven availability of training for local staff. Some organizations provide extensive security training, stress-management training, or liaison training, while others offer little or none. A question was raised about who created certain liaison-training modules and how features were developed. Training programs vary widely and may not be standardized across the sector. Participants also mentioned:

- The need for Hostile Environment Awareness Training (HEAT)-style training adapted for local staff.
- The challenge of providing training in remote or insecure areas.
- The importance of partner-organization training, especially when sub-grantees operate in high-risk environments.
- Another participant referenced a "flow training" that had been shared among NGOs, indicating that some organizations are beginning to exchange training resources, though this remains informal and inconsistent.

Sector-Wide Gaps and the Need for a Community of Practice

Several neglected areas emerged around information-sharing and the absence of communities of practice. Voices around the table noted that organizations rarely share incident data, lessons learned, or policy templates—especially regarding local staff. For HR and legal duty of care questions, Humentum[iv] is worth consulting — though it falls short of a true community of practice. Roundtable participants acknowledged that there was no clear community of practice that they could turn to for sharing information across organizations, though discussants felt as though that would be a good idea. There is a need for a sector-wide platform to share templates, policies or best practices. NGO associations have not provided this.

An exception is Global International Security Forum.[v] Outside of GISF, access is uneven and often limited to member organizations. Country level INGO forums are useful.

Conclusions

The roundtable revealed a sector that is aware of the importance of duty of care for local staff but is far from achieving consistent, comprehensive implementation. Policies remain fragmented, definitions unclear, and coverage uneven. Local staff—who bear the greatest risks—are still insufficiently protected

compared to expatriates. *"The further from headquarters, the harder it is to maintain consistent duty of care standards."*

Linking duty of care to organizational purpose drives leadership buy-in: *"Framing duty of care as mission-driven (not compliance- or HR-driven) is the key to getting executive support."* Universal DoC policies within one organization is challenged around highly diverse staff-expectations (culture, generational, individual priorities), and in turn challenged by changing appetite for shifting organizational risk.

Maturity Levels of NGO Duty of Care Policies for Local Staff

Dimension	Basic	Developing	Advanced
Definition of Local Staff	No clear definition; volunteers and CHWs excluded	Partial inclusion; inconsistent across units	Comprehensive definition including volunteers, CHWs, partner staff
Family & Dependent Support	No provisions	Limited or *ad-hoc* support	Full inclusion in medical, security, and crisis protocols
Psychosocial Support	None or informal	Some access; limited geographic reach	Structured, culturally adapted, confidential services
Security Risk Management	Expat-centric; local staff excluded	Local staff receive basic training	Local staff central to risk analysis and decision-making
Training & Preparedness	Minimal or none	Basic security and wellness training	Regular, mandatory, context-specific training
Partner & Sub-Grantee Coverage	No expectations or oversight	Some guidance; inconsistent enforcement	Clear standards, monitoring, and support for partner duty of care
Policy Harmonization	Fragmented across affiliates	Partial alignment	Fully harmonized global standards
Health Equity	Expat-local disparities unaddressed	Some efforts to reduce gaps	Full equity in medical access, evacuation, and benefits
Resource Sharing Across NGOs	None	Occasional informal exchanges	Active participation in a community of practice

Duty of care should continue to expand beyond formal employees. The discussion highlighted the need to include:

- Volunteers
- Community health workers
- Incentivized workers
- Partner-organization staff
- Sub-grantee personnel

The meeting underscored several critical INGO needs for:

- Clearer definitions of who is covered
- Harmonized policies across complex organizational structures
- Stronger psychosocial and medical support

- Greater investment in training and security systems
- Sector-wide collaboration and shared learning

The roundtable concluded with calls for follow-up sharing and a coherent community of practice on duty of care for local staff. Participants expressed interest in continuing the conversation in future community of practice meetings.

Roundtable Participants (Alphabetical by name of person)

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REFERENCES

[i] https://www.internationalsos.com/insights/what-is-duty-of-care

[ii] During the last decade, several comprehensive tracking systems have come to track attacks on aid workers and health programs in emergencies (not development). Including: https://www.aidworkersecurity.org/, WHO's https://extranet.who.int/ssa/Index.aspx, OCHA's https://data.humdata.org/dataset/shcchealthcare-dataset and Insecurity Insight at https://insecurityinsight.org/projects/healthcare. There is no parallel effort to track aid worker, or local aid work problems in regular aid programs or natural disasters.

[iii] https://www.internationalsos.com/insights/what-is-duty-of-care

[iv] https://humentum.org/

[v] Global Interagency Security Forum (GISF): https://gisf.ngo/about/our-journey-eisf-to-gisf/

Roundtable about the Duty of Care of Local Staff by International NGOs in Times of Disaster

March 13, 2026

Select slides that set the stage

I.

Some Lay of the Land about the Scale of Problems Facing local Staff

Limitations of industry Data

- Data tracking exists for crises, i.e. humanitarian programs, including numbers of staff and incidents affecting local staff
- But not for development (ongoing assistance) programs

Numbers of staff

- UN: 90,000 local staff
- INGOs: 300,000 staff, down from 400,000 two years ago
  - 220,000 Development staff
  - 150,000 humanitarian staff
  - World Vision reports 44,000 local staff
  - Oxfam: 8,000
  - CRS: 7,000

Local Staff Bear Nearly All the Risks

- 97% of all aid worker victims in 2024 were Local, or national staff
- Casualties among national NGO staff now exceed those at INGOs
- Local staff operate in the highest-risk environments with the least protection
- *"808 of 831 victims (97%) were national staff — a 35:1 ratio."*
- Depression, PTSD, Burnout

Earthquakes, Cyclones

- No good tracking data
- A peer-reviewed study of **525 disaster responders** after the Türkiye-Syria earthquakes found that **46% reported physical or mental health problems**, **15% required medical care during the mission**, and local responders reported significantly more problems than international responders
- he most common physical health issues during field operations included musculoskeletal injuries, cuts or wounds (11%), respiratory problems (10%), and gastrointestinal problems (9%).3
- Critically, 11% of participants could not return to their ordinary work after deployment, primarily due to infections or mental health issues. This study demonstrates that injury rates among earthquake responders are substantial, but it does not disaggregate specifically between national and international staff injuries, nor does it track long-term outcomes systematically.
- **February 2026** the IFRC reported that during flood rescues in Syria, **four Syrian Arab Red Crescent volunteers were injured in one vehicle incident and a fifth volunteer was injured separately**.

Earthquakes, Cyclones

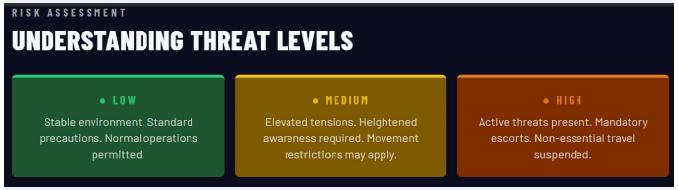
- **WHO/ILO Occupational Health Frameworks: Guidance Without Data**
- The WHO and International Labour Organization jointly published comprehensive guidance on occupational safety and health in public health emergencies, covering disaster response operations, infection control, and emergency worker protection. This manual acknowledges various hazards faced by disaster responders—including physical injuries from debris, extreme weather exposure, and operational accidents—but the framework focuses on risk mitigation protocols rather than systematic injury tracking.

Landmines, UXOs

- Between 2020 and 2025, **559 national aid workers were killed and 195 were wounded** by landmines and unexploded ordnance (UXO) across Asia, Latin America, and Africa—totaling 754 casualties.
- a dramatic escalation in recent years

II.

NGO Functions/Systems that Have Evolved



Risk Transfer over Time

- INGOs shift implementation to local partners
- *"National aid workers increasingly face greater exposure to risk… a striking upward trajectory."*

Kidnapping, Assault, Targeted Attacks

- Kidnapping rising in DRC, Cameroon, Haiti, Pakistan
- Criminal groups—not political actors—are now primary perpetrators
- Local staff face:
- Short-term punitive abductions
- Kidnapping-for-ransom
- Attacks on NGO-supported facilities
- Haiti: 230% increase in health/NGO worker kidnappings (2022→2023)

Criminality as the Dominant Threat

- Latin America: gang extortion, threats to human rights and anti-corruption programs
- Haiti: 300 gangs controlling 80–90% of Port-au-Prince
- Sexual violence risk pervasive for female staff
- *"The gangs can do whatever they want… on that particular day they decide that it's you."*

Organizational & Workplace Harms

According to Local staff experience:

- Low salaries & chronic payment delays
- Job insecurity from funding volatility
- Heavy workloads & limited career pathways
- Disparate treatment vs. international staff
- *"Organizational stressors are the primary driver of mental health decline… often outweighing physical security threats."*

Psychosocial Trauma

Chronic, Cumulative, and Largely Invisible

- Documented prevalence among aid workers:
- Depression: 10–39%
- Anxiety: 4–38%
- Burnout: 8–32%
- PTSD: 0–25%
- Hazardous alcohol use: 16–50%

Key trauma types:

- Vicarious trauma
- Moral injury
- Re-traumatization from inappropriate security training
- The "double burden": worker + affected community member

Types of standards

- Risk assessments
- Risk support
- Risk training
- Escape routes
- Kidnapping procedures

Core Humanitarian Standards (CHS) & Sphere

The Duty of Care for staff is no longer just a "best practice"—it is a formal commitment to quality and accountability.

- Safety and Well-being (8.2): Organizations must maintain a safe and inclusive working environment. This includes taking active measures to protect the physical safety, security, mental health, and dignity of all staff.
- Support and Skills (8.3): Organizations must ensure staff have the necessary support, training, and competencies to do their jobs effectively.
- Fair Treatment (8.7): Human resources must be managed in a fair, non-discriminatory, and transparent manner. This is particularly relevant for local staff to ensure they are not treated as "second-tier" compared to international staff.
- Whistleblowing and Misconduct (8.5 & 8.6): There must be safe, confidential ways for staff to report concerns or misconduct without fear of retaliation.
- **Legal Protection** Ensuring local staff are protected under legal frameworks and have insurance for work-related injuries or illness.

III.

Questions Before Us Today

Discussion Questions:
How has Local Staff Duty of Care evolved within NGOs?

- Systems
- Attention
- Responsibilities
- Policies
- Planning
- Procedures
- Practice?

Discussion Questions:

- Volunteers?
- Family members?
- How does it apply for staff on personal travel? "Home of record"?
- How do policies cut across networks (Save UK, Save Sweden, Save US)?
- How does Duty of Care apply with sub-grantees or partner organizations and their staff? Marjan mentioned "training for partner organizations" Cascading of risks down