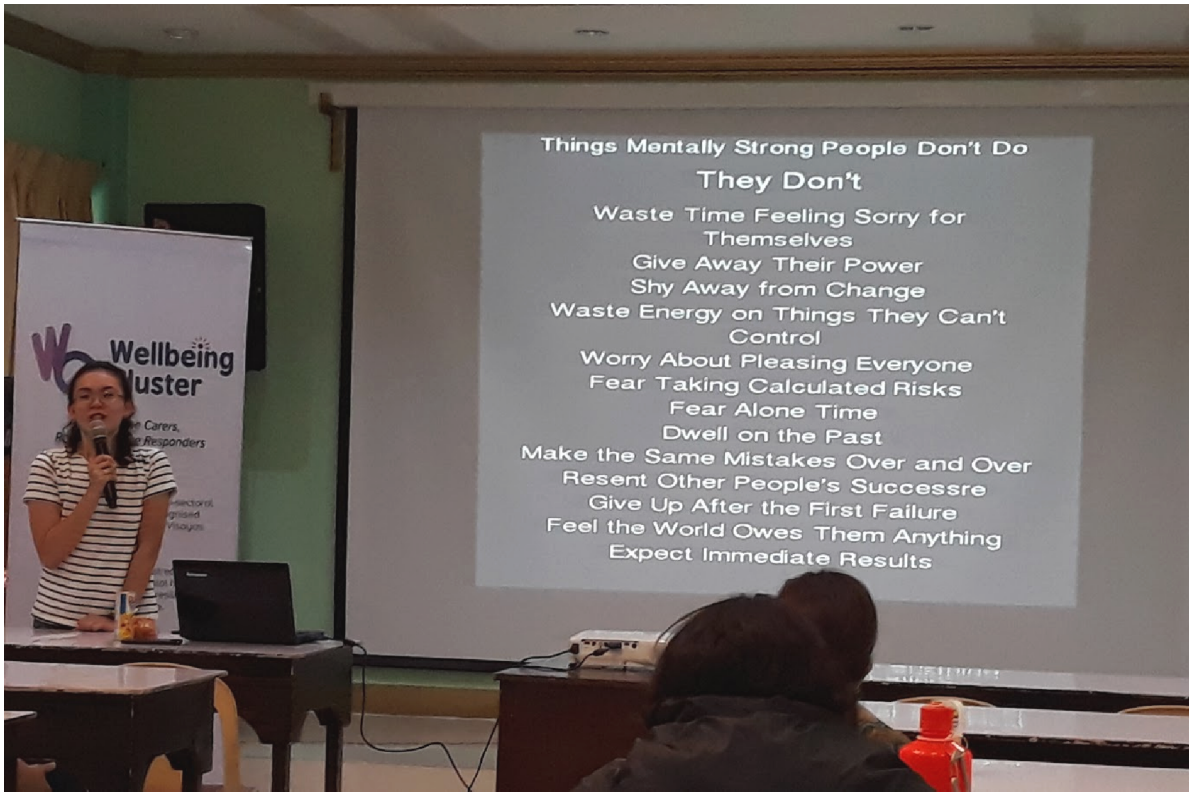
Well-being or ill-being?
Wellbeing and mental health support in the humanitarian sector.



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Statement of Originality

This thesis is the result of my own independent work/investigation, except where otherwise stated. Other sources are acknowledged by explicit references.

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Abstract

The humanitarian and international development is an attractive and competitive field of work. Many ambitious, eager and determined people are trying to enter this profession with the hope of contributing to a better world. However, the nature of this work is physically, mentally and emotionally demanding and aid workers often face invisible challenges. Recent research has revealed that aid workers suffer from anxiety, depression, stress and burnout. Many are fearful of talking about mental health issues in order to avoid stigma and some relief workers adopt negative coping strategies. There is a critical need to tackle the poor state of mental wellbeing in the humanitarian sector. Hence, this research aims to answer the question 'What is a state of wellbeing in the humanitarian sector and how can wellbeing requirements be addressed?' The focus of this research is to explore wellbeing within humanitarian settings and preventative concepts, such as the Wellbeing cluster project and mindfulness, that could be effective in dealing with mental wellbeing requirements of aid workers. The Wellbeing cluster project is a piloting initiative that has been established in the Philippines in 2018 with an ambition to address the lack of mental wellbeing support in the humanitarian sector. The Philippines, as a research site, provided a practical opportunity for evaluation of this new emerging concept in the development field. The study met the research objectives by reviewing relevant literature and the implementation of primary research. A mixed research strategy, combining qualitative and quantitative research approach was adopted. The qualitative research was carried out by utilising semi-structured interviews with key personnel involved with the Wellbeing cluster in order to provide in-depth information on the Wellbeing cluster project, wellbeing and current wellbeing issues in the humanitarian sector. The quantitative approach was based on a survey of aid workers from various NGOs who have practised mindfulness. The findings from this research provide evidence that aid workers are at risk of mental health issues, there is a lack of mental health support and an overarching definition of wellbeing in the humanitarian context is needed. The survey confirmed that mindfulness can be used as a good prevention-based concept but employers do not provide suitable conditions for utilising this practice. The findings from the quantitative analysis show that the Wellbeing cluster project is an effective platform for promoting mental wellbeing and its replication at a global level has the potential to change the humanitarian architecture and thus protect, strengthen and enhance the resilience of humanitarian staff. The main conclusions drawn from this research were that aid workers face many wellbeing challenges and the Wellbeing cluster and mindfulness can help to fill in a gap in the provision of mental health support, but a change in the humanitarian system is

needed in order to protect the mental wellbeing of humanitarian staff. This requires a commitment of employers and their Human resources departments to implement and promote mental wellbeing policies in the workplace.

Keywords: wellbeing, mental health, Wellbeing cluster, mindfulness, aid workers.

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Then, I would like to sincerely thank all research participants involved in this study for their time and sharing invaluable insights and powerful stories.

Finally, my sincere thanks belong to Hilary Churchley who has helped me to accomplish my dream of pursuing development studies.

Dedication

To my mother, Maria.

Thank you for giving me a life and teaching me about the art of life with love and kindness. My love to you is endless. Today, tomorrow and forever.

List of Acronyms

CENVISNET	Central Visayas Network of NGOs
DOH	Department of Health
HLA	Humanitarian Leadership Academy
HR	Human Resources
IASC	The Inter-Agency Standing Committee
PDRRMO	The Provincial Disaster Risk Reduction and Management Office
PTSD	Post-traumatic stress disorder
RAFI	Ramon Aboitiz Foundation Inc.
USC	University of San Carlos
WHO	World Health Organisation

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1 Introduction

1.1 Why is the subject matter important?

The nature of humanitarian work is very stressful and aid workers can be exposed to life-threatening situations, insecure environments and the suffering of others in humanitarian crisis. Humanitarian personnel are often required to be distant from their families, friends and social networks and work in physically and emotionally demanding conditions with no privacy, personal space and psychosocial support. They can experience additional stress from their headquarters, ineffective management and lack adequate training and financial resources (Antares Foundation, 2012). Increasing insecurity and complexity of humanitarian work can have direct implications on the wellbeing and mental health of humanitarian workers. The risk of mental health issues is higher for humanitarian staff than the general population (UNHCR, 2016). A survey on the Global Development Professionals Network reveals that 79% of humanitarian staff have experienced mental health issues and 63% have expressed that this had an impact on their performance at work (Young, 2015). However, the most alarming finding from the survey is that 84% of respondents said that they have continued working with untreated mental health issues (ibid). This can have fatal consequences on the mental wellbeing of aid workers who are expected to be strong and resilient when providing a response to people affected by humanitarian crises.

Aid workers are anxious and fearful to talk about mental health issues and a culture of silence concerning this subject has developed. As a result of silence and stigma, aid workers can adopt negative coping strategies which can be harmful to both the aid workers and affected people. The Antares Foundation (2012) underlines that although stress among humanitarian workers is common, it can be prevented or reduced. Humanitarian agencies have managerial responsibility and duty of care towards their employees and are required to ensure adequate mental health support in the workplace. Unfortunately, no clear system has been set up to provide effective mental wellbeing support for humanitarian staff. Limited guidelines have been developed but the subject of mental health in the humanitarian sector has not been prioritised. The staff care practices are inconsistent, existing guidelines are not been adhered to (Porter and Emmens, 2009) and the academic research and knowledge about wellbeing of aid workers “remains in its infancy” (Ali et al., 2015, p.154). New approaches, such as the Wellbeing cluster project piloted in the Philippines could potentially change the way in which mental health is perceived and prioritised in the humanitarian sector. Introducing mindfulness in humanitarian settings could help to protect, strengthen

and enhance the resilience of humanitarian staff. In this study I will explore how useful and practical can these concepts be when addressing mental wellbeing requirements of the humanitarian community.

1.2 Aim and Objectives

The overall aim of this research is to understand wellbeing within humanitarian settings and explore preventative measures that could be effective in tackling the mental health issues of aid workers, such as the Wellbeing cluster project and mindfulness practice[1]. The underpinning question for this research is:

What is a state of wellbeing in the humanitarian sector and how can wellbeing requirements be addressed?

The following questions have been identified to help answer the main research question:

(i) How can wellbeing be defined in the humanitarian context?

(ii) What are the wellbeing challenges in the humanitarian sector?

(iii) What is the potential of the Wellbeing cluster in addressing the wellbeing requirements?

(iv) What is the prospect of introducing mindfulness into the humanitarian sector?

1.3 Structure of the study

This study is divided into five chapters.

Chapter 1 presents the reasoning behind why the subject of the study is important and identifies the question and objectives of the research.

[1] Sections 2.4.2 and 2.4.4 provide background on the Wellbeing cluster project and mindfulness.

Chapter 2 provides the context and conceptual background to the topic by reviewing existing literature on wellbeing in the humanitarian sector, including changing paradigms for addressing mental wellbeing within the sector.

Chapter 3 explains the research design and methodology adopted.

Chapter 4 presents the research findings and uncovers the research objectives through the synthesis and discussion of key findings and the literature review.

Chapter 5 is the concluding chapter with a summary of key findings and future recommendations.

1.4 Significance of the research

Wellbeing has been discussed and researched in various academic fields. However, a lack of attention has been paid to the subject of wellbeing in the humanitarian sector. Several researchers have studied the prevalence of mental health issues amongst aid workers (Cardozo *et al.*, 2012; Connorton *et al.,* 2012; Ager *et al.*, 2012; Brooks *et al.*, 2015) but no study has specifically look at preventative measures that could ensure wellbeing support in the humanitarian field. The significance of this research is in bridging this gap by providing knowledge on wellbeing in the humanitarian context and exploring concepts that could help to prevent mental health issues. This study will offer recommendations on implementation of wellbeing policies at the organisational level in order to improve mental health support in the humanitarian sector.

2 Literature Review

2.1 Introduction

The literature review sets a theoretical background for the research objectives. This study utilises a number of literature resources including books, journals and websites as well as the United Nation's papers, NGOs and government reports. The academic search of the literature was undertaken by library databases: Factiva, Academic Search Complete, MEDLINE and PsychINFO that provide literature selection on health, behavioural science and mental health. The search of the literature review was limited by time and a scarcity of the wellbeing topics in the humanitarian context. The parameters for the literature search included journal papers published after 2000 in order to review the most recent papers and the key search words covered *'wellbeing', 'mental health', 'aid workers', 'humanitarian workers'* and *'humanitarian sector'.* Papers related to mental health and wellbeing in other disciplines rather than development field were not included. There were limited journals papers on this subject but more academic literature has become available since 2010. This demonstrates an increasing interest in this topic and perhaps a need for more robust data in this sector.

This chapter is divided into three sections. The first section discusses the concept of *'wellbeing'* and defines *'wellbeing'* within the humanitarian context. It shows the importance of wellbeing and its impact on the work of humanitarian staff. It explores wellbeing and mental health policies and guidelines and the implementation of those policies by employing agencies. Finally, the changing paradigms for addressing wellbeing within the humanitarian sector are debated, including the Wellbeing cluster project and mindfulness.

2.2 Wellbeing in the humanitarian sector

2.2.1 What is wellbeing?

The term and definition of *'wellbeing'* vary across studies and disciplines. While philosophy traditionally distinguishes between hedonic and eudaemonic wellbeing, economics considers a distinction between evaluative and experienced wellbeing (Oades and Mossman, 2017). In social sciences, such as in clinical psychology and sociology, wellbeing is concerned with the happiness, satisfaction and contentment of people (Sarot, 1996). This multifaceted nature of wellbeing is complicated and not easily defined. For example, the UK's Department of Health

and Social Care's (2014) definition of wellbeing is emphasising the importance of individual experiences, and evaluation of one's life with social norms and values:

> *'Wellbeing is about feeling good and functioning well and comprises an individual's experience of their life; and a comparison of life circumstances with social norms and values.'*

More precisely, Alatartseva and Barysheva (2015) refer to subjective wellbeing which is associated with one's personal characteristics or features and objective wellbeing which is related to the perception of one's evaluation of human society. According to Adams and Bloom (2017), there are at least two important dimensions of wellbeing which is *'happiness',* the quality of our daily lives, and *'flourishing',* the meaning and purpose we experience in our lives. Wellbeing is also underlined as a keyword in the World Health Organisation's (WHO) definition of health which is understood as:

> *'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.' (Constitution of the WHO, 1946).*

Although there is not a universal definition of wellbeing as such, wellbeing is generally concerned with an individual's subjective and objective experiences, covering physical, mental and social aspects.

2.2.2. Defining wellbeing in the humanitarian context

Terminology related to wellbeing and mental health support within the humanitarian context is in academic literature referred to as: psychosocial wellbeing (Tol *et al.* 2011), psychological wellbeing (Brooks *et al.*, 2015), mental health and psychosocial support (Aggarwal, 2011; UNHCR, 2013), mental health and psychosocial wellbeing (IASC, 2007), staff welfare or staff care (The KonTerra Group, 2017; Porter and Emmens, 2009). Consistent definitions of staff care practices in the development sector are missing (Porter and Emmens, 2009). Interpretations of wellbeing vary between organisations, practitioners and different cultural backgrounds. For example, in the health sector, agencies have adopted the term *'mental health'* but historically have used the terminology *'psychosocial rehabilitation'* and *'psychosocial treatment'* (IASC, 2007). From a linguistic point of view, there is a difficulty in defining *'wellbeing'* in cultures which have limited or no experience with

wellbeing and mental health activities (Aggarwal, 2011). Aggarwal (2011) observed that local workers in India, Pakistan and Jordan were not able to translate *'psychosocial'* to Hindi, Urdu or Arabic. Thus defining wellbeing and mental health might encounter translating difficulties with multiple interpretations. According to The Inter-Agency Standing Committee (IASC) (2007, p.1):

> *"The composite term mental health and psychosocial support are used...to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder."*

IASC's definition understands *'psychosocial wellbeing'* as being linked to *'mental health and psychosocial support,'* where mental health and psychosocial support are terms that are mutually related and complementary. In a similar view, the WHO relates *'wellbeing'* to *'mental health'* (2014, no page):

> *"Mental health is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."*

Likewise, Porter and Emmense (2009, p.10) in their paper on staff care in NGOs refer to a connection between wellbeing and health, recognising the *emotional* aspect of health:

> "Wellbeing is influenced by internal and external factors, and refers to emotional, cognitive, spiritual, and physical health."

It emerges from the various definitions that there is a direct link between wellbeing and mental health but there is no consistency when defining wellbeing. Aggarwal (2011) in his study, debating mental health and psychosocial supports' meaning, asserts that an absence of a formal and agreed definition may interfere with coordinating the minimum response. In fact, a lack of clarity with the terminology might affect the psychosocial response for both, the affected community and humanitarian staff, hence there is a need for an overarching definition of wellbeing within the humanitarian context. To maintain the terminological consistency and following the WHO's definition, this study adopts the term *'mental wellbeing'* throughout the research, as those terms are directly interconnected. By recognising the gap

in academic terminology, this research seeks to define *'wellbeing'* and its specific facets within the humanitarian framework.

2.2.3 Why mental wellbeing matters?

The Aid Worker Security Database (2016) reports that 102 aid workers were killed, 98 injured and 89 kidnapped in 2016. The insecure nature of humanitarian work can cause trauma to those working in the development field. This is evident in Connorton's *et al.* (2012) research which identified that the most common traumas of aid workers are frightening situations, threats or being chased, forced separation from family, shelling and bombing of office or home, and hostility of the local population. In addition, working with affected communities exposes the humanitarian personnel to both, primary as well as secondary sources of trauma. Studies on mental health show that those who work with traumatised populations experience higher rates of Post-traumatic stress disorder (PTSD) symptoms (Connorton *et al*, 2012). On the contrary, in Pigni's view (2016), the stressors and trauma for aid workers do not come from frontline work but from the stress of controlling people in headquarters, the burden of bureaucracy and office politics. Similarly, Langston *et al.* (2007) assert that aside from traumatic stress, there are other work-related stressors such as poor management, lack of peer support and isolation which affect the lives of humanitarian personnel. Also, Brooks *et al.* (2015) found out that particularly poor leadership and support have a significant impact on the psychological resilience of relief staff. Further, the UNHCR's Global Staff Survey (2013) reveals that humanitarian staff have a fear of speaking up about mental health issues and 50% believe that there is a lack of open communication within the organisation on this subject. Likewise, the Start Network Humanitarian Wellbeing Survey (Solanki and Rogers, 2017b) shows that 44% of surveyed aid workers agreed that talking about their mental health needs would have an adverse impact on their promotions and deployment opportunities. *"If you claim that you are too stressed, the organisation will maybe relocate you to a boring job, then it goes on your record...It's a taboo subject, you are seen as unstable, insecure...So it's best only to seek help when your contract comes to an end."* (anonymous cited in Pigni, 2016, p. 42). Silence, stigma and lack of support can result in negative coping strategies, such as the use of alcohol, drugs, sex, excess sleep and social withdrawal (Cardozo and Salama, 2002; IRIN, 2010). Chain-smoking, angry reactions or staring at the screen of the computer without getting much done are among other symptoms mentioned within the community of aid workers (Pigni, 2016). Also, the Antares Foundation (2012) reports on the adverse consequences of negative coping along with callousness,

apathy, over-involvement with beneficiaries, poor decision-making or self-destruction behaviour. Pigni (2016) argues that dysfunctional coping mechanisms are widespread in the humanitarian sector because organisations do not offer healthy alternatives. It is evident that lack of organisational support, insecure working environment, stigma and taboo have a direct impact on the mental wellbeing of humanitarian personnel.

2.3 Addressing mental wellbeing in the humanitarian sector

2.3.1 Current state of mental wellbeing of humanitarian workers

The UNHCR's (2013) survey reveals that 57% of UNHCR staff suffers from symptoms of unhappiness, sadness and emptiness and 47% is dealing with sleeping difficulties. A new UNHCR survey (2016) reports risks of anxiety, depression, post-traumatic stress disorder, secondary stress and burnout among UNHCR staff. A study by Cardozo *et al.* (2012), on the mental health of aid workers across 19 NGOs, manifests that aid workers are at a significant risk of mental health problems in the field as well as after returning home. The statistics show an increased risk of psychological distress among the international staff and even higher for the national staff. For example, the Antares Foundation (2012) reports that 46% to 80% of national aid workers experience symptoms of distress. According to Ager's *et al.* (2012) study, over 50% of aid workers in Uganda experienced symptoms associated with risk of anxiety, depression, burnout and PTSD. Similarly, mental health related symptoms have been reported from the national humanitarian staff in Kosovo (Holtz *et al.*, 2002). Ali *et al.* (2015) argue that one of the reasons why national workers are at more risk is because they are not able to leave the affected country, have limited access to resources and do not maintain the same special status as Western workers. A lack of cultural understanding, language barrier, unequal power and socioeconomic differences are additional stressors for national staff when working with international colleagues (Ahmad, 2002). When mental wellbeing is discussed within a gender context, the female relief workers report significantly higher symptoms of anxiety, depression, PTSD, and emotional exhaustion than male aid workers (Ager *et al*, 2012). In addition, it should be noted that there is no research related to a prevalence of mental health issues within the LGBT community of humanitarian workers and the topic of suicide rates among aid workers is not mentioned and reported at all. The alarming statistics on mental illness amongst aid workers clearly illustrate that there is a need to urgently address the mental wellbeing crisis.

2.3.2 Mental wellbeing and duty of care

It is well-documented that stress can affect work efficiency, increase health care costs and create legal liabilities for NGOs (Ager, 2002; Fawcett, 2001 cited in Ehrenreich and Teri Elliott, 2004, p.55; Cardozo et al., 2012). The Antares Foundation (2012) reports that the staff who are exposed to excessive amount of stress are absent more often from work, have higher illness rates and show less commitment to their agency. This results in higher turnover, increased recruitment and training costs due to a loss of qualified staff and ultimately affects functioning, productivity and ability of agencies to provide efficient services to affected people.

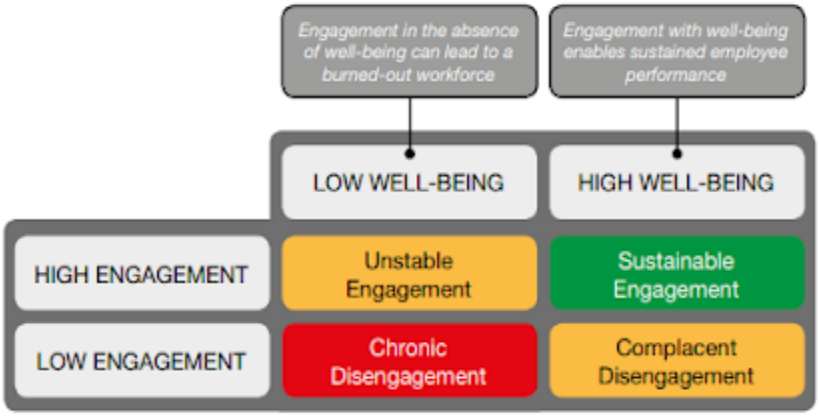

Figure 2.1: The connection between mental wellbeing and engagement, UNHCR, 2013, p.31

Mental health costs the UK an estimated £42bn per annum and 1 in 6 people of working age have a diagnosable mental health condition (Public Health England, 2018). The employing agencies have a duty of care towards their employees and bear legal liability for ensuring staff welfare. It is explicitly mentioned in IASC's Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007, p.87) that *'the provision of support to mitigate the possible psychosocial consequences of work in crisis situations is a moral obligation and a responsibility of organisations exposing staff to extremes.'* The Sphere Project (2011) in the Core Standard 6 states that *'humanitarian agencies provide appropriate management, supervisory and psychosocial support, enabling aid workers to...plan and implement an effective humanitarian response with humanity and respect.'* Likewise, Commitment 8 of the Core Humanitarian Standard (2014, p.17) defines that *'staff are*

supposed to do their job effectively, and are treated fairly and equitably' and organisational responsibility is to ensure that *'policies are in place for the security and the wellbeing of staff.'* The Antares' Guidelines for Good Practice[2] (2012) have been developed to help humanitarian organisations to design their own staff care system and include eight principles that can be applied for mitigating stress in humanitarian workers. Similarly, the Approaches to Staff Care in International NGOs[3] by People In Aid and InterHealth (Porter and Emmens, 2009) and Essential Principles of Staff Care[4] by The KonTerra Group (2017) have been developed to help organisations to implement comprehensive staff care programmes and build the resilience and psychological health of humanitarian workers.

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2.3.3 Exploring agencies experiences of implementing mental wellbeing policies

Despite the known occupational hazards, many agencies do not have adequate policies in place to ensure the mental wellbeing of their employees. For instance, an evaluation of UNHCR's staff care policies found out that UNHCR was compliant with only two out of the eight Antares Principles (UNHCR, 2013). Ali *et al.* (2015, p. 156) refer to a *'culture of denial'* among some organisations which are not able to cope with the psychosocial requirements of their staff. Researchers have noted that there is limited pre-deployment preparation to prevent psychosocial stress in the field, staff support resources are not sufficiently developed and stress management practices are not consistent (Cardozo *et al.*, 2012; Connorton *et al.,* 2012; Douglas and Quinn, 2016; Pigni, 2016). Similarly, Simmonds *et al.* (1998 cited in Ali *et al.,* 2015) point out that pre-deployment support is lacking systematic briefing and in some cases even comprehensive medical cover. Porter and Emmens' (2009) study of 20 development organisations shows that almost half of the agencies do not have policies for staff to access medical check-ups and only one-quarter carry out post-assignment psychological review or debriefing. Connorton *et al.* (2012) argue that organisational studies recognise the importance of debriefing after assignment but the focus is mainly on personnel serving in the field and not enough attention is paid to the transition of aid workers to a normal life. Thus, mental wellbeing support should be offered during pre-deployment, deployment and post-deployment. Pigni (2016) points out that self-care should also be about working reasonable hours, peer support, clear boundaries and job descriptions. According to Porter and Emmens (2009), more specific guidelines are required to provide staff care

[2] See Appendix A
[3] See Appendix B
[4] See Appendix C

comprehensively. Douglas and Quinn (2016) are of the same view and argue that NGOs' policies have to support staff comprehensively. It is evident from the discussion that there is no unified wellbeing policy in place and various organisational approaches create inconsistency and a gap in mental wellbeing provision. Then a question has emerged as to how to develop a comprehensive, consistent, sustainable and effective mental wellbeing system that ensures adequate and inclusive mental wellbeing support for humanitarian workers?

2.4 Changing paradigms for addressing mental wellbeing within the humanitarian sector

2.4.1 Building resilience

Resilience is understood as *"a person's capacity to respond to the changing and sometimes challenging world around them"* (Adams and Bloom, 2017, p.256) or *"the ability to adapt and thrive despite experiencing adversity"* (Feder *et al.*, 2011, p.1). The KonTerra Group (2017, p.4) asserts that organisations should *"ensure that staff have access to staff care and resilience resources and services"*. Highly-resilient people are more likely to recognise stressful situations and take appropriate actions to reduce them (Adams and Bloom, 2017). The Antares Foundation (2012) argues that staff psychosocial care plays a vital role in stress management and prevention of traumatic and post-traumatic stress. For example, this might mean that relief workers are fully informed of the risks of potential exposure to trauma and humanitarian agencies provide culturally appropriate ongoing psychological support during and after the deployment (Connorton, *et al.,* 2012). Cardozo *et al.* (2012) suggest that when recruiting and preparing the humanitarian workers for assignments, agencies should take into account also the history of mental illness and follow the necessary steps to eliminate chronic stressors and strengthen social support networks. Culturally appropriate training methods should be adopted to improve cultural empathy and prevent isolation of individuals when being deployed in new working environments (Hullett and Witte, 2001). Further, post-assignment consultations should be included as a standardised part of the post-assignment process (The KonTerra Group, 2017). Having appropriate mental wellbeing programmes in place can help to prevent mental health issues of aid workers, strengthen an individual's resilience and build organisational capacity. Despite the progress of humanitarian organisations in staff welfare, it is evident that existing programmes and policies do not effectively address the requirements of mental wellbeing of humanitarian staff. Programmes

are lacking a contextualised approach and comprehensive settings. This is where the concept of the Wellbeing clusters can potentially be utilised and make a real difference.

2.4.2 Concept of the Wellbeing clusters

The Wellbeing clusters is a piloting concept with an ambition to change the humanitarian architecture in order to tackle the lack of mental wellbeing support in the humanitarian sector (Solanki, 2018a). The development of the Wellbeing cluster model has emerged from the Start Network's[5] portfolio of projects under the Disasters and Emergencies Preparedness Programme and the Mindfulness & Wellbeing component of the Transforming Surge Capacity project, funded by UK Aid (Solanki and Rogers, 2017a). The term 'cluster' was deliberately used to replicate the UN cluster's terminology in order to emphasise the importance of wellbeing and prioritise the mental health support for humanitarian workers (*ibid.*). In comparison to the UN clusters, which are activated in the case of humanitarian emergencies, the Wellbeing clusters will work as a permanent and sustainable model (Solanki, 2018b). The Wellbeing clusters will adopt a *'multi-agency'* or *'multi-sectoral'* approach linking local and national NGOs with INGOs, governmental bodies and key stakeholders to support relief workers more effectively during all stages of humanitarian response and build capacity on an individual and organisational level in the matters of wellbeing and mental health (Solanki and Rogers, 2017a). The advantages of the 'multi-sectoral' approach can be potentially seen in reduced costs through sharing resources, expertise and services and offering more consistent and quality controlled training (*ibid.*). In addition, by training the trainers, promoting wellbeing policies and good practice guidelines, monitoring and evaluating frameworks, the capacity of organisations can be strengthened and thus even small agencies and community-based groups will be able to benefit from those services (Solanki and Rogers, 2017a; Solanki, 2018a). According to Estallo and Solanki (2017) local ownership, autonomy, relevance and sustainability are the building stones of the creation of the Wellbeing clusters. One of the key emphasis of the Wellbeing clusters is prevention and preparedness. The focus on prevention and preparedness ensures that wellbeing support is available prior to a disaster, as well as during emergencies at the grassroots level, is linked to building capacity and resilience of individuals and organisations, and thus eventually mitigating stress and trauma (Solanki, 2018a). The model of the Wellbeing clusters is built on recognising the importance of localisation. The benefits

[5] The Start Network is made up of 42 aid agencies across five continents, ranging from large international organisations to national NGOs which aim is to deliver more effective emergency aid.

of a localised approach are in contextualisation and the ability to adjust the wellbeing needs to culturally appropriate backgrounds, then overcoming stigma by sharing different global perspectives and in building capacity together as a community in contrast to individual efforts (Solanki and Rogers, 2017a; Solanki, 2018b). According to Solanki (2018b, no page), the Wellbeing clusters can provide a *"localised and relevant grassroots-led model"* which is able to change the way in which mental health and wellbeing are addressed and ultimately create *"open and accepting environments to tackle mental illness more effectively."*

2.4.3 The first Wellbeing cluster in the Philippines

The very first localised Wellbeing cluster in the world was piloted and publicly launched in the Philippines, Cebu on 30 July 2018 (Wellbeing Cluster Philippines, 2018).

Figure 2.2: Public launch of the Wellbeing cluster, source: the author

This unique multi-sectoral collaboration in Cebu, cross-promoting wellbeing and mental health programmes, involves NGOs, government agencies, local government units, civil society organisations, faith-based organisations, the private sector, media and the academia (RAFI, 2018; Cervantes, no date)[6]. Since January 2017 the Cluster is led by the Ramon Aboitiz Foundation Inc. (RAFI) and the Central Visayas Network of NGOs (CENVISNET) with the support of the Humanitarian Leadership Academy (HLA) and other stakeholders (Solanki, 2018a; Cervantes, no date).[7] In this multi-sectoral collaboration, the academia

[6] A full list of organisations involved in the Wellbeing cluster can be found in Appendix D.
[7] The organisational structure of the Wellbeing cluster can be found in Appendix E.

supports the Cluster with research provides psychosocial expertise, where other working groups are managing financial sustainability, communication, policy development, monitoring and evaluation (Estallo and Solanki, 2017). The Cluster is already developing operational plans, designing training resources, mapping needs and conducting research for delivering efficient mental wellbeing services (Solanki, 2018b). Further, training on stress reduction and mindfulness-based approaches will be developed to mitigate stress, anxiety, depression and foster mental wellbeing (*ibid.*). Since its establishment, the Cluster has gained a lot of interest which demonstrates the urgency and need for supporting mental wellbeing in humanitarian settings. For example, the Cluster has been recognised by the Department of Health (DOH) and been working collaboratively with the Philippines Red Cross, Action Against Hunger UK, Humanitarian Leadership Academy and Plan International. It is locally linked to the University of San Carlos (USC), Ateneo de Manila University and globally to London South Bank University in order to facilitate knowledge on mental wellbeing and psychosocial support (Solanki, 2018b). By 2020 the locally led Wellbeing cluster in the Philippines is aiming to be fully recognised and functional in Central Visayas (RAFI, 2018). Solanki (2018b, no page) asserts that:

> *"the creation and pilot of the first Wellbeing cluster in Cebu offers a practical and tangible opportunity for agencies to address, mitigate and positively change the way in which mental health is managed and approached in the humanitarian sector."*

The scope of the Wellbeing cluster in Cebu is much broader and will support not just the first responders but also social workers, carers and communities during emergencies, as well as in peace-time (Solanki, 2018b). As a new model within the humanitarian architecture, Solanki (2018a, no page) has envisioned the Wellbeing cluster in the Philippines as the first of many *"living networks of pooled knowledge, expertise, services and resources"* that can be implemented regionally, nationally and globally. Discussions about replicating the Cebu cluster in the northern part of the Philippines are already taking place and Action Against Hunger UK is in a process of developing the UK Wellbeing cluster (Solanki, 2018b). Both, the UK and Cebu Wellbeing clusters will be linked, representing a global-local working group, and facilitating learning and development opportunities for tackling mental health globally (*ibid.*). Solanki is confident that if the Wellbeing cluster in the Philippines is piloted successfully, it can represent a template that can be replicated globally (Solanki and Rogers,

2017a). But can the concept of the Wellbeing cluster work in practice and what is the real potential of the Cluster in addressing the wellbeing requirements of aid workers?

2.4.4 Mindfulness

Mindfulness has recently been widely popularised, particularly as a part of positive psychology programmes. Many institutions, especially in the corporate sector, offer mindfulness training in order to prevent stress in the workplace and boost performance. For example, Google, British Telecom and the UK Parliament invest in mindfulness, as a way to support the wellbeing of employees (Rupprecht, 2017). Mindfulness has also been introduced in the Philippines, as a component of the Wellbeing cluster programmes (Solanki, 2018b). Mindfulness is a meditation practice which claims benefits in improving wellbeing and health of individuals. Mark Williams and Danny Penman (2011) show that mindfulness-based cognitive therapy is clinically proven to prevent feelings of anxiety, stress and sadness, halve the risk of depression, and it is at least as effective as antidepressants. Similarly, Adams and Bloom (2017) note that 5 minutes of mindfulness practice can contribute to positive changes in stress response, physical health and resilience. Research of employed patients on sick leave by Netterstrom *et al.* (2013) demonstrated that 67% of patients who received the 8-week mindfulness training returned to work compared to only 36% who undertook psychotherapy sessions. Further, 20% increased productivity, enhanced resilience and wellbeing were recorded in employees who undertook a short online mindfulness course (Aikens *et al.*, 2014). The evidence of mindfulness benefits is mounting but its use in humanitarian settings is still in an embryonic state. Just recently, Alessandra Pigni, a humanitarian psychologist, has been sharing the mindfulness practice with aid workers in Israel and Palestine (Mindful staff, 2011). According to Pigni (2016), many relief workers experience burnout and mindfulness-based stress reduction training can significantly help to tackle mental health issues. Hitendra Solanki, Mindfulness & Wellbeing Adviser, has also been exploring mindfulness within the humanitarian sector as a way to prevent stress and mental health issues. Solanki adapted the Mindfulness-Based Stress Reduction course to specifically fit the needs of aid workers (Ravelo, 2017). Chemali *et al.* (2018) in their study on working with mindfulness programmes during humanitarian refugee crisis report that those programmes helped aid workers to improve problem-solving skills, overcome challenging situations, become more aware of negative emotions and think more positively. While there is an overall excitement regarding mindfulness and its benefits, academic research evaluating the impact of mindfulness on relief workers is almost

non-existent. Therefore, more tangible data is needed to establish how useful and practical mindfulness use in the humanitarian sector is.

2.5 Conclusion

In conclusion, the literature review helped to formulate the research questions and identified the key themes that will be further discussed in the next chapters. To find out about the state of wellbeing in the humanitarian sector, the research will establish how wellbeing is understood in the humanitarian context. Then, current wellbeing challenges and their root causes will be explored in order to find out what are the wellbeing requirements of aid workers. Finally, a discussion will follow to determine if the Wellbeing cluster and mindfulness have the potential to address some of the current wellbeing challenges.

3 Methodology

3.1 Introduction

This chapter sets out the research strategy chosen to address the research objectives defined in section 1.2. It explains the rationale behind adopting the mixed methodology. The research methods used are semi-structured interviews and a survey. Then, the means of the primary data collection and data analysis are discussed. Finally, the importance of the ethical considerations and limitations of this research design are presented.

3.2 Research strategy

Considering the scale and time-frame of this research, the mixed methods strategy, combining a qualitative and quantitative research approach, has been chosen as an appropriate strategy that is likely to be successful in achieving the objectives of this study. Mixed methods using more than one research method can provide more a complete picture of the studied subject and data produced by different methods can be complementary (Descombe, 2014). Using combined methods can give better credibility to the research and help to evaluate the extent to which findings are trusted and inferences made. The qualitative aspect of this research adopts semi-structured interviews and the quantitative approach utilizes a survey. Initially, I considered adopting a focus group research method. But after careful evaluation, I decided not to use this method, as the professional credibility of the research participants might be undermined due to disagreements and different views on the sensitive topic of mental wellbeing. The primary research was performed in Cebu over a period of 3 weeks.[8] Cebu, as a research site, provided a great opportunity to collect data on both the Wellbeing cluster and mindfulness.

3.2.1 Semi-structured interviews

16 face-to-face semi-structured interviews were conducted from mid-July until early August 2018 and 1 semi-structured interview was carried out over the phone. The interviews were performed in meeting rooms, hotels and quiet restaurants that were convenient for the research participants. The interviews lasted around 60 minutes and were audio-recorded with permission in order to retain accurate data for the transcript and interpretation. No

[8] The Wellbeing cluster has introduced mindfulness as a practical component for reducing stress and building the resilience of aid workers.

translator was needed, as all interviewees spoke fluent English. Semi-structured or 'open-ended' interviews are defined by a rich conversation between interviewer and interviewee (Wisker, 2008) where more emphasis is on the interviewees who can give valuable insights based on their experience or position (Descombe, 2014). When designing the research strategy, I recognised that interviewing, the transcription of interviews and the analysis of transcripts is a very time-consuming process (Bryman, 2012). However, in order to explore the topic of mental wellbeing in humanitarian settings, the semi-structured interviews offered a useful way of collecting in-depth information on this subject. This method of data collection allowed flexibility in the interview process and helped me to look at the researched subject differently, discover interesting leads in a discussion, as well as identify new aspects of the topic. For example, the role of HR and the sustainability of the Wellbeing cluster were among the topics that were further explored. The interview questions were carefully chosen to obtain knowledge on the key aspects of wellbeing, wellbeing issues in the humanitarian sector, the concept of the Wellbeing cluster and mindfulness. An example of the interview questions can be found in Appendix F. By conducting the interviews face-to-face I was able to use gestures and visual signs to show affirmation, especially when the sensitive topic of mental health was discussed, and encourage the research participants to be full in their answers.

The interviewees were selected through snowball sampling. This sampling approach was useful because it provided an opportunity to construct my own sample and as Given (2008) asserts, sometimes it might be the only way to access individuals from certain subcultures. The snowball sampling was chosen over the purposive sampling, allowing me to recruit participants that are members of the same group or share similar interests that are relevant to the research (Given, 2008). New participants were recruited when participants referred to other potential participants based on criteria that they have been working in the humanitarian sector and had an understanding of the Wellbeing cluster concept and mindfulness. Hitendra Solanki[9], the Mindfulness & Wellbeing Adviser from Action Against Hunger, facilitated the initial introduction between the researcher and the Wellbeing cluster network. Further contacts were made through snowballing from the first interviews which provided a broader sample including aid workers, academics, HR professionals, professors, educational specialists, executive staff and government representatives. Staff from the Start Network's Transforming Surge Capacity project, RAFI and CENVISNET were interviewed for their contribution to the establishment of the Wellbeing cluster. Psychosocial experts and

[9] I was initially liaising with Save the Children regarding this research topic. They introduced me to Hitendra Solanki who facilitated mindfulness training in the Philippines and developed the concept of Wellbeing cluster.

professors from the University of San Carlos were interviewed with a purpose to understand how academic research can help to enhance knowledge on the mental wellbeing of humanitarian staff and link it with the Cluster. Research participants from the Humanitarian Leadership Academy were included in the study for their views on the Wellbeing cluster, learning and preparedness of aid workers. Then, the representatives from the Department of Health, The Provincial Disaster Risk Reduction and Management Office and local government provided information related to policies on mental health and wellbeing in the workplace. Finally, two persons who participated in mindfulness training were interviewed in order to gain rich qualitative data on the mindfulness experience. The variety of research participants and their knowledge expertise brings an invaluable contribution to the validity of the research.

Mindfulness & Wellbeing Adviser
Nurse and Co-ordinator of Mental Health Programmes
Professor in Psychology
Director of Community Extension Service
Staff from Kauban[10]
Regional Coordinator
Project Assistant
Programme Head of Humanitarian Disaster Preparedness and Response Unit
Executive Director of Integrated Development Unit
Vice President for Social Development
Assistant Vice-President Human Resources
Philippines Centre Director
Program Manager for Business Continuity Planning
Head of Human Resource Management Office
Chief
Humanitarian worker (mindfulness course)
Graduate student (mindfulness course)

Table 3.1: Overview of the interview participants

[10] Kauban is a support group for people manifesting symptoms of depression, anxiety and suicidal ideations.

3.2.2 Survey

An online survey was conducted with humanitarian staff, who have had previous experience with mindfulness practice. The survey was launched on 1 September for a period of 3 weeks. 151 aid workers were invited to take part in the survey and it was completed by 46 respondents, a 30% response rate. The aim of the survey was to obtain data on the mental wellbeing of aid workers and understand the use of mindfulness in humanitarian settings. The survey comprises a cross-sectional design in relation to which data is collected predominantly by questionnaire (Bryman, 2012). The benefit of this research strategy is that it gathers data in a standardised form from a relatively large number of individuals (Robson and McCartan, 2017). I recognised that the self-completion questionnaire requires a lot of time and skill to be designed (Walliman, 2016), relies on self-reporting and the response rate is not guaranteed (Walliman, 2016). However, it allows anonymity which encourages the respondents to provide honest answers (Robson, 2011). Therefore, this research method is very useful, especially when collecting data on the sensitive subject of mental health from geographically dispersed research subjects, that I would not be able to reach personally. A list of research participants, represented by both sexes, was created with the help of Mr Solanki and included aid workers from various NGOs who participated in mindfulness training in the Philippines or the United Kingdom.

Action Aid	UK
Plan International	UK
THET	UK
Restless Development	UK
Save the Children	UK
IMC	UK
CAFOD	UK
Action Against Hunger UK	UK
Ortigas Healing Space (mixed Agency participants)	Philippines
Ateneo de Manila Psychologists Group Participants	Philippines
Ateneo de Manila Mindfulness & Wellbeing Research	Philippines

Table 3.2: Overview of the survey participants

Primary nominal and ordinal data were collected by a questionnaire which combined 24 close-ended and open-ended questions. The questionnaire was designed by the 'Google forms' tool and was divided into sections: About the research, About you, General wellbeing and About mindfulness. The development of the questionnaire was informed by the consultation with Hitendra Solanki in order to include relevant and appropriate questions on mindfulness. The section 'General wellbeing' was influenced by the design of the UNHCR's staff wellbeing survey (2013) which helped to reflect on wellbeing challenges in the sector. To ensure a sufficient response rate and technical proficiency of survey data, a pilot questionnaire was launched. Three participants had provided feedback on the questionnaire which helped to improve its design and structure. For example, text paragraphs were added to give option to write additional comments and the questionnaire was broken into four sections to introduce new topic and present a better visual design. The final version of the questionnaire can be found in Appendix G. The survey was conducted online and research participants received an email link to the questionnaire with information about the purpose of the research, confidentiality and deadline for completion. A reminder email was sent out after two weeks and the survey closed a week later. The data were securely stored in a Cloud archive.

3.3 Data analysis

3.3.1 Qualitative analysis

The interviews were transcribed in full in order to gather enriching qualitative data for the thematic analysis. Guest et al. (2012, p.10) describe thematic analysis as a type of inductive analysis that 'moves beyond counting explicit words or phrases and focuses on identifying and describing both implicit and explicit ideas within the data, that is 'themes'. Boyatzis (1998, iv) importantly notes that the thematic analysis is not another qualitative method but it is 'a process of encoding qualitative information.' When analysing qualitative data I was first guided by the themes identified in my research questions which are:

- Defining wellbeing in the humanitarian context
- Wellbeing issues
- Wellbeing requirements
- Wellbeing cluster
- Mindfulness

Then, I used six phases of thematic analysis developed by Braun and Clarke (2006).

1. Familiarisation	Reading and re-reading transcripts. Making notes of any initial analytic observations.
2. Coding	Coding interesting features of the data in a systematic way and collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes.
4. Reviewing themes	Reviewing themes and generating a thematic map of the analysis.
5. Defining themes	Ongoing analysis to refine the specifics of each theme. Generating clear definitions and names for each theme.
6. Producing the report	Final analysis and producing a report for the analysis.

Table 3.3: Phases of the Thematic analysis, Braun and Clarke, 2006

Following the six phases of thematic analysis, the data was manually analysed by coding which indexed and categorised the text, and then was broken down into sub-themes. For example, questions related to wellbeing requirements identified sub-themes of wellbeing requirements in pre-deployment, deployment and post-deployment stage of humanitarian response. Through an iterative process, different responses were compared and contrasted within each group of themes and final results were revealed. Quotes were highlighted in order to be used as an evidence in synthesis and discussion.

3.3.2 Quantitative analysis

Quantitative data, collected by online questionnaire, was analysed by the Google Forms' analytic tool 'Summary of responses'. Data was downloaded into an Excel sheet, checked for errors and missing data were excluded. This is why the number of participants is varied for each question. Nominal data based on sex, age and occupation and ordinal data based a five-point Likert scale, were compared in order to draw conclusions. Then the data was organised in a form of tables and charts for a clear visual interpretation.

3.4 Ethics

In this research, I gathered views, opinions and feelings of human participants on mental health and wellbeing which can raise ethical considerations. As argued by Walliman (2018) researchers must be aware of ethical standards and avoid any harm that might be caused by carrying out or publishing the research. I followed the key principles of research ethics including no harm to participants, voluntary consent and scientific integrity (Denscombe, 2014). I was very careful when collecting data and mindful of possible latent traumas of the research participants, especially when interviewing female participants. This research was approved by the Faculty Research Ethics Committee and adheres to the Code of Practice for Research Ethics for Research Involving Human Participants (2016). To avoid any psychological and social harm, research participants were informed about the purpose of the study, their anonymity and confidentiality was assured, and they had the right to withdraw from the research at any stage. The Participant Information Sheet was emailed to the research participants in advance and they were asked to read it carefully before the interview. Formal consent was required in order to be able to participate in the research. The Ethics Review Form E1 and E2, Research Ethics Approval Form E3, Consent Form and Participant Information Sheet can be found in Appendix H.

3.5 Limitations

Topic sensitivity could limit the knowledge and scope of the research. Researching wellbeing and mental health can be a taboo for many NGOs and humanitarian staff. Thus, gathering sufficient data can be challenging and participants might be cautious in sharing their views. I had limited time for data collection in Cebu which resulted in limited number of interviews. More time spent at research site would allow me to create better rapport with aid workers and obtain further information and open up new area of the research. For example, to explore special wellbeing needs of women. The survey might not provide accurate data, as it was based on self-perception of research participants. Especially, participant expectations of mindfulness training can be challenged by preconceptions and misconceptions and the individual experiential experience might not reflect the true nature of the practise. Further, investigating only one Wellbeing cluster with no means of comparison and collecting data from stakeholders involved in the Cluster rather than wider population can generalize the findings. It has to be noted that there is no peer literature related to the Wellbeing cluster, except the reports written by the key-stakeholders and limited literature was the main constraint of the research.

4 Findings, Discussion and Synthesis

4.1 Introduction

This Chapter presents the results of the primary data collection. It will show and discuss the implications of the findings and its relevance in discussion with the literature review. The online questionnaire collected data on mental wellbeing and mindfulness from aid workers in various NGOs with the purpose of uncovering objectives (ii) and (iv). The data was broken into 3 categories, including demographics[11], general wellbeing, mindfulness, and then analysed. Females represented 76% (n=35) of the surveyed sample, while male accounted for 24% (n=11). Semi-structured interviews were conducted to define wellbeing in the humanitarian context, investigate the current wellbeing issues, explore the potential of the Wellbeing cluster project and thus uncover objectives (i), (ii) and (iii). The interviews also included questions related to mindfulness in order to gain additional information for an analysis of objective (iv). Based on the research findings, first the wellbeing in the humanitarian context will be defined, then the current wellbeing challenges will be identified and finally, the potential of the Wellbeing cluster and mindfulness in addressing the wellbeing requirements will be explored.

4.2 How can wellbeing be defined in the humanitarian context?

The literature review highlighted that the definition of 'wellbeing' is not consistent and varies across disciplines, manifesting its multifaceted nature. Further, there is a lack of recognition and clarity in terminology when wellbeing in the humanitarian context is explored and this has also been reaffirmed in the quantitative analysis:

> *"...institutions or workplaces do not recognise wellbeing. Perhaps, because they cannot define it." [Anonymous]*

Indeed, the findings from the interviews showed that one of the real issues in the global humanitarian sector is that *'wellbeing'* is not clearly defined. As the literature review underlined, an absence of a formal definition might interfere with coordinating minimum response (Aggarwal, 2011). Therefore, a distinct definition of wellbeing is important and

[11] See Appendix I.

needed. When defining wellbeing in the humanitarian context, research participants stated that mental health represents the core aspect of wellbeing.

> *"For me, wellbeing has so many aspects. It's a totality of one wellness, one improvement or a state of being. Well, both, physically, financially, even your social relationships. But for me, wellbeing is more about mental health." [Anonymous]*

In this respect, although the IASC's (2014) definition links 'psychosocial wellbeing' to 'mental health and psychosocial support,' it is the WHO's definition of 'mental health' that is the closest to directly link to wellbeing, where:

> *"**Mental health is** defined as **a state of well-being** in which every individual realises his or her own potential, **can cope with the normal stresses of life** [my emphasis in bold], can work productively and fruitfully, and is able to make a contribution to her or his community." (WHO, 2014, no page)*

However, this definition does not consider other aspects of health such as physical, emotional, social, spiritual and financial, which were identified by the interviewees.

> *"Wellbeing is holistic. It's looking into health in terms not just mental but physical, social and economic." [Anonymous]*

Porter and Emmense (2009) have recognised this, and likewise the research participants, connect wellbeing with *"...emotional, cognitive, spiritual, and physical health.*" Interestingly, the WHO's definition of 'health' refers to ***'a state of complete physical, mental and social wellbeing**...'* (Constitution of the WHO, 1946). Further, the WHO's definition of 'mental health' highlights that *"...[it is] a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life…".* Similarly, the interviewees acknowledged that wellbeing is about an individuals' ability to deal with stresses and problems of life.

> *"It's a state of you having the capacity to counteract with problems in your life because there is no assurance that you won't encounter problems...." [Anonymous]*

Therefore, by reviewing and analysing the existing definitions and evaluating the findings of the research, the following overarching definition of wellbeing in humanitarian context is proposed:

> ***Wellbeing is a state of mental health that includes different aspects of health such as physical, emotional, social, spiritual and financial which allows individuals to realise their potential, cope with normal stresses of life and thus contribute to their community.***

To conclude, a formal definition of wellbeing in the humanitarian sector will provide clarity when designing a psychosocial response for the affected community, as well as for humanitarian workers.

4.3 What are the wellbeing challenges in the humanitarian sector?

The literature review presented alarming statistics on the state of mental wellbeing of humanitarian staff. The survey results confirmed this prognosis where 100% (n=46) of research participants admitted facing wellbeing challenges while working in the humanitarian sector and this includes humanitarian staff in the Philippines as well as in the UK. Among frequent issues experienced by many are stress (37%, n=17) and anxiety (27%, n=12). In addition, reported were occasional burnout (41%, n=18), depression (28%, n=12) and PTSD (7%, n=3). UNHCR's survey (2016) highlights similar findings and reports risks of anxiety, depression, post-traumatic stress disorder, secondary stress and burnout among the UNHCR staff. In addition, the 2013 UNHCR survey showed that 57% of humanitarian staff suffers from symptoms of unhappiness, sadness and emptiness. Likewise, 61% (n=28) of research participants occasionally experience feelings of sadness and emptiness.

It was highlighted in the literature review that there is a higher prevalence of symptoms of anxiety, depression and PTSD among female aid workers than male workers (Ager et al, 2012). Taking into consideration that females represented 76% of the surveyed sample, attention should be paid to the specific safety wellbeing needs for women.

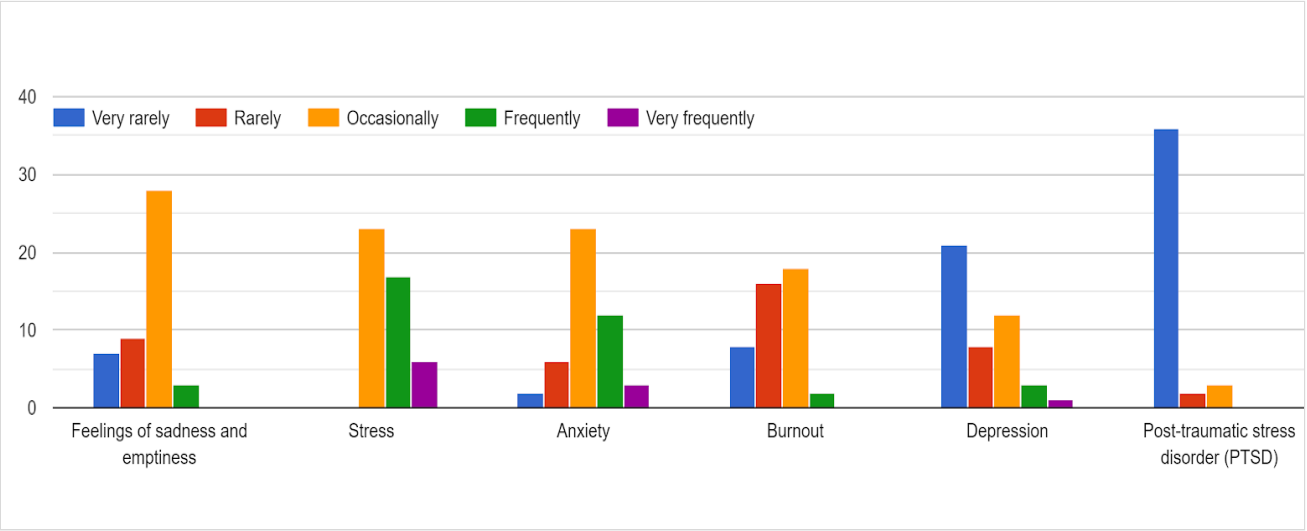


Figure 4.1: Frequency of mental wellbeing issues experienced by aid workers

Shockingly, 72% (n=33) of those surveyed stated that they are aware of their colleagues having experienced mental wellbeing issues.

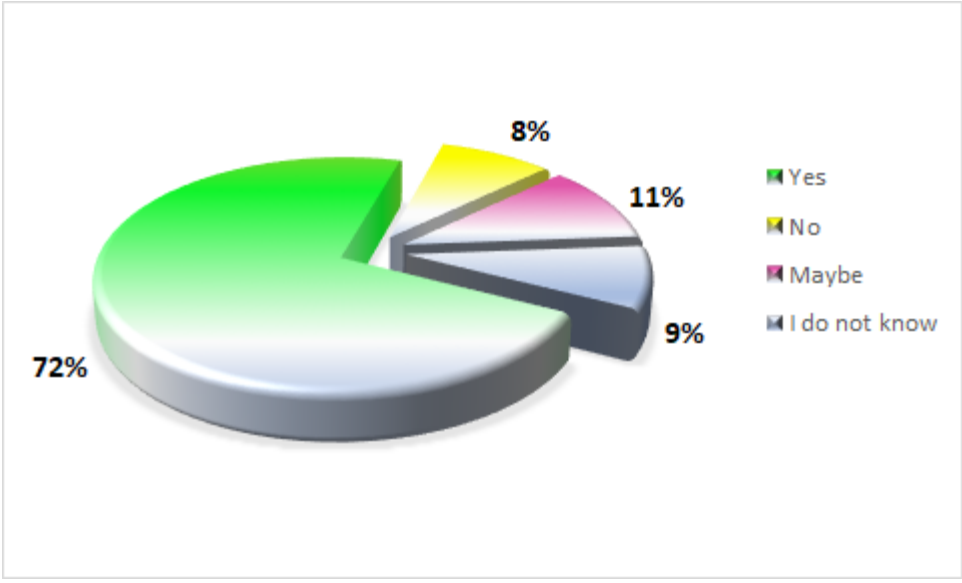
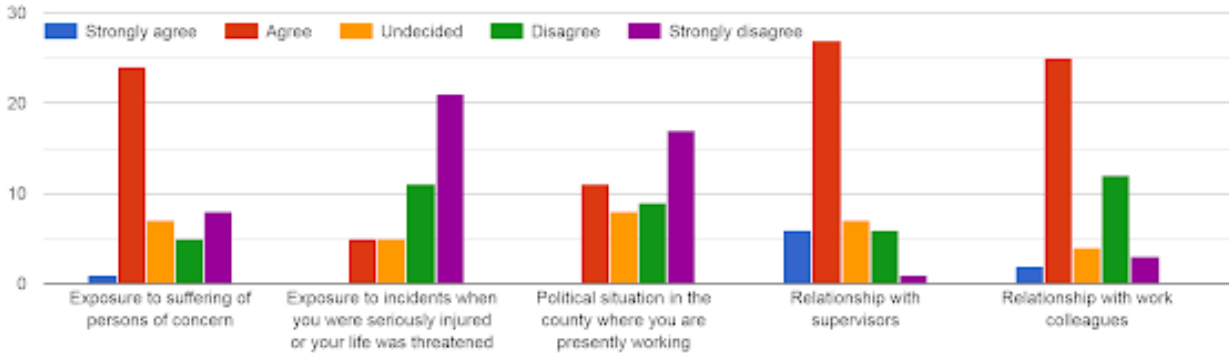


Figure 4.2: Awareness of mental wellbeing issues of colleagues

They have particularly noticed their colleagues suffering from symptoms of stress, anxiety, depression, burnout, as well as low mood, heightened emotions, tension, anger, negativism, withdrawal, isolation, lack of focus at work or not having the ability to make wise decisions due to tiredness.

"High-stress levels and signs of burnout are common among my colleagues, as is a general sense that this is just the nature of the sector and that there is not much which can be done apart from continuing to do the work at pace." [Anonymous]

The literature review further identified that the roots of stress are coming from frontline work as well as from employing agencies. A summary of the survey revealed that the research participants strongly agreed that occupational stressors are the main cause of stress, including workload (44%, n=20), ability to achieve work goals and objectives (30%, n=14) and working hours (27%, n=12). This agrees with Pignis's view, who pointed out that stress at work is caused by controlling people in headquarters, from the burden of bureaucracy and office politics. The majority of participants agreed that the stress in the workplace is caused by a relationship with the supervisors (59%, n=27), work colleagues (54%, n=25) and exposure to the suffering of persons of concern (53%, n=24). They strongly disagreed that exposure to incidents when they were seriously injured or their life was threatened (50%, n=21) or political situation in the country (38%, n=17) and safety concerns (29%, n=13) are major causes of stress.



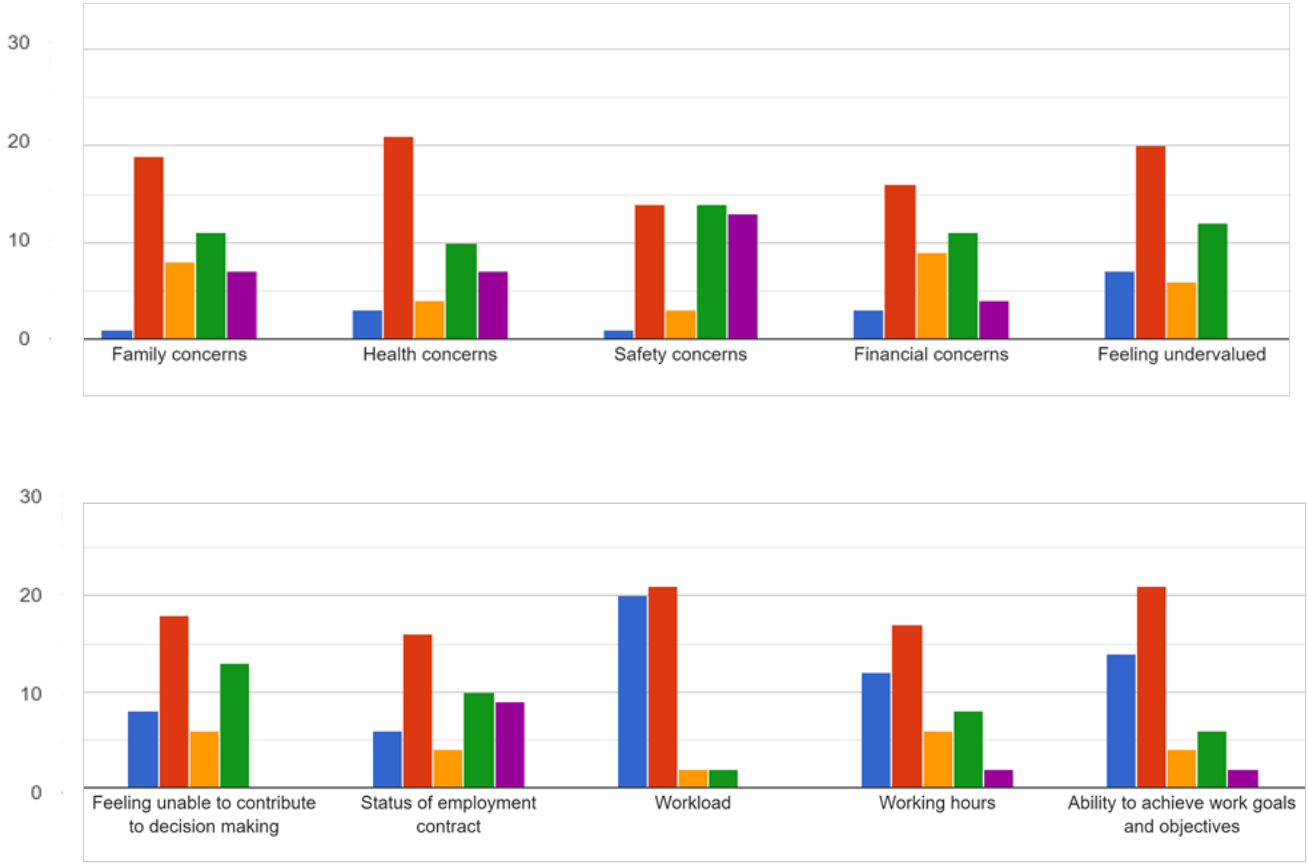


Figure 4.3: Main causes of stress at work

The literature review noted that it is poor leadership, lack of peer support, fear of speaking up about mental health and isolation which significantly affect the lives of humanitarian workers (Brooks *et al.*, 2015; Solanki and Rogers, 2017; Langston *et al.,* 2007). Similarly, it was acknowledged in the qualitative analysis that stigma and silence have an impact on the wellbeing of aid workers which can consequently result in negative coping strategies.

> *"After the last assignment I had, it took me about a month to work properly again. And I did some negative coping such as drinking and that even cost a relationship with my family. ...I didn't get any help that time besides of this coping mechanism that I did, talking and drinking…." [Anonymous]*

According to Pigni (2016), these dysfunctional coping mechanisms are widespread in the sector because organisations do not provide support and healthy alternatives. As one research participant noted:

> *"The problem in the humanitarian industry is that it is like an automatic thing, that you have to be resilient but actually it's OK to say that you are not OK." [Anonymous]*

In the same vein, the qualitative findings underlined that there is a lack of mental health support and the subject of mental wellbeing has not been prioritised and when mental health support is provided, it is tailored for affected people only.

> *"When we provide psychosocial support it is to the victims...and first responders are not really given any support...They just go on their own and deal with the situation themselves...We had a student...who was not able to sleep after seeing all the dead bodies and injuries. And he said that how he deals with that is that he tries to distract himself and that there is not really a support group that could provide help.." [Anonymous]*

The problem truly is that there is no organisational infrastructure that could support aid workers.

> *"There is no clear system so far that would support responders on mental health and wellbeing." [Anonymous]*

In addition, there is no managerial responsibility and acceptable guidelines on how to implement wellbeing policies in the workplace.

> *"...one of the most important things which are being left behind is that there is no clear responsibility or accountability, who should be managing it. Even humanitarian and aid organisations do not have internal policies or guidelines on how to deal with mental health amongst aid workers. So, everything is very tentative, depending maybe on the Leaders, if they feel like doing something about it." [Anonymous]*

The literature review argued that organisations have a commitment to staff welfare (IASC, 2007; The Sphere Project, 2011; Antares Foundation, 2012, CHS, 2014) and have a legal and moral obligation to fulfil their duty (KonTerra Group, 2017). Likewise, it emerged from the qualitative analysis that employers need to ensure a provision of wellbeing support.

> *"I think the primary role of the organisation...is to really ensure that the mental state of mind is protected even before the deployment. We do not want to be blamed that a responder would go back from the deployment and bring stress to home and have a huge impact to his or her family or children inflicting to himself because of the whole experience was not processed." [Anonymous]*

It has been further stressed that ensuring the protection of mental wellbeing of employees can lead to better retention of qualified staff.

> *"We have to take care of mental health of people. And it is very important because you spend most of the time in the office and you might also like to make this office mentally healthy environment...one of the struggles for HR practitioners is the scarcity of talent. So, once we have that talent, we have to take care of that person and part of it is taking care of mental health...otherwise, the company will also suffer and we will lose the talent." [Anonymous]*

The literature review noted that the existing wellbeing guidelines, such as the Approaches to Staff Care in International NGOs (Porter and Emmens, 2009), Antares' Guidelines for Good Practice (2012) and Essential Principles of Staff Care (The KonTerra Group, 2017), can help humanitarian agencies to develop their wellbeing policies. However, a consistent and systematic mental wellbeing support system is required. It is evident from the research that aid workers have been facing mental health issues and this problem has not been adequately addressed. These findings are significant, as they show that the current state of mental wellbeing within the humanitarian sector is seriously critical and organisations bear responsibility for ensuring psychosocial support for their employees.

4.4 What is the potential of the Wellbeing cluster in addressing the wellbeing requirements?

Considering the extent of identified wellbeing issues in the sector, the Wellbeing cluster can address some of the challenges through its various competencies. The findings of the qualitative analysis established that the Wellbeing cluster has the ability to support the wellbeing requirements via the following competencies:

Figure 4.4: Competencies of the Wellbeing cluster, source: the author

Knowledge transfer

The literature review pointed out that cultures who have little experience with mental health activities encounter translational difficulties when wellbeing is discussed (Aggarwal, 2011) and the same evidence was found in the Philippines. This is where the Cluster is making a real difference and facilitating a highly relevant knowledge of wellbeing.

> *"When I got informed about the nature of the Cluster I got very excited, precisely because we were simply using terms such as healing the healers, wounded healers, these were ways by which we understood what the volunteers were going through… In fact, we did not use the word wellbeing until we were part of the Cluster. I think the vocabulary evolved along with our participation in the Cluster."*

The qualitative findings further acknowledged that employers should recognise their responsibility in promoting knowledge on wellbeing to their employees.

> *"First of all, there should be a better presentation because not everyone can easily understand the concept of wellbeing. ...the issue of wellbeing or being prepared is not really brought by the employees. Wellbeing should be something tangible, something always to be reminded about." [Anonymous]*

Advocacy

The literature review and the findings from the interviews established that there is a stigma when talking about mental health issues in the humanitarian field and mental wellbeing of aid workers have been under-prioritised. Advocacy has been highlighted as the core function of the Wellbeing cluster and offers a practical way of breaking down stigma and prejudice.

> *"I believe that the Wellbeing cluster will be able to fight prejudice. Because one of our goals will be mainstreaming mental health and wellbeing." [Anonymous]*

In addition, the literature review and qualitative findings noted that organisations are not able to address the psychosocial needs of their staff (Ali *et al.*, 2015) and the Wellbeing Cluster provides capacity in order to change the current humanitarian environment, as well as break stigma.

> *"Since we have different committees in the Wellbeing cluster, the first thing the Cluster really wants to do is to envisage the knowledge on mental health in the humanitarian sector and that's one of the priority activities of the Cluster for next two years." [Anonymous]*

> *"If we have the Wellbeing cluster and we provide a whole series of tools, training, services, training of trainers, what that can do is to immediately give access to things which small agencies would not have or could not afford. It means to make the consistent vision, mission and mindset and importantly break stigmas." [Anonymous]*

Local context

Findings from research determined that mental wellbeing programmes have to be inclusive and locally sensitive. In a similar vein, the literature review argues that psychological support has to be culturally appropriate (Connorton *et al.,* 2012). This is where the Cluster is filling another gap because it recognises the importance of local context.

> *"We really want to have a localised wellbeing and mental health. Something that could be understandable to the locals." [Anonymous]*

Interestingly, it was pointed out by the interview participants that localisation provides an opportunity to effectively use local capacity and create a shift in power which can break the hegemony of international development and dependency. According to the interviewees, the main benefits of local contextualisation are in resilience building, resource mobilisation, community engagement, ownership and relevance to local needs. This confirms Solanski and Roger's (2017a) view that a localised approach has the ability to adjust the wellbeing needs to different cultural backgrounds and build capacity through community engagement.

> *"If a local initiative can happen with a global framework and if it can be done using its own technology, resources, its own capacity, then it can be replicated across the world." [Anonymous]*

Importantly, the interview participants recognise the link between the localised cluster and the global context through learning, knowledge sharing, mutual connectivity and influence on the local level, but consistency at the global level.

Multi-sectoral approach

The literature review presented that the Wellbeing cluster adopts the 'multi-agency' approach, linking various stakeholders together, to support humanitarian workers more efficiently. The literature review stressed that this approach can reduce costs through sharing resources, expertise, services and provide consistent training (Solanki and Rogers, 2017a). Indeed, the interview analysis found out that stakeholders are willing to contribute to the Cluster through collaborative work with other partners, resource sharing, knowledge transfer, provision of fundings, training and development of new learning resources that can have positive implications on the costs.

> *"We will continue to be the main provider of learning related to resilience and wellbeing but at the same time we were hoping that we can support the documentation of their [Wellbeing cluster's] experience, so that would be easier for other regions to learn from it, adopt the process, as they replicate it. And maybe later on, if we can support customizing some courses that are needed, we will be happy to support that also." [Anonymous]*

Simply, coordinating with different organisations can provide resources in a more systematic and impactful way.

Preparedness and mental wellbeing support in different stages of a humanitarian response

To address the lack of mental wellbeing support, access is a critical issue.

> *"The responders should know about anxiety, how to address it because you shouldn't continue to do your work if you are not mentally healthy. The problem is that people are unprepared and don't know what to expect from the assignment. Even us, who have to assign people, we do not have preparedness." [Anonymous]*

Therefore, it was importantly highlighted by the interview participants that preparedness is essential in the prevention of mental health issues.

> *"...before you go to a field, you have to prepare yourself. So, those mindfulness sessions, provision of tools, assessment of your capacity, capability, your potential, strength, that is the preparedness part...So, when you are in the field, you are already prepared and you know that in the field might be mortalities, you might see dead bodies, people will be losing homes, they will cry..." [Anonymous]*

> *"...as a humanitarian worker, your first priority are the people. But if you are not prepared enough, instead of helping...you are putting them in a danger...and at the same time you are also exposing yourself to the danger because, in the long run, you will get anxiety, depression." [Anonymous]*

Similarly, psychosocial care can prevent stress, strengthen the resilience of staff and help aid workers to avoid negative coping mechanisms. This has been argued by the Antares Foundation (2012), Adams and Bloom (2017) and likewise confirmed by the research participants.

> *"The preventive part would ensure that the whole response work will run smoothly and effectively and will avoid responders further going back to negative coping habits, not just drinking but maybe it would distort in sexual exploitation, hiring prostitutes, just to release it. So, it will have a bad image on humanitarian response." [Anonymous]*

In addition, preparedness can help to retain the productivity and reputation of the organisation.

> *"[prevention] is very important because once there is a problem in terms of the mental health of a person, the productivity is also affected. Not only the productivity but also the interpersonal relationships are very much affected. There is a need really to incorporate the wellbeing and mental health programme in the workplace because a lot of us are stressed with our work and we don't have any ways to talk about our stressors." [Anonymous]*

It is beyond doubt that preparedness and access to mental wellbeing support are key in tackling mental health issues. However, as already acknowledged, the current humanitarian sector is not set up to adequately support aid workers and this is where the Wellbeing cluster is filling another gap. The Cluster's concept of *'preparedness and prevention'* is demonstrated in capacity building, awareness raising, work with the government, and delivery of training and mental wellbeing programmes.

> *"The cluster is structured in such a way that we have the Capacity Development Committee that will eventually produce training materials, modules and assessment tools and will do lots of presentations and education around mental health. In a preparedness aspect we are also looking at collaboration and coordination work with government agencies, for example, the Department of Health, the Disaster Risk Reduction Offices, Department of Social Welfare and other organisations. So, a lot of partnerships...getting in touch with universities to develop modules, training materials and assessment tools." [Anonymous]*

> *"In the workplace, you need to be productive and I suspect that wellbeing is proportional to productivity...As an HR practitioner, I was very excited [about the Wellbeing cluster] because I think that before things get any worse, we need to have prevention. I usually make it [Wellbeing cluster] to a comparison of the day when Denim was discovered. Because it will never be out of fashion. It is needed and it will go along with the future." [Anonymous]*

In addition, the Cluster has the ability to ensure a preventive role through mental wellbeing support in the different stages of humanitarian response, including pre-deployment, deployment and post-deployment. The literature review pointed out that pre-deployment is lacking systematic briefing (Simmonds *et al.*, 1998 cited in Ali *et al.,* 2015) and aid workers should be informed of the risks of exposure to trauma (Connorton, *et al.,* 2012). The qualitative analysis equally found out that briefings, pre-deployment training and an assessment on mental and emotional resilience of humanitarian staff are needed. Equally important is the promotion of a healthy working environment.

> *'Pre-deployment means that you have an environment within an organisation which is accepting, and open to mental health issues, can provide a preventative frame.' [Anonymous]*

The Cluster offers tangible support in the pre-deployment stage:

> *"Our initial plan for the Wellbeing cluster is to help with the assessment of the humanitarian workers. We are trying to develop a tool to assess if they are psychologically ready or not and if they pass, they can proceed to the field and if not, they need to have training. We are also thinking of providing training such as mindfulness, psychosocial support and psychological first aid. When you are in the field and you don't know basic psychological first aid, it might be difficult for you to deal with the situation." [Anonymous]*

Hullett and Witte (2001) argue that policies should be in place to prevent the isolation of individuals deployed in new environments. This is reaffirmed in the qualitative analysis where the research participants identified the need to have feedback mechanisms and access to emergency mental health services during deployment.

> *"We are familiar with R & R[12] but to me it's meaningless. There has to be someone who will talk to the responders, who will listen, like feedback sessions." [Anonymous]*

[12] Rest and recuperation.

It was suggested that having staff trained in psychosocial skills would be helpful in both the office environment as well as in the field. Again, this is where the Wellbeing Cluster can make a real contribution:

> *"...we would go to the place and provide support to humanitarian workers. For example, if they need to have a brief counselling before they go back again, so we would provide them with that." [Anonymous]*

The findings established that debriefing is essential in the post-deployment stage. Likewise, it was shown in the literature review that post-assignment consultations should represent a standard part of the post-deployment process (KonTerra Group, 2017). The research further identified that a reassessment by the trained staff should be available during this stage.

> *"...we do not do post-debriefing. Ask them [aid workers] how are you, what are their issues in terms of protection when they were deployed...So, there is no systematic approach of support to check if they are mentally ok." [Anonymous]*

This links again with the requirement to ensure the presence of staff with psychosocial expertise within the organisation. In addition, the literature review pointed out that policies should support staff comprehensively (Douglas and Quinn, 2016) and the Cluster reiterates this, as the services provided are meant to be equally available to all staff regardless of the nature of work.

> *"All those structures are for everyone because we found that the level of stress didn't matter whether you are the first responder or sitting in the office thousands of miles away. So, the Cluster isn't just for the first responders, the localised context off course that is...but the global context says that we have these wellbeing policies that look after our staff." [Anonymous]*

The research participants recognised that the Cluster has also the potential to provide mental health support to the affected communities.

> *"My biggest push for the Wellbeing cluster is to be able to import some skills and knowledge to the community. So, in times of disasters, these sectors in*

the communities can respond and address the mental health of victims. The Wellbeing cluster is a rich resource in transferring these skills for the first aiders, for the victims." [Anonymous]

Again, the findings stressed the importance of HR support in all stages of humanitarian response, including preparedness and the recruitment process. The literature review pointed out similar recommendations, suggesting that humanitarian agencies should also consider the history of mental illness when recruiting aid workers and preparing them for deployment (Cardozo *et al.*, 2012). This was also acknowledged by the interview participants.

"...HR should really start thinking in terms of putting systems, integrating wellbeing prior to deployment. It means that HR policies should be tackled in, even in the recruitment process. For example, in recruitment we do not have questions about mental health: Are you prepared? Are you ready to be deployed? Second, HR personnel should be trained on the basics of mental health, so they know how to spot qualified staff but they lack that set of skills." [Anonymous]

These are significant findings and show that the involvement of HR has to be ensured if effective psychosocial support is to be provided in the humanitarian sector. However, in many cases, HR doesn't have appropriate policies or programmes in place and the Wellbeing cluster could provide a fruitful source of guidance and perhaps a shift in HR's traditional role:

"I pitched a little story of the Wellbeing cluster if it is possible for our HR office to implement the idea. And this is a total shift of what is the traditional role of the HR which is hiring, firing but not caring. They said 'tell us, teach us how to do it'." [Anonymous]

Further, an alternative emphasis of HR was suggested:

"Perhaps, those roles in HR get to split a little bit...and we have wellbeing offices, wellbeing champions. Why don't we stick with a Wellbeing Lead in each organisation and they will be responsible for the policy and then you get an infrastructure within an organisation." [Anonymous]

The literature review identified that specific guidelines and systems are needed to provide comprehensive staff care (Porter and Emmens, 2009; Douglas and Quinn, 2016). In summary, the research showed evidence that the Wellbeing cluster has strong potential to establish a functional platform for the provision of systematised, consistent and comprehensive psychosocial support. This is through advocacy, knowledge transfer, multi-sectoral approach, localisation, preparedness and by providing and ensuring mental wellbeing support during all stages of humanitarian response. However, it is apparent that the role of HR is fundamental in designing a new humanitarian infrastructure that will be protecting and supporting the wellbeing of aid workers.

> *"I really envision that work industry becomes much more sensitive towards the welfare of employees but ensuring that the productivity and efficiency are not hampered and we can do that. The Wellbeing cluster is really a cut-crossing initiative...The Wellbeing cluster is not just making you more efficient at work, it's making you a better person. And the better person makes a better society and better society makes a better world." [Anonymous]*

4.5 What is the prospect of introducing mindfulness into the humanitarian sector?

The literature review established that staff psychosocial care is essential in stress management and prevention of stress (Antares Foundation, 2012). Introducing mindfulness into the humanitarian sector could offer a way of protecting aid workers and building their emotional resilience. The survey showed that 43% (n=20) of respondents participated in the mindfulness training with the aim of learning how mindfulness can help to reduce stress. 35% (n=16) were aware of mindfulness and wanted to learn the practice. This shows that mitigating stress was the main reason for aid workers exploring this practice.

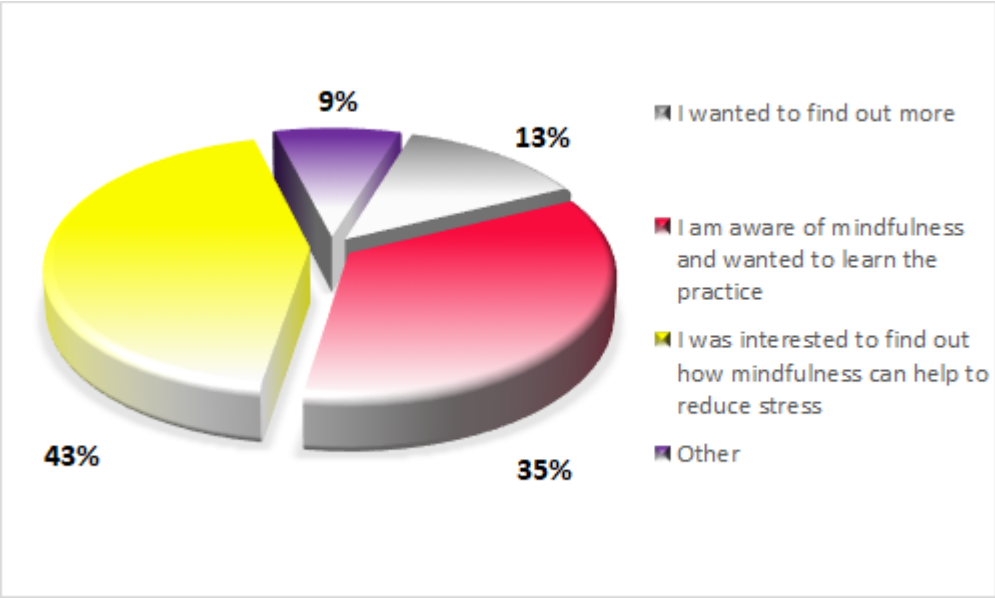


Figure 4.5: Reasons for participating in mindfulness training

91% (n=41) of research participants considered the mindfulness sessions helpful and 80% (n=35) used it since the initial training in comparison to 20% (n=9) who did not continue practising. 53% (n=19) of aid workers practice mindfulness occasionally but it is only 8% that do the practice daily.

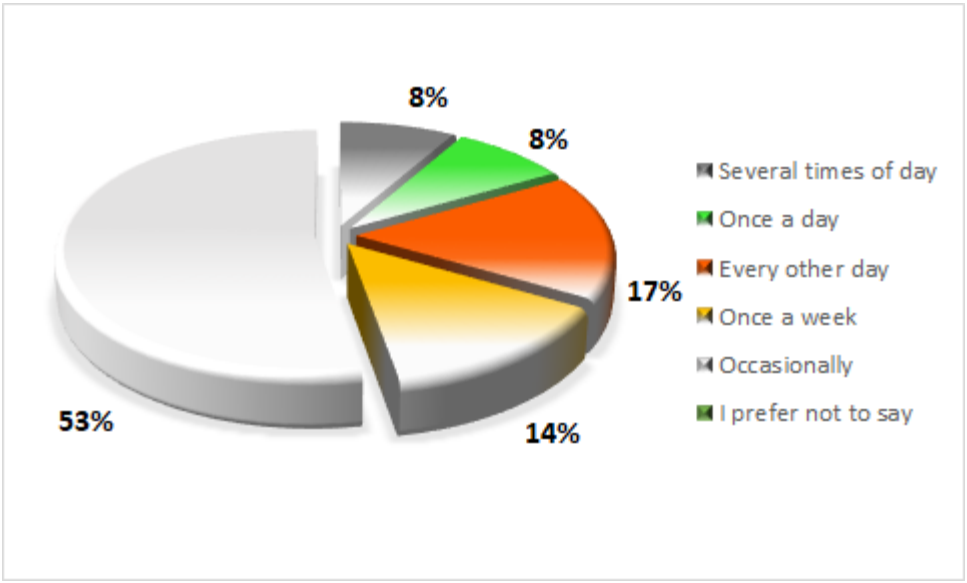


Figure 4.6: Frequency of mindfulness practice

The survey identified that this could be because aid workers have no access to a quiet space and their workload doesn't allow them to fully embrace the practice.

> *"...it is difficult to prioritise it during working hours as there is always more to be done, and the feeling that time away from your desk spent on mindfulness now will create a greater workload later on as you will have to catch up." [Anonymous]*

Overall, for 98% of humanitarian workers mindfulness is somehow useful, useful or very useful in everyday life.

> *"I'm surprised that not all humanitarian workers know about this...because in a stressful situation it can actually be a good tool to use so that you can think clearly, you can calm yourself, even if there is chaos all around...If humanitarian workers will be able to learn this skill, then they would have another means how they can counteract the stress of the experience." [Anonymous]*

The literature review highlighted that mindfulness practice can contribute to positive changes in wellbeing, stress response, physical health, enhance resilience and prevent feelings of anxiety, stress and sadness (Williams and Penman, 2011; Adams and Bloom, 2017). Considering the research findings reporting that aid workers suffer from stress, anxiety and feelings of sadness and emptiness, mindfulness could provide a useful tool for tackling these issues. According to 47% (n=20) of humanitarian workers, using mindfulness in their life is somehow helpful, for 28% (n=12) it is helpful and for 23% (n=10) it is very helpful.

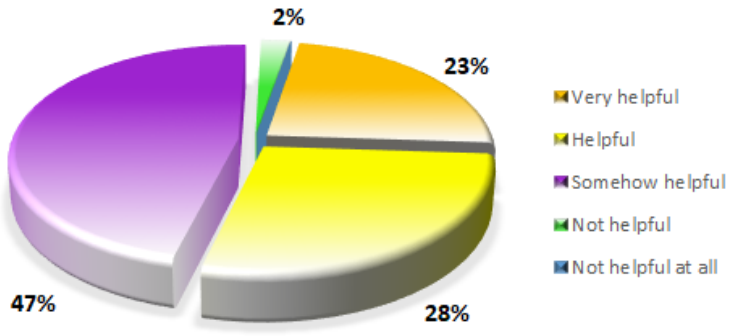


Figure 4.7: Benefits of mindfulness in everyday life

The survey showed that aid workers see the benefits of mindfulness mainly in stress relief and similarly the interviewees noted that mindfulness is useful for stress management.

> *"I meditate as often as I can for stress relief and to help with sleep." [Anonymous]*

Further, the interview participants noted self-awareness and an ability to calm the mind as important benefits of mindfulness.

> *"I've started doing short meditations to try to clear my head and focus." [Anonymous]*

> *"In the response stage, it would give you some sort of relax and recreation, sense of calmness. It's a lifestyle after all." [Anonymous]*

According to the survey, mindfulness helps aid workers with anxiety, panic, feelings of frustration at times of conflict.

> *"Sometimes when I feel my anxiety peaking before or after a specific event I will do a quick 10-minute practice or breathing exercise." [Anonymous]*

It was also recognised that practising mindfulness helps them to focus better on tasks and enhances social skills.

> *"Knowing yourself better means that you can make decisions that are a little bit more spacious because you can respond rather than react and that has an implication on better leadership. And one of the key competencies that is required for leadership and managing others is self-awareness." [Anonymous]*

This corresponds with Chemali *et al.*'s (2018) research which argues that mindfulness programmes help aid workers to improve problem-solving skills and overcome challenging situations. In a similar vein, as the interviewees, the surveyed aid workers acknowledged that practising mindfulness helps with personal interactions. A total of 86% (n=38) of aid

workers believe that mindfulness could be very useful or useful in preventing stress in the workplace.

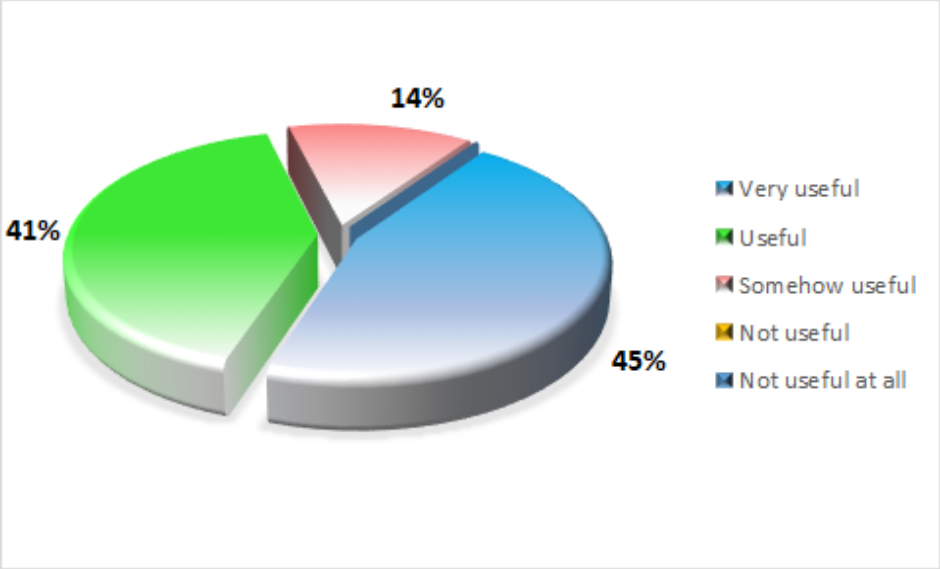


Figure 4.8: Role of mindfulness in stress prevention in the workplace

The survey further included questions about downsides and challenges of mindfulness practice. The research participants reported that there is often no quiet space for the practice and they feel pressure if they don't practice regularly. In addition, time spent away from the desk can create more workload and stress.

> *"Sometimes if I miss a day or more I tend to feel guilty like I'm letting myself down, and that makes me more stressed." [Anonymous]*

Sitting comfortably, trying to calm the mind and avoid distractions is another challenge. Stress can be difficult to acknowledge and face in the course of a session and the practice can bring sad memories.

> *"It brought sad memories that are best forgotten." [Anonymous]*

However, it has to be taken into account that those who are new to the practice can have unrealistic expectations of what mindfulness can and cannot do. It can be a challenge for early practitioners to realise that mindfulness is allowing awareness of all emotions as they

arise, and this might be misunderstood by the participants. Then, for some aid workers, the length of practice is problematic and not having an experienced teacher to consult or receive guidance from, presents another challenge.

> *"I struggle not having any guidance. I don't know if I'm doing it right." [Anonymous]*

It was pointed out that it is impossible to meditate when on a mission and not practising often enough means that the practitioner is not able to achieve the right level of mental state. The research established that when implementing mindfulness in the workplace, having regular practice, an experienced teacher and dedicated space are essential and this was acknowledged by both the participants of the survey and interviewees.

> *"[The employer could help] by offering regular guided mindfulness sessions to staff members and providing space for staff to follow up on challenges identified as part of their practice." [Anonymous]*

Both groups are of the opinion that mental wellbeing should be promoted internally within the organisation and it is the responsibility of the management. Likewise, the literature review stressed that employers have a duty of care and legal liability for ensuring staff welfare.

> *"It would be great to have a yoga/meditation corner in the office where I could go and unwind in between the meetings." [Anonymous]*

Despite some of the challenges, 89% (n=40) of aid workers would recommend the mindfulness training to their colleagues in the humanitarian sector. Likewise, the interviewees held a positive view on introducing mindfulness in humanitarian settings.

> *'It really helps you to be more resilient. It's like a self-care. It's like a mental first aid exercise." [Anonymous]*

The discussion outlined the positive impact of mindfulness on aid workers and demonstrated a strong appetite for introducing mindfulness in the humanitarian sector. Therefore, mindfulness could provide a useful preventative approach, helping to mitigate stress and build the mental resilience of humanitarian workers. Finally, when implementing mindfulness

in the workplace, it is predominantly the employer's duty to ensure and facilitate the promotion of mental wellbeing support.

5 Conclusion and Recommendations

5.1 Conclusion

This Chapter reflects on the research objectives set in this study and draws conclusions based on the summary of discussions. In addition, recommendations and topics for future research are presented. This research has achieved its overall aim of understanding mental wellbeing in the humanitarian sector, particularly in relation to humanitarian staff.
Moreover, this study presented that the definition of wellbeing is varied across the disciplines and wellbeing is not defined in the humanitarian context. To reiterate Aggarwal's (2011) view, an absence of a clear and consistent definition of wellbeing interferes with coordinating the minimum response and hinders the effective provision of psychosocial support. Therefore, a formal overarching definition of wellbeing in the humanitarian sector was developed to provide clarity when designing a psychosocial response.

The findings presented evidence that wellbeing involves many aspects but most importantly it is linked to mental health. There was a great deal of evidence to show that the subject of mental wellbeing in the humanitarian sector is hugely undervalued and there is an acute lack of mental health support. The academic literature on the prevalence of mental health issues among aid workers is growing and presents mounting evidence of the challenges of humanitarian work. This study similarly revealed that staff in the development field are exposed to multiple mental health issues. Among frequently experienced wellbeing issues by aid workers are stress and anxiety, followed by a high rate of occasional feelings of sadness and emptiness. Similar findings were confirmed by UNHCR staff (UNHCR, 2013; 2016). The research determined that workload, ability to achieve work objectives and long working hours represent the biggest causes of stress. Also, relationships with supervisors, colleagues and exposure to the suffering of others are seen as additional stressors. Langston's *et al.* (2007) research indicated similar findings showing that aside from traumatic experiences, the work-related stressors greatly affect humanitarian workers. On top of that, the research showed that stigma and silence, when talking about mental health, are deeply rooted in the humanitarian culture. This also confirms the concerning statistics from the UNHCR's Global Staff Survey (2013) where 50% of humanitarian staff reported fear of speaking up about mental health issues related to their work. One of the most significant findings to emerge from the research was that all research participants have been confronted with mental health issues while working in the humanitarian sector and are also aware of their colleagues facing

similar problems. This clearly shows the extent of the hugely unresolved situation of poor mental health support and presents a powerful case for the need for developing mental wellbeing support strategy for humanitarian staff. This is the first critical step towards the protection of mental wellbeing of aid workers and offers a potential help from the negative and harmful coping strategies observed in the sector.

A significant gap identified in the material collected is the absence of a comprehensive and consistent framework that would ensure adequate mental wellbeing support. The Wellbeing cluster concept has demonstrated a great capacity in addressing some of the current wellbeing challenges and offers a new model for tackling the mental health crisis in the humanitarian sector. Solanki's (2018b) vision that the Wellbeing cluster can represent a localised grassroots-led initiative that has the ability to address mental wellbeing requirements more effectively is tangible. Indeed, the research showed that the piloted Wellbeing cluster in the Philippines provides practical steps for addressing the mental wellbeing challenges through advocacy, knowledge transfer, multi-sectoral approach, localisation, preparedness and provision of mental wellbeing support during all stages of humanitarian response. The research findings further established that briefings, pre-deployment training, assessment of emotional resilience, feedback mechanisms, debriefing, access to an emergency mental health service and trained staff in psychosocial skills are required when ensuring mental wellbeing support. Again, the findings determined that the Wellbeing cluster can offer possible solutions to meet these requirements through the benefits of the localised approach which allows the sharing of resources in a more efficient and impactful way. This further confirms Solanki and Rogers' prognosis (2017a) that the localised approach has the ability to adjust the wellbeing needs to culturally different backgrounds. In addition, the multi-sectoral approach which brings more than 30 stakeholders in the Philippines together to tackle mental wellbeing challenges in the humanitarian sector shows that Solanki (2018b) is right in the view that there is greater potential to overcome stigma and build capacity together as a community as opposed to individual efforts. Evidently, the Cluster can represent a practical template for the future replication at the national and global level for addressing mental wellbeing support in the humanitarian sector. However, sustainability and continuity of this project has to be ensured and progress and future development of this model needs to be measured and continuously assessed.

Although mindfulness practice, as a way of preventing stress and increasing performance, has been widely popular in the corporate sector, the research findings established that there is also a strong demand for introducing mindfulness into the humanitarian sector. Various academic studies claim the benefits of practising mindfulness and the research equally confirmed the beneficial impact of mindfulness in the not-for-profit sector. The research showed that mindfulness can help to mitigate stress, enhance social skills, improve self-awareness and ability to focus. This confirms similar findings with Chemali's *et al.* (2018) study on mindfulness programmes used by aid workers during the humanitarian refugee crisis. These are significant findings because the research identified that aid workers heavily suffer from stress and due to lack of focus they struggle to make decisions. It was manifested that mindfulness can improve self-awareness and this contributes to a better focus and decision-making. In addition, mindfulness can build resilience and thus support the mental wellbeing of aid workers. Mindfulness further responds to the definition of wellbeing in the humanitarian context, as it is equally linked to a mental and emotional aspect of wellbeing. There are evident benefits of mindfulness related to the stress management of humanitarian workers and the research findings determined that employers should take a proactive approach in facilitating access to mindfulness training and ensure a healthy working environment. However, it has to be recognised that facilitating mindfulness in humanitarian settings can be a challenge if the regular practice is hampered by the demanding nature of humanitarian jobs.

The main conclusion and lesson that can be drawn from this research are that employing agencies have to prioritise mental wellbeing programmes for their staff. Aid workers are daily affected by many challenges in their work and continuous exposure to difficult working situations, with no adequate support, can have fatal consequences on their wellbeing. Humanitarian workers need to have a means of developing resilience in order to face adversities and respond to the quickly changing environments around them. Importantly, the findings of the research highlighted an employer's responsibility in the provision of mental health support in the workplace which should not be underestimated but widely promoted. HR has a strategic role in building new humanitarian infrastructure that will protect the wellbeing of aid workers and the whole humanitarian community. There is a need for a shift in HR's role from passive to more active when it comes to a provision of mental health support. Both the Wellbeing cluster and mindfulness offer a practical and tangible tool on how to ensure the consistent and systematic provision of mental wellbeing requirements and

implementation of comprehensive wellbeing programmes can protect humanitarian staff, build resilience and eventually improve the humanitarian response.

5.2 Recommendations

This research brought new knowledge on the state of mental wellbeing of aid workers in the humanitarian sector and provides a useful source of learning and evidence-based findings for humanitarian agencies in order to adapt and design mental wellbeing policies and programme that can be ultimately beneficial for the whole humanitarian community. This research established the following recommendations and implications for policy and wider context:

i) Adopt the overarching definition of wellbeing at an institutional level.

ii) Employers and HR departments ensure a provision of mental health support in the workplace.

iii) HR personnel are trained in mental health in order to support the recruitment process and wellbeing needs of humanitarian staff.

iv) Humanitarian staff should receive training in mental health that is specifically aimed at preparing aid workers for humanitarian work. Training in Mental Health First Aid is essential.

v) Training and provision of mental wellbeing support are ensured during all stages of humanitarian response, including pre-deployment, deployment and post-deployment.

vi) Qualified staff are present to provide psychosocial services in the field and in the office-based environment.

vii) Wellbeing cluster develops clear documentation and strategy for national and international replication including details on how to adopt and implement the Cluster at a local level.

viii) Wellbeing cluster is globally promoted encouraging NGOs to become members of the wellbeing network.

ix) Mindfulness is introduced, as a prevention-based concept.

x) HR regularly promotes mental health support to all members of staff.

xi) Mental wellbeing surveys should be conducted periodically in the workplace.

xii) Employers ensure a healthy working environment to avoid occupational stressors and negative coping mechanisms.

5.3 Further research

It would be interesting to evaluate the Wellbeing cluster project in 5 or 10 years and also investigate the sustainability of this pioneering model. The short-term and long-term prognosis of sustainability of the Cluster can be found in Appendix J. Real-time research on setting up a new Wellbeing cluster is suggested, along with a comparative study of two Wellbeing clusters. In addition, it would be interesting to explore if there has been a shift in HR strategies towards incorporating mental wellbeing support into HR's policies. Further, an investigation of the long-term impact of mindfulness on the resilience of aid workers and clinical research on mindfulness in the humanitarian settings would be wort to conduct. Also, future research will need to look into the safety and mental wellbeing needs of women.

Bibliography

Adams, C. and Bloom, M. (2017) 'Flourishing in ministry: Wellbeing at work in helping professions', *Journal of Psychology and Christianity*, 36(3), pp. 254-259.

Ager, A., Pasha E., Yu, G., Duke, T., Eriksson, C. and Cardozo, BL. (2012) 'Stress, mental health, and burnout in national humanitarian aid workers in Gulu, northern Uganda', *Journal of Traumatic Stress,* 25 (6), pp. 713-20.

Ahmad, M. (2002) 'Who cares? The personal and professional problems of NGO fieldworkers in Bangladesh', *Development in Practice*, 12(2), pp. 177-19.

Aggarwal, NK. (2011) 'Defining mental health and psychosocial in the Inter-Agency Standing Committee guidelines: Constructive criticisms from psychiatry and anthropology', *War Trauma Foundation,* Vol. 9 (1), pp. 21-25.

Aikens, K. A., Astin, J., Pelletier, K. R., Levanovich, K., Baase, C. M., Park, Y. Y., & Bodnar, C. M. (2014) 'Mindfulness goes to work: Impact of an online workplace intervention', *Journal of Occupational and Environmental Medicine*, 56 (7), pp. 721–731.

Alatartseva, E. and Barysheva, G. (2015) 'Well-being: Subjective and Objective Aspects', *Procedia - Social and Behavioral Sciences,* Vol. 166, pp. 36-42.

Ali, A., Khan, S. and Waheed, A. (2015) 'Problems confronting the humanitarian workers.' *Acta Technica Corvininesis - Bulletin of Engineering*, Vol. 8 (4), pp. 159-162.

Antares Foundation (2012) *Managing stress in humanitarian workers: Guidelines for good practice*, 3rd edition. Amsterdam: Antares Foundation. Available at: https://www.antaresfoundation.org/filestore/si/1164337/1/1167964/managing_stress_in_humanitarian_aid_workers_guidelines_for_good_practice.pdf?etag=4a88e3afb4f73629c068ee24d9bd30d9 (Accessed: 4 May 2018).

Boyatzis, R. (1998) *Transforming Qualitative Information: Thematic Analysis and Code Development.* London: SAGE.

Braun. V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology,* Vol. *3 (2). pp. 77-101.*

Brooks, S. K., Dunn, R., Sage, C. A. M., Amlôt Richard, Greenberg, N. and Rubin, G. J. (2015) 'Risk and Resilience Factors Affecting the Psychological Wellbeing of Individuals Deployed in Humanitarian Relief Roles After a Disaster,' *Journal of Mental Health*, 24(6), pp. 385–413.

Bryman, A. (2012) *Social Research Methods,* 4th edition. Oxford: Oxford University Press.

Cardozo, B. and Salama, P. (2002) ‘Mental health of humanitarian aid workers in complex emergencies’, in Danieli, Y. (ed.) *Sharing the front line and the back hills: Peacekeepers, humanitarian aid workers and the media in the midst of crisis.* Amityville: Baywood, pp. 242 - 257.

Cardozo, B., Crawford, C., Eriksson, C., Zhu, J., Sabin, M., Ager, A., Foy,D., Snider, L., Scholte, W., Kaiser, R., Olff, M., Rijnen, B., Simon, W. (2012) ‘Psychological Distress, Depression, Anxiety, and Burnout among International Humanitarian Aid Workers: A Longitudinal Study’, *Plos One*, 7(9), pp. 1-13.

Cervantes, M. (no date) *Wellbeing Cluster launch renews commitments to humanitarian resilience.* Philippines: Humanitarian Leadership Academy. Available at: https://www.humanitarianleadershipacademy.org/wellbeing-cluster-launch-renews-commitments-to-humanitarian-resilience/?utm_source=Academy+Newsletter+2018&utm_campaign=12f82ad982-EMAIL_CAMPAIGN_2018_July_newsletter_COPY_01&utm_medium=email&utm_term=0_184305c7d3-12f82ad982-282683229 (Accessed: 1 September 2018).

Chemali, Z., Smati, H., Johnson, K., Borba, C. and Fricchione, G. (2018) ‘Reflections from the Lebanese field: “First, heal thyself”‘, *Conflict and Health*, 12(8), pp. 1-5.

Connorton, E., Perry, M., Hemenway, D. and Miller, M. (2012) ‘Humanitarian relief workers and trauma-related mental illness’, *Epidemiologic Reviews,* Vol. *34*, pp. 145-55.

Constitution of the World Health Organization (1946) *Constitution of WHO: principles.* World Health Organisation. Available at: http://www.who.int/about/mission/en/ (Accessed: 12 May 2018).

Core Humanitarian Standard (2014) *Core Humanitarian Standard on Quality and Accountability.* CHS Alliance, Groupe URD and Sphere. Available at: https://corehumanitarianstandard.org/language-versions (Accessed: 1 August 2018).

Department of Health and Social Care (2014). *Wellbeing: Why it matters to health policy.* GOV.UK. Available at: https://www.gov.uk/government/publications/wellbeing-and-health-policy (Accessed: 2 May 2018).

Denscombe, M. (2014) *The good research guide for small-scale social research project*s. 5th ed., Maidenhead: Open University Press.

Douglas, R. and Quinn, R. (2016) *In the news: Psychological Support and Wellbeing for Aid Workers.* Reliefweb. Available at: https://reliefweb.int/report/world/news-psychological-support-and-wellbeing-aid-workers (Accessed: 20 August 2018).

Ehrenreich, J. and Elliott, T. (2004) ‘Managing Stress in Humanitarian Aid Workers: A Survey of Humanitarian Aid Agencies’ Psychosocial Training and Support of Staff’, *Journal of Peace Psychology*, 10(1), pp. 53-56.

Estallo, C. and Solanki, H. (2017) *WELL-BEING CLUSTERS: Improving Well-Being for Humanitarian Workers.* Ramon Aboitiz Foundation Inc. Available at: https://www.rafi.org.ph/well-being-clusters-improving-well-being-for-humanitarian-workers/ (Accessed: 23 June 2018).

Feder, A., Charney, D. and Collins, K. (2011) ‘Neurobiology of resilience’, in Southwick, S., Litz BT., Charney, D. and Friedman MJ. (ed.) *Resilience and Mental Health: Challenges Across the Lifespan.* Cambridge: Cambridge University Press, pp. 1-30.

Given, L. (2008) *The SAGE Encyclopedia of Qualitative Research Methods,* 1st ed., London: Sage.

Guest, G., MacQueen, K. and Namey, E. (2012) *Applied Thematic Analysis.* London: SAGE.

Holtz T., Salama P., Lopes Cardozo B., Gotway C. (2002) ‘Mental health status of human rights workers, Kosovo, June 2000’, *J Trauma Stress,* 15(5), pp. 389-95.

Hullett, C. and Witte, K. (2001) ‘Predicting intercultural adaptation and isolation: Using the extended parallel process model to test anxiety/uncertainty management theory’, *International Journal of Intercultural Relations*, 25(2), pp. 125 - 139.

Inter-Agency Standing Committee (2007) *IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings.* World Health Organisation. Available at: http://www.who.int/mental_health/emergencies/9781424334445/en/ (Accessed: 10 May 2018).

IRIN (2010) *Aiding aid workers.* Dakar: IRIN. Available at: http://www.irinnews.org/news/2010/08/19/aiding-aid-workers (Accessed: 3 May 2018).

Langston, V., Gould, M. and Greenberg, N. (2007) ‘Culture: What Is Its Effect on Stress in the Military?’, *Military Medicine*, Vol. 172 (9), pp. 931–935.

Mindful staff (2011) *Mindfulness brings relief to humanitarian workers.* Mindful. Available at: https://www.mindful.org/mindfulness-brings-relief-to-humanitarian-workers/ (Accessed: 1 September 2018).

Netterstrom, B., Friebel, L., & Ladegaard, Y. (2013) ‘Effects of a multidisciplinary stress treatment programme on patient return to work rate and symptom reduction: Results from a randomised, wait-list controlled trial.’ *Psychotherapy and Psychosomatics*, 82(3), pp. 177–186.

Pigni, A. (2016) *The Idealist's Survival Kit: 75 Simple Ways to Prevent Burnout.* Berkeley: Parallax Press.

Porter, B. and Emmense, B. (2009) *Approaches to Staff Care in International NGOs.* CHS Alliance. Available at: https://www.chsalliance.org/files/files/Resources/Articles-and-Research/approaches-to-staff-care-in-international-ngos.pdf (Accessed: 22 May 2018).

Oades, G. and Mossman, L. (2017) 'The science of wellbeing and positive psychology', in Slade, M., Oades, L. and Jarden, A., (ed.) *Wellbeing, Recovery and Mental Health.* Cambridge: Cambridge University Press, pp. 7-23.

Public Health England (2018) *The importance of health and work.* GOV.UK Available at: https://www.gov.uk/government/publications/health-and-work-infographics/the-importance-of-health-and-work (Accessed: 10 August 2018).

RAFI (2018) *Multi-Sectoral Collaboration to Launch the First Wellbeing Cluster in the Philippines.* Ramon Aboitiz Foundation Inc. Available at: https://www.rafi.org.ph/multi-sectoral-collaboration-to-launch-the-first-wellbeing-cluster-in-the-philippines/ (Accessed: 15 September 2018).

Ravelo, J. (2017) *Mindfulness meditation: Can this practice help mitigate aid worker stress?* Devex. Available at: https://www.devex.com/news/mindfulness-meditation-can-this-practice-help-mitigate-aid-worker-stress-89997 (Accessed: 3 September 2018).

Research ethics for research involving human participants - code of practice (2016). Oxford Brookes University. Available at: https://www.brookes.ac.uk/research/research-ethics/policies/research-ethics-for-research-involving-human-participants---code-of-practice/ (Accessed: 15 August 2018).

Robson, C (2011) *Real world research.* 3rd ed., Chichester: Wiley.

Robson, C. and McCartan, K. (2017) *Real world research.* 4th ed., Chichester: Wiley.

Rupprecht, S. (2017) "Mind the Teachers! The Impact of Mindfulness Training on Self-Regulation and Classroom Performance in a Sample of German School Teacher," European Journal of Educational Research, 6(4), pp. 565–581.

Sarot, M. (1996) 'Happiness, Well-being and the Meaning of Life,' in Brummer, V. and Sarot, M., (ed.) *Happiness, Well-being and the Meaning of Life: A Dialogue of Social Science and Religion.* Kampen: Pharos, pp. 1-25.

Solanki, H. (2015) *Mindfulness and Wellbeing. Mental Health and Humanitarian Aid Workers: A Shift of Emphasis from Treatment to Prevention.* Action Against Hunger. Available at: https://www.actionagainsthunger.org.uk/publication/mindfulness-and-wellbeing

(Accessed: 2 May 2018).

Solanki, H. (2018a) *Wellbeing clusters - a significant milestone.* START Network. Available at: https://startnetwork.org/news-and-blogs/wellbeing-clusters-significant-milestone (Accessed: 15 September 2018).

Solanki, H. (2018b) *A game changer for wellbeing.* CHS Alliance. Available at: https://www.chsalliance.org/news/blog/a-game-changer-for-wellbeing (Accessed: 2 September 2018).

Solanki, H. and Rogers, T. (ed) (2017a) Mindfulness & Wellbeing: An Overview of the Project. Unpublished document.

Solanki, H. and Rogers, T. (ed) (2017b) *Start Network Humanitarian Wellbeing Survey. Key Findings from a 2016 Survey of START Network. Agencies and Personnel.* Transforming Surge Capacity and START Network. Available at: https://disasterpreparedness.ngo/wp-content/uploads/2017/04/Start-Network-Humanitarian-Wellbeing-Survey-V2-final-1.pdf (Accessed: 12 June 2018).

The Aid Worker Security Database (2016) *Major attacks on aid workers: Summary statistics (2006-2016).* The Aid Worker Security Database. Available at: https://aidworkersecurity.org/incidents/report/summary (Accessed: 3 May 2018).

The KonTerra Group (2017) *Essential Principles of Staff Care: Practices to Strengthen Resilience in International Humanitarian and Development Organizations.* The KonTerra Group, InsideNGO and DisasterReady.org. Available at: http://www.konterragroup.net/admin/wp-content/uploads/2017/03/Essential-Principles-of-Staff-Care-FINAL-1.pdf (Accessed: 28 May 2018).

The Sphere Project (2011) *Core Standard 6: Aid worker performance.* Sphere. Available at: http://www.spherehandbook.org/en/core-standard-6-aid-worker-performance/ (Accessed: 1 September 2018).

Tol WA., Barbui C., Galappatti A., Silove D., Betancourt TS., Souza R, Golaz A. and van Ommeren M. (2011) 'Mental Health and Psychosocial Support in Humanitarian Settings: Linking Practice and Research,' *Lancet*, 378(9802), pp. 1581–91.

UNHCR (2013) *UNHCR'S mental and psychosocial support for staff.* Geneva: UNHCR. Available at: http://www.unhcr.org/51f67bdc9.pdf (Accessed: 4 May 2018).

UNHCR (2016) *Staff Well-Being and Mental Health in UNHCR.* Geneva: UNHCR. Available at: https://www.unhcr.org/56e2dfa09.html (Accessed: 12 December 2018).

Walliman, N. (2016) *Social research methods.* 2nd ed, London: Sage.

Walliman, N. (2018) *Research methods: The basics.* Abingdon: Routledge.

Wellbeing Cluster Philippines (2018) *First Wellbeing Cluster in the Philippines to Launch on Monday.* Ramon Aboitiz Foundation Inc. Available at: https://www.rafi.org.ph/first-wellbeing-cluster-in-the-philippines-to-launch-on-monday/ (Accessed: 12 September 2018).

Williams, M. and Penman, D. (2011) *Mindfulness: A practical guide to finding peace in a frantic world.* London: Piatkus.

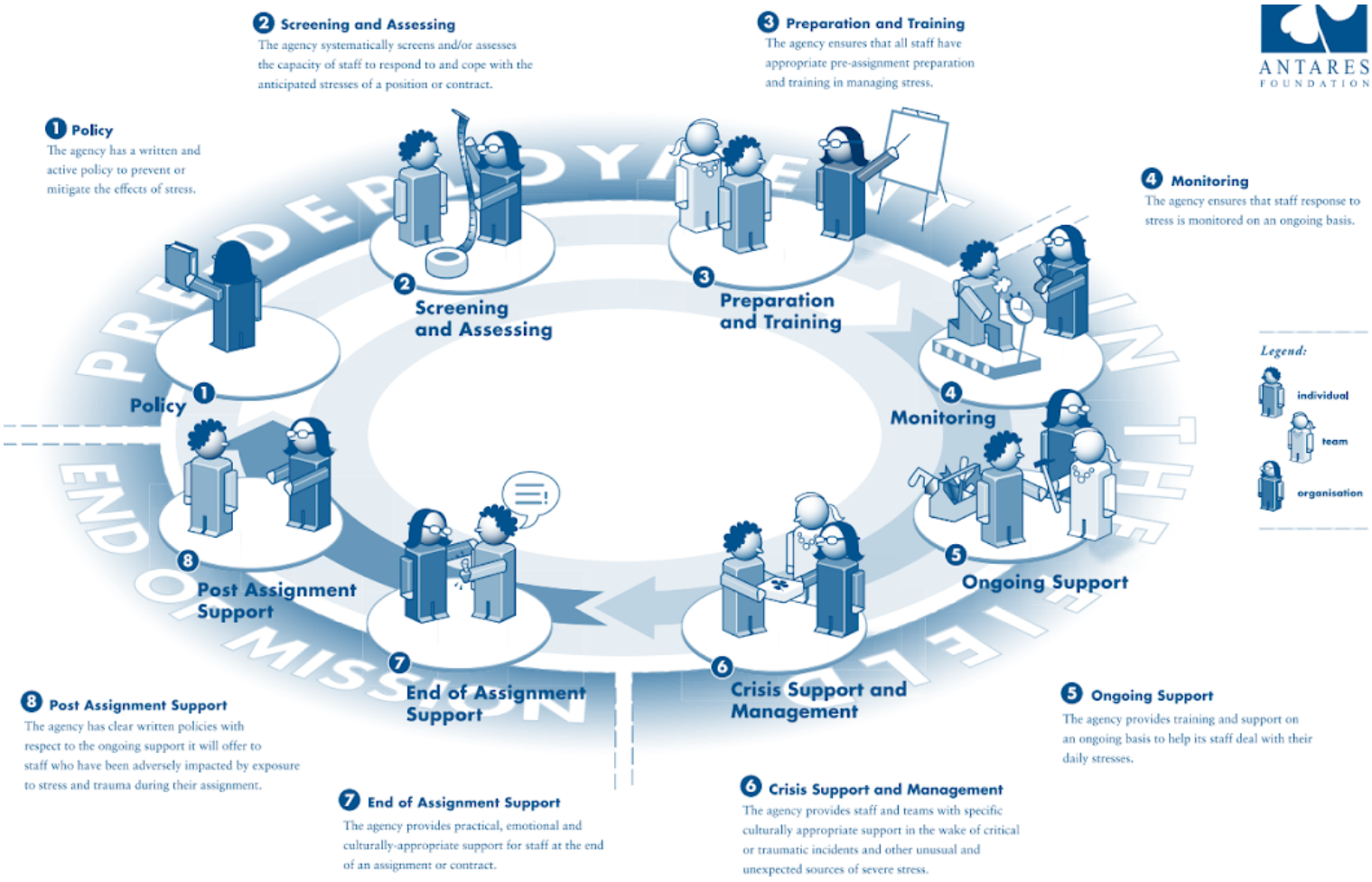
Wisker, G. (2008) *The postgraduate research handbook.* 2nd ed., New York: Palgrave.

WHO (2014) *Mental health: a state of well-being.* World Health Organisation. Available at: http://www.who.int/features/factfiles/mental_health/en/ (Accessed: 1 May 2018).

Young, H. (2015) *Guardian research suggests mental health crisis among aid workers.* The Guardian. Available at: https://www.theguardian.com/global-development-professionals-network/2015/nov/23/guardian-research-suggests-mental-health-crisis-among-aid-workers (Accessed: 11 May 2018).

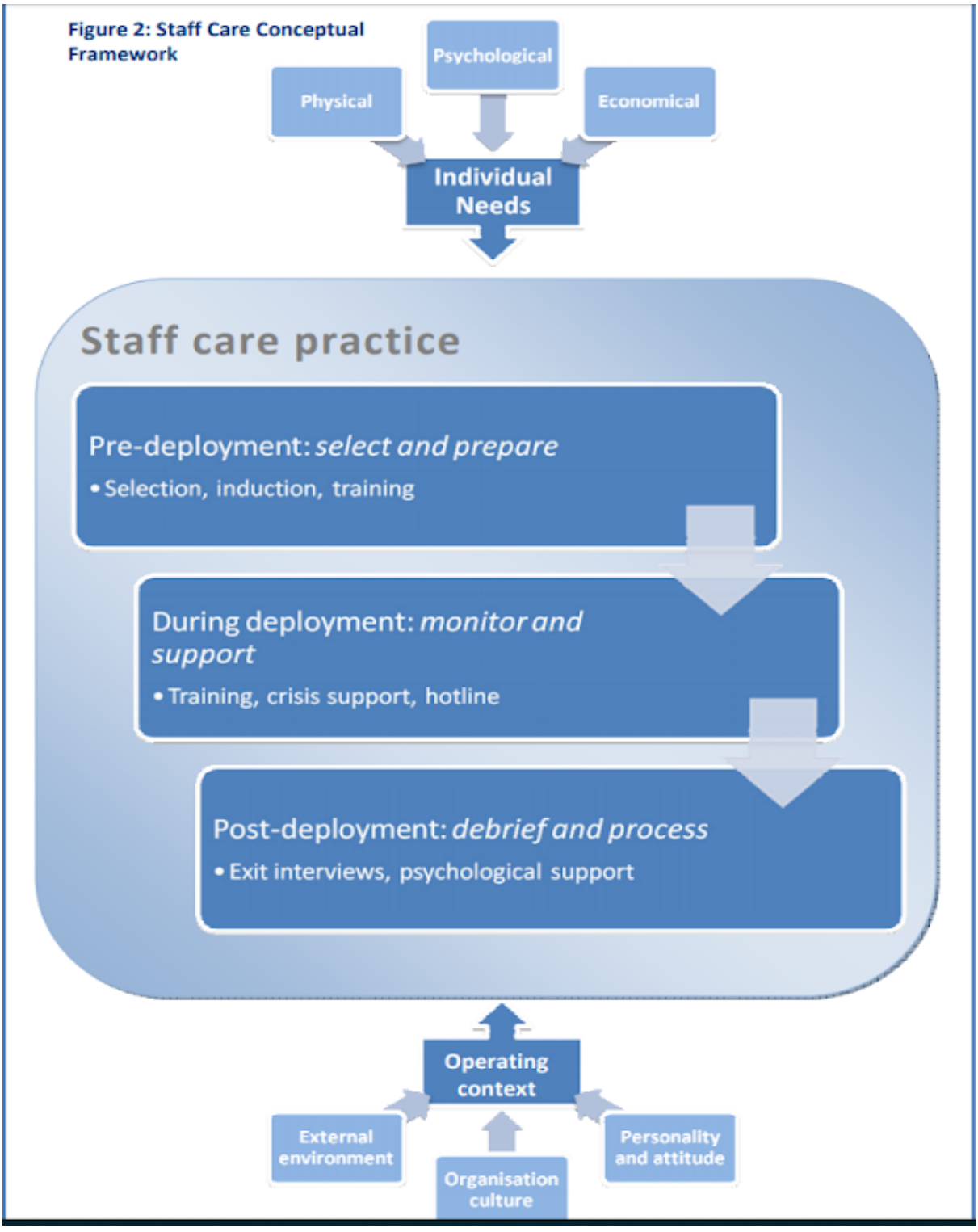
Appendices

Appendix A: The Antares' Guidelines for Good Practice



Source: Antares Foundation, 2012

Appendix B: Approaches to Staff Care in International NGOs by People In Aid and InterHealth



Source: Porter and Emmens, 2009

Appendix C: Essential Principles of Staff Care by The KonTerra Group

Source: The KonTerra Group, 2017

Appendix D: List of organisations involved in the Wellbeing cluster

Local organizations:

- Bohol Chambers of Commerce (BCCI)
- Bohol Consortium on Humanitarian Assistance (BCHA)
- Center for Disaster Preparedness (CDP)
- Central Visayas Network of NGOs (CENVISNET)
- Federation of Volunteers through Radio Communications (FVRC)
- Fellowship of Organization Endeavors (FORGE)
- Independent POCU Film
- Kaabag sa Sugbo
- MINSAC
- Organization Advocates of Inclusion
- Philippine Red Cross (PRC) - Cebu Chapter
- Ramon Aboitiz Foundation Inc. (RAFI)
- Social Action Center (SAC) - Dumaguete

International Organizations:

- Action Against Hunger UK
- Christian Aid
- Humanitarian Leadership Academy
- OXFAM
- Plan International
- UN-OCHA
- World Vision

Government Agencies:

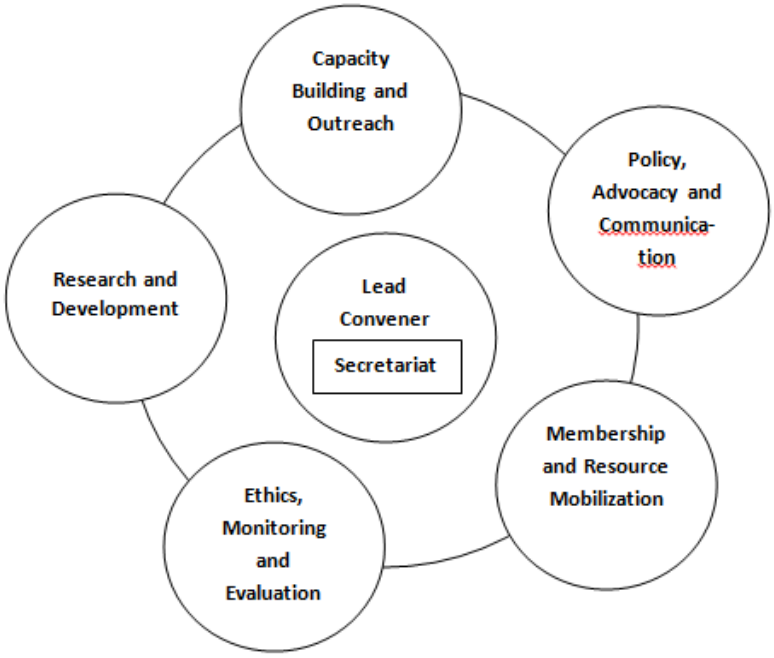
- Cebu Provincial Government - PDRRMO
- Cebu Provincial Government - Human Resource Department
- DOH 7
- DSWD 7
- OCD 7

The Academic community:

- Ateneo de Manila University
- University of Bohol
- The University of San Carlos - Community Extension Services (USC-CES),
- The University of San Carlos - Psychology Department
- The University of the Philippines - Visayas

Source: Wellbeing cluster

Appendix E: Organisational structure of the Wellbeing cluster



Source: Wellbeing cluster

Appendix F: Example of the interview questions

1. How is ‘wellbeing’ understood and defined in the humanitarian context?
2. What is the most critical issue related to mental health and wellbeing support within the humanitarian sector/your organization?
3. Is there a taboo talking about mental health issues?
4. Why is it important to address the issue of mental health support and wellbeing within the sector?
5. Why is it important to implement the prevention of mental health issues and develop the concept of wellbeing in the workplace?
6. How is the concept of ‘prevention and preparedness’ in the Wellbeing cluster understood?
7. What was the rationale behind getting involved with the Wellbeing cluster?
8. What is your role within the Wellbeing cluster?
9. How is the Cluster addressing the importance of mental health and wellbeing of aid workers?
10. How is the Cluster going to build the capacity and resilience of individuals and support mental health and wellbeing of humanitarian workers?
11. What are the practical ways in which the Cluster and your organisation is going to support aid workers in different stages of humanitarian response?
12. The cluster has been set up locally in Cebu. What are the benefits of the localised approach?
13. How is the Cluster going to be sustainable?
14. What are the challenges of sustaining the Cluster?
15. How do you see the role of the Cluster in a short term of 1 - 2 years?
16. How do you see the role of the Cluster in a longer term of 5 - 10 years?
17. Are you familiar with the Mindfulness tool?
18. What is the role of Mindfulness within the Cluster?
19. What is the impact of Mindfulness on resilience and wellbeing of aid workers?
20. Could Mindfulness be added as a part of wellbeing programmes? If yes, why?

Appendix G: Example of the survey

Wellbeing and Mindfulness survey

About the research

You are being invited to take part in a research study related to mental health and wellbeing in the humanitarian sector. Your participation in this study will provide useful information on this topic and will help to design, shape and implement new effective wellbeing frameworks and programmes for non-governmental organisations. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the Participation information sheet attached in the email carefully. Thank you for your assistance and taking time to participate in the survey.

1. *Mark only one oval per row.*

I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	◯
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	◯
I agree to take part in the above study.	◯

About you

2. **What is your gender?**
Mark only one oval.

- ◯ Female
- ◯ Male
- ◯ Prefer not to say
- ◯ Other

3. **What is your age?**
Mark only one oval.

- ◯ 18 - 22 years old
- ◯ 23 - 27 years old
- ◯ 28 - 32 years old
- ◯ 33 - 42 years old
- ◯ 43 - 52 years old
- ◯ 53 - 62 years old
- ◯ 63+
- ◯ Other

4. **How long have you been working in the humanitarian sector?**
Mark only one oval.

- ◯ Less than 1 year
- ◯ 1 - 3 years
- ◯ 4 - 6 years
- ◯ 7 - 9 years
- ◯ 10 - 15 years
- ◯ 16 - 20 years
- ◯ More than 20 years

5. **Which of the following best describes your role?**
Mark only one oval.

- ◯ Upper management
- ◯ Middle management
- ◯ Administrative support
- ◯ Support staff
- ◯ Other

6. **Where are you based?**
Mark only one oval.

- ◯ Office-based
- ◯ Field-based
- ◯ Mix of both

General wellbeing

7. **Have you experienced any of the following while working in the humanitarian sector? If yes, please specify from the options listed below and rank accordingly.**
Check all that apply.

	Very rarely	Rarely	Occasionally	Frequently	Very frequently
Feelings of sadness and emptiness	☐	☐	☐	☐	☐
Stress	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Burnout	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Post-traumatic stress disorder (PTSD)	☐	☐	☐	☐	☐

8. **Are there any other experiences you would like to mention? If yes, please, specify below.**

9. **Are you aware if any of your colleagues have experience any of the above symptoms?**
Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Maybe
- ◯ I don't know

10. **If you have answered yes to the previous question, what sort of things have you noticed?**

11. **What are the main causes of stress at your work? Choose all that apply and rank accordingly.**
Check all that apply.

	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
Exposure to suffering of persons of concern	☐	☐	☐	☐	☐
Exposure to incidents when you were seriously injured or your life was threatened	☐	☐	☐	☐	☐
Political situation in the county where you are presently working	☐	☐	☐	☐	☐
Relationship with supervisors	☐	☐	☐	☐	☐
Relationship with work colleagues	☐	☐	☐	☐	☐
Family concerns	☐	☐	☐	☐	☐
Health concerns	☐	☐	☐	☐	☐
Safety concerns	☐	☐	☐	☐	☐
Financial concerns	☐	☐	☐	☐	☐
Feeling undervalued	☐	☐	☐	☐	☐
Feeling unable to contribute to decision making	☐	☐	☐	☐	☐
Status of employment contract	☐	☐	☐	☐	☐
Workload	☐	☐	☐	☐	☐
Working hours	☐	☐	☐	☐	☐
Ability to achieve work goals and objectives	☐	☐	☐	☐	☐

12. **Are there any other causes of stress at work for you? If yes, please specify below.**

About mindfulness

13. **Why did you decide to participate in the mindfulness training?**
Mark only one oval.

- ◯ I wanted to find out more
- ◯ I am aware of mindfulness and wanted to learn the practice
- ◯ I was interested to find out how mindfulness can help to reduce stress
- ◯ Other: _____

14. **What type of mindfulness training did you participate in?**
Mark only one oval.

- ◯ Introduction to mindfulness – audio-visual sessions
- ◯ Half day introductory session to mindfulness
- ◯ Full day introductory session to mindfulness
- ◯ Full Mindfulness-based Stress Reduction (MBSR) course
- ◯ Face to face mindfulness session
- ◯ Online mindfulness session
- ◯ App-based mindfulness session

15. **Did you find the training useful?**
Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ I don't know

16. **Have you used the mindfulness practice since the initial training?**
Mark only one oval.

- ◯ Yes
- ◯ No

17. **If you have answered yes to the previous question, how often do you practice mindfulness?**
Mark only one oval.

- ◯ Several times a day
- ◯ Once a day
- ◯ Every other day
- ◯ Once a week
- ◯ Occasionally
- ◯ I prefer not to say

18. **How do you use mindfulness in everyday life?**
Any specific practices? Certain situations?

19. **How helpful is using mindfulness in your life?**
Mark only one oval.

- ◯ Very helpful
- ◯ Helpful
- ◯ Somehow helpful
- ◯ Not helpful
- ◯ Not helpful at all

20. **How useful do you think mindfulness could be in preventing stress at the workplace?**
Mark only one oval.

- ◯ Very useful
- ◯ Useful
- ◯ Somehow useful
- ◯ Not useful
- ◯ Not useful at all

21. **How could your agency help you to implement this into a practice?**

22. **Have you noticed any downsides of the mindfulness practice?**

23. **Are there any challenges for you when practicing mindfulness?**

24. **Would you recommend the mindfulness training to your colleagues in the humanitarian sector?**
Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Maybe
- ◯ I don't know

25. **Would you recommend any other wellbeing practices to prevent and mitigate stress at the workplace?**

Appendix H: The Ethics Review Form E1 & E2, Ethics Approval Form E3, Consent Form and Participant Information Sheet

OXFORD BROOKES UNIVERSITY

TDE Form E1

Faculty of Technology, Design and Environment - Ethics Review Form E1

- This form should be completed jointly by the **Supervisor and Student** who is undertaking a research/major project which involves human participants.
- It is the **Supervisor** who is responsible for exercising appropriate professional judgement in this review.
- Before completing this form, please refer to the University **Code of Practice for the Ethical Standards for Research involving Human Participants**, available at http://www.brookes.ac.uk/Research/Research-ethics/ and to any guidelines provided by relevant academic or professional associations.
- Note that the ethics review process needs to fully completed and signed **before fieldwork commences**.

(i) Project Title: Dissertation thesis (Wellbeing in humanitarian sector)

(ii) **Name of Supervisor and School in which located: Cathrine Brun**

(iii) Name of Student and Student Number: Martina Adamcikova (16042581)

(iv) Brief description of project outlining where human participants will be involved (30-50 words):

The aim of this research is to investigate the Wellbeing cluster approach as a potential to address the wellbeing requirements within the humanitarian sector and evaluate the mindfulness approach, as a new prevention concept of wellbeing support.
A set of interviews and focus groups will be conducted with academics, governmental and non-governmental agencies to evaluate the Wellbeing cluster approach.
Questionnaire and interviews will be undertaken with the participants who took part in the Mindfulness training.

		Yes	No
1.	Does the study involve participants who are unable to give informed consent (e.g. children, people with learning disabilities)?	☐	☒
2.	If the study will involve participants who are unable to give informed consent (e.g. children under the age of 18, people with learning disabilities), will you be unable to obtain permission from their parents or guardians (as appropriate)?	☐	☒
3.	Will the study require the cooperation of a gatekeeper for initial access to groups or individuals to be recruited (e.g. students, members of a self-help group, employees of a company)?	☐	☒
4.	Are there any problems with the participants' right to remain anonymous, or to have the information they give not identifiable as theirs?	☐	☒

5.	Will it be necessary for the participants to take part in the study without their knowledge/consent at the time? (e.g. covert observation of people in non-public places?)	☐	☒
6.	Will the study involve discussion of or responses to questions the participants might find sensitive? (e.g. own traumatic experiences)	☒	☐
7.	Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to the study participants?	☐	☒
8.	Will blood or tissue samples be obtained from participants?	☐	☒
9.	Is pain or more than mild discomfort likely to result from the study?	☐	☒
10.	Could the study induce psychological stress or anxiety?	☐	☒
11.	Will the study involve prolonged or repetitive testing of participants?	☐	☒
12.	Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?	☐	☒
13.	Will deception of participants be necessary during the study?	☐	☒
14.	Will the study involve NHS patients, staff, carers or premises?	☐	☒

Signed:	Catrine Dunn	**Supervisor**
Signed:		**Student**
Date:	19/06/2018	

What to do now:

1. If you have answered **'no'** to all the above questions:

   (a) The student must **send** the completed and fully signed E1 form to their **Dissertation Module Leader.**
   (b) The student must keep a copy of the E1 form which must be bound into their dissertation as an appendix.
   (c) The supervisor must keep a copy of the E1 form as they are responsible for monitoring compliance during the fieldwork.

2. If you have answered **'yes'** to **any** of the above questions:

   (a) The supervisor and student must complete the TDE E2 form available at http://www.brookes.ac.uk/Research/Research-ethics/Ethics-review-forms/
   (b) Note that the information in the E2 must be in **sufficient detail** for the ethical implications to be clearly identified.
   (c) The signed E2 and signed E1 Form must be emailed to Bridget Durning (bdurning@brookes.ac.uk) who is the Faculty Research Ethics Officer (FREO) for review. Please allow **at least two weeks** for this review process.
   (d) If/when approved the FREO will issue an E3 Ethics Approval Notice.
   (e) The student must send the E1, E2 and E3 Notice **to the Dissertation Module Leader**.
   (f) The student must also keep copies which must be bound into their dissertation as an appendix.
   (g) The supervisor must keep a copy of documentation to monitor compliance during field work.

OXFORD BROOKES UNIVERSITY

Faculty of Technology, Design and Environment

Ethics Review Form E2

This form is only for graduate (MSc) and undergraduate students on taught programmes. Before completing this form, Form E1 should have been completed to establish whether a Form E2 is required.

The E2 Form should be completed by the Principal Investigator / Student undertaking the research. Reference should be made to the University **Code of Practice for the Ethical Standards for Research involving Human Participants**, available at http://www.brookes.ac.uk/Research/Research-ethics/, and to any guidelines provided by relevant academic or professional associations.

Please complete the form and email it and the E1 form to the TDE Faculty Ethics Officer (Bridget Durning – bdurning@brookes.ac.uk). Please ensure this is done well in advance of fieldwork as ethics approval is needed before data collection can commence.

---

1. Name of Principal Investigator / Supervisor: . . . . .Cathrine Brun . . . . . .

2. Name of Student: . . . . . Martina Adamcikova . . . .

3. Department/School. . . . . .TDE. . . . .

4. Dissertation Module Number. . . . . Module P30399 . . . .

5. Project Title: . . . . . From treatment to prevention: mental health and wellbeing support in the humanitarian sector.

6. Project Type:

MPhil	
Master's	x
Diploma	☐
Undergraduate	
Other (please specify)	

7. Project funded by (if applicable): N/A

5th January 2016

8. Summary of proposed research:

In this section please provide the following:

i) A background and rationale for the study - this should be sufficient to justify the proposed research (limit=300words)

Recent research revealed that humanitarian workers face multiple mental health and psychosocial challenges, including risk for anxiety, depression, post-traumatic stress disorder and burnout. Employers, including humanitarian organisations, have a duty of care towards their employees and should have appropriate safeguarding policies in place to protect them. However, there is a lack of organisational support when wellbeing of aid workers is concerned. This research project examines new wellbeing approaches in the humanitarian sectors by researching the establishment of the Wellbeing cluster by the humanitarian community in the Philippines and their use of Mindfulness. The research will consider the role of the Wellbeing cluster and mindfulness practices as potential prevention concepts mitigating distress and mental health issues of humanitarian aid workers in order to design effective wellbeing frameworks and programmes for non-governmental organisations.

ii) Aims and objectives of the research (or the research question/s) (limit=100 words)

- Explore frameworks and policies relevant to mental health and wellbeing support within the humanitarian sector.
- Investigate the Wellbeing cluster approach as a potential to address the wellbeing requirements within the sector.
- Examine the mindfulness approach, as a new prevention-based concept of wellbeing support within the humanitarian sector.
- Formulate recommendations on the use of wellbeing cluster and mindfulness technique as an approach of building capacity and resilience of humanitarian workers.

iii) Methods of data collection – please outline in detail how data will be collected (limit = 400 words). Please attach a copy of any questionnaires, interview schedules or observation guidelines to be used

By focusing on the research questions 2 and 3, the empirical research will combine a qualitative and quantitative research strategy. The qualitative aspect of the research will adopt semi-structured interviews and focus group strategy to address Objective 2. Objective 3 will be met by adopting a survey approach. This research will take a place in Cebu, Philippines. Cebu has been deliberately chosen as a research destination where the first localized Wellbeing Cluster has been piloted as a new approach to deal with wellbeing and mental health issues in the humanitarian sector and where the Mindfulness approach has been introduced to the humanitarian agency staff.
Staff from Start Network's Transforming Surge Capacity project, Ramon Aboitiz Foundation Inc. (RAFI) and Central Visayas Network of NGOs (CENVISNET) will be interviewed for their over-arching role in a creation of the Wellbeing Cluster in the Philippines. Similarly, psychosocial experts from the University of San Carlos in Cebu, who have provided their expertise and research support to the establishment of the cluster, will be included in the study to give an academic perspective and views on the wellbeing support needs within agencies and communities. Finally, the representatives from the Department of Health in Cebu will be invited to participate in the research to share an opinion on the first wellbeing cluster and health policies related to staff wellbeing.
The focus group will be based on cross-section of people and participants will be selected from academic, governmental and non-governmental sector in order to combine different views and perspectives on a concept of the wellbeing cluster.
To evaluate the mindfulness approach, as an actual prevention technique under the overall wellbeing architecture structure a small survey will be conducted. A sample of participants who have previously participated in this training have been selected and will be represented by both sexes in order to reveal experiences of using mindfulness tool as a way to build resilience and eventually mitigate stress, trauma and other mental health related issues of aid workers. The counterpoint of the research will be complemented by the key-informant interviews from The Oxford Mindfulness Centre, within the Department of Psychiatry, University of Oxford, which has been researching Mindfulness since 2008. To collect data in Oxford will provide an opportunity to explore unbiased and different views on an idea of adopting the mindfulness approach in the humanitarian field.

5th January 2016

9. Participants involved in the research:

In this section please provide the following:

i) Please outline the number of participants involved; give details of how potential participants will be identified and invited to take part in the study (limit = 300 words)
ii) Please identify any gatekeeper or third parties that will be used to recruit participants (if applicable) (limit 100 words).

i) The following participants will be invited to take a part in the study:

- Key informants from Transforming Surge Capacity Start Network & RAFI & CENVISNET (3 - 5 participants)
- Representatives of the Department of Health in Cebu (1 - 2 participants)
- Wellbeing cluster co-ordinator
- Academics from the University of San Carlos (1 - 2 participants)
- Survey-participants of the Mindfulness training (10 – 12 participants)
- Researchers from the Oxford Mindfulness Centre (1 - 2 participants)

I'm working closely with Hitendra Solanki from Action Against Hunger UK, who is the Mindfulness & Wellbeing Adviser, and who will introduce me to contacts within the humanitarian wellbeing sector. The participants are identified via our contacts in RAFI & CENVISNET & Wellbeing cluster and will be invited to take a part in the study either via our contacts or via an email invitation.

ii) N/A

10. Estimate of the risks and benefits of the proposed research:

In this section please provide the following:

i) Please outline any potential adverse effects to participants and steps to deal with them. Adverse effects may include potential psychological stress, anxiety or upset or any harm or negative consequences (limit 100 words)
ii) Please outline any potential risks to the researcher and how they will be addressed including the production of any necessary risk assessments http://www.brookes.ac.uk/services/hr/health_safety/docs/obuhsn24.html (limit 100 words)
iii) Please outline the benefits of the research. (limit 100 words)

i) I will be talking mainly to people who have been previously actively involved in the wellbeing and mindfulness pilot project and thus this should not experience any particular stress in relation to this topic. All participants involved in the study will be given a participation sheet to be signed which will explain the details of the study and will inform about a possible negative and emotional effects arising from the research.

ii) The researcher has read and understood the health and safety regulations related to fieldwork, including the OBUHSN-38 and the risk assessment was completed. In a case of emergency, the emergency contact details have been shared with the University.

iii) This research will provide an evaluation of new wellbeing approaches in order to mitigate distress and mental health issues, strengthen resilience and help to design effective wellbeing frameworks and programmes for non-governmental organisations.

11. Plan for obtaining informed consent:

In this section please provide the following:

i) Outline to process for obtaining information consent ie how will you provide the participant information sheet, how will you ensure participants give informed consent. If you are not using a written consent form please say why (e.g. for some types of research such as observation of crowd behaviour it may not be possible to get written consent from all participants) (limit 100 words)
ii) please attach copy of
    a. participant information sheet and

b. consent form to application.

Please ensure these contain all the necessary information so that participants can make informed consent. Please ensure it is clear on the consent form what the participants are consenting to i.e. it accurately reflects the methodology you are using to collect the data – you may need to amend the pro forma document.

i) The researcher will ensure that all participants understand the purpose and nature of the study, what their participation in the study requires and what are the intended benefits resulting from the study and this information will be communicated in advance. A written consent form and the participant information sheet will be emailed to participants in advance (minimum of 48 hours) and they will be asked to sign it and return it back to the researcher. In addition, there will be printed copies of the consent form and the participant information sheet available to be filled in before the data collection session. In a case of survey questionnaire, consent will be implied by the completion and return of the survey.

12. Steps to be taken to ensure confidentiality of data:

i) Please outline steps to ensure confidentiality, privacy and anonymity of data during collection, storage and publication (limit 100 words)
ii) Please outline to whom/where the results will be disseminated? For example, by dissertation, oral presentation.... (limit 50 words)

i) To conduct ethical research and promote good practice, this research will adhere to the Code of Practice for Research Ethics for Research Involving Human Participants (2016). All participants will take a part in the research voluntarily and will have the right to withdraw from the research at any stage. To avoid any psychological and social harm, participants will be informed about the purpose of this research and, what their participation in the research entails and how the collected data will be used. Their anonymity and confidentiality will be respected and protection of their personal data will be assured in accordance with the Data Protection Act 1998. Participant's right to privacy will be ensured through the collection, storage, analysis and disposal stages of the research. Permission to audio-record the interviews will need to be granted by the participants and the data will be kept secure at all times. Laptops and other devices will be password protected and encrypted and data will be securely stored in Google Drive.

ii) The summary of findings from the research will be disseminated to all participants and relevant stakeholders. Further, the research outputs will be shared by conference posters when appropriate and in a form of report with non-governmental organizations.

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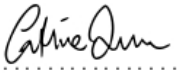
13. Signed:  Principal Investigator / Supervisor

Signed: . . . . . Student

Date: . . . . . 5th January 2016

Faculty of Technology, Design and Environment

Decision on application for research ethics approval

The Faculty Research Ethics Officer has considered the application for research ethics approval for the following research:

Project title:	From treatment to prevention: mental health and wellbeing support in the humanitarian sector.
Name & Department of Principal Investigator:	Martina Adamcikova (School of Architecture)
Name of supervisor (if student):	Catherine Brun

Please check the appropriate box:

1. The Faculty Research Ethics Officer gives ethics approval for the research project. ***Please note that research protocol laid down in the application and hereby approved must not be changed without the approval of the Faculty Research Ethics Officer.*** [x]

2. The Faculty Research Ethics Officer gives ethical approval for the research project subject to the following: [ ]

3. The Faculty Research Ethics Officer cannot give ethics approval for the research project. The reasons for this and the action required are as follows: [ ]

4. The research will also require approval from:

   [ ] Another external Research Ethics Committee

Signed: B. Durmuj

Date: 29/6/18

OXFORD BROOKES UNIVERSITY

CONSENT FORM

Full title of Project: From treatment to prevention: mental health and wellbeing support in the humanitarian sector.

Name, position and contact address of Researcher
Martina Adamcikova
MA student in Emergency Practice and Development
Oxford Brookes University
Headington Campus
Buckley 2.08
Oxford
OX3 0BP
Email: 16042581@brookes.ac.uk

	Please initial box
1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
3. I agree to take part in the above study.	☐

	Please tick a box	
	Yes	No
4. I agree to the interview / focus group / consultation being audio recorded	☐	☐
5. I agree to the use of anonymised quotes in publications	☐	☐
6. I agree that my data gathered in this study may be stored (after it has been anonymised) in a specialist data centre and may be used for future research.	☐	☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

From treatment to prevention: mental health and wellbeing support in the humanitarian sector.

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

This research project examines new wellbeing approaches, such as the Wellbeing cluster and Mindfulness, as potential prevention concepts mitigating distress and mental health issues of humanitarian aid workers. The study is performed as a partial fulfilment of the requirements for my Master's degree in Emergency Practice and Development at Oxford Brookes University, Department of Architecture and has been approved by the University Research Ethics Committee, Oxford Brookes University.

You qualify for participation if you have been involved in the Wellbeing cluster project or took a part in the Mindfulness training. Your participation in this study will provide useful information on this topic and will help to design, shape and implement new effective wellbeing frameworks and programmes for non-governmental organisations.

Participation in this study is strictly voluntary. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

Although there are no foreseeable risks to the participant, the interviews and survey contain questions related to mental health and wellbeing within the humanitarian sector. If you feel questions of this type would upset you, please feel free to decline from participation at any point in this project.

If you decide to participate you will be asked to answer questions related to the wellbeing cluster in an interview which will last approximately 60 minutes or complete a short questionnaire that will take no longer than 15 minutes.

All data from this research are confidential and will be used for research purposes only. Data from questionnaires and interviews are anonymous and will be kept securely in electronic form for a period of ten years after the completion of a research project. If you have any concerns about the way in which the study has been conducted, contact the Chair of the University Research Ethics Committee on ethics@brookes.ac.uk.

The results of this research will be used in dissertation and summary report will be shared with participants, relevant stakeholders and non-governmental organizations.

Thank you for your assistance and taking time to read the information sheet.

Martina Adamcikova
Oxford Brookes University
Headington Campus
Buckley 2.08
Oxford
OX3 0BP
Email: 16042581@brookes.ac.uk

Appendix I: Demographics

Female respondents represented a majority of 76% (n=35) of the surveyed sample, while the number of male respondents was significantly lower, making only 24% (n=11).

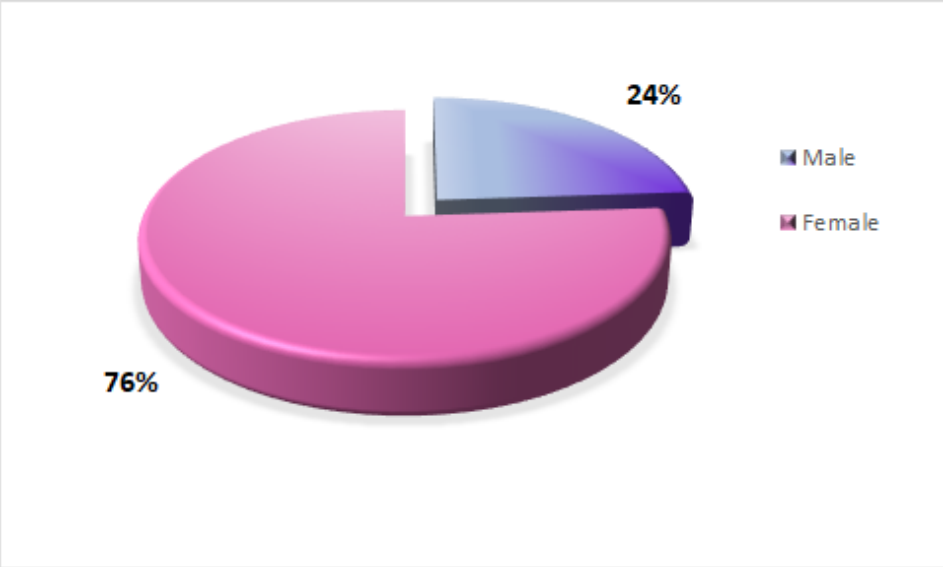


Figure 1: Gender diversification

A group of younger respondents was the most frequent to participate, where 33% (n=15) were age of 18 - 32, 26% (n=12) age of 23 - 27 and 24% (n=11) age of 33 - 42.

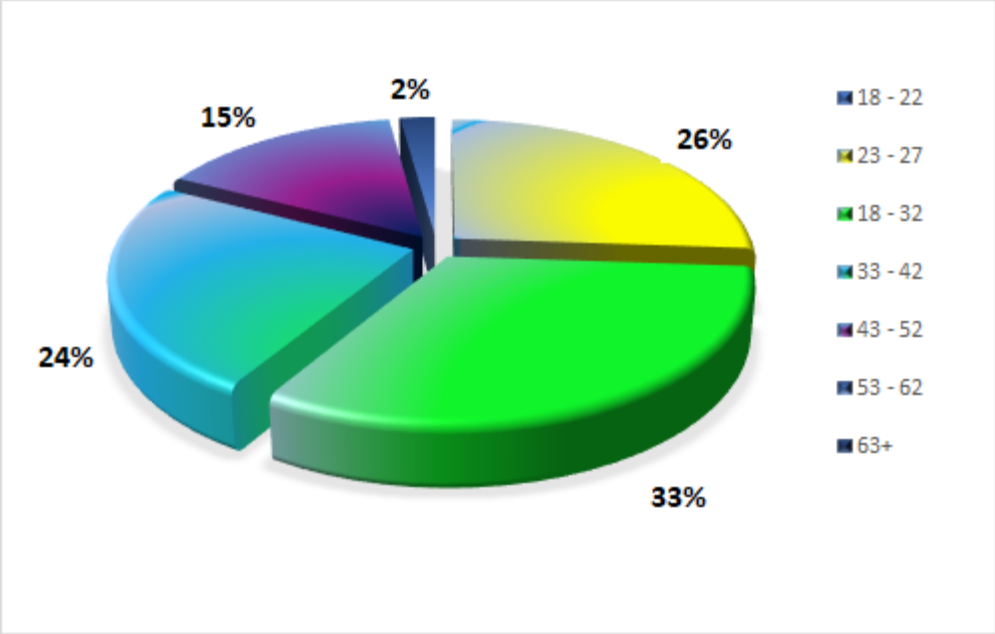


Figure 2: Age diversification

41% (n=19) of responders has worked in the humanitarian sector from 1 to 3 years, 22% (n=10) has 4 to 6 years of working experience, followed by 13% (n=6) of those who have been employed in the humanitarian sector from 7 to 9 years.

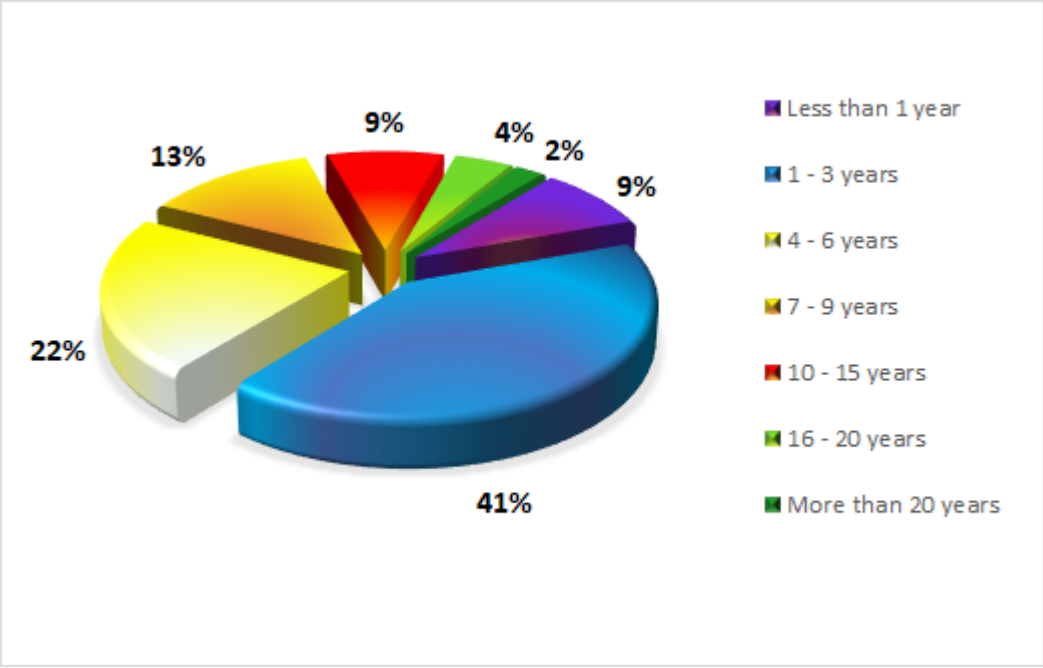


Figure 3: Length of employment

The participants of the survey are mostly employed in middle management, representing 33% (n=15), 22% (n=10) works as support staff and equally 22% (n=10) is employed in other areas of the humanitarian field.

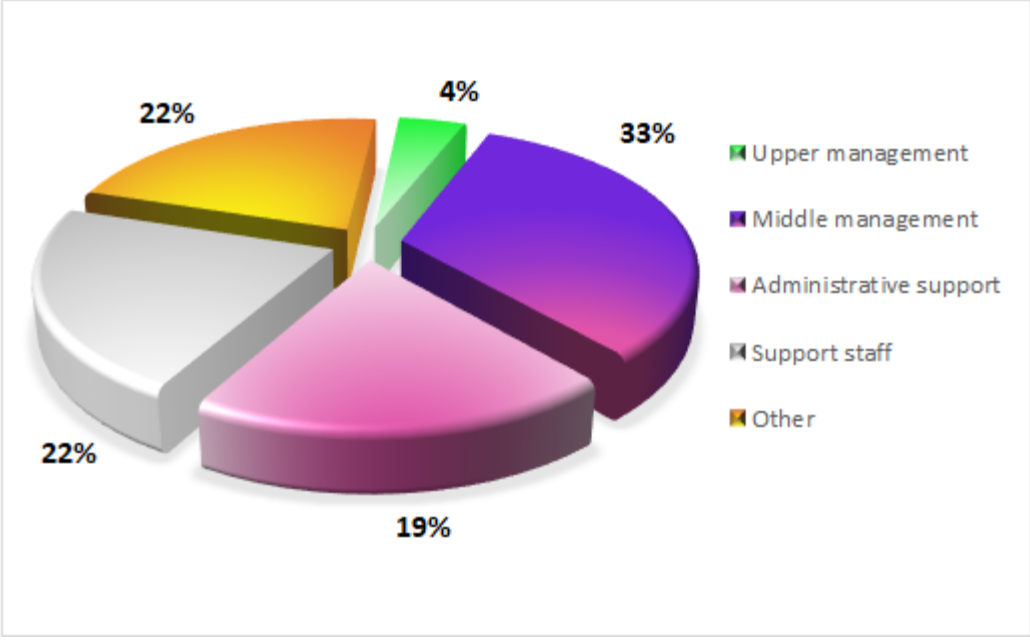


Figure 4: Nature of the employment

Majority of responders, 81% (n=37), are based in the office and 17% (n=8) work both, in the field and in the office. Only 2% are actually based in the field.

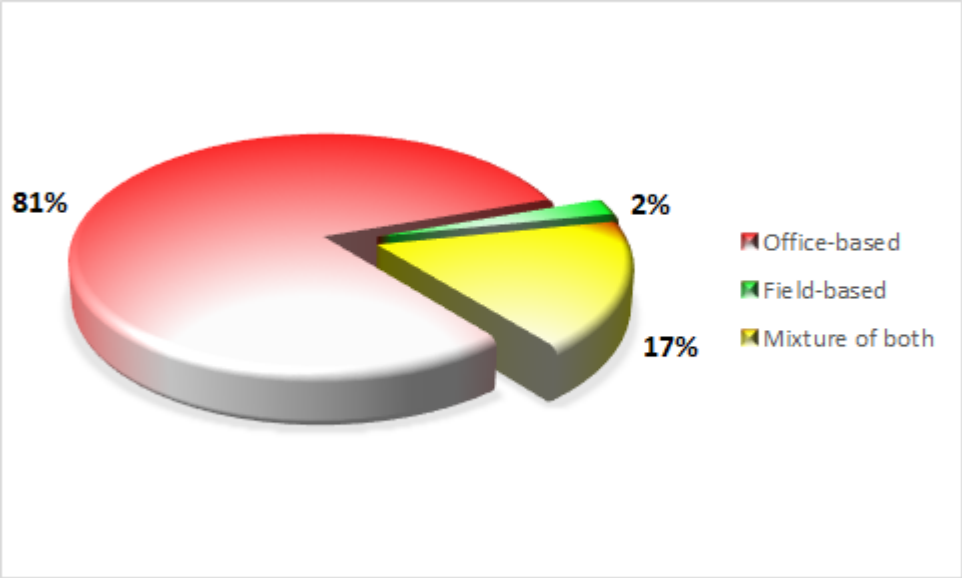


Figure 5: Place of employment

Appendix J: Sustainability and future of the Wellbeing cluster

Short-term sustainability

In a short time of 1 to 2 years, the stakeholders would like the Cluster to continue raising awareness of mental wellbeing through advocacy work and continue expanding.

> *"I hope that it is going to be some sort of seed for a major change for supporting the wellbeing of humanitarian aid workers and communities and addressing mental health globally to break the stigma."* (Anonymous)

It is believed that the Cluster will become an influential network for sharing and learning and will be replicated across other regions.

> *"Maybe in 2 years time, we would have 2 or 3 regional clusters already working. And if we can achieve that, I think then we can start advocating for national adaptation."* (Anonymous)

Further, the partnerships, operational, development and communication plans will be in place along with the defined service delivery programmes. By this time the Cluster should be institutionalised, operational and functional, mainstreamed by the government with good documentation and a pool of mental health specialists.

Long-term sustainability

In a long-term horizon of 5 to 10 years the stakeholders think that the Cluster should be fully institutionalised, legitimate, recognised, implemented into the government service delivery, have monitoring and evaluation frameworks in place and possibly be incorporated into the UN cluster system (n=2).

> *"I would want to have strategic clusters in different parts of the country. Number two is to have this institutionalised. A centre, a learning centre, where we can produce knowledge materials, there are experts, volunteers, stakeholders, partnerships. A centre that renders services from different aspects, for example, runs training, policy advocacy, a centre that is rendering mental health support."* (Anonymous)

It should represent a standardised tool for influence and policy-making and become a part of business continuity plans with policies already being in place. The Cluster should grow and involve more stakeholders, keep increasing the awareness of wellbeing programmes but not become monopolised by the government.

The interviewees agreed that regardless of short-term or long-term vision, the Cluster should be institutionalised, have defined policies and be incorporated into the government's programmes. It should keep expanding through strong advocacy work and become an influential network.

Further, the interviewees suggested that the Wellbeing cluster can sustain through integration with the government, collaboration with other organisations, resource mobilisation and service delivery.

> *"Government participation is the key [...] government agencies like Department of Health who is also a leader in terms of psychosocial, mental health, is now on board. [...] Second, involving academic organisations, so we talk about San Carlos University. Psychology Department is very much into it and these are experts in mental health. Involving the provincial government as well [...]. So, the major players are already in the Cluster."* (Anonymous)

> *"I think what will sustain the Cluster is a good combination of institutions within the Cluster. For example, CENVISNET has the funding and there is the convener RAFI. RAFI is one of the biggest and strongest NGOs in Cebu. [...] so should the government institutions fail in institutionalising this at the governmental and political level and should funding from CENVISNET be available, the Cluster can still survive."* (Anonymous)

Among other important aspects contributing to the sustainability of the Cluster is institutionalisation, functional organisational structure, good management, programmatic and financial planning. Cross-sectoral outreach and sustaining the momentum is also relevant.

> *"We need to have a memorandum of agreement, a binding authority, where we can define our roles, responsibilities and commitments. If we don't have this, we might*

have a problem when working with the government. This will make the programme visible and sustainable." (Anonymous)[13]

The biggest sustainability challenges are operational funds and the design of effective service delivery packages.

"Here we really need to continue, put the budget in order to address that challenge of sustainability, documentation, put that into writing and share it with the world. [...] But I'm very confident because this is one of the advocacies, the wellbeing, and it is very beautiful." (Anonymous)

In addition, communication, documentation, membership expansion, effective M&E framework, a change in political leadership or keeping the momentum going might also represent sustainability issues.

"There will be a challenge if a new political leader is elected or if there is a policy shift in the Department of Health. So, that is why we, as civil society must still remain in the cluster to prevent that." (Anonymous)

[13] This has already been implemented through the Memorandum of Agreement which was officially signed by the Cluster's member at the public launch.