BACKGROUND PAPER: NOVEMBER 2017

Learning about training

Impact evaluation of training activities – a case study from Lebanon

SUMMARY

This paper explores the impact of the training and learning process. It focuses on a case study that was part of a project aiming to decrease tensions between Syrian refugees and host communities in Lebanon by improving the healthcare system. The training and learning component of this project consisted of a series of activities and processes to build the capacity of healthcare providers in conflict sensitivity.

Three approaches were used: conflict-resolution skills training, mentoring and coaching sessions, and dialogue-based awareness-raising sessions.

Stories of change were collected through interviews with participants, trainers, social workers, and patients in primary healthcare centres. Results show that the training and learning process produced significant changes among staff, in their relationships with patients, and in a few cases, resulted in changes of policies in primary healthcare centres.

Introduction

In conflict transformation and peacebuilding, training is an intervention, a part of the overall strategy. It is not an end, but a means to an end. In the early days of peacebuilding, training constituted a big part of an intervention. Trainings were organised to support civil society groups in their activism, to provide opportunities for sharing learning from other places with similar conflict contexts; to network with other like-minded people; to bring people from conflicting sides together in a safe space; and to learn new skills and strategise together.

Given the multiple possible purposes of trainings, the impact of training needs to be seen through the context in which and where it is delivered. Simply quantifying the number of people who learn new skills and gain new knowledge is not sufficient to understanding if a training resulted in a short-term or long-term change. It is essential to know if and how participants applied the new knowledge and skills; and, additionally, what changes were produced due to – in part or in full – the training(s).

The goal of training is change, therefore, identifying the impact is important, even if it is challenging to collect and measure. The challenge is often due to the lack of time and resources allocated to do so. However, without this it is difficult to show and justify the importance of training and the changes that can be attributed to the intervention. The danger of being unable to prove positive impact – intended or unintended – is that it can then minimise future investment in training and learning, encourage shorter trainings or repeating the same types of trainings and topics without understanding what worked well and what should be improved, and minimise the time for reflection, creativity and innovation. When this happens, trainings are shortened and participant numbers increased per training, and it becomes a tick-box exercise to produce numbers without connection between the training and intervention.

Good and effective training can make a huge impact, for example, it can increase productivity and improve practice as a result of the new knowledge and skills gained, it can help in the finding of new and creative solutions to problems, and it can also improve relationships between participants. Therefore, it is important to make sure that training in peacebuilding is as effective as possible.

In order to emphasise the positive role that training in peacebuilding and conflict transformation can have, we will review an example from a project that International Alert managed in Lebanon where one of the main components was change-focused training.

Project background

International Alert, in partnership with the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO) and the Ministry of Public Health (MOPH) of Lebanon, implemented an 18-month project from 2013–2015 on conflict reduction. The overall aim of the project was to reduce tensions between Lebanese host communities and Syrian refugees by providing support to the public healthcare system. Alert's role was to increase the capacity of programme partners and other humanitarian actors to implement programmes using a conflict-sensitive approach.

As part of the consortium with the three UN agencies, Alert's specific role was to support the partners to ensure the project's conflict-reduction objective was achieved and that activities were implemented in a conflict-sensitive manner; to capture lessons learned from the project, including on the ability of improved service provisions to reduce conflicts related to the huge pressure on the healthcare system due to the influx of over a million Syrian refugees; and to enhance the ability of healthcare providers to design and implement conflict-sensitive programmes.

The aim of this paper is to collect lessons learned from Alert's healthcare capacity-building activities in Lebanon and offer a comparison of methodologies, summarising strengths and weaknesses in these approaches to produce best-practice recommendations for future interventions.

The Lebanon capacity-building programme for conflict sensitivity had three major components:

- Training for public healthcare (PHC) staff in conflict resolution including communication and stress management.
- Mentoring and coaching sessions for PHC staff on resolving conflicts, as part of WHO's Mental Health Gap Action Programme (mhGAP).
- Dialogue-based awareness-raising sessions for communities.

Theoretical background

A number of theoretical discussions and academic research findings have a bearing on the exploration of the impact of training and learning in the conflict context. In this section, we will look at some of the discussions regarding conflict sensitivity, training, learning and change, and how to evaluate the impact of training.

Conflict sensitivity

Conflict sensitivity is about being aware of the conflict dynamics in the context in which the project or work is happening, and making a commitment to thinking through how to structure and manage the work and adapt the presence of the people, systems and so on needed to implement the work.[1] It is not a specific tool or checklist. Rather, conflict sensitivity means integrating the appropriate attitudes, approaches, tools and expertise into an organisation's culture, systems, processes and work.

The Lebanon healthcare project training aimed to increase awareness and understanding of conflict and tensions in society, and support healthcare practitioners in developing creative ways to respond to conflict situations with more knowledge, understanding, skills and confidence. We designed the intervention by looking at the three general competences for understanding and using conflict sensitivity. These are knowledge, skills and attitudes, as elaborated below.[2]

Knowledge:

- understanding of conflict; and
- understanding of conflict sensitivity.

Skills:

- able to have a conversation with individuals/groups about conflict;
- able to analyse conflict;
- able to find the links between programming and conflict; and
- able to convince others of the need for conflict sensitivity.

Attitudes:

- accepting that programming or the overall organisation's action can inadvertently contribute to conflict;
- self-awareness of own biases and of how individual actions may be perceived in different contexts;
- possessing good inter-cultural sensitivity and understanding; and
- able to challenge assumptions and look for various ways to gather and analyse information concerned with social justice.

Building capacity in conflict sensitivity in these areas, in general, aims to increase the understanding of conflict, tension and stress, the ability to understand self and others, to communicate constructively, and explore alternative and creative ways in responding to conflicts and stress. In each training context, we address the specific needs of the target audience, given where they are as a group and the type of work that they do.

Training and learning

Learning in this context is broadly defined as: "a relatively permanent change in behaviour with behaviour including both observable activity and internal processes such as thinking, attitudes and emotions."[3] Motivation is included in this definition of learning. It is also important to note that learning often manifests itself in observable behaviour sometime after an educational programme has taken place. Thus, as stated previously, measuring immediate impact can be a challenge.

The theory of learning used in this programme of training is facilitation theory based on the humanist approach. Carl Rogers and others have developed the theory of facilitative learning.[4] The basic premise is that learning will occur through the educator acting as a facilitator, by establishing an atmosphere in which learners feel comfortable to consider new ideas and are not threatened by external factors. In general, facilitative trainers are less protective of their constructs and beliefs than other trainers. Facilitative trainers include in the core of how they work a focus on listening to learners, including their feelings, paying as much attention to their relationship with learners as to the content of the course, incorporating feedback, both positive and negative, and using constructive insight into themselves and their behaviour.

At the same time, learners are encouraged to take responsibility for their own learning, and they provide much of the input for the learning that occurs through their insights and experiences. They are encouraged to consider the value of self-evaluation and that learning should focus on factors that contribute to solving significant problems or achieving significant results.

Change

The main goal of training and learning programmes is to enable and support change. Two models will be presented, to help understand the impact of training and the relationship between training and change.

A) The first model is known as 'Key People – More People', and is developed by Anderson and Olsen.[5] It is presented in Figure 1.

Figure 1: 'Key People – More People' model

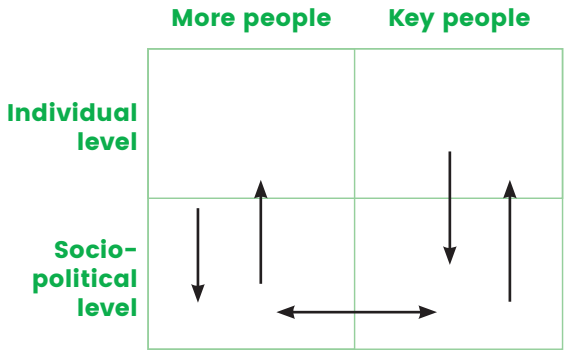


Figure 2: Model of change

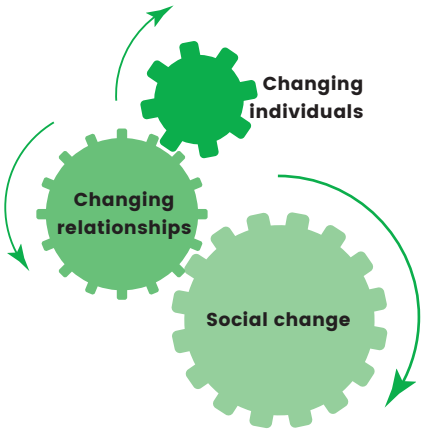


Figure 1 looks at the ways in which most strategies for peacebuilding can be understood. The horizontal axis represents a difference in strategies ranging from activities aimed at involving as many people as possible, to activities aimed at a limited number of key people. The vertical axis shows two other dimensions of peacebuilding work. Activities aimed at the individual or personal level tend to start building peace by changing people's attitudes and perceptions. Socio-political-level strategies aim at systemic, institutional change, at the level of society as a whole.

Evidence shows that when programmes focus only on change at the individual/personal level without regard to how these may be translated to the socio-political level, actions inevitably fall short of having an impact on the larger goals. Many peace efforts that work either with more people or with key people at the individual/personal level aim to build relationships and trust across lines of division, to increase tolerance, to make peace seem possible and within reach to people, and/or to inspire hope. However, to have a real impact on conflict, personal change must be translated into actions at the socio-political level.

B) The second model to understanding how change can happen categorises change into three levels: changing individuals, relationships and social change. In general, we can put these changes into the previous model and look at how they relate to each other, and/or how we might initiate social change through individual and relationship change. The model is presented in Figure 2.

Changing individuals

This involves strategies that shift attitudes and perceptions, feelings, behaviours and motivations of participants in an intervention. Training and learning activities focus on individual changes as the main objective. However, there is the expectation that following on from the training, they will go further and initiate bigger changes. Individual changes can be cognitive, emotional/affective and behavioural.

Changing relationships

These change strategies aim to affect both individuals and social structures. Programmes that focus on changing relationships often suggest that new networks, coalitions, alliances and other cooperative relationships between members of conflicting groups not only positively change the individuals directly involved, but can also be a powerful force for fostering social changes that help resolve conflicts.

Social change

Structural, institutional and systemic changes are the primary focus for some conflict-intervention programmes. The current trend of 'mainstreaming conflict-sensitive approaches' into development and humanitarian assistance projects has contributed new peacebuilding strategies to the usual small group of interventions. These efforts are often directly aimed at legislative, electoral and judicial reform, establishing new mediating mechanisms and forums within society, economic development initiatives and infrastructure support for basic human necessities.[6]

Evaluating the impact of training

There are many models for evaluating training activities. While very similar to each other, each emphasises specific elements of an intervention. Those that come from vocational and business practice will emphasise aspects such as return on investment, and those from the non-profit sector will most likely emphasise other elements such as organisational learning.[7]

The first popularised and broadly used model was Kirkpatrick's training evaluation model.[8] The four levels of this model are: reaction (what participants thought and felt about the training), learning (the resulting increase in knowledge and/or skills, and change in attitudes), behaviour (transfer of knowledge, skills, and/or attitudes from classroom to the job), and results (the final results that occurred because of attendance and participation in a training programme). Kirkpatrick's model has been amended slightly over time to include a fifth level of measurement, return on investment (ROI).[9] In the context of training, ROI is a measure of the monetary benefits obtained by an organisation over a specified time period in return for a given investment in a training programme.

Specifically, for the Lebanon trainings, we evaluated impact using the Learning for Change model (Figure 3). This model is specifically developed to help plan, design and evaluate peacebuilding training and learning activities.

The model emphasises the importance of grounding peacebuilding trainings in change objectives, identifying what needs to be changed as a result of a training activity. Then, based on the change objectives, learning objectives are defined. These are based on knowing what that particular group of people need to learn to be able to achieve the intended change. Impact evaluation is consequently assessing if and what kind of changes are the result of the training. This is where the focus of impact evaluation lies.

Evaluating impact of training – case study from Lebanon

Capacity building in conflict sensitivity

The Lebanon capacity-building programme was informed by findings from baseline research,[10] which identified tensions and conflicts in the healthcare sector (Box 1), and the need for conflict-sensitivity capacity building (Box 2) overleaf.

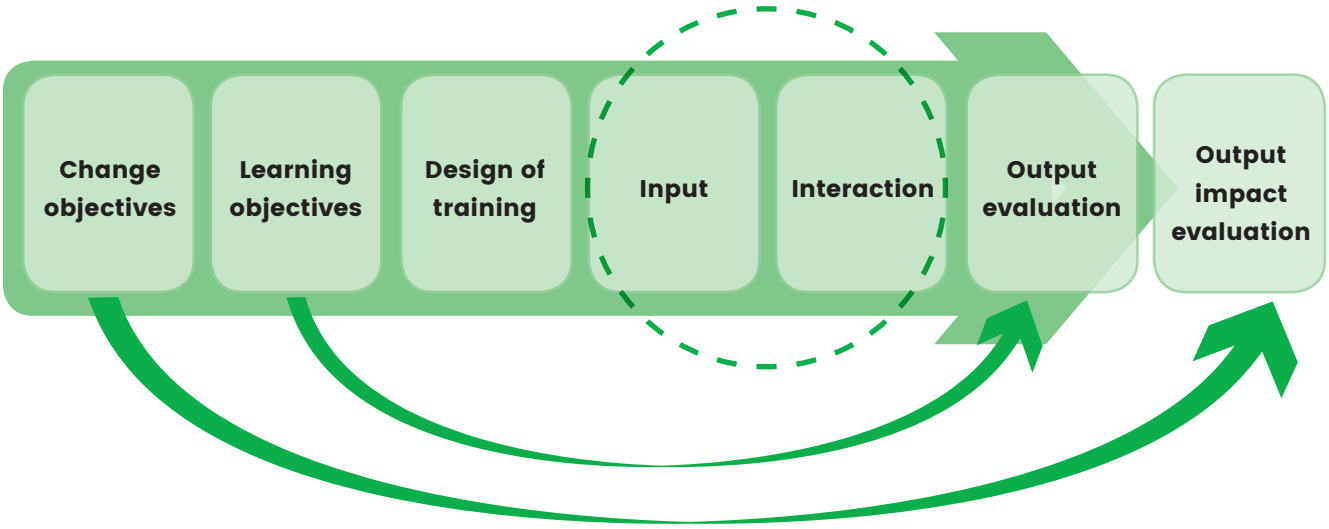
Alert was involved mainly in capacity-building for conflict sensitivity. The capacity building plan had three major components:

- Training PHC staff in conflict resolution including communication and stress management.
- Mentoring and coaching sessions for PHC staff on resolving conflicts, as part of WHO's Mental Health Gap Action Programme (mhGAP).[11]
- Dialogue-based awareness-raising sessions for communities.

Training component

The training needs assessment stated that healthcare workers are faced with increased workload and pressure in the workplace. The most frequently given examples of problems at work were the increased number of patients,

Figure 3: The Learning for Change model



Box 1: Tensions in primary healthcare centres (PHCs) in Lebanon[12]

In summary, the findings from the baseline conducted in 2015 show that there was widespread hostility expressed by PHC staff across almost all PHCs towards Syrians, with a few notable exceptions. Several themes emerged as:

- the perception that Syrians take jobs, force up rents, and put pressure on education;
- the perception that Syrians have too many children;
- the perception that Syrians are dirty, unhygienic, and uneducated; and that Syrians are introducing diseases into Lebanon;
- the belief that all Syrians are pro-Assad; and
- a sense of coercion in supporting the Syrians.

Interestingly, in stark contrast to the above attitudes, three PHC staff in senior positions demonstrated degrees of empathy and tolerance towards Syrians in looking for ways to promote co-existence between Lebanese and Syrians.

In the analysis, it was noted that widespread hostility toward Syrians seriously undermines institutional capacity for conflict sensitivity. Guiding principles for conflict sensitivity, as articulated in the Resource Pack for Conflict Sensitivity, include the importance of impartiality, knowledge, skills and attitudes for conflict sensitivity and inter-cultural sensitivity.

From the baseline, we identified the point of departure for strengthening institutional capacity for conflict sensitivity to be the promotion of tolerance and the challenging of negative perceptions and stereotyping amongst PHC staff.

Box 2: The need for conflict sensitivity

Conflict sensitivity was not formally integrated into the understanding of any roles among PHC staff interviewed. In general, staff felt that the coping measures they were undertaking were as much as they could manage, and they did not see a need for action to be conflict sensitive beyond these mitigation measures, nor the need for it to be integrated into staff roles.

On probing, staff did describe a number of skills and attitudes that they thought would be helpful: suggested by PHC staff to enable conflict sensitivity:

- Communication skills
- Listening skills
- Stress management
- Conflict resolution
- Empathy/understanding/compassion
- Patience/taking time
- Non-discrimination
- Humanitarian approach

shortage of staff and time pressure on existing staff, difference in patients' mentality, perceived low health awareness of Syrian refugees, and increased fees and inability of patients to cover them.

The main causes for problems at work were harassment by patients of PHC staff, friction between centre staff and patients and among patients, specifically Lebanese and Syrians.

Considering these needs and findings, we decided that the aim of the training should be **to improve the healthcare staff's understanding of conflict and enhance their communication skills to develop creative options for dealing with conflict and stress.** The course consisted of three training days and a follow up. The training had three modules:

1. Conflict resolution, covering conflict analysis, perspectives and perceptions in conflict, conflict styles, and practical exercises in dealing with conflict situations.
2. Communication skills, covering active listening, understanding others' perspectives and views, models of communication, team work, cooperation and practising communication.
3. Stress management, including understanding stress at the individual and social levels, differentiating between stress and anger, approaches to transferring negative stress into positive energy, and practical relaxation techniques.

Coaching and supervision

Alert worked with a group of mhGAP supervisors which included psychologists, psychiatrists and psychotherapists, to mainstream conflict sensitivity into the mental health unit work; more specifically, to increase understanding of conflict, improve skills for working with conflict, and to design processes for incorporating conflict-training sessions into regular supervision sessions. This was done by adding five sessions on different topics to monthly visits by supervisors. Topics included:

1. interpersonal conflicts, focused on problem solving;
2. intercommunity relations and tolerance (dealing with the 'other');
3. personal skills for dealing with difficult situations;
4. stress management in crisis; and
5. self-care and personal growth.

Each session was linked to sessions from mhGAP training and included a reflection on the topic from the previous visit to monitor the use of new skills.

Dialogue-based awareness-raising sessions

Amel Association International[13] and Alert started a pilot initiative to test using awareness-raising sessions to build social trust and linkages between refugees and host communities. Social workers were using dialogue to create safe space for communities to engage with each other and explore issues of common concern. The social workers aimed to gradually move away from information delivery towards open dialogue, which was expected to increase sharing and interaction and thus contribute to trust building and social cohesion.

Methodology

The specific objectives are as follows.

1. To learn about the effects of trainings on practice in PHCs:
   a. to explore whether and how new skills were applied in work contexts, specifically communication, conflict-resolution, and stress-management skills;
   b. to explore what the changes were, if any, that occurred including in improving social cohesion in communities following the awareness session; and
   c. to explore if adding conflict-resolution coaching sessions had a cumulative effect on PHC staff in dealing with tensions and conflicts with patients or among staff.

2. To compare three different approaches (training, individual coaching, and dialogue sessions), and explore the advantages and weaknesses of these.

3. To recommend best practices in capacity building in the context of healthcare in Lebanon during a time of crisis that might also be applicable in other contexts.

Sample

Out of approximately 125 participants in the capacity-building programme, 40 were interviewed. These included PHC staff, mentors, social workers and trainers. Twenty-one community members interviewed were participants in the awareness-raising session that took place in communities. Additionally, 11 patients from the PHCs were interviewed.[14] There were three training teams (six trainers in total), five supervisors and four dialogue facilitators In the project. The sample summary is in Table 1.

Table 1: The sample

Region	Centres	People	Gender		Profession of staff*				
			M	F	Nurse	Phar	Soc W	Rec	Doc
Beirut and Mt. Lebanon	3	11	1	10	6	1	2	2	0
South	3	15	0	15	9	0	3	2	1
Bekaa	1	6	3	3	1	2	0	0	3
North	2	8	0	8	4	0	2	2	0
Total	**9**	**40**	**4**	**36**	**20**	**3**	**7**	**6**	**4**
Community members		21	0	21					
PHC patients		11	3	8					

* Nurse, Phar = Pharmacist, Soc W= Social worker, Rec = Receptionist, Doc = Doctor

Findings

Findings are presented in three major groups based on the three main objectives:

- To learn about the effects of training on practice in PHCs.
- To compare three different approaches.
- To recommend best practices in capacity building.

Training and change – what are the effects of training

Overall, those interviewed reported changes at the individual level, changes in their relationships with patients and staff, and more long-term social impacts as a result of the trainings. The majority of the changes cited included increased understanding, knowledge, new skills and models of understanding and dealing with conflict. Concrete examples were offered of how they were applied in practice.

For example, people reported changes in the policies of how the PHC operates, such as forming peer-support groups to exchange issues and having focal points for "dealing with conflicts". "We organised a group in our PHC which meets once a week, where we talk about problems and conflicts we face. The initiative came from our social worker who attended the training and thought it will be useful for all of us," said a PHC staff member.

Improved relationships among staff was evident in many cases and was supported with examples, such as: increased confidence to make suggestions to colleagues on how to deal with difficult situations; asking for help more freely; organising sharing sessions on what they learned; and organising trainings for the staff who were unable to attend the Alert training. However, while on the one hand, PHC staff reported on improved relationships between staff and patients, this was not corroborated by patients, although patients did not report a worsening of relationships between staff and themselves. Here it would have been useful to interview more repeat-visit patients.

Impact at the community level was reported in cases where centres formed regular groups that attended dialogue-based awareness-raising sessions. These were voluntary groups/ sessions with both Lebanese and Syrian women. They reported the following changes:

- Increasing interactions with neighbours to discuss common problems and raise issues.
- Recommending and advising members of the community to look for support in PHCs, through their own personal examples of trusting them and finding them useful.
- Encouraging their youth to participate in Lebanese and Syrian mixed-youth groups.
- Including their husbands, by asking them to drive them to the group meetings where they interact with the other men.
- Mobilising other members of community to participate in the group.

Further, those interviewed reported improved relationships in their community, finding more things in common with those from a different background, and "feeling closer to the other". All in all, interviewees felt that they were becoming better neighbours. These results and examples support the assumption that dialogue-based sessions can contribute to social cohesion.

Tables 2, 3 and 4 summarise the changes that were reported, which are grouped into individual, relationship and social changes.

Table 2: Changes at the individual level

Cognitive	• Learned new models, tools and skills, including seeing beyond the surface and better understanding the needs of patients. • Improved communication, including better and increased listening skills. • Increased understanding of others, conflict and problems, stress and stress-management techniques. • Increased understanding of their own stress and how to manage it. • Increased understanding of conflicts and analysing a situation before reacting, including seeing layers in conflicts. • Thinking differently about patients, understanding and empathising with their needs. • More comfortable with trying new ways to approach problems and conflicts.
Emotional	• Better understood their own emotions. • Increased control and management of their own emotions, especially anger, aggression and frustration. • Understood that a range of emotions are healthy and they are allowed to feel all of them. • Felt less fear when facing conflicts and problems. • Able to deal with their own stress and frustrations. • Felt morally and psychologically supported. • Felt that people cared about them and their work.
Behavioural	• Treated patients differently, more attentively. • Allowed more time for explanations from patients. • Tried different techniques in managing conflicts. • Improved communication skills – especially listening skills. • Used stress-management techniques in dealing with patients' issues. • Tried different approaches and responses to conflicts, often in a more creative way. • Increased motivation and commitment to work.

Table 3: Changes in relationships

Between staff and patients	• Increased tolerance and politeness from patients toward staff. • Less aggression from patients in words and actions with staff. • Increased understanding between staff and patients.
Among staff	• Improved communication among staff. • Trust developed among staff who attended training. • Better teamwork. • More mutual support. • More support between centres. • Increased tension between staff trained and those who were not.
Among community members	• Increased mutual understanding among community members. • Improved relationships. • Increased support among community members.

Table 4: Social changes

Change of practice	• Improved team work; improved mutual support among staff. • Developed a network of colleagues across centres in the region, who are now able to share their experiences, problems and advise each other. • Increased cooperation between centres. • Developed and implemented new policy on how to deal with angry patients. • Ongoing delivery of training in PHCs, to staff who didn't attend the training. • Changed practice in dealing with too many patients in waiting rooms, by trying different options.
Change in communities	• As a result of awareness-raising sessions, groups are empowered to influence their communities and lead sessions themselves, and this was seen as a powerful way to achieve social change at the level of community.

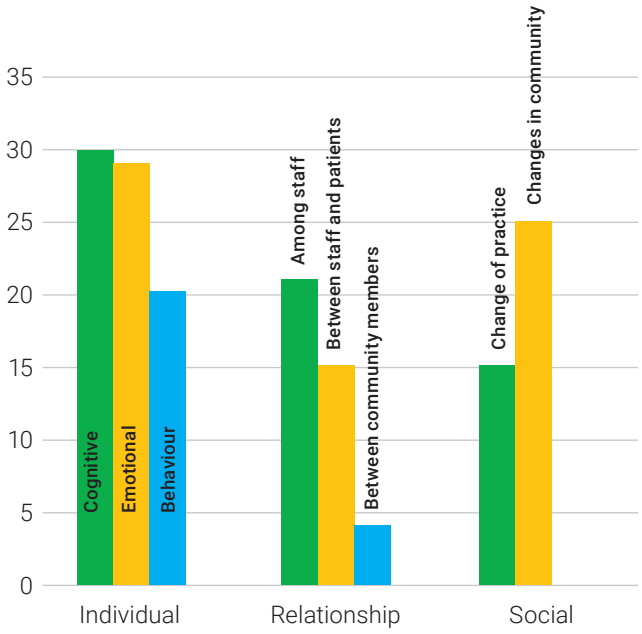
Figure 4 summarises the changes at individual, relationship and social levels, and shows a decrease in changes as we move further from immediate individual learning. This is an expected trend, as it will take time for individual learning to be implemented in practice, or to have effects at the community level. Additionally, if there are no benefits when tested, individual learning might not be used or put into practice.

Other findings

Improved relationships between staff and patients?

Most of the staff who were interviewed reported that they had an increased understanding of their patients and their needs, especially Syrian refugees. This awareness essentially demonstrates a shift in the staff's attitudes and behaviour. They also noticed changes in patients' behaviour towards staff – many patients had become both politer and nicer. The positive knock-on effect was that there were fewer conflicts and tensions in PHCs.

Figure 4: Level of change (based on number of people that reported change)



However, the patients interviewed that had been visiting PHCs on a regular basis stated that, at first, they were very reluctant to talk about any mistreatment or conflicts (apart from a few cases). Patients were very appreciative of the staff and did not recognise any noticeable changes in how they were being treated by staff. Most of them felt the care was just as good as it was before.

How can this be explained?

a) Socially desirable responding

One possible explanation is that people tend to report what they think we are expecting them to say. For example, if the staff believes that the interviewer wants to hear that the training had brilliant impact that could result in more training; or patients out of fear that staff will hear about their complaints might respond that they are treated well all the time.

b) Perception and level of conflict

With increased confidence after the training, the staff perceived the level of conflicts decreasing and becoming less intense. With the confidence and opportunity to explore their emotions and reactions, they realised that they shared similar feelings and that their colleagues were also facing conflicts. Also, staff had new techniques and tools at hand and had less fear of and discomfort when dealing with conflicts.

For the patients, their most important issue in relation to the PHCs is access to medical care, and other issues are less important and less visible. They are, therefore, perhaps less aware of the conflicts if they know they will get care, or less eager to complain given the alternative of not having access to medical care.

Increased tension among staff?

Interestingly, interviewees from two centres reported an increase in conflicts in PHC among staff. This could have been due to one or a combination of at least three factors.

a) Generational gap

The difference in beliefs and ways of working between generations of those who participated in the training – younger, less experienced, and those who didn't – older, more experienced, was one explanation, offered by those who reported on increased tension. In general, older generations can be less open to change and innovations, which could cause tensions when participants return from trainings with new ideas and ways of working. This links to the next point.

b) Resistance to change

Another possible explanation is that trained staff started to introduce changes in their work, and the rest, who were 'left behind' resisted unknown and unfamiliar ways of work.

c) Training as an incentive

Another possibility is that staff perceived training as a reward, and those who were not chosen to participate felt excluded and unappreciated.

Comparison of approaches

There are some indications that the impacts were the most where all three approaches (training, mentoring and community dialogue sessions) were used. This would make sense given that they were all part of the same process, and effects would therefore be greater when approaches were combined.

As individual approaches, each has their strengths.

Training

Training with a group of people that have similar problems provides an opportunity to:

- understand that others face similar problems;
- network in the PHC and across the regions;
- build relationships with colleagues from the same and other centres;
- support each other in the workplace;
- introduce and share new practices and ideas; and
- learn from one another, from feedback through a group learning process with an intentional focus on individual learning.

Coaching/mentoring

This approach was taken either on a one-on-one basis or in small groups of not more than five (in most cases two or three).

The advantages of these sessions included:

- sessions tailored specifically for the participants based on their experiences;
- more individual attention from the supervisor; and
- more space for participants to work on themselves, including opportunities to focus on their own issues, styles and emotions.

These sessions resulted in more personal change, such as increased understanding of themselves, their emotions and how to manage them.

Dialogue-style awareness sessions

The purpose of this approach was to slowly transform standard awareness-raising sessions, which were input-heavy, into more open, safe-space sessions, for community members from different backgrounds to come together, find common ground, and develop trust and support one another.

The process of 'opening' the sessions was gradual, starting with participants choosing topics that they were interested in, and ending with an open space for conversations with spontaneous topics. As a result, community members became mobilisers and moderators for other community dialogue initiatives. The best feature of this approach was that it reached out to communities and it had continuity. For example, some groups are still meeting on a regular basis, and many of the same community members are attending. This can lead to even more possibilities for relationship development, for increased trust and understanding.

Learning about training – identifying best practices from the Lebanon case study

Findings here will be grouped into two parts: findings focusing on trainers and findings focusing on the training.

About trainers

Trainers were crucial for the changes reported. Apart from expected qualities of trainers, such as knowledge, skills and experience in training topics and in the training process itself, it was found that the personal qualities, attitudes and approaches of trainers played a crucial role in the learning process. In the project, there were three training teams (six trainers in total), five supervisors and four dialogue facilitators. Significant satisfaction differences were reported for different training teams, supervisors and facilitators. Data supports this being the most important aspect of the activity and for the achievement of the objectives of that activity.

The qualities that participants appreciated and valued the most for supporting and motivating their learning include the following:

1. humble and modest;
2. respectful of people, treating them as equal and as adults;
3. empathising with participants; understanding problems that people have;
4. understanding emotions and what to do with them;
5. being open to learning, and being open about not having all the answers;
6. creating the space for learning and not just filling the space with lectures and PowerPoint presentations;
7. being open to sharing their own experiences;
8. committed to the training, so they can inspire and motivate others; and
9. listening to feedback and being flexible to changing the programme when needed.

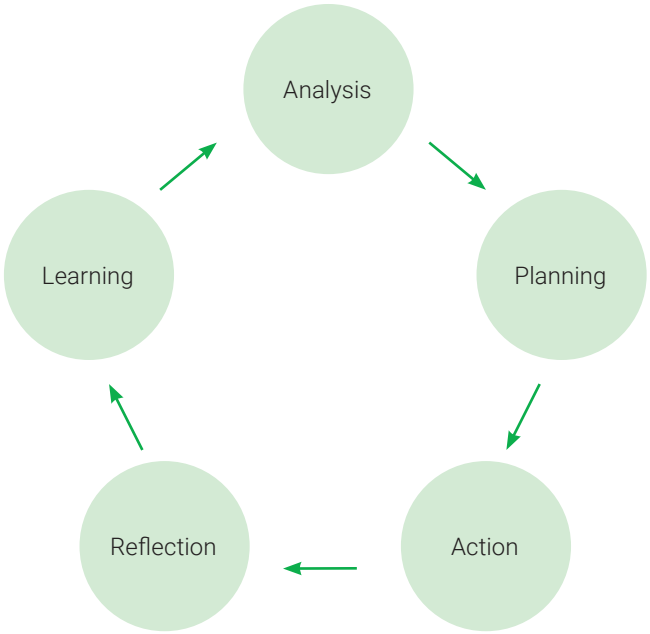
All these qualities correspond with the description of facilitative trainers.[15] The role of a good trainer is also that of change agent – one who can motivate and inspire change in others.

Good practice in training

Findings about what works in training were collected from participants' responses and evaluations. Although we have taken examples from this particular case study, these can be generalised and used as examples of good practice in training.

Findings will be summarised using the Action Learning model, depicted in Figure 5, as a reminder of the importance of each phase of learning.

Figure 5: Action Learning model[16]



Each action-learning phase will have a few points and reminders of what is important in each stage. Phases are not always clearly differentiated and learning and reflection can happen in any stage and the process can start in any phase.

24 tips for good training

Analysis

1. Understand a broader context and how the training intervention is going to interact with the context; whether training is the best way to address the issues.
2. Conduct a training needs assessment and respond to identified needs.
3. Understand participants: who they are, what they want to learn and why; what they want to change; what are their capacities.
4. Choose the best trainers based on their experience, knowledge, skills and personal qualities; create trainers' teams; consider teams' capacities and weaknesses and how to overcome them.

Planning

5. Design the curriculum based on an understanding of the context, problem, participants and their needs.
6. Use problems, issues and challenges that people identify in the training needs assessment as case studies and examples for practice and exercises.
7. Design training material – use examples and situations that people can recognise as relevant for them.
8. Process is important – make it varied, inclusive, participatory, elicitive, interesting and creative; encourage a safe and learning-focused environment.
9. Be realistic; design a training that can be delivered; limit the topics to those that can be covered in the time allocated.
10. Plan the time/duration of the training based on peoples' availability.
11. Plan for time between modules to enable participants to internalise the learning and to practice/apply some of the techniques and tools.
12. Plan for follow-up from the beginning. Think of the training as a spiralling cycle of learning.

Action (implementation)

13. Implement what you planned, but be flexible.
14. The group is the focus of the training, and the most important thing is for the group to learn what is useful for them and what they want to apply.
15. Make it practical: use exercises to try and test different models and tools; provide time for practice and application during training, and between modules/trainings.
16. Provide time and space for reflection, practice, input, discussions, questions, and encourage critical thinking.
17. Don't include too much content to be processed. How is more important than what.

Reflection

18. Allow enough time for reflection throughout training; especially between modules/days/trainings – for participants to raise challenges, share their learnings and difficulties; and incorporate those into the next module/day/training.
19. Trainers need to learn from participants' reflections; they also need to reflect themselves on their learning about their own practice; include regular daily debriefings for the training team; and encourage learning from feedback.

Learning

20. Learning from reflections and debriefings needs to be included into further cycles of training.
21. Learning from participants' evaluations needs to be summarised, reflected upon, and also included into further cycles of training.
22. Impact evaluation needs to be conducted to check what the impact of training on the context is – are there any planned changes and why.
23. Learn from mistakes as much as from successes. Encourage a reflective practitioner approach, and constructive feedback as a way of learning.
24. Be open to re-examining your assumptions – encourage double-loop learning (learning to change underlying values and assumptions).

Conclusion

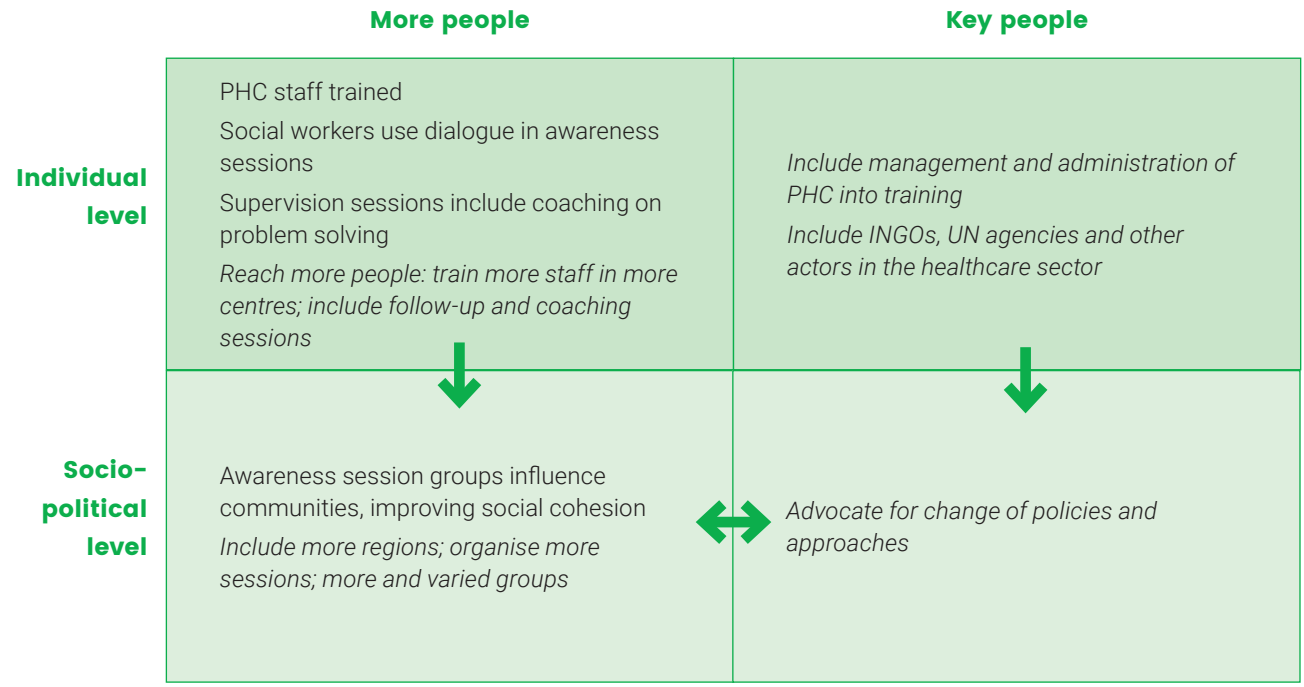
The project took place in the context of the healthcare sector in Lebanon during the ongoing Syrian crisis. Different tensions in society were reflected in the healthcare system, and the most visible ones were in the primary healthcare centres (PHCs), where tensions were present between patients – the Lebanese hosts and Syrian refugees, between staff and patients, and among staff. The point of departure for strengthening institutional capacity for conflict sensitivity was to promote tolerance amongst PHC staff and challenge negative perceptions and stereotyping. The aim of the training was to improve healthcare staff's understanding of conflict and enhance their communication skills to develop creative options for dealing with conflict and stress.

Findings show that the training had positive impacts in PHCs, as the tension between staff and patients decreased, staff could understand patients better and communicate differently, which in turn changed the behaviour of patients from being aggressive to becoming more polite. Better team work, improvements in the functioning of the PHCs, introducing new ways of working, and developing new policies at the centre level were all reported as changes following the intervention. These changes had a positive impact on staff, their morale, and commitment to work.

The 'Key People - More People' model can be used to summarise the main recommendations, keeping in mind that these are aiming to link changes achieved at the individual level with more socio-political level changes, or in the case of the example used here, at the level of social cohesion. This is presented in Figure 6.

In Figure 6, most activities in the case study are gathered in the quadrant 'more people on an individual level'; and some are in 'more people on the socio-political level', represented by the community dialogue sessions. For impact to reach the socio-political level, there is a need to involve and connect other relevant actors, to include new activities, but most importantly, to link and strengthen advocacy activities.

Figure 6: Clustering training activities into 'Key People - More People' model



Note: The table describes delivered activities as part of the capacity-building process.
Italics are used for recommended activities to increase impact.

Recommendations

There are six recommended pathways for primary healthcare centres and healthcare providers in Lebanon in general, to continue to reduce tension between Lebanese host communities and Syrian refugees by providing support to the public healthcare system. These include the following:

1. Follow-up trainings or other continuous learning activities with staff that were trained in this intervention are needed.
2. Feedback mechanisms need to be put in place for the changes that those trained are introducing to ensure effectiveness.
3. It is important to train other staff to avoid division and potential tension between those who are trained and the rest. This would also help ensure that there is a shared understanding about the best practices in PHCs. Additionally, given the responses from interviewees, this would continue to support better team work and collegiality among staff.
4. For the changes to be more sustainable and for policy changes, the management and administrative leadership of PHCs should be involved in similar but specifically tailored training.
5. Broadening the training and activities to other centres would support networking and sharing learning among them.
6. Community dialogue and awareness-raising sessions can be used to improve relationships in communities as demonstrated by the Amel Association International pilot project. It was shown that facilitated open and safe spaces for host and refugee communities to openly discuss relevant issues had an impact beyond the participants in the sessions, namely among their families, in their neighbourhoods and in the broader communities. It is very important to take this component further, given how dialogue can reach communities, improve relationships and contribute to social cohesion.

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Endnotes

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13 Amel Association International is a leading health and social organisation in Lebanon.

14 110 people attended training for PHCs, three centres had an active mhGap supervision process, and two centres included dialogue sessions with communities.

15 C. Rodger, Freedom to learn for the 80s, Columbus, OH: Charles E. Merril, 1983

16 This model is adapted from the social psychologist Kurt Lewin's approach to cyclical, iterative learning, explained in the book Resolving social conflicts, 1948. The concepts of action learning and action research (AR) build on the idea of third-order, strategic learning. Here, too, learning takes place by doing, reflection, and experimentation – while at the same time, there is a focus on the underlying implicit theories and values of the learner. Lewin proposed a cyclical, iterative approach to learning involving planning what was to be done, taking action and fact-finding about the results. Lewin's ideas have since become one of the key influences in what is now known as action research.

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