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Promoting healthy lifestyles in humanitarian organizations: challenges and opportunities.

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Abstract

The increasing awareness of the risks and demands of humanitarian work has prompted the strengthening of safety and mental care protection strategies for humanitarian staff in the last decade. Humanitarian organizations in their duty of care are transforming their programs towards more holistic health approaches for their personnel. However, some organizational dynamics plus the complexity of the context where they operate, pose a variety of difficulties to promote healthy lifestyles for those involved in the humanitarian aid sector. Through searching databases and conducting interviews with researchers and health staff managers from four International Humanitarian Organizations, this document explores health practices covered by these organizations’ units of staff care. The main challenges in promoting health are related to issues inherent to the definition of the concept of lifestyle itself, narrow staff care policies, cultural diversity, living locations constraints, weaknesses in health data gathering systems and an organizational culture that neglects selfcare.

Key words: Lifestyle, Health, promotion, staff-care, humanitarian workers and health practices.
Acronyms and Abbreviations

ALNAP: Active Learning Network for Accountability and Performance
ECHO: European Community Humanitarian Office
ECB: Emergency Capacity Building Project
HQ: Headquarters
HR: Human Resources
IASC: Inter-Agency Standing Commission
ICRC: International Committee of the Red Cross
IFRC: International Federation of the Red Cross/Red Crescent
MSF: Médecins Sans Frontières
MHPPS: Mental Health and Psychosocial Support
NGO: Non-Governmental Organisation
OCHA: Office for the Coordination of Humanitarian Affairs
UN: United Nation
UNHCR: United Nations High Commissariat of Refugees
WHO: World Health Organization
1. Introduction

Today more than ever, humanitarian organizations recognize the importance of comprehensive staff care. The institutional awareness on the risks of aid workers has increased significantly in recent years, as well as the recognition of the close relationship between the welfare of the staff and the efficiency of humanitarian action.

Nowadays, the attention of the world is on daily media reports about the number of aid workers killed, kidnapped and injured. In the last twenty years, the number of attacks on humanitarian staff around the world has risen sharply (Mckay, 2008). According to the Office for the Coordination of Humanitarian Affairs, 2013 was the most dangerous year for humanitarian workers, with 251 security incidents affecting more than 461 aid workers (OCHA, 2015) and the International Committee of the Red Cross reports more than 1,650 violent incidents affecting health personnel in 23 countries in 2014 (ICRC, 2014).

Aid workers not only face significant threats to their physical health security but also to their psychological wellbeing. Researchers have found that approximately 80% of aid workers experience distress symptoms and that 3-7% suffer to an extent that interferes with their duties and life quality (Connorton, Perry, Hemenway, & Miller, 2012). Furthermore, the exposure to complex humanitarian settings encompasses risks of posttraumatic stress disorder (PTSD) and burnout.

As a consequence, a new set of international policies and guidelines to protect aid workers has been mainstreamed in the humanitarian system around the world. There is a wide range of literature available from different disciplines highlighting the importance of training, resilience strengthening programs, and the access to professional services in critical situations (Swords, 2007). Nonetheless, current approaches to staff care mainly focus on stress variables and safety issues. Humanitarian settings include a range of risks not only in traumatic circumstances, but also in the daily work. Environmental aspects of emergency zones, the exposure to unexpected events, the pressure of families, communities and public, organizational problems, and lack of resources are part of the most frequent challenges for this population. Thus, the vulnerability of aid workers implies the analysis of a more complex set of factors affecting their quality of life and a more integrated approach to health staff care in humanitarian settings ((Lankester, for Interhealth¹, 2013). In this respect, words such as

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¹ InterHealth is an International health charity based in London, UK, founded in 1989. This organization provides medical, psychological, occupational and travel health services to those working in the International
wellbeing, wellness, and healthy lifestyle promotion are frequently emphasized in institutional programs and policies. But what is understood by healthy lifestyle? Is there “one” aid worker’s healthy lifestyle? And how have researchers and staff managers in humanitarian organizations analyzed this construct?

The lifestyle concept has many connotations, from sociological, health, psychological, anthropological and economic theories, but in this research it will be operationalised from healthy lifestyle theories. Cockerham refers to healthy lifestyles as “collective patterns of health-related behavior based on choices from options available to people according to their life chances” (Cockerham, 2005, p.55). For example behaviours such as the abuse of substances, exercising, nocturnal sleep and rest, diet, personal hygiene, leisure activities or hobbies, interpersonal relations, and sexual behavior (Yalçinkaya, Özer, & Karamanoğlu, 2007)

The purpose of this study is not to characterize the lifestyles of aid workers, but to analyze from a critical perspective how international organizations are integrating health practices in their staff care programs.

For this end, searching databases, meeting with experts and conducting interviews were the methods used to gather information on aid workers’ healthy lifestyles. After reviewing health promotion and lifestyle theories, nine out of fourteen health practices were identified as being addressed by the humanitarian organizations within their staff health programs. However, and despite the efforts of each organization towards a more holistic approach to health personnel care, health managers in promoting health referred several challenges.

Even though most of these challenges are issues of global and public health, humanitarian organizations have a broad range of capacities and opportunities to contribute not only to health improvement of the most vulnerable communities, but also to the strengthening of their staff welfare.

Research Questions

1. To what extent and how are humanitarian organizations implementing health practices in their staff care programs?

2. What are the limitations, challenges and opportunities of humanitarian organizations in the promotion of healthy lifestyles within their staff?
2. Methodology

To answer the research questions proposed in this study, different methods were selected to collect and process key information about humanitarian workers and healthy lifestyles. First, databases such as PubMed, Sage, Lilacs, NHS Evidence, Cochrane Library, Google Scholar, and the University of Geneva Library were used to explore the literature available on the subjects. Subsequently, communications were held (via email and Skype) with humanitarian organizations’ networks specialised in staff care such as People in Aid and Interhealth. Similarly, experts and authors of books on humanitarian workers’ lifestyles and staff management were contacted via email. Finally, with the aim of exploring current and specific practices in health promotion within the staff, four meetings with the people responsible for the health staff care of international humanitarian organizations were conducted. These organisations shared specific and internal information that was included in the literature review and was considered in some parts of the discussion.

The criteria for selecting these organizations were (a) having published studies and guidelines on staff health care, risks behaviours, health promotion, and lifestyles, (b) being referenced in studies on these topics, (c) having a staff care office within their structure and a coordinator or focal point, (d) having operations in countries of more than two continents, and (e) having international and local staff in their teams. The organizations were the International Committee of the Red Cross (ICRC), the International Federation of the Red Cross and Red Crescent (IFRC), Médecin sans frontières Suisse (MSF) and the United Nations High Commissariat of Refugees (UNHCR).

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2 People In Aid is a global network of development and humanitarian assistance organisations to enhance the impact they make through better management and support of staff and volunteers (People in Aid, 2003).
3. Literature Review

3.1. Lifestyle theory and Health Promotion

Lifestyle is a mainstreamed concept used nowadays to express almost anything of interest, be it fashion, Zen Buddhism or French Cooking (Sobel, 1981, p.1 in Chancey, 2001). However, and despite of all the difficulties reaching agreement on its meaning, important contributions especially from sociology have allowed its understanding and have supported the formulation of the theory of healthy lifestyles (Cockerham, 2005).

According to Anderson and Golden (1984), it is not clear when the term lifestyle was first mentioned in the literature. As an analytical construct, it has its roots in Thorstein Veblen’s theory of the leisure class (1899) and Max Weber’s (1946) studies on status and social goods’ consumption. Inspired by the convulsive changes of the industrial revolution, Weber analysed the production of lifestyles through interactions of people’s life choices and life chances. Later Veblen (1970) proposed variables such as education, occupation and income as factors that characterise lifestyle in a continuous relation to cultural preferences, tastes and consumption patterns (Anderson & Golden, 1984).

In contrast, and reacting to an economic reductionism of the lifestyle paradigm, Bourdieu (1984) introduced the concept of habitus as “tendencies socially created that guide behaviour and thinking which are not fixed but can be changed under unexpected situations or over a long historical periods” (Navarro, 2006, p.16). Thereby, Bordieu contributions broaded the understanding of how culture and education can modify lifestyles and opened the way for new disciplines to deepen this construct.

Alongside, it is important to refer to the work of Alder (1956) in Individual Psychology theories (Embaucher, 1976 in Anderson & Golden, 1984) and the studies of William Lazer (1964) on marketing, consumer behaviours and patterns within social groups (Thyca, 1996 in Ritzer 2007).

Furthermore, the development of Lifestyle as a construct has been significant from the health perspective. The most recent body of literature has been compiled from a relatively new branch originally developed in the United States called Lifestyle Medicine (Mora, 2012).

The European Society of Lifestyle Medicine, the American College of Lifestyle Medicine and the Australian Lifestyle Medicine Association have conceptualized the scope of this new area. These associations define Lifestyle Medicine as “a branch of evidence-based medicine in which comprehensive lifestyle changes (including nutrition, physical activity, stress
management, social support and environmental exposures) are studied to prevent, treat and reverse the progression of chronic diseases by addressing their underlying causes.” (ESLM, 2015, para.2). From several resources like journals and other publications on this topic stands out the manual by Rippe “Lifestyle Medicine” (2010) which is a compilation of evidence-based research covering topics such as nutrition, exercise, behavioral psychology, public policy, chronic management disorders; health promotion in the workplace and health care systems (Ritzer, 2010).

Moreover, a broader approach emerging from the 80’s on healthy lifestyles has been proposed by Cockerham who defines it as “collective patterns of health related behavior based on choices from options available to people according to their life chances” (Cockerham, 2005, p.55). Cockerham (2005) proposes not only the development of a lifestyle branch as a particular discipline, but also a whole theory of healthy lifestyle.

Strongly influenced by Weber and Bourdieu, Cockherman in his article “Healthy lifestyle Theory and the Convergence of Agency and Structure” (2005) challenges the individualistic paradigm predominant in health promotion. He poses a theoretical model to describe healthy lifestyle dynamics composed by four categories: "(a) Structural variables3, (b) socialization and experience influencing, (c) life choices (agency), and (d) life chances (structure)” (Cockerham, 2005, p.56). According to this author, the interplay between life choices and life chances originates habitus and practices (Cockerman, 2005). In terms of health, the most common lifestyles practices researched are alcohol use, smoking, dietary habits, and exercise. Another less explored but also key practice in a more comprehensive view of health, include personal hygiene, rest, seatbelt use, contact with the medical profession for preventive care and routine checkups (Freudenberg, 2007). Thus, health practices can be explained as devices that constitute healthy lifestyles. Another key point identify in lifestyles theory is the plural character of this concept. Given the cultural diversity, needs and variety of human expressions, there is not only one healthy lifestyle, but rather a number of possibilities to achieve adequate and harmonious state of health and wellness.

Despite the controversies on the concept of lifestyle applied to medicine and health (Korp, 2010) health promotion is considered a strategic tool for improving health in the 21st century (Freudenberg, 2007). Additionally, and considering that much of contemporary life develops in the workplace, studies have shown the effectiveness of institutional health promotion

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3 Structural variables: Class circumstances, age, gender, race/ethnicity, collectivities and living conditions. Cockerham’s healthy lifestyles paradigm (2005).
programs on quality of life and therefore in workers’ productivity (Carvalho & Costa, 2011). Also, a vast body of charters and declarations\(^4\) supports the implementation of these programs as part of the institutional responsibility with their employees. Considering the diversity and complexity of humanitarian action, what has been done so far to improve wellbeing of their workers and to promote healthy lifestyles?

### 3.2. Humanitarian workers’ world

Over the past three decades, the complex contexts where humanitarian action\(^5\) takes place have drawn the attention of scholars and researchers to look more closely to the factors, challenges, hazards, risks and demands of this field. The concern on humanitarian workers' vulnerability has mobilized a variety of disciplines to develop studies and diverse publications addressing this issue with possible strategies towards the wellbeing of aid workers.

Nonetheless, this task has not been easy due to the lack of unified data and disagreement on the scope of humanitarian workers (Walker & Russ, 2010). One attempt to fill this gap was in 2008 when Stoddard et al. estimated a number of 595,000 humanitarian workers from UN agencies, the Red Cross and Red Crescent Movement and most NGOs, but this study did not include peacekeepers and human rights workers (Walker & Russ, 2010). That reflected a still ongoing debate\(^6\) on whether development aid and human rights actors should be considered as part of the same group of humanitarian workers or not (Silke, 2015).

In addition, the understanding of a heterogeneous population like humanitarian workers implies the study of diverse variables in terms of culture, occupations, forms of employment, and organizations’ structure (Silke, 2015). In this endeavor, important analyses on this topic appear from 2000 in the fields of political science, sociology and anthropology. For instance, the controversial critic to humanitarianism by Reiff in the book “A Bed for the Night:

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\(^4\) In this respect UNHCR (Arena, 2014) lists: “the 1986 Ottawa Charter for Health Promotion, the 1997 Jakarta Declaration on Leading Health Promotion into the 21st Century, the 2005 Bangkok Charter for Health Promotion in a Globalized World, the Luxembourg Declaration on Workplace Health Promotion in the European Union, the Lisbon Statement on Workplace Health in Small and Medium Sized Enterprises and the Barcelona Declaration on Developing Good Workplace Health Practice in Europe by the European Network for Workplace Health Promotion” (UNCHR, 2014, p.4).

\(^5\) Humanitarian action is here defined as “the aid and action designed to save lives, alleviate suffering and maintain and protect human dignity during and in the aftermath of man-made crises and natural disasters, as well as to prevent and strengthen preparedness for the occurrence of such situations” (Global Humanitarian Assistance, n.d.)

\(^6\) Aware of the distinctions underpinned in the debates, in this paper, it will be used both terms of humanitarian workers and aid workers to refer the same population. This decision responds to the aim of covering all categories of actors involved in the humanitarian action.
Humanitarianism in Crisis” (2003) poses some dilemmas between humanitarian workers’ intentions and the constraints to achieve their goal on the field. In the same line, Eyben (2013) explores the values, expectations and altruistic motivations of development workers, and Fechter (2008-2012) describes expatriates transnational lives, their practices and imaginaries comparing them with a continuity of postcolonial style (Fechter & Walsh, 2010).

Despite these contributions, characterizing humanitarian workers, Slim and Rességuiér (2014) agreed on the limited study of this population and indicated the existence of a trend in the recent academic literature to focus only on macro-level analysis of the political, geopolitics and operational challenges of humanitarian action (Slim & Rességuiér, 2014).

Regarding this gap, one important contribution has been made by the sociologist and professor Roth Silke, an author of several articles on aid workers identities, roles, skills, risks and dilemmas. In her last book, “The Paradoxes of Aid Work: Passionate Professionals” (2015), the author uses a fictional place named Aidland, where she presents a varied spectrum of humanitarian workers, their perceptions, complex relationships and challenges in reaching a "work-life balance". Although social sciences have notably contributed to the decoding of humanitarian aid workers’ "lifestyles", the majority of articles found in this review on humanitarian workers lifestyles promotion come from staff management approaches.

3.3. Humanitarian Action and staff management

The awareness on humanitarian workers’ complexity and workplace demands has prompted aid organizations to reinforce and transform their approaches, especially in security issues and staff management programs (ECB Project, 2006) The latter has been traditionally more centered in payroll administration, job designing and programs to maximize the speed, performance quality and capabilities of their human resources (Min-Harris, 2011). However, in pursuing coherence with their humanitarian principles and its duty of care, “the humanitarian and development sector has made considerable progress with respect to staff care in the last 10-15 years” (Interhealth & People in Aid, 2004). For example, People in Aid, a global network conformed since 1995 by a group of development and humanitarian agencies, launched in 1997 the “Code of Good Practices” with the purpose of supporting organizations in staff management process (People in Aid, 2003). This code, evaluated in 2001 and thereafter reviewed in 2003, is included in the Core Standard number six of Sphere Standards relative to Aid workers performance (Sphere Project, 2013) and is a central part in
the “Core Humanitarian Standard on Quality & Accountability 2015” (Lacroix, 2015). In addition, this network has published specific guidelines on staff health care and welfare. The first guideline was contributed by Howell in 2002, “Health and Safety in Aid Agencies” (which gave origin to principle 7 in their code of practices); and a second one entitled “Staff Health and Welfare” by Lankester in 2004. Both documents present legal aspects of staff care and recommend measures on medical and psychological aspects to protect personnel who travel internationally.

Later in 2006, the Emergency Capacity Building Project7 (ECB Project), aiming to identify good practices on staff management programs in aid organizations, published the “Review of Current Practices in Developing and Maintaining Staff Capacity”. In its section “development and duty of care”, this review identifies four interplaying dimensions for aid workers staff management: Security, Safety, Wellness and Health (ECB Project, 2006). The latter two highlighted key staff care activities such as: limiting time in emergencies, workload alternation, rest and recuperation (R&R), services for staff in hardship situations, stress awareness activities and training, hotlines for emergency assistance and debriefings (ECB, 2006).

In 2009, Emmens and Porter for People in Aid and Interhealth conducted a similar study “Approaches to Staff Care in International NGOs”. The study presents an analysis of humanitarian organizations staff care systems, from different institutional experiences and “complex interwoven of several disciplines” such as safety/security, mental health, travel medicine, and occupational health (Emmens & Porter, 2009).

Apropos of safety and staff care, Güss conducted in 2012 the research “Focus on staff care: Assessing safety and security support of expatriate field staff in Switzerland based humanitarian organisations” (Güss, 2012). In this study, the author takes into account People in Aid and Intehealth’s staff care program phases (before, during, after assignment) to analyse safety practices. Güss (2012), based on the studies on safety and risks of Van Brabant (2001) and Stoddard, Harmer and DiDomenico (2009) points out key advancements in the organizations’ efforts but at the same time remaining problems in staff care approaches. From one side, there is a reinforcement of safety with the implementation of “induction courses, e-

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7 Interagency Working Group (IWG) on Emergency Capacity Building In 2003, CARE International, Catholic Relief Services (CRS), the International Rescue Committee (IRC), Mercy Corps, Oxfam-GB, Save the Children-US, and World Vision International formed the. An assessment of their emergency response capabilities identified four main areas where inter-agency collaboration would greatly improve response. These areas formed the basis of the ECB project (www.ecbproject.org), funded by The Bill & Melinda Gates Foundation and Microsoft Corporation” (ECB, 2006).
learning courses, mentorship programs, pools of trained emergency staff, security and psychological focal points in the field and returnee’s weekends” (Güss, 2012). On the other hand, according to this author there is still a need to raise more awareness about high-risk field missions complexities and enhance safety practices within selection, training, medical screening, stress support and institutional integration.

Regarding mental health issues and the psychological impact on humanitarian workers, this topic has been the interest of researchers for more than 25 years (Ehrenreich, 2002). This is visible in the work of Ehrenreich, who provides a comprehensive bibliography on this topic in his review “Managing Stress in Humanitarian, Health Care, and Human Rights Workers” (2002). After Ehrenreich’s reviews, the production of studies and manuals on stress management, resilience and psychosocial support for humanitarian workers has thrived.

Thus, Antares Framework (2012); IASC Mental Health and Psychosocial Support (MHPSS) Guidelines, 2007; the Sphere Guidelines, 2011; “Good practice guidelines for staff health and psychosocial care reformatted” 2013 by Lankester for Interhealth, represent an important group of publications on staff care developed in the last decade. According to UNHCR theses publications have contributed to the transformation of organization traditional approach to MHPSS (Welton-Mitchell, 2013).

On the same topic, but in terms of Institutional publications, it can be mentioned the seminal but still in force booklet of ICRC “Cope with stress” (Bierens de Haan, 1992), the “Psychosocial support toolkit caring for volunteers” from International Federation of the Red Cross (Snider, 2013), and the UNHCR's Study “Mental Health and Psychosocial Support for Humanitarian for Staff” (Welton-Mitchell, 2013).

On the other hand, a substantial body of research has also been carried out from the Travel Medicine discipline. In this area, measures are proposed to protect staff health and welfare before, during, and after travel as presented in the “Textbook of Travel medicine” by Keystone et al., (2008) and “The Yellow Book: CDC Health Information for International Travel” by Gushulak (2012).

Additionally to travel risks of humanitarian work, other variables related to violence and security, mental health, accidents and diseases have also been researched from the occupational health field. According to Güss “staff care is not only a moral and ethical but also a legal obligation” (Güss, 2012, p.9) and the employer is legally responsible for safe working conditions as is shown in WHO and International Labour Organisation (ILO) conventions (Simmonds et al. in Güss, 2012).
In the humanitarian context, the World Health Organization pilot study “Occupational Health of Field Personnel in Complex Emergencies” highlights a number of deficiencies and concerns on risk reduction and mitigation actions in organizational programs (WHO, 1998).

Later, a closest study to healthy lifestyles in aid workers was conducted by Elliot et al. on "Promoting Healthy Lifestyles: Alternative Models’ Effects Firefighter Study" (2007). The paper highlights the importance of both individual and centered models in promoting healthy lifestyles. Nonetheless, due to characteristics inherent to firefighters structure and roles, the authors indicate that team-centered formats are more effective in promoting health (Elliot, et al., 2007).

Similarly, in a more recent research “Emergency Services: A Literature Review on Occupational Safety and Health Risks” (2011), Hauke et al., presents key descriptions of the wide range of hazards, negative health outcomes and adverse health effects in the emergency worker population (Hauke et al., 2011). Although the author provides a comprehensive list of the studies on this topic, the research only focuses on expatriate workers.

The same target is considered by the ICRC in its research “Health Risks and Risk-Taking Behaviors Among International Committee of the Red Cross (ICRC) Expatriates Returning From Humanitarian Missions” (Dahlgren, DeRoo, Avril, Bise, & Loutan, 2009). This study developed in 2009, highlights the variety of factors and conditions that worsen humanitarian aid workers’ health during overseas missions. This study emphasizes more in the role that expatriates play “engaging behaviours that could endanger their health” (Dahlgren et al., 2009, p.386). For instance, the study explores lifestyle and risk taking variables such as alcohol consumption, smoking, the use of drugs and lack of prevention measures during sexual encounters. The authors report no considerable changes in alcohol, but increased levels of smoking and use of recreational drugs during missions. Another key finding is related to sexual and reproductive health, on which the study indicates “more than one-third of the expatriates reported having had sexual contact with at least one person who was not their regular partner (...) and a low rate in the use of condoms” (Dahlgren et al., 2009, p.389).

As one of their recommendations, the authors insist on the implementation of new approaches to address the problematic areas identified, for instance activities of health promotion in selection process, briefing, training, and following up in field by regular reminders and support (Dahlgren et al., 2009).

Woodman and Calain (2012) from Médecins Sans Frontières Switzerland (MSF) conducted other paper related to health risks and humanitarian aid. This study entitled “Morbidity in front-line humanitarian aid workers”, explored staff medical cases
between 2010 and 2011. They report Malaria as the most common diagnosis accounting 20% out of 62% medical issues; 21% of health problems were due to occupational accidents or illnesses and 17% called for psychological support (Woodman & Calain, 2012). Although, the authors point out the need for more emphasis on pre-departure preparation and advice, the paper does not provide more details about specific practices to reduce this morbidity and occupational accidents rates.

Finally, published “Staff Health Risk Appraisal Survey Report” (Arena, 2014), a study that could be so far the most comprehensive and discipline integrative on profiling humanitarian staff health. Using an online survey sent to 13,500 registered email UNHCR users, the agency explored medical, mental, working and living conditions of their staff. The study includes a special chapter on risks and lifestyles where it analysed elements such as; physical activity, hours of sitting per day, hours of sleep per night, sunscreen use, smoking habits, alcohol consumption, use of seatbelts, use of helmets, healthy eating habits and sexual behaviours (UNHCR, 2014). This study reports high rates of sedentarism; the lack of use of sunscreen, helmets and seatbelt, high prevalence of smoking, and patterns of poor daily intake consumption of fruits and vegetables (Arena, 2014). This appraisal provides important data on lifestyle variables and recommendations to guide managers in the implementation of strategies for staff care. In the effort of international humanitarian organizations, this document is an important step forward to fill the gap in the incorporation of specific activities to promote health within humanitarian workers.
4. Interviews

As it was presented in the literature review, there is an important body of research and guidelines on humanitarian workers staff care. The inputs (academic and technical) to this topic, stem from different disciplines, areas and theories. The closest references addressing humanitarian workers lifestyle are ICRC Risk Behaviours study (Dahlgren, et al., 2009), Güss study “Assessing safety and security support in staff care” (2012), and UNHCR Staff Health Appraisal (Arena, 2014). Nonetheless, and despite the fact that all the studies mention the importance of enhancing a healthy lifestyle, there still a gap in terms of specific needs and practices promoting health within the humanitarian workers.

In order to contribute filling this gap, in this section the first part describes some characteristics of institutions and their current approaches and activities, and presents a list of health practices found in the literature review and through interviews with staff managers and experts. The next chapter will indicate seven main challenges promoting health in staff care units of humanitarian organizations.

Since only four organizations were consulted, it is important to mention that the scope of this paper is limited and it represents only an attempt to explore lifestyle practices in this sector. In addition, only health staff managers view was considered without examining other areas or the opinions of the staff. Plus, most of the institutional information on staff care programs and processes is compiled in internal documentation and currently under review. Moreover, case records confidentially led managers to generalize examples and situations, which limited the level of detail in describing health issues and practices in this paper.

4.1. Health staff care structures in Humanitarian Organizations

Four International Humanitarian Organizations based in Switzerland were chosen to explore healthy lifestyles: the International Committee of the Red Cross (ICRC), the International Federation of the Red Cross and Red Crescent (IFRC), Médecins sans Frontières Switzerland, and the UN Agency United Nations High Commission for Refugees (UNHCR). These organizations operate around the world providing humanitarian aid in the contexts of disasters and armed conflicts. The staff of these organizations is integrated by expatriates, volunteers and local personnel (see Table 1. for figures of staff organizations). These organizations with their headquarters in Geneva coordinate their actions through regional/zone and country offices. Although the design varies, all the organizations have structured their programs of staff care under human resources departments (HR). Within
these areas of staff care, medical doctors, nurses, and psychologists are in charge of the units Health Staff and Welfare. The units are usually small (no more than five people in HQ) but expanded at regional and country level with variable availability of health focal points, medical coordinators, health advisors, and consultants. Health staff offices have to coordinate with other areas in HQ such as security, training and communication; and to support regional offices and managers in the field. In order to guarantee staff health as a priority independent of the demands or pressures from the field, health staff care units are part of HR areas and not of operational areas (A. Salvador, personal communication July 15, 2015).

Table 1.

<table>
<thead>
<tr>
<th>Organization</th>
<th>ICRC</th>
<th>UNHCR</th>
<th>IFRC</th>
<th>MSF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of staff</td>
<td>13,866</td>
<td>13,500</td>
<td>1,756</td>
<td>3840</td>
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<tr>
<td>Expatriate / Mobile staff members deployed</td>
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<td>2476</td>
<td>430</td>
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<tr>
<td>Health staffcare</td>
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<td>4</td>
<td>2</td>
<td>2</td>
</tr>
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4.1.1. Policies enhancing staff welfare

Since staff health care and welfare areas are under restructuration, their policies are in reformulation. For instance, ICRC recently approved a new Stress policy, which emphasizes the importance of a broader approach that focuses on staff skills strengthening rather than on traumatic stress. From this view, the organization aims to reinforce the engagement and participation of all organizational levels in stress management (F. Althaus, personal communication, May 2015). In the same line, MSF has a policy on “Stress Prevention and Management (SPAM)” which guides the development of diverse processes and materials to protect and improve staff resources for mental health self-care.

In the case of UNHCR and IFRC, currently they are in a process of writing and approving occupational health, staff accommodation, and health staff and welfare policies. For instance, IFCR counts with road safety guidelines that include, for example, the prohibition of the use of motorcycles for IFRC delegates; and MSF has a policy that covers medical treatments additional to the standardized services for local staff in cases where the local health system does not cover high-cost treatments or surgeries (H. Haggman; A. Salvador, personal
communication, July 14, 2015). However, to implement health policy has not always been easy for staff care units. For example, the four organizations consulted mentioned the failure process on anti-tabac policies approbation. Managers referred that despite the awareness of the risk of smoking, free smoking spaces proposals were perceived too coercive, and given the discussions on these measures they did not have enough strength to be put in place. To this respect, nourishing a better environment to adopt these types of policies in the future, staff care units have reframed their approaches emphasizing more on smoking reduction.

4.2. Main activities in health staff care

Humanitarian organizations have developed a wide range of activities and services within their programs of staff care. In terms of medical services and tests, these institutions have standardized processes such as: admission examinations, semestral and annual check-ups, periodical screenings, counseling (email, chat, hotlines, presidential consultations), vaccinations and individual case management. Three out four organizations have outsourced their medical admission tests, according to them to maintain distance and protect the confidentiality on personal medical records. Most of the organizations provide additional support and health services to expats’ family members and local staff, especially when the local health system has service gaps. Plans for medical evacuations, risks assessments, and insurance activation are coordinated with security areas and operational departments.

On the other hand, all the organizations highlight the relevance and advancement in the implementation of psychological and mental health activities within their programs of staff care. These programs include individual and group-level counseling, briefings, debriefings, defusing, assistance on critical incidents and crisis management. Health staff managers also pointed out that organizations are enhancing measures emphasizing on chronic stress and burnout prevention. These activities are complemented by services from insurance programs and internal campaigns (e.g. using intranet and handouts distribution) on basic measures of occupational health such as ergonomics and weight management.

Occupational health (OH) programs for international staff are not linked to Swiss Law but covered by insurance and outsourcing services, while local staff are protected by country programs and local occupational health laws. Also, organizations on its duty of care are aware of the need to complement the programs of occupational health. Thus, most health units have implemented additional processes such as the design and update of country and
project health risks assessments. Those materials are socialized through brochures and fact sheets in deployment phases (H.Haggman, personal communication, July 14, 2015).

Regarding the training and education of staff, health care units are responsible for designing briefings and induction process about institutional health services and self-care. Sensitization activities focus mainly on waterborne diseases and VIH Aids, previous to the provision of protection equipment and materials (e.g. mosquito nets, soaps and chlorine, etc.). Educational activities as the most mainstreamed methods in health promotion are key components of the induction process and briefings. However, as some managers pointed out, a large amount of data is provided at this stage not only from staff care units but also from all the areas of the organization. This large amount of information to assimilate, plus individual expectations and stress, probably could minimize staff capacity to receive and integrate all the messages in protecting their health. Therefore, staff units are improving the delivery of key messages all along staff management cycles (H.Haggman, personal communication, July 14, 2015)

The difficulty in identifying health promotion activities within organizations lies in the fact that health practices are scattered in different areas holding different aims (See Table 2). For example, mental health care programs address exercise as a protective factor in stress management; while from security areas, physical activity has been promoted to guarantee resistance and adaptation to difficult environments or specific situations such as evacuations. Another case is related to alcohol and drug abuse prevention, which from psychosocial programs is tackled as a common stress coping mechanism (V.Braissan, personal communication, July 2015), whereas security areas address this issue to ensure adequate performance and to protect the image and institutional mission.

As it is shown below (though, the list is not comprehensive due to the scope of this paper), there is an important engagement from different areas in covering staff issues related to health. However, as managers referred, sometimes this atomization not only leaves gaps in some practices (e.g. dental health, nutrition, skin protection) but also creates difficulties in programs and the coordination of different areas. Organizations do not intend neither to control nor to assume the total responsibility for their staff’s health, but there is a shift in their management approaches to a broader and more integrative perspective of staff welfare.
Table 2.  

Prioritization of healthy practices within staff care approaches.

<table>
<thead>
<tr>
<th>Healthy practices / Areas and Institutional programs</th>
<th>Medical Services and tests</th>
<th>Mental health and Psychosocial support</th>
<th>Occupational Health</th>
<th>Security and Safety Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Routine check ups and consultation</td>
<td>x</td>
<td>x</td>
<td>-</td>
<td>x</td>
</tr>
<tr>
<td>2. Profilaxis/Vaccination</td>
<td>x</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3. HIV and ETS prevention</td>
<td>x</td>
<td>-</td>
<td>x</td>
<td>-</td>
</tr>
<tr>
<td>4. Seatbelt and headmets use</td>
<td>-</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>5. Sleep, rest and recuperation (R&amp;R)</td>
<td>-</td>
<td>x</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Personal hygiene</td>
<td>-</td>
<td>x</td>
<td>x</td>
<td>-</td>
</tr>
<tr>
<td>7. Physical Activity/Exercise</td>
<td>-</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>8. Leisure and recreation</td>
<td>-</td>
<td>x</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>9. Alcohol abuse prevention</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>x</td>
</tr>
<tr>
<td>10. Nutrition</td>
<td>-</td>
<td>-</td>
<td>x</td>
<td>-</td>
</tr>
<tr>
<td>11. Smoking reduction</td>
<td>-</td>
<td>-</td>
<td>x</td>
<td>-</td>
</tr>
<tr>
<td>12. Drug abuse prevention</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>x</td>
</tr>
<tr>
<td>13. Social network support, prevention of social isolation.</td>
<td>-</td>
<td>x</td>
<td>-</td>
<td>x</td>
</tr>
<tr>
<td>14. Sun cream and skin protection</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>15. Dental health</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

(x): activities, (-) no registers on this topic.

4.3. Steps towards a more holistic health care

According to heads of staff care and experts, a few years ago health programs were more focused on medical services and activities to attend staff health emergencies in the field (F. Althaus; A. Salvador; H.Haggman; N.Lessard, personal communications May – August, 2015). In this sense, Organizations have been more reactive and curative than centered in preventive strategies. Salvador explains that the first step in this transition was the standardization and systematic application of processes of prophylaxis and vaccination (A. Salvador, personal communication July 15, 2015). The second step was the incorporation of strategies and policies on mental health and management of stress within staff care. In turn, approaches of mental care have been changed from activities only focused on clinical treatment and emotional first aid, towards resilience strengthening and burnout prevention (D. Suzic, personal communication, July 15 2015)

Also, changes in the paradigm of health and welfare in the last decade have motivated the incorporation of more collective and holistic approaches within global and public health (F.Althaus, personal communication, May 20, 2015). To that end, organizations have renamed their units with words such as 'Wellbeing' and 'Welfare' and created new areas in their
structure of HR (e.g. staff care accommodation in UNHCR). These units of staff care have decentralized their processes not only looking for better reaction times to the needs of the people in the field but also greater participation and empowerment of the staff in their health self-care.

Today, units of staff health care have as a priority maintaining services already implemented and creating activities to raise institutional awareness on the mission risks on the staff health. From an integrative view of health and wellbeing, organizations aim to develop specific training spaces and resources to support the maintaining and improving of health. Nevertheless, and despite the commitment in the disposal of mechanisms for a better staff adaptation to their workplace, staff care units face some common critical limitations and challenges in promoting health.
5. Discussion.

Challenges implementing healthy lifestyles practices

As described before, staff health practices are executed from different approaches such as stress management or occupational health and safety, and not from an independent area or health promotion theoretical framework. However, from a long list of health care management challenges provided by staff managers, in this paper seven main issues are prioritized related to healthy lifestyles promotion within staff in international humanitarian organizations.

5.1. Data Gap profiling staff health

Nowadays country health systems and organizations have advanced considerably in their efforts to report, collect and analyze health variables to develop based needs approaches (Garcia & McCarthy, 1996). Likewise, the humanitarian field has improved its strategies in profiling communities and beneficiaries’ health conditions. However, in terms of staff health care the development of data systems has not been so successful.

As it was mentioned in the previous chapter of this paper, last year UNHCR risk survey made a significant contribution to measuring humanitarian workers’ health. Although the study was proposed as a health staff baseline (Arena, 2014) the document does not indicate correlations between the health conditions described and the demands of humanitarian work. This issue responds not only to the limitations of the survey but also to challenges inherent in measuring health in humanitarian contexts. In this regard, UNHCR mentions the difficulty of measuring staff health in humanitarian settings due to the complexity and multidimensional aspects of this population. Also, and regarding its holistic aim on staff care, this UN agency indicates that studies of this type « require the adoption of an integrated set of indicators beyond the ones derived from the traditional surveillance and monitoring activities (e.g. sick leave, disability, service incurred injuries and illnesses data)” (Arena, 2014, p. 4).

From this perspective, another challenge relates to the costs of studies, monitoring and staff health surveillance systems. As Güss mentions, staff programs improvements are often perceived as additional burdens and usually are sacrificed for the operational costs (Guss, 2012). Also, funds and donors conditions frequently leave a narrow space for investments in staff welfare (Stoddard, 2008). Besides, little personnel within units of health care is not enough to develop and coordinate a whole health staff data system (F.Althouse; H.Haggman personal communication, May-July, 2015).
Moreover, managers also indicate a gap in the access to the data from outsourced medical services established for staff. With the aim of preserving the confidentiality of medical staff status, records on staff health remain with consultants, insurances and external companies providing these services. (A. Salvador, personal communication, July 2015). Therefore, a pending task would be the design of a joint system with outsourced health services to gather general information and statistics that could guide the organization to prioritize health practices and to enhance health programs.

5.2. Team members’ roles and liability level

Humanitarian action is integrated by a broad range of actors, local or expatriates; volunteers or paid personnel, permanent employees or consultants (Silke, 2015). For organizations, this variety allows flexibility in the institutional dynamics, integration of different perspectives and an oxygenated organizational environment. Nonetheless, such diversity demands resourcefulness from staff managers to address mixed needs within the teams, individual preferences and health coverage disparities. The latter represents a critical aspect, especially in compensating inequity perceptions in terms of health system access, insurance, and wellbeing benefits among all aid workers (A. Salvador, personal communication, July 2015). Last year during staff medical evacuations in West Africa in the Ebola operations, humanitarian organizations had to face health system constraints in medical services for both local personnel and expatriates. Thereby, HR departments and health workers care units, mobilized budgets and additional resources to fill services gaps mainly for local staff. (A. Salvador, personal communication, 2015). Addressing inequalities in health access not only indicates accountability on fairness and impartiality inside the institution; but also contributes to team cohesion. In turn, this group integration facilitates collective engagement in healthy lifestyle practices and the strengthening of social support networks within the organization.

5.3. Missions' scope and length

Managers interviewed agree that the design of health staff activities varies in function of operation types. Staff needs, expectations, coping mechanisms and adaptation skills change in emergency settings (e.g. response and relief phases), middle and long-term operations (reconstruction, rehabilitation and development phases). As Mckay describes, the operational first stages imply limitations to develop routines and commodities for the staff (Mckay, 2008). A combination of the rapid conditions of deployment, poor timing, long schedules,
poor facilities to eat, rest and hygiene allow, in certain way, people to be justified for their negligence of self-care. Thus, managers and staff tend not to prioritize eat and rest recommendations. In this regard, MSF HR departments have established a rule for expats deployment during short time frames (maximum three weeks/months), for example in complex contexts such as the Haiti earthquake in 2010 and the Ebola outbreak in 2015 (A. Salvador, personal communication, July, 2015). On the other hand, middle and long-term operations provide more opportunities to adequate facilities and people to adapt. Nevertheless, in these phases it is crucial to monitor and support field managers to maintain healthy measures and motivation to health care within the staff until the end (H. Haggann, personal communication, July, 2015).

5.4. Work and living conditions

Cockerham (2005) states that despite the little research linking living conditions to healthy lifestyles, there is an important interrelation between environmental variables (chances) and the practices (choices) that people can implement to improve health care (Cockerham, 2005). The living conditions in humanitarian settings are particularly variable due to a wide range of environmental and social factors. For instance, humanitarian teams in disasters and armed conflicts are exposed to extreme temperatures, collapsed places, chemical threats, visual, auditive contamination and violence (Valero, 2002). Also, the locations where humanitarian organizations develop their activities are under blockage or have limited access to services and supplies (A. Salvador, personal communication, July 2015). As a consequence, humanitarian teams have to deal with the lack of proper places to rest, potable water, food, toilets and privacy (H. Haggman, personal communication, July, 2015).

Regarding this landscape, health staff care units have designed recruitment and training processes to prepare staff for the psychological and physical overstrain to cope with these work demands. (N. Lessard, personal communication August 2015). For example, MSF Suisse recruiting web advertisements are explicit about the life conditions during missions. “Les conditions de vie varient d’un contexte à l’autre. (…) sur des missions d’urgence, les conditions de vie peuvent parfois être très précaires. Un nouveau style de vie vous attend dans lequel l’intimité et les temps libres peuvent être rare” (MSF Suisse, 2015, para.8). The advertisements also indicate that MSF engages in proving “decent working and living conditions to promote the effective implementation of programs while taking into account local living standards” (MSF Suisse, 2015, para.8). Nonetheless, as mentioned by
Suzic (2015) for international organizations, it is not possible to standardize one single process to guarantee basic wellbeing for all the staff. For example, there are specific needs for staff working in HQ and regional offices in comparison to field personnel (personal communication 10 July 2015). Therefore, humanitarian organizations are usually aware that the staff is not always in the best conditions to support the community prioritized in the aid.

In addition, in some cases the staff has to work and live in the same place, thus is problematic to find balance between work and personal life in these kind of humanitarian settings. This lack of boundaries between work and living space increase the levels of staff stress creating difficulties to rest, to detach from work and to allow emotional ventilation (Valero, 2002).

Space constraints also limit the incorporation of measures to maintain health. For example, to promote physical activity and exercise in locations like strict compounds or land mined areas. Consumption patterns also have influenced the way people perceive their options to enroll in physical activities, and today exercise is related to the possibility to run or to have access to a gym. According to Haggman, staff managers are key in supporting teams to find more feasible physical activities identifying local resources, indoors tools and team member skills (personal communication, July, 2015). For instance, kickboxing, yoga, and stretching sessions have been some of the practices the staff itself have successfully incorporated in the field (V.Braissant; H.Haggman & D.Suzic; personal communications, July 2015). Therefore and building on Cokherman’s lifestyle model, these alternatives based on local capacities, could leverage humanitarian environmental chances.

5.5. Cultural diversity

Cultural diversity implies specific efforts in the understanding of customs, religious practices, and health views of both teams and local communities. In their effort to develop cultural sensitivity skills, humanitarian organizations are more aware of the importance of integrating local practices and traditional healers in their programs. Reaching common points of understanding about health is a key step in the interaction between communities and aid teams. Nonetheless, this issue is frequently overlooked when it comes to staff’s health cosmovision. Each team member brings not only a repertoire of habits and preferences but also their own health images. Therefore, health promotion within teams implies as well to raise the question: is everyone talking about the same wellness needs? Moreover, in some regions cultural aspects regulate healthy lifestyles. For instance, in some places with Sharia
law\textsuperscript{8} influence, some managers have had difficulties promoting sexual and reproductive health, especially concerning distribution and allocation of condoms in staff’s accommodations (A. Salvador, personal communication, July 2015). In this regard, IFRC and MSF health officers expressed the importance of being especially careful discussing in advance with local partners the implementation of these practices and avoiding tensions within mixed teams (H. Haggman; A. Salvador, personal communication, July 2015). However, in situations where this type of activities are not allowed, it is vital to foresee how to provide resources for health care to everyone without discrimination, but at the same time to respect local customs.

Intercultural sensitivity skills are required also to manage daily aspects of the mixed teams’ cohabitation, especially related to hygiene habits and cooking/nutrition practices. In this regard, health staff care managers focus their interventions on facilitating minimum conditions to access to clean water, fresh fruits and vegetables to all staff (A. Salvador, personal communication, July 2015). However, once this point of wellness is reached, problems in group relationships emerge often. The novelty of the «melting pot»\textsuperscript{9} experience tends to diminish in long-term operations, and stress accumulation limit the capability of the group to accept and tolerate diversity. The frequency of bathing, laundry styles, use of spices and salt, amount of fast food, or even wearing shoes inside the house; are breaking points in the teams’ agreements on what are health practices. Thus, the challenge for managers is to monitor continuously these transitions and encourage all team members’ participation in the setting up of explicit rules of conviviality for a healthy adaptation (H. Hagmann, personal communication, July-August, 2015).

Another issue mentioned by managers, about cultural contingencies is related to boundaries of individual and group privacy, particularly on leisure activities in unsafe settings, and with strict social regulations distal to Western ones. Nowadays, the role that leisure and free time represent to health is undeniable (Hutchinson & Nimrod, 2012), but so is its association to risk taking behaviours such as alcohol, drugs and overeating (Carruthers & Busser, 2013). This issue for humanitarian settings where staff is allocated, even in private, can affect community perception and therefore the whole operation. In that sense, humanitarian organizations have done efforts to frame those behaviours in codes of conduct,

\textsuperscript{8} Sharia Law: Muslim or Islamic law that encompasses both civil and criminal justice as well as regulations of individual conduct, both personal and moral (Duhaime’s Law Dictionary, 2015).

\textsuperscript{9} Expression used to refere «a place where different peoples, styles, theories, etc. are mixed together” (Oxford dictionary, 2015)
rules, and contracts about the conditions of the mission. Nevertheless, especially in confined accommodations, the staff struggles to find other ways of recreation. For instance, and paradoxically, the lack of options increases alcohol, drug abuse and unsafe sex (Dahlgren, DeRoo, et al., 2009), and in other cases staff copes with boredom through work-alcoholism\textsuperscript{10} as a more accepted practice that is even rewarded by the culture of some organizations.

The list of challenges addressing diversity in health promotion is extensive as the variety of humanitarian settings is. However, Humanitarian Organizations guided by the principle of impartiality have advanced significantly in cross-cultural health approaches in the work with communities, experience and lessons learnt that are being profited by their staff welfare institutional programs.

5.6. Imaginaries of a sacrificed lifestyle

Humanitarian action in its aim to alleviate human suffering is not only a synonym for the highest altruistic values, but as well represents romantic imaginaries about adventure, adrenaline, and passions (Silke, 2015). Also, Media has played an important role reinforcing stereotypes of the aid work as a heroic, reckless and sacrificed profession (Ogrizek, 2008). Besides, celebrities' participation in advocacy and fundraising campaigns have broadcasted certain glamour around humanitarian work lifestyle (Waal, 2008) stimulating young generations to join this sector. However, as referred by Rigby (2013) “Aid workers are entering their profession with unrealistic expectations, uncertainty and unproblematic identities and notions about what it is to be an aid worker” (Rigby, 2013. para.10).

Wrong perceptions of the humanitarian work entails issues of team building and institutional efficiency in delivering opportune aid. Likewise, staff’s unadjusted motivations make it difficult for the staff to internalize humanitarian principles and to adopt security protocols and safe behaviours (Roberts, 2005). In this respect, Salvador states that 70-80% of the staff recruited only lasts one mission, some of them burn out during the first weeks, being unable to withstand humanitarian settings conditions (personal communication, July 2015). Every year, this staff flow phenomena represents for humanitarian organizations the loss of important resources on recruitment, training and deployment. However, these misleading imaginaries also have critical effects on staff care organizational culture. Pigni (2011) points

\textsuperscript{10}“Workaholism” defined by Oates as “uncontrollable need to work incessantly. An addiction very similar to alcoholism” (Oates (1971) cited by Sussman, 2012)
out that “some consider the idea of any staff care was indulging, an attitude reinforced by a ‘super - humanitarian’ culture that disapproves of rest, support, boundaries, and personal needs » (Pigni, 2011, P.8). Pigni adds that organization culture in aid agencies tends to encourage ‘defensive' and 'sacrifice' attitudes leading to burnout and affecting the resilience of humanitarian workers (Slim and Rességuier, 2014). A poor and mislead leadership forces the staff to show themselves stronger that they really are, preventing them from reporting health problems opportunely; and from accessing institutional medical services and psychological support programs.

In the same line, Rességuier (2014) indicates “altruism and the desire to save lives sometimes evolves in destructive and self-destructive behaviors and leads to a 'negative life' ” (Slim and Rességuier, 2014). For instance, some aid workers tend to compensate people’s suffering transgressing their own needs as human beings; “the worse I treat myself, the fairer and better aid worker I become” (Salvador, personal communication, July 2015). In addition, the urgency in attending communities in crisis seems to legitimize that aid workers prioritize operational and institutional needs over their health care. Regarding burnout prevention, Pigni (2011) indicates the importance of “unlearning the ethics of perfectionism and sacrifice, and substituting it with an ethics of care for oneself, as well as for others” (Pigni, 2011, para.6).

Another factor aggravating this trend, as reported by ECB Project is “ the existence of some generalized imaginaries on staff care viewed as a luxury rather than a priority or guilty towards having "better" conditions than communities” (ECB, 2006). Plus, budgetary pressures and staff deployment constraints, usually fuel the staff work overload and negligence in self-care. For Haggann, managers must be aware about how operational decisions affect staff welfare (personal communication, July 2015). Besides their responsibility to incorporate measures to protect staff welfare, they should ‘model’ healthy attitudes towards self-care. For example, sleeping and eating on time are critical issues in emergency settings for team leaders and field managers, and they should “ go first to rest ” to promote healthier practices within the staff (Haggman, personal communication, July 2015).

A shift to a healthier lifestyles mindset is needed in all levels of humanitarian organizations, as well as more mechanisms to clarify people's expectations to engage in humanitarian action and the enforcement of policies and protocols as part of the rules of missions. Organisations’ commitment to the strengthening of resilience and professionalization of humanitarian aid should motivate the development of institutional
spaces where people can learn not to survive but to cultivate adaptation skills from a perspective of self-care.

5.7. Self management vs. Duty of care (Agency and structure)

The commitment of humanitarian organizations with staff’s wellbeing as part of their duty of care goes beyond the payment of large insurances, implementation of medical services, evacuations of staff and complying with occupational health regulations. The principle of ‘do no harm’ applied inside the organizations has encouraged reformations of staff care units. Even more the protection of staff’s health has been even referred to as a ‘moral obligation’ (Min-Harris, 2011).

However, to what extent can an organization assume the responsibility of their staff health? What are the real capabilities of humanitarian organizations in controlling environments where their actions take place? What are the boundaries between the duty of care and individual responsibility and personal choices?

First, people’s wellness is a public and global health issue, which challenges go beyond humanitarian action. For instance, Korp indicates that the barriers to the promotion of health emerge from the notion and scope of the concept of health itself. Even though today there are more efforts on prevention, health practices around the world are still concentrated in reactive, curative and palliative strategies (Korp, 2010). Also, lifestyle challenges are a global concern, reflected on how chronic diseases have mobilized the interest on smoking, sedentarism, fast food consumption, drug and alcohol and ETS prevention. In that sense, it is important to consider that aid workers’ health is part of a public system with global responsibilities and macro level concerns.

From this perspective, and according to health staff managers, humanitarian organisations need to be constantly updated on public health issues both at international and locals levels. Health promotion strategies imply the analysis of public health staff background and its interaction with health demands of the context where humanitarian action takes place. Understanding humanitarian workers in a global health landscape, including systems’ gaps,

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11 Duty of care: “a moral or legal obligation to ensure the safety or well-being of others”; “the obligation to avoid negligence, particularly to take reasonable care not to cause physical, economic, or emotional loss or harm to others” (Martin & McFerran, 2008).

12 “The ‘do no harm’ principle is derived from medical ethics. It requires humanitarian organisations to strive to ‘minimize the harm they may inadvertently be doing by being present and providing assistance’” (Kahn & Lucchi, 2009).
needs and opportunities; could facilitate the improvement of staff wellbeing in more sustainable way.

Regarding the question about the boundaries in the responsibility of care, staff managers highlight on the individual responsibility in health care or self-care. For instance, UNHCR in their appraisal states, “occupational health and safety at the workplace is a corporate responsibility that begins with the individual employee” (UNHCR, 2014, p.1).

Nevertheless, health staff units are aware that people attribute more importance to the services and benefits that the organization can provide, rather than to a role of self-care in the improvement of health. Thus, to encourage staff willingness and commitment to self-care, a first step is to provide essential information to facilitate people's health choices. For instance, the staff is briefed on effects of soft stimulants such as coffee, sodas and fast food on their performance, stress and long-term wellness. Likewise, as enforced by occupational law and institutional policies, staff is informed about the use of helmets, masks, seatbelt and biosafety equipment.

Other aspects of health self-care are more problematic. For instance, IFRC has dealt with the resistance of people to engage in prophylaxis (e.g. Malaria). In cases like this, staff cannot be obliged to take the treatment. However, once people are provided with information, they make assertive decisions about their health (H. Haggmann, personal communication, July 2015).

Conversely, MSF and ICRC have a different approach in terms of prophylaxis and vaccination as a precondition to deploy staff to the field (A. Salvador; F.Althaus, personal communication, May-July 2015).

Although this sort of rules can be perceived as problematic in terms of personal freedom, the organisations have to weigh the implications of the absence or evacuation of a sick team member on the development of the whole operation.

Finding the balance between macro level concerns (global, public, and institutional issues) and micro level concerns (aid workers identity and individual responsibility), according to Binkey is key to understand and address lifestyles determinants (Binkey in Ritzer, 2008). Staff care implies not only to weigh responsibilities to protect the team, but also a whole organization that has made a commitment to the most vulnerable communities’ welfare.
7. Conclusion

Humanitarian workers’ wellbeing has a multiplying effect on the success of the Mission. Every action of protection and promotion of the staff’s health indicates an organization well harmonized, but most importantly it reflects coherence with humanitarian principles and a high institutional commitment to its duty of care.

From medical services, occupational health, security and mental health programs, particular efforts have been made incorporating health practices, but not from a systematic lifestyle approach. This gap in promoting healthy lifestyles for staff in humanitarian organizations corresponds to three main aspects. First, theoretical issues integrating the contributions of lifestyle theories, with staffcare approaches and characterization of humanitarian workers. Second, challenges to promote health due to external variables of humanitarian settings such as working and living conditions, international and local health systems, and cultural aspects inherent to the context. And third, internal institutional issues related to health data gathering, operational constraints, and organizational culture dynamics.

In this regard and considereing several opportunities to improve the promotion of healthy lifestyles in humanitarian organizations, some concrete recommendations are:

**At organizational level**

- To enforce the implementation of health practices for the staff as part of the mission through policies, protocols and codes of conduct.
- To integrate health care and self-care skills in competencies lists, and in the debates about the professionalization of humanitarian workers.
- To incorporate health staff care and self-care indicators in cycle management frameworks and staff performance appraisals.

**At staff management level**

- To incorporate self-care practices as part of job description functions and responsibilities.
- In the recruitment process, to scan candidates’ expectations about field living conditions, their motivations to engage in humanitarian action, and the limits and boundaries of the aid worker role.
- In the selection process (appraisals, screenings, and trials) to identify self-care skills and attitudes towards choosing health practices, especially under stressful situations.
• In briefings and trainings, to incorporate health care and self-care key messages, avoiding excessive information that staff usually cannot assimilate especially in stressful situations such as emergency deployment phases.
• To capitalize and integrate knowledge and tools from institutional programs such as ‘Lifestyles promotion for communities’ by IFRC and ‘Health Care in Danger’ by ICRC, in the design of healthy lifestyles promotion strategies.
• To empower team managers in their responsibility of care, providing them with training and technical resources to facilitate health practices within the staff.
• To encourage field managers in shaping a new and healthier image of humanitarian workers and modelling the application of health practices.
• To support the application of staff care standards and its customization according to different humanitarian settings needs.

At managers level
• To identify local resources for the implementation of daily health practices.
• To encourage the personnel in the utilization and contact of health staff care units and medical services.
• To encourage peer support practices as a mechanism to promote health within the team.

For the humanitarian sector and future research
• To network with the academy and research centers in developing studies, surveys and appraisals on health staff related to the impact of humanitarian action on aid workers.
• To evaluate the list of 14 health practices identified in this paper as individual lines of research.
• To explore the integration of emotional hygiene and spirituality practices such as meditation and mindfulness in the list of health practices as part of a new holistic health approach.
• To deepen in understanding of the correlation between healthy lifestyles and resilience, emphasizing on health practices as mechanisms for burnout prevention and devices to strengthen protective factors in stress management.

The promotion of healthy lifestyles in humanitarian organizations is essential in projecting from inside a legitimate interest on the improvement of people’s wellbeing, where everyone has the opportunity to participate and commit in co-create diverse strategies to promote and protect their health.
8. References


A. List of Experts consulted and Staff manager Interviewed.

Dr. Fabrice Althous. Md. Head of Staff Health Centre of Expertise. ICRC. Interviewed on 20th May 2015.


Ms. Emmanuelle Lacroix: People in Aid.UK. Email contact on 15 of July 2015.

Mr. Normand Lessard: Psychologist, Cosultant. Former Stress Advisor ICRC. Interviewed on 4th August 2015

Dr. Ainhoa Salvador. Md. Staff Health Coordinator. MSF SUISSE. Interviewed on 20 July 2015

Ms. Dubravka Suzic. Chief of Staff Welfare Section. UNHCR Psychologist. Interviewed on 10th July 2015
B. Interview Questions.

1. Does your organization count with a policy of staff care?
   - If yes what are the main topics or goals of this policy?
2. Does your organization have a staff care program?
   - If yes what are the main topics or areas and goals of this program?
3. What is the approach of your staff care program?
4. Your staff care program has specific variations according to the type of humanitarian setting/Context?
5. In this program are included expats, local staff, volunteers? Any differences in the approach to each group?
6. Does your organization include health care/promotion activities, practices?
7. Does your organization have data about morbidity/mortality of your staff? Another statistic?
8. In terms of the following practices, does your organization have statistics?
   9. Smoking, diet, alcohol use, rest/sleeping and relaxation, exercise, drug abuse, personal hygiene, sexual and reproductive health, routine check-ups and control with medical staff.
10. Among those practices does your organization doing monitoring, strengthening, promotion activities?
11. From your point of view, how could be related those practices to safety issues?
12. From your point of view how could be related those practices to stress management and mental health care of the staff?
13. Could you mention the main gaps and challenges in staff care programs implementation in humanitarian contexts?