BMJ Open

Characteristics, determinants and perspectives of experienced medical humanitarians: a qualitative approach

Ramin Asgary,[1] Katharine Lawrence[2]

To cite: Asgary R, Lawrence K. Characteristics, determinants and perspectives of experienced medical humanitarians: a qualitative approach. *BMJ Open* 2014;**4**:e006460. doi:10.1136/bmjopen-2014-006460

▸ Prepublication history and additional material is available. To view please visit the journal (http://dx.doi.org/10.1136/bmjopen-2014-006460).

Received 24 August 2014
Revised 3 November 2014
Accepted 21 November 2014

CrossMark

[1]Departments of Medicine and Population Health, New York University School of Medicine, New York, New York, USA
[2]Department of Medical Education, Herbert Wertheim College of Medicine, University Park, Miami, Florida, USA

Correspondence to
Dr Ramin Asgary;
ramin.asgary@caa.columbia.edu

ABSTRACT

Objective: To explore the characteristics, motivations, ideologies, experience and perspectives of experienced medical humanitarian workers.

Design: We applied a qualitative descriptive approach and conducted in-depth semistructured interviews, containing open-ended questions with directing probes, with 44 experienced international medical aid workers from a wide range of humanitarian organisations. Interviews were coded and analysed, and themes were developed.

Setting: International non-governmental organisations (INGOs) and United Nations (UN).

Results: 61% of participants were female; mean age was 41.8 years with an average of 11.8 years of humanitarian work experience with diverse major INGOs. Significant core themes included: population's rights to assistance, altruism and solidarity as motives; self-identification with the mission and directives of INGOs; shared personal and professional morals fostering collegiality; accountability towards beneficiaries in areas of programme planning and funding; burnout and emotional burdens; uncertainties in job safety and security; and uneasiness over changing humanitarian principles with increasing professionalisation of aid and shrinking humanitarian access. While dissatisfied with overall aid operations, participants were generally satisfied with their work and believed that they were well-received by, and had strong relationships with, intended beneficiaries.

Conclusions: Despite regular use of language and ideology of rights, solidarity and concepts of accountability, tension exists between the philosophy and practical incorporation of accountability into operations. To maintain a humanitarian corps and improve aid worker retention, strategies are needed regarding management of psychosocial stresses, proactively addressing militarisation and neo-humanitarianism, and nurturing individuals' and organisations' growth with emphasis on humanitarian principles and ethical practices, and a culture of internal debate, reflection and reform.

Strengths and limitations of this study

- This study uses a qualitative descriptive approach and is the first systematic comprehensive study to explore many aspects of medical aid provision and operation from the perspectives of experienced international humanitarian workers, and characterise their motivation, experience and perspectives.
- Our findings provide important insight into unique experiences and characteristics of seasoned humanitarians, and help guide this field in its personnel recruitment, management and training.
- Our in-depth analysis calls for greater attention to nurturing individual and organisational growth, humanitarian principles, culture of debate and reflection, psychological stresses, organisational independence and impartiality, and broader policies and interventions to actively address concerns over limited humanitarian space.
- While our sample population represented a variety of humanitarian international non-governmental organisations (INGOs), the experience and perspectives of the participants may not fully represent the overwhelming number and diversity of medical aid workers representing thousands of INGOs around the world.

BACKGROUND

The late 20th and early 21st centuries have been marked by rapidly increasing interest in and provision of humanitarian work. The number of organisations with expertise in disaster and emergency relief increased fivefold in the early 2000s.[1] Currently, there are between 3000 and 4000 non-governmental organisations (NGOs) in the Northern industrialised states operating internationally, including development, relief and social organisations.[2] Worldwide, around 19 million people are employed by some kind of NGO and engaged in humanitarian efforts.[3] There is greater public visibility of humanitarian emergencies, natural and manmade alike; coverage of events such as the Sri Lankan tsunami, Hurricane Katrina, the earthquake in Haiti and Arab Spring highlights the immense human cost of humanitarian crises, increasing awareness and interest in relief work.[4–6] While international health experience was once a

fringe element in medical practice and education, it is now more widespread and acknowledged for its valuable contribution of increasing understanding of international health issues, and diversifying practitioners' capabilities and contributions to this field.[7–9]

Limited literature exists to characterise, define and describe the population of medical aid workers, and assess their experiences and the conflicts they face with potential impact on the overall aid community.[3 10–12] The humanitarian field itself is heterogeneous, with organisations varying widely in affiliations and philosophies. Potential discordant interests—among different aid organisations and/or individual aid workers—due to differing motivations, perspectives, training and competencies may contribute to high turnover and burnout rate. These have critical implications for the nature and quality of humanitarian interventions, as well as the prospects and expectations of the profession itself seeking to retain professional aid workers and maintain expertise,[13 14] and may impede proper interagency and intra-agency collaboration and coordination, and adversely impact the overall effectiveness of aid operations.[15 16] Characterising shared understanding, attitudes and experience provides an opportunity to reinforce collective motives and efforts, and enhance synergy, human resource support and overall humanitarian efforts. Using qualitative data is one of the best ways to elicit relevant information from participants' perspectives, especially regarding philosophical and ideological underpinnings of their work.[17] To help guide this field in its personnel recruitment, management and training, we aimed to evaluate career medical aid workers' perspectives, experiences, particularly the motivating factors and barriers in their pursuit of and commitment to a career in medical humanitarianism, the emotional impact of their work, and views on the future of humanitarian operation.

METHODS

We recruited participants (n=44) using prospective purposive, snowball and criteria sampling techniques. Using personal contacts, information from major international NGOs (INGOs) and discussion with key players in this field, we identified and connected to an initial sample of participants from major INGOs via emails, with a description of the study objectives. Those who participated were asked to recommend additional participants with similar or different experiences and views. Criteria sampling was used to assure inclusion of genders, varying educational backgrounds, different age groups and family status, participants from different geographic locations and types of humanitarian work, and from a diverse range of major INGOs. We used two complementary data gathering methods: semistructured interviews and analyses of industry discourse relevant to research themes. Preliminary informal interviews were conducted with key players in the field whom we defined as persons positioned to possess knowledge relevant to the research themes, including individuals with particular backgrounds of aid operations such as recruitment and retention, ethical challenges, and moral and philosophical ideologies. These interviews and feedback sessions continued throughout the study to improve validity and accuracy.

Inclusion criteria included (1) individuals who worked for any large medical humanitarian INGO outside their country of origin, (2) with a minimum of 3 years international field experience and (3) having some supervisory and/or coordination experience at country or headquarter levels. Individuals who exclusively worked for governmental organisations or United Nations (UN) agencies and local medical aid workers were not included in this study. Sixty people were approached with recruitment continuing until thematic saturation occurred with 44 participants recruited; non-participation was due to non-response or lack of reliable phone or internet connection and scheduling conflicts after multiple attempts. Study was incepted in 2008 and data collection was concluded by 2012.

Owing to the sensitive nature of discussing personal, ethical and psychological experiences, we chose to conduct personal interviews, which allowed for deeper exploration, and facilitated a more candid and safe environment to discuss opinions and experience freely. Interviews were conducted via phone or video telecommunication. Informed consent was obtained verbally. Alongside social demographic questions, participants were asked a series of 16 open-ended questions, with additional probing questions designed to elicit discussion about their motivations and trigger points for participating in humanitarian work, perceptions of medical humanitarianism, experiences in the field, burnout and coping strategies, future plans in humanitarian work, accountabilities in aid operations, and perceptions and views towards international organisations, UN agencies, recipients of aid, and humanitarian access and space. A more in depth evaluation of ethical experience was also elicited, but is discussed elsewhere. Interviews were conducted by one trained interviewer.

We applied a qualitative descriptive approach. Close to 500 pages of transcribed data were coded and analysed for key phrases and categories using content analysis. We developed preliminary coding based on priority codes derived from the theoretical framework and conceptual model guiding the study. We conducted in-depth comprehensive analysis, including critical deliberation about initial coding, and reviewed coding for similarities and variations among coders' output. Initial discrepancies were discussed and a high level of agreement was achieved. Coding of transcripts was performed using Excel and through open, inductive and selective coding. Two authors (RA and KL) independently identified a total of 425 codes, then met and meticulously reviewed codes, discussed the specific categories and used independent inputs as needed. Patterns in responses and

Table 1 Demographics and characteristics of career humanitarians and their work

Characteristic (n=44)	N (%)
Gender	
Male	17 (39)
Female	27 (61)
Age group (years)	
<30	1 (2)
30–39	18 (41)
40–49	19 (43)
>50	6 (14)
Average age	41.8
Region of origin	
Africa	1 (2.25)
Asia/Oceania	3 (6.75)
North America	21 (48)
Europe	19 (43)
Educational/professional background*	
Medical	14 (32)
Public health	11 (25)
Allied health (nursing, occupational therapy, etc)	6 (13)
Political science	7 (16)
Law	1 (2)
Social sciences (sociology, anthropology)	4 (9)
Earth/biological sciences	3 (7)
Finance	3 (7)
Number of years in humanitarian field	
3–5	5 (11)
6–10	15 (34)
11–15	10 (23)
>15	14 (32)
Number of missions (means primarily working in the field, not field trips)	
3–4	11 (25)
5–6	9 (20)
7–8	9 (20)
9–10	6 (14)
>10	9 (20)
Range of duration of mission	1 month–2 years
Average number of missions	7
3–5	15 (34)
6–9	19 (43)
10+	10 (23)
Area of humanitarian experience*	
Africa	
Northern	22
Western	18
Eastern	20
Southern	1
Middle	22
Asia	29
Americas	20
Europe	11
Current position	
HQ	17 (39)
Field	10 (23)
Both†	12 (27)
In between position	5 (11)
Current humanitarian agency‡	
International NGO	37 (84)
UN agencies	5 (11)
IGO	2 (4.5)

*These are not exclusive categories.
†Participants who indicated they did HQs/coordination level work as well as field work; this was described as mostly HQ work, with shorter missions into the field.
‡Participants who indicated working in UN or IGOs had previous experience with NGOs.
HQ, headquarter; IGO, international governmental organisation; NGO, non-governmental organisations; UN, United Nations.

codes were analysed to explore and develop relevant themes. Codes fell into distinct but overarching categories. Authors then characterised, described and agreed on important emerging themes, and compared themes across cases to elucidate commonality and variability. Subcategories were created when needed. Observational data including setting and non-verbal communication (pauses in conversation, intonations, etc) were collected and noted in order to enhance analysis.

RESULTS

The average age of participants was 41.8 years. Roughly two-thirds were female. Participants represented major INGOs including, but not limited to, Médecins Sans Frontieres (MSF), International Confederation of the Red Cross and Red Crescent, International Rescue Committee, Save the Children, Action Contra la Faim/Action Against Hunger, the MENTOR Initiative, Human Rights Watch and Doctors for Global Health as well as WHO, Unicef and United Nations High Commissioner for Refugees (UNHCR). Those who indicated working with governmental or UN organisations also had experience with humanitarian INGOs. Assignments included emergencies/complex humanitarian crises, and longer term medical and public health or development projects. The majority described their current position as a mix of fieldwork and headquarters work, with fieldwork consisting of shorter supervisory or field visits (1–6 weeks). Demographics, characteristics, areas of international experience and positions held by participants are presented in table 1 and box 1.

Thematic characterisation of participants' perception and experience included following overarching categories and subcategories.

Humanitarian motivations and altruism

Overwhelmingly, participants expressed a sense of personal responsibility driving their humanitarian work. "I think it is our responsibility. I am a physician and I cannot stay like this, seeing people that are suffering" (#24; F37 years; Medical & Anthropology). Additional motivating factors included solidarity and feeling

Box 1 Positions and locations of humanitarian experience

Areas of international humanitarian experience
Afghanistan, Angola, Bahrain, Bangladesh, Belize, Bosnia, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Chechnya, China, Christmas Island, Colombia, Congo, DRC, Dominican Republic, East Timor, Ecuador, Egypt, El Salvador, Ethiopia, Georgia, Ghana, Guatemala, Guiana, Haiti, Honduras, India, Indonesia, Iraq, Ivory Coast, Jordan, Kenya, Kosovo, Kyrgyzstan, Liberia, Libya, Macedonia, Madagascar, Malawi, Mali, Morocco, Mozambique, Myanmar, Nicaragua, Niger, Nigeria, North Korea, Pakistan, Palestine, Rwanda, Russia, Senegal, Sierra Leone, Sri Lanka, Somalia, Somaliland, South Africa, Sudan, South Sudan, Tanzania, Thailand, Turkmenistan, Uganda, Ukraine, Uzbekistan, Vietnam, Yemen, Zambia, Zimbabwe.
Type of current position
Chief Executive Officer, Chief/Senior Health Advisor, Chief Medical Officer, Chief of Health Department, Country Director, Director of Emergency Preparedness and Response, Director of Human Rights Country Office, Director of Human Resources, Director of Humanitarian Affairs, Director of Humanitarian Studies, Director of Operations, Executive Director, Executive Medical Coordinator, Field Physician, Finance Manager, Head of Mission (country level), Health/Medical Coordinator, Humanitarian Policy Advisor, Infectious Disease Surveillance Coordinator, Logistical Coordinator, Member of Board of Directors, Programme Coordinator/Manager, Programme Officer, President of Organisation (former and current), Resident Advisor for Malaria, Senior Advisor for Social Development, Senior Health Consultant, Senior Health Director, Technical Advisor for Women's Empowerment, Technical Health Advisor, WHO Coordinator.

compelled to address the rights of others. "You choose to go over [there] because you believe in human rights and want to fight for it…ultimately you do it because you have a solidarity to the people around us" (#15; F31 years; Public Health). Charity and philanthropy were also noted as motivations, but with certain qualifications/reservations. The terminology used was important; in particular, 'charity' was seen as loaded with negative implication. "I don't like the term charity so much…providing assistance to others without expecting anything in return; if that's the definition of charity then yes I identify with it. [But] charity to me also means giving something without really giving thought to where it's going…" (#32; M49 years; Medical). "I like charity in its true sense, not in a demeaning sense, not in a colonial sense" (#8; M48 years; Public Health).

Values from family, community, early education, or experiences with colonial history were cited as major contributors to motivations, mostly through a learned dedication to, or inspired interest in, community service. "I think I was taught to really want to dedicate a large part of my life to people I've never met before" (#32; M49 years; Medical). "My parents were both teachers, and I saw them giving their life to really investing in young people…So that value of service [and] understanding people and doing what you can to help" (#31; F35 years; Political & International Development). Overwhelmingly, participants iterated they "always wanted to do this, since I think I was a child" (#20; F40 years; Political & International Relations). Some cited the work of specific organisations as personal tipping points, inspiring entry into humanitarian work. "MSF tends to recruit people who were inspired at a fairly young age…[as an example] of what a mature humanitarian organization that's been able to maintain its energy and its innovation and its new approach to things could look like" (#25; M62; Medical & Ethics).

Some recounted specific events triggering involvement in humanitarian work: international, personal or family experiences; exposure to poverty; mentors; education; mid-career dissatisfaction; or particular humanitarian crises. "In my medical training, it was all in inner city… then from there it was, I wanted to do the same kind of work overseas...working with high-risk areas and high-risk populations" (#17; F45 years; Medical & Public Health). "A turning point for me was the Rwandan genocide, seeing the scale of suffering" (#8; M48 years; Public Health). Other respondents did not identify a specific trigger and cited becoming interested in humanitarian work over time. "You really don't know what you're getting into…I just took one step, and took another, and learned about it…And the more opportunities that I took, [the more] I became extremely interested" (#28; F44 years; Medical). "I feel that I kind of fell into it" (#42; F32 years; Public Health). Participants also spoke about evolution of their motivations and involvement throughout the span of their experiences. "My motivations in the 90s [were] quite different from my motivations now" (#34; M34 years; Political & International Relations). "I think that the fundamental [motivations are] still the same…perhaps they're more nuanced" (#25; M62 years; Medical & Ethics). See online supplementary appendix table 3 for additional quotes.

The mission of organisations and collective motives

Participants strongly identified with their respective INGOs and universally felt the organisations shared their values. "I really like [my organization's] vision, about looking at that equity and…where the high risk populations are" (#17; F45 years; Medical & Public Health). "I think it's a kind of noble mission, to provide care sort of irrespective of politics, religion, government. I think it's a good mission" (#21; M58 years; Medical). A significant number elaborated that the organisational mission and motives are directly associated with the dedication, motivation and collective will of the staff. "I think the people in [my organization] are…really, really committed to what they're doing. And really think and believe in what they're doing" (#20; F40 years; Political & International Relations). Participants also noted that individual humanitarian workers' motives varied, and that different organisations had different target programmes and populations. "Based on my experience, I would say I have seen many different reasons for people

to get involved [in aid work]. There is no single answer" (#41; F37 years; Social Science & Education). In our participants' views, the outcome of an organisation's motivation was a commitment to shared end goals, including providing value-added skills, capacity-building, community development, information sharing and training. "I feel like our whole purpose of being there should be to build the capacity of a nation…so that we can hand over and move on" (#26; F30 years; Public Health).

Personal and emotional experience

Participants discussed positive and disheartening experiences about their aid work. Positive responses included challenging, rewarding experiences and a sense of accomplishment, pride, honour and fulfillment. "Sometimes I can feel very satisfied and feel a big sense of accomplishment" (#14; F40 years; Medical & Public Health). "I think it's been really challenging and therefore rewarding.…that's been positive" (#25; M62; Medical & Ethics). Among negative experiences were feelings of frustration, questioning one's contributions, and the burden of dealing with trauma and/or death. "Witnessing the suffering, and realizing that your impact is important, but you're not going to change the life of the person...This is very very tough" (#30; F47 years; Political Science). "If you save this kid from malnourishment and he comes back 1 month later still malnourished, it's tough sometimes. And it [is] difficult to see all the misery" (#39; M36 years; Medical). Other difficulties included issues with security, isolation (physical and emotional) and physical hardship. "You live under very difficult circumstances...sleeping in tents, terribly hot, humid, there were insects everywhere, we didn't have proper hygiene….the food was the same every time...of course it's tough" (#39; M36 years; Medical). "Being lonely is one of the things that happens… when you are a single woman and you are assigned at the end of the world, well sometimes you feel lonely" (#20; F40 years; Political & International Relations). Participants also noted particular issues of reintegration on returning to their home countries. "It's more difficult to come home than it is to go. Confronting your own society is harder than confronting others" (#28; F44 years; Medical).

Participants were split on emotional preparedness for fieldwork. "I was not at all prepared to be able to process my emotions while doing the work" (#42; F32 years; Public Health). "Generally I was satisfied throughout my experience in the field with the level of preparation" (#40; F46 years; Business & Engineering). They did not necessarily believe that additional institutional preparation for the emotional experience would be meaningful or feasible. "There's no training that can help you anticipate how you will react in real time and the real situation [in the field]. Only life experience" (#30; F47 years; Political Science). Participants elaborated that specific, contextual technical training might be valuable, as well as more support in the field and postassignment. "I think that we need to be prepared about the security context we are living and working in…I would say your behaviour in security contexts could be addressed, and I probably would have liked that" (#36; M40 years; Political & International Development). Postassignment support was considered critical. "The truth is that at a certain point you can't really prepare people; they just have to be there, and it's the follow-up that they're provided with that can often determine whether they hang in there and how successful they are" (#38; F47 years; Political & Public Policy).

Burnout and coping strategies

The majority of participants experienced burnout during the course of their work. Overworking, overwhelming emotional exposure, hardship in the field, lack of self-care, poor personnel management, and underlying or pre-existing emotional conditions were the most common given reasons for burnout. "It is quite addictive work…There's always going to be more work, there's always going to be more need, and you always feel like you can do something" (#13; F29 years; Public Health & Development). "There's a very big push and a very big culture of moving from one thing to another, keeping things going quite quickly, not talking about your feelings, always saying yes to [projects]…never taking a break…and I think that culture is not built up with support systems, and money for self-care, and breaks…[and this] inevitably leads to burnout" (#42; F32 years; Public Health). Additional sources of burnout included poor programme management, not seeing tangible changes in humanitarian situations, imbalance in personal life, and lack of social support from family and home community. "People who are not managed well feel like they're not being listened to, or that, you know, they're not being counseled with their problem-solving, when conflicts come up…that someone who's not handled well is that much more likely to get burnt out quicker and not come back" (#25; M62 years; Medical & Ethics).

Participants offered suggestions for burnout prevention, including improved personnel and field management and taking time away from the field. Also recommended were improved work–life balance, good social support, institutionally supported mental health education, and postfield counselling and debriefing. "I think every time that I see a potential burnout [that] has been prevented, it's because a manager or a country director or a team leader takes the time and literally forces people to stop working…so I think some training, management training, should [be implemented]" (#13; F29 years; Public Health & Development). "I know some organisations have a psychologist on staff…I think that's one method of surviving…It is really important that people have somebody to talk to outside of work" (#15; F31 years; Public Health).

Social connections were noted as important coping mechanisms for dealing with stress and intense personal experiences in the field. Connecting with fellow aid

workers, talking with friends/family, self-reflection and being open with others were most common. "The life conditions are very hard. And I think that if I don't have the backup of support from my family I could not stay here for a long time" (#23; M48 years; Medical). "Probably getting a [smartphone] has been one of the best changes of my life…I can really easily email my family and my friends, [which] has made it so much easier" (#15; F31 years; Public Health). Other forms of stress management included journaling, social media and exercise. "I meditate, I do yoga…I run…I kind of create space to just zone out, or to purposefully work through some of the emotional things that are happening to me" (#42; F32 years; Public Health). Formal therapy or psychiatric interventions were mentioned, but not common. Many elaborated on the prevalence of self-medication, but did not believe it to be a significant problem. "There tends to be very heavy and regular alcohol use at night and on weekends in our missions. And I think, yeah that's part of people's coping mechanisms, part of our tradition and everything else" (#25; M62 years; Medical & Ethics). "It's very very very common. I don't know if it's an issue…. it's a way of coping" (#42; F32 years; Public Health). Of the participates who discussed self-medication, half recounted their own alcohol or cigarette use, and identified their usage as potential self-medication.

Personal impact and outlook for continued humanitarian commitment

Generally, participants felt positively changed by their careers in humanitarian work. They cited being more realistic and practical in their lives and careers, having strengthened beliefs, learning about themselves and becoming more understanding, open, compassionate and socially conscious. "I think I'm more compassionate and more patient than I used to be" (#40; F46 years; Business & Engineering). "It changed me in that I learned a whole new dimension of both living and suffering. And it changed me in the sense that I felt that I could contribute to alleviating that, or at least buffering that" (#22; F53 years; Public Health). Some participants felt more cynical or less idealistic. "I think over the years…I've been required to become much more hardened. I've become much more cynical…I have kind of less hope, I think, for the work that we're doing in the field in general" (#42; F32 years; Public Health). The majority of participants noted interest in continuing to work in the field, but were unsure of the future trajectory of their commitment. Some indicated needing a break or change, including time in a headquarters-level position. "I don't see myself in the field forever, that's for sure. But I think I will be, in some capacity, one way or another, whether it's looking at policy, whether it's doing advocacy…I think will be linked to this type of work" (#13; F29 years; Public Health & Development). Reasons for this uncertainty included desire for increased job security and more traditional lifestyle. "I think I won't be doing this for much longer….I don't think I'm done with [my organization] or humanitarian work in general. But I think I'm ready for a longer break" (#40; F46 years; Business & Engineering). The main barriers to continued work included family obligations, job fatigue, too much time in the field, absent social life, other career commitments or goals, financial conflicts and general frustration with the humanitarian field. "I'm getting a little more cynical as I get involved in higher levels of the bureaucracy [in humanitarian work]" (#25; M62 years; Medical & Ethics). "For me it's a prioritization of my personal life over work that's making me make the choice that I am approaching" (#40; F46 years; Business & Engineering). "I think that I will need to sort of significantly restructure my position once I have a kid...I don't think I'm prepared to continue in this field, given the challenges and what you have to give up once you have a family" (#42; F32 years; Public Health).

Humanitarian views and perspective

Defining the host population

Participants had difficulty defining the populations they served: terms such as misfortunate, beneficiaries and claimants were often considered too broad or inadequate. "My organization uses the word beneficiary. I've used that word before but I don't care for it too much" (#32; M49 years; Medical). Participants preferred to elaborate on their definitions; this was a combination of descriptive, value-based terminology (strong, resilient, vulnerable) and practical terminology (patients, children, women, people, target population). "First of all they are patients…we still define who we work for based on the medical action" (#40; F46 years; Business & Engineering). "I see them as exceptional people. Some of them are really exceptional, very strong, and are able to just get back on their feet and then fight back" (#18; M49 years; Legal). "In my own mind I suppose they are people affected by conflict and war or by discrimination…I would prefer to think of them as people" (#22; F53 years; Public Health). It was easier to use the word 'victims' when discussing natural disasters or clear infrastructure failures. "Strong. Vulnerable. Unfortunate. Um, victims, well victims of man-made disaster, or other people failing their responsibility, and as such, the people we assist are victims of that" (#27; M37 years; Public Health & Economics). Most of our participants insisted on noting skills that communities brought to the table, preferring to view them as contributors with agency. "For me, it was more coming from strength-based work and understanding the strengths that they bring to the table, and focusing on the things that people are good at, and building off of those things" (#6; F36 years; Political Science & International Development). "I think they feel like they are doing their own process, and that we are supporting them" (#31; F35 years; Political Science & International Development). The majority felt their organisation was

well-received, appreciated and respected by populations. "I think it's definitely positive, I can speak, I guess, to my experience…I've been touched often with how appreciative people are, especially to see international volunteers in really remote and difficult settings" (#25; M62 years; Medical & Ethics). Others mentioned that their positive reception depended on context, including duration of presence in the community and type of programme. "It really differs from one place to another. If you are working in Central African Republic, you are seen as an offshoot of French colonial colonization. If you work in Kosovo, you are seen as a Western[er]…I mean, how do people see us? It really depends" (#34; M34 years; Political Science & International Relations). "I think it differs a little bit by the program, the approach, and the quality of our work, which I think varies across the world" (#42; F32 years; Public Health). A few added that INGO presence in the country provided local populations with particular benefits such as jobs, funding and other resources.

Accountability

Conceptually, the majority of participants considered themselves accountable to three distinct stakeholders—the beneficiary population, donors and themselves/INGOs. "I feel like we're responsible to our donors and our beneficiaries. I mean, most responsible to the beneficiaries, and secondly accountable to the donors. And thirdly, I guess accountable to the national, you know, the humanitarian community, ourselves" (#25; M62 years; Medical & Ethics). However, many had practical concerns regarding this shared accountability, and doubted the reality, or feasibility, of implementing accountability towards beneficiaries. "This [accountability] is a question that we discuss quite a lot. Because the answer to that, the right answer, is we are accountable to our beneficiaries. Well, I don't see really how we do that. Because we don't ask all our beneficiaries to take a box and fill out a form and so on" (#22; F53 years; Public Health). "Um, if I said the beneficiaries, it's not true... Maybe the beneficiaries, but who's going to go back to the beneficiaries and say 'Hey, did we do good or did we do wrong?'" (#20; F40 years; Political Science & International Relations). Those working in long-term programmes felt they made efforts to demonstrate and enforce accountability to beneficiaries, specifically by including communities in decision-making processes and operations, and to a much lesser extent funding processes. "In the countries where we work with patients in the long-term, where we see patients every day, every month, every six months…there is a sense of accountability, because we provide services in the long term… but we haven't gone beyond that yet" (#36; M40 years; Political Science & International Development). When considering the financial responsibilities of humanitarian projects and the ultimate proprietor of organisational funds, participants were split between beneficiaries and the organisation. Those who felt the funding belonged to the organisation cited an unfeasibility of including beneficiaries in funding allocation and decision-making processes "I'm not a very strong believer that beneficiaries should be fully involved in decision-making...I think yes, in theory it would be great to have a bigger involvement of the population that we serve. But it would make all kinds of challenges" (#27; M37 years; Public Health & Economics).

Rights-based approach to humanitarian assistance

Participants were familiar with the concept that people in humanitarian situations have the right to receive assistance. However, while addressing the rights of others was an often-cited personal motivation, participants were often split on the role of a rights-based framework in humanitarian aid provision, and quickly pointed to its problematic definition and use. "[A rights-based approach] should be the overriding approach to humanitarian assistance and the work in the field" (#11; M54 years; Medical). "I don't think it's my duty to address the rights [to receive assistance] of others" (#34; M34 years; Political Science & International Relations). Most believed it is a positive theoretical viewpoint, but took issue with its practicality in the field. "In terms of assessment of that concept, I think it's really [just] a concept, and something that people put in proposals" (#42; F32 years; Public Health). Advantages of the practice included the importance of equity, rights, community participation in interventions, transparency, advocacy and addressing the underlying causes of humanitarian situations. "The advantage… when you know the rights, or when the people know their own rights, the action then will be done. When people know their rights, they will demand, they will make their demand" (#23; M48 years; Medical). Concerns included an undefined concept of rights, operational difficulties in implementation, contested rights, possible misuse of rights rhetoric and movement away from a needs-based approach. "I've seen the risk [of] sometimes not getting past an abstract set of meanings around the tables that have no practical effect" (#29; M43 years; Public Health). Among those who worked in medically centred and acute or short-term aid work, a rights-based framework was considered less critical than a needs-based approach. Success of rights-based implementation depended on specific projects, including longer term projects and development aid projects. "The only component of [a] rights-based approach that we could see…is our approach to HIV/AIDS. And our advocacy of HIV/AIDS, which actually includes a lot of active issues, [and] which focuses on marginalized groups" (#30; F47 years; Political Science).

Humanitarian operation and organisation

Decision-making process

Most participants at this stage of their career were familiar with their organisations' decision-making frameworks for identifying whom to help and where and when to

intervene. Participants stressed the importance of 'need-based' and 'field-based' assessments as fuelling coordination-level policies. Most recognised the importance of input from the field, believing that decision-making should be informed from the bottom up, and that this was, to some extent, taking place in their respective organisation. "You don't just go in like cowboys and act like you know what's going on. I think there's a huge, huge effort to push local ownership of things" (#13; F29 years; Public Health & Development). Some elaborated on the disconnect between headquarters' decision-making and field input. "I feel like I knew where and when decisions were being made…But I think that doesn't always mean you understand why decisions are being made" (#40; F46 years; Business & Engineering). Those who spent more time in the field than at headquarters were more likely to highlight tensions between headquarters' decisions and field needs. "I think ideally decisions are supposed to made from our directives and mission and beneficiary populations; but I think in reality those decisions are made by a few numbers of vice presidents, presidents, and…directors of the organization. [So] I think those of us who have been responsible for oversight and implementation of programs [in the field] feel like there needs to be a better assessment of the needs on the ground with the structures and competencies of the organization" (#42; F32 years; Public Health).

Impression towards the overall work of INGOs

The work of the overall INGO community was described as positive and effective in aid provision. "[My impression is] very positive. You know, we all have the same goals and…there's been a lot of work on coordination and information sharing and collaboration, so that we do find kind of best practices [and] push each other along in terms of being innovative and finding even better ways of responding to emergencies" (#10; F54 years; Environmental Science). Participants, however, were reflective of their own as well as their organisations' limitations and shortcomings. They emphasised that sound quality of work depended on specific INGOs, with individual expertise, support of staff, communication with local partners and cultural/institutional identity. "There's definitely a difference in the quality of services that various NGO's provide; it depends a lot on accountability…who is overseeing the program, who are they reporting to, and how transparent they really are in that programming" (#5; F30 years; Medical & Public Health). They expressed strong sensitivity for their work's repercussions—with concerns about perpetuating corrupt or colonial governments, negative impacts on communities, and undermining local initiatives and capacity-building—and often felt that, overall, humanitarian aid provision is frequently insufficient compared with existing needs. Generally, participants had concerns about competitiveness and uncoordinated efforts among INGOs, as well as resource waste and the variable quality of interventions. "Most humanitarian organizations fight with each other, at the best they compete. But at the worst, they backstab. I know agencies will phone up a donor and will tell lies about another agency who is competing for the same money to try to get them out of the way and to obtain their funds" (#8; M48 years; Public Health). Lack of financial independence, poor accountability and failure to do sustainable work were additional concerns. "The problem I have with INGOs [is] that their work, their role is not sustainable. When they leave the country, everything was good, the function of the health facility was good, everything was good, very good…two months after that, everything goes down" (#23; M48 years; Medical).

Views towards UN agencies

The general view of the UN was one of dissatisfaction, particularly regarding programme implementation. Most believed the organisation had a role in humanitarian interventions, but that its on-the-ground execution was poor. "With the UN, they're too outside of specific emergencies…They're always striving in a response to work towards better coordination and work towards being good partners and good donors, [but] it's kind of a mixed bag as far as what happens on the ground with the UN" (#10; F54 years; Environmental Science). The potential strategic role of the UN regarding management, humanitarian coordination, advocacy, policy and diplomacy was viewed positively. Negative views included overwhelming bureaucracy, inefficiency, lack of direct contact with populations, excessive politicisation, and resource and financial waste. "My personal experience with UN agencies is not good. I always have the idea that a lot of money [is] spent in bureaucratic issues and administrative costs with little money spent on effective activities…" (#16; F36 years; Public Health). Most UN agencies were viewed as problematic partners. "Working directly with the UN, I always found it's terribly difficult to be supported, terribly difficult to get information, and terribly difficult to work with them" (#16; F36 years; Public Health). Overwhelmingly, participants did not view the UN overall as a humanitarian agency; this was attributed to its military component and governmental foreign policy agendas. "I would not consider them humanitarian…I don't think that any time a military organisation is involved, I personally do not believe you can say that it is [truly] humanitarian" (#15; F31 years; Public Health).

Future of humanitarian access

Participants felt the freedom of access to intended populations—the humanitarian space—had become increasingly complex in the past 10–15 years. Many felt the current humanitarian space had been compromised; concerns ranged from conceptual meaning of the space to more pragmatic issues of access, especially regarding politicisation, militarisation, functionality and professionalisation of the aid. "The humanitarian space is getting

smaller and smaller" (#27; M37 years; Public Health & Economics). "Humanitarian action has been co-opted by so many forces for so many reasons…it's been politicized, it's been part of strategies to win hearts and minds" (#39; M36 years; Medical). "What I think is being packaged in a different way is the military interventions that are being put forth…are really crossing the line between humanitarian action and military objectives" (#40; F46 years; Business & Engineering). The majority expressed a need for realistic humanitarian reform, within INGOs and also within the overall international humanitarian community. They felt reform was required on internal and systemic levels to improve safe access, quality and outcomes of humanitarian work, as well as the attitudes/motivations of aid workers. "So there is a lot of…work to be done by the NGO community to try and address these issues…in a transparent and honest way. I think that if the aid system wants to survive, and wants to keep the strong credibility in the mind of the public, we absolutely need to go through this reflection" (#30; F47 years; Political Science).

DISCUSSION

Humanitarianism: personal ideologies and institutional culture

Aid workers represent a diverse, international community of medical, public and allied health, social and political experts, whose values and beliefs are unique and personal but also strongly shaped by the shared experiences in humanitarian settings. Despite the variety of personal histories, by and large our participants identified a strong personal responsibility to serve others and shared feelings of altruism as overriding motivational values. This is consistent with limited existing sociological research on aid workers and military medical personnel.[3 11] Early sensitisation to these values—through education, media, international travel and family experiences (particularly those dealing with exposure to trauma, displacement or discrimination)—and early politicisation to forms of social inequality and injustice, seem to have instilled and reinforced a rights and responsibility discourse, with central focus on solidarity, community participation and agency, and a rejection of paternalism, colonialism and other asymmetrical social–political relationships. Accordingly, our participants did not positively identify with ideologies of philanthropy or charity, likely because of negative historical connotations attached to these concepts.[18] Possibly, early life exposures (via family, travel and education) contributed to the cultivation of these values, which subsequently evolve into concepts of solidarity and rights through a better understanding of culture, society and international politics. Importantly, this shared sense of personal responsibility may reflect a selection bias within the humanitarian industry, as those who commit to a career in humanitarian aid work may self-select for the above qualities, which they perceive as effective philosophies for engaging in the challenges of the humanitarian aid profession.

The perspectives and experience of career medical aid workers are closely tied to personal ideologies, and the sense of mission, directive and purpose of the aid organisations they represent. Humanitarian philosophies seem to be derived from intensive interactions between aid workers, their INGOs and the overall humanitarian community. These interactions create strong, frequently shared personal and institutional identities, as well as personal value systems that are reflected in institutional mission statements and programming; this particularly applies to the concepts of responsibility, solidarity, accountability and sustainability, which represent both a strong unifying value system as well as a source of conflict between individuals and organisations. Perceived discrepancies in an organisation's theoretical mandate and its treatment/application of these values, was a major cause of aid worker dissatisfaction, turnover and burnout. This suggests that the humanitarian aid industry could benefit from a clarification of goals and values in the area of programme mandates and project missions, as well as worker recruitment and retention; this represents a unique opportunity to strengthen and reform the humanitarian aid industry, thereby improving not only aid provision itself, but also worker satisfaction, health and performance.

Despite clear critical assessments of the INGO community, the strong belief in the positive reception and impact of INGO programming on impacted communities and stakeholders is promising, and is strongly linked to the dedication, motivation and collective will of the staff. The sense of collectiveness, synergy and shared values with the respective organisation likely contributes to a culture of continuous debate and reflection, further nurturing the evolution of motivations and ideological maturation. In return, this helps to retain humanitarian workers beyond their early assignments. The need for collaboration and compromise in a dynamic aid system is universally recognised, and is frequently achieved through active contribution by aid workers to their organisational programmes and directives. Interestingly, this observation was most prominent with participants from MSF, who emphasised active internal and external debate on humanitarian issues and transparency as part of the organisation's culture. In general, these feelings translated to a sense of agency on the part of experienced aid workers as active decision-makers, which contrasted with their appraisal of the UN and governmental organisations' cultures as lacking, both in the spirit of volunteerism and 'true' humanitarian response, based on the needs of populations and representation of its constituents (employees and recipient populations).

Conflicts, criticisms and accountability dilemmas in aid work

Career humanitarians are deeply aware of the limitations, shortcomings and negative consequences of their

aid operation and its inefficiencies and ineffectiveness. Not every aid is good aid.[19] These shortcomings and consequences include failure to reach intended beneficiaries; perpetuation of corrupt governments; depletion of limited local material and human resources; and negative impacts on local capacity-building, infrastructure and sociopolitical institutions through financial dependence, mismanagement of resources, and a neglect of cultural norms or local priorities and expectations.[8 18–23] While the immediate goal of saving lives is a fundamental objective of medical humanitarian interventions, humanitarian aid often fails to address overwhelming needs, and is ineffective in the long term if mechanisms to address underlying sociopolitical causes of human suffering are not available. Success and sustainability of programmes require the collaboration of multiple stakeholders, as well as the recognition and addressing of power dynamics based on finances, political allegiance, citizenship status, etc.

Our participants had difficulty describing local populations with disempowered terminology and highlighted their strength, coping strategies and significant contribution to overall aid,[19] and asserted that their rights to assistance and protection should be guaranteed as it is in disaster survivors in the Northern countries.[24] Several factors likely contribute to such pervasive views among career humanitarians, including the recognition of power imbalance between aid workers and recipients, a forward moving 'rights concept' rooted in the civil rights movement of the 1960s, and human rights and women's rights movements of recent years. The concept of rights-based versus need-based care provision was a particular source of critical concern for some participants, and recognised as a key area of divisiveness between individual values and institutional realities. Popularly, there is a distinction between rights to health as a general human right and broader rights to humanitarian assistance, including rights to protection and representation[25 26]; the unique position of medicine as separate from 'contested rights discourse' was pronounced among our study population, especially among participants from MSF, even as concepts of solidarity, agency, and community empowerment were touched on as driving personal and institutional values. The tendency to try to separate these rights may represent an attempt to depoliticise medicine as a historically independent and politically neutral field. The intersection of medicine and politics represents a key area of discomfort, conflict and debate for medical humanitarians, many of whom support politicised approaches to culture and power while at the same time eschewing the political components of medicine. Our study population expressed doubt about the benefit and field practicality of a theoretical rights-based approach, especially in the absence of an effective accountability mechanism. There is also considerable tension between the conceptual idea of accountability towards intended beneficiaries and its practicality; the tripartite accountability structure identified by participants, while considered ideologically appropriate, was in reality difficult to maintain, with the common result being the marginalisation of beneficiary voices. This is in stark contrast to participants' abstract or personal consideration of beneficiary populations, which was viewed through a strongly rights-based lens. Reasons for the impracticality of accountability mechanisms are generally theoretical, including but not limited to difficulty adjusting programme management to reflect existing local skills and customs, dysfunctional or chaotic local institutional settings and attempts by powerful local actors to divert resources from those most in need.[27] Additionally, aid organisations might have to convince larger donors to accept the sharing of accountability with aid recipients. Although mechanisms exist and are proposed to improve accountability,[28] such as integrating the community in operational or programmatic decision-making via true partnership, when it comes to funding and financial accountability, the issue is particularly complex.[28 29] Could beneficiaries be effectively involved in financial decision-making, allocation of resources, and programming? Is there space for a rights-based approach in aid provision, and can these conflicting views be reconciled? What does this mean for reform within the aid industry? These questions require renewed consideration from the humanitarian field. Giving the voice to aid recipients to exercise their health rights is a critical social justice issue to address, and a way to assure, capacity-building, but the focus may need to be on specific approaches for increasing accountability that lead to meaningful improvements of aid operation and effectiveness.[28 29–31] The mind-set and structure of operations in major INGOs may need significant institutional reforms to absorb this sharing process and there is a dire need to transform the current dynamic from merely connecting resources to brokering better governance, true collaboration and cooperation among community, government and international actors.[28 29]

Finally, the friction between governmental organisation and NGOs was an important and central theme that cannot be ignored if future humanitarian interventions are to be successful. Member states' politically motivated foreign policy agendas on aid direction and distribution, and the history of military involvement in decision-making processes in the UN, have contributed to a hesitancy on the part of INGOs to consider them as true humanitarian agencies, or as desirable partners. At the same time, there is recognition among many humanitarians that organisations such as the UN play an important role in strategic movement, coordination, and relationship-building with local governments and authorities. Advocacy resources and diplomatic channels could be extremely helpful if they are consensus based, need based, and free of political agendas when it relates to health and other basic humanitarian needs; however, in the view of our participants, this has been difficult to achieve, with the exception of a very few agencies such

as UNHCR and Unicef, and even among participants the success of these groups was seen as widely variable. It is unclear whether the current UN structure allows for its agencies to effectively apply a need-based approach to humanitarian situations in collaboration with INGOs. This parallels a similar concern participants shared over the mission, role and scope of practise of fledgling INGOs that have blossomed out of the recent trend in global volunteerism. Although INGOs are generally considered critical to providing needed services and effective in alleviating suffering, there are concerns over quality of work and services generally, and especially among those NGOs that have limited resources and expertise, are newly conceived, or that cater to the global medical volunteerism for trainees or the lay population.[8] For the UN as well as for these new organisations, a clarification of roles and responsibilities is essential, and strong internal discussion must be held to define values and organisational philosophies, especially regarding the critical concepts of rights-based and need-based care provision. Our participants drew a slight distinction between the work of major INGOs with significant experience and smaller or newly formed NGOs, but communicated factors that could define better service, including INGO specialisation, improved logistical expertise, communication, collaborative approaches with local partners, and critical assessment of cultural and institutional identity.

Humanitarian access

Humanitarian aid provision has undergone considerable changes in the past 20 years. A substantial body of literature discusses issues of ethics and accountability in humanitarian aid provision, as well as the idea of 'neo-humanitarianism', which addresses the embedded nature and appropriation of humanitarian principles for political and military operations.[32–38] Recently, the post–9/11 wars in Afghanistan, Iraq, Libya and Syria have contributed to and reinforced the 'blurring' of lines between military operations and humanitarian aid, further narrowing the humanitarian space and creating dangerous situations for aid workers and for target populations.[28 33 38] The concerns over conceptual and practical access to populations in humanitarian situations have important implications for training, debriefing and retention of employees, as well as their physical safety and emotional health. While negotiating at the local level with different parties to ensure short-term access has always been an important component of facilitating access to populations,[39] broader and more proactive sociopolitical approaches are desperately needed to counter the shrinking humanitarian space. Clearly, there is a need for broad range reform, reflection and restrategising for approaches within INGOs and the broader humanitarian aid community, in addition to the UN and other governmental structures. This includes addressing the overarching political forces that limit humanitarian access based on foreign policy agendas, and emphasising a more need-based approach in aid evaluation and provision. Successful advocacy initiatives against the interests of powerful pharmaceutical industry such as MSF's access campaign for generic HIV medications, and the drugs for neglected diseases initiative (DNDi), could serve as models for pushing targeted, need-based agendas in aid work, and could be replicated at the policy level to address humanitarian access internationally.[40 41] Finally, the profession of medicine itself is uniquely positioned to play a proactive and important role in international humanitarian aid work, resisting political and social coercion and maintaining a strong commitment to the core principles and concepts of independency, impartiality and neutrality.

Moving forward: building and maintaining a healthy workforce in a changing aid environment

Substantial emotional responses to extreme humanitarian experiences are common, especially among aid workers, and may present as burnout, depression, post-traumatic stress disorder (PTSD) and excessive or unhealthy alcohol use or cigarette smoking during or on returning from mission trips.[42–47] A limited number of aid organisations provide formal debriefing for their returning volunteers,[44 45] and aid workers are generally expected to develop personal management skills to deal with their emotional stress.[44 47 48] Many institutions, especially those engaged in short-term volunteerism, provide no psychosocial support.[44–49] Overwhelming emotional exposure, lack of self-care and personal management skills, lack of social support, pre-existing emotional conditions, and ineffective and dissatisfying aid programmes are contributing factors, according to our study population. The emotional effects of field hardship could be minimised with clearer communication and transparency about cumulative emotional burden, potential emotional situations and ethical scenarios volunteers may encounter, stress management techniques and training, clarification of expectations, and debriefing on returning.[42 49–52] The INGO community is beginning to recognise the need for institutional support and reform in this area. Notably, balancing work and personal life, as well as taking time off, are important, actionable habits that are increasingly encouraged within larger INGOs. Skills can also be developed to successfully alleviate some of the burden of emotional and physical isolation.[44 47 49 53]

Despite a continued commitment to medical aid work, experienced aid workers are unclear about the scope or details of their future commitment. Significant physical and emotional challenges in the field influence decisions to seek more headquarters or coordination positions, or to take regular breaks between positions. Lack of job security, environmental challenges for raising children or having a family, other family obligations, a need for more normal social life, changing career or educational goals, and financial constraints are issues that need to be systematically addressed by the INGOs to

assure continuing commitment by experienced medical aid workers. In addition to personal needs, barriers in institutional hierarchies are contributing factors to work dissatisfaction. Decision-making processes for field projects differ widely among INGOs, and tensions often develop when decisions are made without input from key stakeholders within organisations. As a result, aid workers may feel disenfranchised by their organisation, or feel their talents, knowledge and field expertise are not properly accounted for in decision-making processes. This disjunction is problematic and can compromise effectiveness.

Despite important concerns regarding the scope, success and sustainability of their work, job satisfaction remained high among our participants, and early motivations and personal philosophies were by-and-large reinforced through a career in the humanitarian field. The positive emotional impact of delivering effective aid could not be overemphasised. Career humanitarians asserted personal growth, and indicated becoming more understanding, reflective, compassionate and socially conscious. They demonstrate a trend of strong, sensitive, and fundamentally political foundations as a self-selected and highly motivated subgroup; this may contrast with prevailing ideologies among short-term humanitarian aid workers, charity, or philanthropic organisations, many of which employ more traditional, paternalistic or non-accountable views and approaches.[8 18 32 33 54] Exploration of the personal values of humanitarians is helpful when cultivating the next generation of aid worker. Specifically, it may help identify goals, values and beliefs that correlate with emotional resilience and positive personal growth among humanitarian recruits. Alternative rubrics and complementary approaches to evaluate and transparently communicate the impact of aid operations and projects' outcomes should be systematically explored.

Limitations

Our study is not without limitations. Many of these topics were explored in the absence of any prior systematic assessment, and were meant as tools to shed light onto important topics identified by aid workers and to generate ideas for future research. Our study survey was not designed to provide a comprehensive look at the psychological, moral and ideological beliefs of overall aid workers, or to fully capture the issues within the overall humanitarian operations, governance, or the future of humanitarian movement. We applied a qualitative descriptive approach to begin a dialogue and provide a forum for debate, with a research-based advocacy approach that explores many aspects of medical aid provision and operation from the perspective of international career medical aid workers. Most of our participants worked in more than one organisation over a period of 5–20 years, bringing in broader perspective and experience as a result. However, while our sample population represented a variety of humanitarian INGOs, the opinions and ideas of the participants may not fully represent the diversity of opinions in the humanitarian field; further exploration of the experiences of non-medical humanitarian aid workers, local, community-based and host-country aid workers, and short-term or mid-term medical aid workers is warranted. Finally, our study did not explore the perspectives of aid workers who had left the field of aid work.

CONCLUSIONS

Exploring and further understanding the identities of career medical humanitarians provides important insight into their unique experiences and characteristics, and helps guide the field in its personnel recruitment, management and training. This understanding is critical when dealing with the high turnover rates, low retention, high stress levels, and increasingly complex and limited humanitarian space that is unique to the current humanitarian field. Discordant interests, perspectives and agendas between INGOs and aid workers affect competencies and experiences of aid personnel, as well as collaboration and coordination between INGOs. Establishing and supporting/nurturing a culture of shared attitudes, motives and beliefs may help create a more synergistic environment for the improved effectiveness of humanitarian operations. The concepts of rights, solidarity and accountability need to be transformed beyond theoretical frameworks into practice, with available space for internal debate, discussion and reform. Individual motives, altruism, sense of mission and organisational mission, and directives, operate in a cycle with reciprocating effects, and are significantly influenced by the evolution of the aid industry and its community. Emphasis on humanitarian principles, and ethical policies and practices, with an institutionalised culture of debate and self-reflection, are paramount in maintaining a viable, experienced aid workers corps. Strategies must be implemented to improve personal and career experiences, and to systematically address psychological and social burdens felt by aid workers. The principles of independence, neutrality and impartiality are more difficult to define or maintain today compared with decades ago. However, INGOs must maintain independence from governmental, political and financial influences, while preserving their collaborative approach in the overall context of humanitarian access. However, a monumental task in itself, broader proactive policies drawn from previous successful initiatives are needed to maintain a productive and effective humanitarian access and space, and to protect aid workers and intended beneficiaries in the field.

Acknowledgements The authors thank all participants for their invaluable work, and their time and commitment to participate in this study. We thank Alexis Kearney for her contribution to preparing the Institutional Review Board application and Zoya Grigoryan for her contribution to the drafting of the manuscript.

Contributors RA made substantial contribution to this study including conception and design, analysis and interpretation of data, technical and

material support and supervision, drafting and critical revision of the manuscript for important intellectual content, and the approval of final version of the manuscript. KL made substantial contributions to this study including acquisition of data, interpretation of data, drafting and critical revision of the manuscript for important intellectual content, and the approval of the final version of the manuscript.

Funding This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None.

Ethics approval This study received Institutional Review Board approval from the Mount Sinai School of Medicine, New York.

Provenance and peer review Not commissioned; externally peer reviewed.

Data sharing statement No additional data are available.

Open Access This is an Open Access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/

REFERENCES

1. Kent R. International humanitarian crises: two decades before and two decades beyond. *Int Aff* 2004;80:851–69.
2. Stoddard A. *HPG briefing: humanitarian NGOs—challenges and trends*. Humanitarian Policy Group (12) Report 12. 2003. http://www.odi.org.uk/resources/docs/349.pdf (accessed 31 Mar 2014).
3. Bjerneld M, Lindmark L, McSpadden L, *et al*. Motivations, concerns, and expectations of Scandinavian health professionals volunteering for humanitarian assignments. *Disaster Manag Response* 2006;4:49–58.
4. Benjamin E. Principles and practice of disaster relief: lessons from Haiti. *Mt Sinai J Med* 2011;78:306–18.
5. Teson FR. Eight principles for humanitarian intervention. *J Mil Ethics* 2006;5:93–113.
6. Clukey L. Transformative experiences for hurricanes Katrina and Rita disaster volunteers. *Disasters* 2010;34:644–56.
7. Drain PK, Primack A, Hunt DD, *et al*. Global health in medical education: a call for more training and opportunities. *Acad Med* 2007;82:226–30.
8. Asgary R, Junck E. New trends of short-term humanitarian medical volunteerism: professional and ethical consideration. *J Med Ethics* 2012;39:625–31.
9. Ripp JA, Bork J, Koncicki H, *et al*. The response of academic medical centers to the 2010 Haiti earthquake: the Mount Sinai School of Medicine experience. *Am J Trop Med Hyg* 2012;86:32–5.
10. Slim H. The continuing metamorphosis of the humanitarian practitioner: some new colours for an endangered chameleon. *Disasters* 1995;19:110–26.
11. Bjerneld M, Lindmark G, Diskett P, *et al*. Perceptions of work in humanitarian assistance: interviews with returning Swedish health professionals. *Disaster Manag Response* 2004;2:101–8.
12. Hunt MR. Moral experience of Canadian healthcare professionals in humanitarian work. *Prehosp Disaster Med* 2009;24:518–24.
13. Hunt MR. Strengths and challenges in the use of interpretive description: reflections arising from a study of the moral experience of health professionals in humanitarian work. *Qual Health Res* 2009;19:1284–92.
14. Loquercio D, Hammersley M, Emmens B. *Understanding and addressing staff turnover in humanitarian agencies*. Humanitarian Practice Network Paper. 55. London: Overseas Development Institute, 2006. http://www.odihpn.org/documents/networkpaper055.pdf (accessed 31 Mar 2014).
15. Leader N. *The politics of principle: the principles of humanitarian action in practice*. Humanitarian Practice Group (HPG) Report 2. 2000. http://www.odi.org.uk/resources/details.asp?id=252&title=politics-principles-humanitarian-action-practice (accessed 31 Mar 2014).
16. Hunt MR. Establishing moral bearings: ethics and expatriate health care professionals in humanitarian work. *Disasters* 2011;35:606–22.
17. Neuman WL. *Social research methods: qualitative and quantitative approaches*. Boston, MA: Allyn & Bacon, 2009.
18. Slim H. Not philanthropy but rights; the proper politicisation of humanitarian philosophy. *Int J Hum Rights* 2002;6. http://www.tandfonline.com/doi/pdf/10.1080/714003759 (accessed 23 Mar 2014).
19. Cuny F, Hill R. *Famine, conflict and response: a basic guide*. Kumarian Press Inc, 1999. ISBN-10: 156590908.
20. Wessells MG. Do no harm: towards contextually appropriate psychological support in international emergencies. *Am Psychol* 2009;64:842–54.
21. Roberts M. Duffle bag medicine. *JAMA* 2006;295:1491–2.
22. Roy N, Shah H, Patel V, *et al*. Surgical and psychosocial outcomes in the rural injured: a follow-up study of the 2001 earthquake victims. *Injury* 2005;36:927–34.
23. Ten Have HA. Global bioethics and communitarianism. *Theor Med Bioeth* 2011;32:315–26.
24. ARC. American Red Cross (ARC). The Charter. http://www.redcross.org/what-we-do/disaster-relief (accessed 23 Mar 2014).
25. Sphere Project. *The sphere project: humanitarian charter and minimum standards in disaster response*. 3rd edn. Geneva, 2004. http://www.spherehandbook.org (accessed 28 Dec 2013).
26. International Federation of Red Cross and Red Crescent Societies. The Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief. World Disasters Report 2003: Focus on ethics in aid. Geneva: IFRC, 1994. http://www.ifrc.org/Global/Publications/disasters/WDR/43800-WDR2003_En.pdf (accessed 13 May 2014).
27. Wenar L. Accountability in international development aid. In: *Chapter 14, ethics & international affairs*. 3rd edn. Rosenthal JH, Barry C, eds. Georgetwon: University Press, 2009:235–306.
28. Humanitarian Accountability Partnership-International Editorial Steering Committee. HAP 2010 Standard in Humanitarian Accountability and Quality Management. http://www.hapinternational.org/pool/files/2010-hap-standard-in-accountability.pdf (accessed 31 Mar 2014).
29. Fowler A. Authentic NGDO partnerships in the new policy agenda for international aid: dead end or light ahead? *Dev Change* 1998;29:136–59.
30. Fleshman M. Africa pushes for better aid quality. *Afr Recovery* 2004;17:18.
31. Kickbusch I. The development of international health policies—accountability intact? *Soc Sci Med* 2000;51:979–89.
32. Slim H. Doing the right thing: relief agencies, moral dilemmas and responsibility in political emergencies and war. *Disasters* 1997;21:244–57.
33. Barnett M. Humanitarianism transformed. *Perspect Politics* 2005;3:723–40.
34. De Waal A. The humanitarians' tragedy: escapable and inescapable cruelties. *Disasters* 2010;34:130–7.
35. Rieff D. Humanitarianism in crisis. *Foreign Aff* 2002;81:111–22.
36. Darcy J. Locating responsibility: the Sphere Humanitarian Charter and its rationale. *Disasters* 2004;28:112–23.
37. Mills K. Neo-humanitarianism: the role of international humanitarian norms and organizations in contemporary conflict. *Global Governance* 2005;11:161–83.
38. Wheeler V, Harmer A. Humanitarian Policy Group at Overseas Development Institute, Resetting the rules of engagement. *Trends and issues in military-humanitarian relations*. 2006. http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/273.pdf (accessed 23 Mar 2014).
39. Doctors without Borders, The Centre de reflexion sure l'action et les saviors humanitaires (CRASH). Humanitarian Negotiations Revealed: The MSF Experience. http://www.msf-crash.org/livres/en/humanitarian-negotiations-revealed (accessed 23 Mar2014).
40. Medecins Sans Frontieres (MSF) Access Campaign. http://www.msfaccess.org/ (accessed 23 Mar 2014).
41. Drugs for Neglected Diseases initiative (DNDi). http://www.dndi.org (accessed 23 Mar 2014).
42. Hunt MR, Schwartz L, Elit L. Experience of ethics training and support for health care professionals in international aid work. *Public Health Ethics* 2012;5:91–9.
43. Elsharkawi H, Jaeger T, Christensen L, *et al*. Mobile field hospitals in the Haiti earthquake response: a Red Cross model. *Humanitarian Exchange Magazine* 2010;48. http://www.odihpn.org/humanitarian-exchange-magazine/issue-48/mobile-field-hospitals-in-the-haiti-earthquake-response-a-red-cross-model (accessed 23 Mar 2014).
44. Ehrenreich JH. Managing stress in humanitarian aid workers: the role of the humanitarian aid organization. In: Reyes G, Jacobs G, eds. *Handbook of international disaster psychology*. Westport, CT: Praeger/Greenwood, 2006;4:99–112.
45. Cardozo BL, Salama P. *Mental health of humanitarian aid workers in complex emergencies*. Sharing the front line and the back hills: peacekeepers, humanitarian aid workers and the media in the midst of crisis. Amityville, NY. Baywood Publishing, 2002:242–55.

46. Eriksson CB, Van de Kemp H, Gorsuch R, *et al*. Trauma exposure and PTSD symptoms in international relief and development personnel. *J Trauma Stress* 2001;14:205–12.
47. Holtz TH, Salama P, Cardozo BL, *et al*. Mental health status of human rights workers, Kosovo, June 2000. *J Trauma Stress* 2002;15:389–95.
48. Petrosoniak A, McCarthy A, Varpio L. International health electives: thematic results of student and professional interviews. *Med Educ* 2010;44:683–9.
49. Antares Foundation. *Managing stress in humanitarian workers: guidelines for good practice*. 2nd edn. 2006. http://www.antaresfoundation.org/download/managing_stress_in_humanitarian_aid_workers_guidelines_for_good_practice.pdf (accessed 23 Mar 2014).
50. Elsharkawi H, Sandbladh H, Aloudat T, *et al*. Preparing humanitarian workers for disaster response: a Red Cross/Red Crescent field training model. *Humanitarian Exchange Magazine* 2010;46. http://www.odihpn.org/humanitarian-exchange-magazine/issue-46/preparing-humanitarian-workers-for-disaster-response-a-red-cross/red-crescent-field-training-model (accessed 23 Mar 2014).
51. McCall M, Salama P. Selection, training, and support of relief workers: an occupational health issue. *BMJ* 1999;318:113–16.
52. Michael M, Zwi AB. Oceans of need in the desert: ethical issues identified while researching humanitarian agency response in Afghanistan. *Dev World Bioeth* 2002;2:109–30.
53. Hunt MR. Resources and constraints for addressing ethical issues in medical humanitarian work: experiences of expatriate healthcare professionals. *Am J Disaster Med* 2009;4:261–71.
54. Leaning J. Medicine and international humanitarian law. Law provides norms that must guide doctors in war and peace. *BMJ* 1999;319:393–4.