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amel association International

Integrating Social Stability into Health and Protection Services

Action Research Summary

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International Alert works with people directly affected by conflict to build lasting peace. Together, we believe peace is within our power. We focus on solving the root causes of conflict, bringing together people from across divides. From the grassroots to policy level, we come together to build everyday peace. Peace is just as much about communities living together, side by side, and resolving their differences without resorting to violence, as it is about people signing a treaty or laying down their arms. That is why we believe that we all have a role to play in building a more peaceful future.

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About Amel Association International

Amel Association International (Amel) is a civil, non-sectarian organization established in 1979. Through its 25 centers, 6 Mobile Medical Units, 2 Education Mobile Units, 1 Protection Mobile Unit, and 800 workers across Lebanon, Amel provides access to quality health, education, protection, livelihood and food security activities and implements development programs targeting underprivileged communities, regardless of their nationality, political or religious affiliations. Amel also aims to strengthen the culture of rights among citizens, refugees, and migrants; to promote access to their rights and their involvement in society.

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Layout: Marc Rechdane

Front cover image: Syrian refugee and host community men and women attending a social stability session in Amel's center located in Khiam, Lebanon © Amel Association International

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Action Research Summary

This report has been produced with the financial support of the AFD within the framework of the project 'Health and Protection as a Vector of Social Cohesion' (Santé et Protection, vecteurs de cohésion sociale). The views expressed in this research do not necessarily reflect the views of AFD.

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Introduction

Eight years into the Syrian crisis, tensions between host communities and Syrian refugees in Lebanon continue to remain high and affect all spheres of daily life. The deepening economic crisis pushes more Lebanese and Palestinians from Lebanon into poverty and in need of services provided by institutions and organisations serving the most vulnerable. This crisis is also worsening the living conditions of the Syrian refugees. The primary healthcare sector has adapted to serve hundreds of thousands of refugees while taking measures to ensure access to health for host communities.

This action research explores how community-based healthcare centres can provide health and protection services in a way that promotes social stability. It finds that, given the centrality and importance of healthcare provision to both host communities and refugees, healthcare centres can act at the same time as spaces to exacerbate tension, but also provide opportunities to reduce it and create connectedness between different communities. The study clearly shows that the integration of social stability and conflict sensitivity into healthcare and protection services contributes to mitigate and decrease tension between different groups at the level of the centres by improving relations between staff and users and between users from different communities. This alone does not necessarily transform all community centres from 'healthcare and protection services providers' to 'active agents of change' on a wide scale in the community and the region. Consequently, this model needs to be contextualised.

The action research was produced as part of the 'Health and Protection, Vectors for Social Stability' project funded by the Agence Française de Développement (AFD) and implemented by Amel International Association (Amel), in partnership with International Alert (Alert) and Samusocial International (SSI). As part of the project, Alert accompanied Amel staff and extracted lessons and best practices from the work of three pilot centres in Mount Lebanon, Bekaa and South Lebanon. Over four years, as part of this project and an earlier phase in 2016–2017, Alert and Amel developed a comprehensive model on integrating social stability within service provision, and more specifically into the health and protection programmes at Amel centres.

The research was conducted in June–August 2019 by an independent academic researcher who collected evidence and lessons on the model. A validation workshop on the findings was held in September 2019 with active actors in the fields of health, protection and social stability.

Social worker facilitating a dialogue-based awareness session in a Primary Healthcare centre, Bazourieh, South of Lebanon
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Background on social stability

Tension between host communities and Syrian refugees remains high and a potential threat to the country's social stability. According to a regular perception surveys on social tensions publication,[1] the most cited perceived cause of tension for both Lebanese and Syrians is competition over lower-skilled jobs or for services and utilities, in addition to the wider regional and/or national political conjuncture. This uneasy tension is further exacerbated by the emergence of populist discourses, increasing the stigmas related to the refugee populations. While this official discourse coarsens, incidents of tension also appear on formal and informal media outlets. In fact, some observers note that Syrian refugees are being made a "scapegoat for all the political, economic, social & environmental turmoil that predate their arrival" into Lebanon.[2]

It should be noted that the subsequent ARK report finds that, even though the salience of the tension has "steadily declined" (from 2017 to 2019), the percentage of the public evaluating relations between Lebanese and Syrians as 'negative' or 'very negative' increased from 7.4% in 2017 to 16.9% in 2019.[3]

While it should be noted that a number of significant challenges, including systemic ones to accessing basic services, predate the crisis, from 2011 onwards, they began to take their toll on different sectors in Lebanon, including health, education and infrastructure. Healthcare is among the most important sectors that have been

1 ARK, Regular Perception Surveys on Social Tensions throughout Lebanon, Wave V, Lebanon: ARK, June 2019, https://data2.unhcr.org/en/documents/download/70101

2 C. Saghir, Propagating a hostile narrative towards Syrian refugees is more harmful than helpful to the Lebanese economy, Beirut Today, 28 June 2019, http://beirut-today.com/2019/06/28/narrative-syrian-refugees-lebanon/

3 ARK Group DMCC, Regular Perception Surveys on Social Tensions throughout Lebanon, Wave VI, Lebanon: ARK, August 2019, https://data2.unhcr.org/en/documents/download/71599

impacted by the increase in demand on services. As stated in the Lebanese Crisis Response Plan (LCRP, updated in 2019): "Since the onset of the crisis, Lebanon's healthcare facilities have been overstretched by an increase in utilization, 30 per cent of service recipients through Ministry of Public Health (MoPH) primary healthcare centres are displaced Syrian women, men, girls and boys."[4] This exacerbates the already strained public health infrastructure. In 2006, the 95 primary healthcare centres (PHCs) provided by the government benefited about 8% of the population, according to the World Health Organization (WHO).[5]

The leading sources of tension related to healthcare in Lebanon are numerous, some of which precede the Syrian crisis. The sector faces structural constraints with low public investments, in addition to its highly privatised nature (private clinics and hospitals), and suffers from relatively politicised and entrenched clientelist practices.[6] This leads to 'low' morale in Lebanese public hospitals, and intra-governmental disputes sometimes lead to staff salaries and hospital funds being held up for months.[7] In sum, it is a system that excludes people who are on the margins of power and, therefore, is "informally biased against non-citizens".[8]

In general, providing health services to the Syrian refugees is not "a matter of choice for the Lebanese authorities as the failure to provide assistance could lead to social tensions between the two communities" and to "risks of epidemics".[9] However, the way in which this tension unfolds at the healthcare centre level and what mechanisms should be adopted in order to help reduce it while increasing the level and quality of services has not been studied in depth. From this perspective and given the centrality of healthcare provision, it can be said that healthcare centres can act at the same time as spaces to exacerbate tension, but also provide opportunities to reduce it and create connectedness between different communities.

4 Government of Lebanon and UN Resident and Humanitarian Coordinator for Lebanon, Lebanon Crisis Response Plan 2017–2020, Social Stability Sector (2019 Update), https://www.unhcr.org/lb/wp-content/uploads/sites/16/2019/04/LCRP-EN-2019.pdf

5 World Health Organization, Health action in crises, Lebanon, WHO, August 2006, https://www.who.int/hac/crises/Lebanon_Aug06.pdf

6 B. Chen and M. Cammett, Informal politics and inequity of access to health care in Lebanon, International Journal for Equity in Health, 11(1): 23, 2012, https://doi.org/10.1186/1475-9276-11-23

7 S.E. Parkinson and O. Behrouzan, Negotiating health and life: Syrian refugees and the politics of access in Lebanon, Social Science & Medicine, 146, 2015, pp.324–331, https://doi.org/10.1016/j.socscimed.2015.10.008

8 Ibid.

9 K. Blanchet, F.M. Fouad and T. Pherali, Syrian refugees in Lebanon: The search for universal health coverage, Conflict and Health, 10(1): 12, 2016, https://doi.org/10.1186/s13031-016-0079-4

Methodology

The research aimed to produce evidence on successful ways of integrating social stability objectives into the medical, social and protection services in community-based centres. Its main objectives were to assess the success of such a model by identifying best practices, lessons learned and recommendations for supporting social stability through services provision. The evidence generated by the research forms the basis for an advocacy strategy for promoting the right to access basic and social services while developing social stability.

In the framework of this action research study, a c*ase-study approach* was adopted. Three healthcare centres were used as the focus of this study, due to the larger concentration of Amel's activities and staff accompaniment by Alert during the project implementation. The centres are located in Bourj El Barajneh (Mount Lebanon), Mashghara (Bekaa) and Tyre (South Lebanon), and serve populations with different demographic and social characteristics.

Tyre: the centre is located on a large boulevard in a large city of South Lebanon. Syrian refugees live in rented accommodation in the city, as well as in informal settlements and gatherings. It opened its doors in 1986 and started to provide healthcare services in 1995. In addition to health services, it also provides a wide range of vocational training. The centre consists of two floors: the ground-floor hosts clinics and the underground floor includes meeting rooms. It is accessible by public transportation. It has a strong and active Outreach Volunteer Unit and organises outreach activities, including through its Mobile Medical Unit. Awareness sessions were organised both in the centre and in people's houses.

Bourj El Barajneh: the centre was established in 1983 and has a long history of offering services to Lebanese and other nationalities living in this suburb of Beirut. The centre's proximity to Bourj El Barajneh and Shatila Palestinian refugee camps allows Syrian refugees from both the neighbourhood and the camp to use its services. The onefloor centre is also accessible by public transportation. In Haret Hreik, Amel has a Protection Mobile Unit, operated in partnership with the SSI.

Mashghara: the centre is the most recently established one, officially inaugurated in October 2011. Mashghara is a small town in Bekaa. Syrian refugees are settled in private accommodation in town and in informal settlements. The centre is located in a building that consists of two floors. Due to the lack of public transportation in the area, it is not widely accessible and residents from surrounding areas find it relatively difficult to reach. A recently established Outreach Volunteer Unit attracts both Lebanese and Syrian refugee volunteers. A Mobile Medical Unit is operated by Amel in the center's catchment area, mitigating the above-mentioned accessibility challenge.

In addition to healthcare services, the centres offer a range of other services, including medical and social awareness sessions for the elderly or migrant workers, vocational training such as photography or language education, campaigns, community events, GBV and youth programmes (e.g. in Tyre centre). In addition, a Protection Mobile Unit in Mount Lebanon offers protection and psycho-social support, and Medical Mobile Units operate in the three governorates of Mount Lebanon, Bekaa and South Lebanon.

Mixed research methods were used in the study, including:

a. **Literature and project documents review:** the study drew from secondary resources, which provided analysis and findings on public health trends in Lebanon. It also benefited from Alert's monitoring reports and context analysis, which provided a general understanding of the project's context and its development. Finally, Amel's centres' data and records provided information on the number of patients, according to their nationality, in the last three years.

b. **One-to-one in-depth interviews** (semi-structured) were conducted with key informants in order to explore the project from different perspectives, including Alert and Amel staff, PHC users and other stakeholders.

c. **Direct observation** of facility operations in the three centres was conducted. The physical space of the centres and how it affects the behaviour of the healthcare users (e.g. is there a space for users to interact; is the space welcoming; are there spaces to inform users about other activities, etc.) was closely observed.

d. **Half-day workshop with healthcare centres' heads and social workers** was held. The objective of this workshop was to interactively engage the centres' staff and social workers in the study as co-authors of the learning process. They reflected on their experiences and practices, and proposed adjustments. They are very familiar with the project and the healthcare beneficiaries' needs.

e. **Focus group discussions** (FGDs) drew on a quasi-random sample of healthcare users and non-users in order to analyse their perceptions of the centres and the healthcare services provided. Four FGDs were held with Lebanese and Syrian men and women in each of the three centres, including one discussion with healthcare users who also participated in the awareness sessions.

f. **A quantitative survey:** a questionnaire was distributed to and completed by 93 respondents (68 female and 25 male beneficiaries) in the three centres over a one-week period in order to collect data on specific questions relating to service users' profiles and how they access services.

Social worker providing an awareness session on family planning during a health campaign in Tyre municipality

Limitations

The main methodological limitations of the selected methodology include:

- Time for data collection was limited, which restricted access to some informants.
- The study relies on qualitative data and, therefore, is indicative of the centres in the study and the respective contexts of their operation.
- The recruitment for the FGDs proved to be extremely challenging. While it was very easy to recruit users, it was challenging to recruit a high number of non-users.
- Most of the healthcare users who participated in the FGDs were women, and, therefore, the analysis is influenced by a gender bias (for example, in Tyre, only one man participated in an FGD alongside 20 women participants).
- During data collection, it was difficult for study participants to identify specific projects, as Amel has a wide range of activities, which are not *per se* project based (for example, when asked about 'awareness sessions', it was not always clear to participants whether these sessions were specifically those of Alert/Amel or any other sessions organised and conducted within the centre). While on occasion this made it difficult to specify the exact project, the integrated nature of the social stability approach meant that activities were embedded within centres' activities.

Conflict sensitivity and social stability model of the project

Alert applied a 'coaching model' to integrating social stability objectives in Amel's community-based centres and their medical and protection services. The approach aimed at supporting Amel staff (administration, medical and social workers) to adopt new views about and skills in dealing with different communities and tensions inside the centres. Coaching involved training programmes related to conflict sensitivity, dealing with problems and stress, communication and mediation skills, advocacy and how to design conflict- and gender-sensitive campaigns.

The project convened different local coordination meetings with health and social stability actors and national actors, such as municipalities, to discuss local needs and sources of tension between different communities, as well as the role of service provision in reducing these tensions. In addition, the project organised health campaigns with social messages – cycles of interactive health awareness called 'dialogue-based awareness sessions' – both inside the centre and sometimes in other local community-gathering points, targeting groups of Lebanese and Syrians. Each cycle covers a series of sessions, such as family planning or dealing with stress and trauma, in addition to other topics chosen by the attendees. Indeed, health questions related to chronic disease or cancer are considered entry points to address sensitive issues that might compromise stability among different communities, such as mutual distrust and misperceptions.

Findings

Hypothesis 1: The integration of social stability and conflict sensitivity into the healthcare and protection services improves the ability to **mitigate and decrease tension** between the users of the community-based centre from different communities, and between the users and staff, **improving relationships and the working environment, and making the centre a friendly space for positive interaction**.

Table 1: Changes before and after intervention

Before the intervention	During and after the intervention
• Staff members are under a lot of stress • Tensions arise between staff members and users • Prejudices and misperceptions emerge between users of different nationalities • Staff and users unwilling to interact with the 'other' • Overcrowded space • Mismanagement of appointments	• Staff members are very aware of and vigilant about the role they play in social stability • Individual staff and users feel respected and treated equally at the centre • Individual staff and users consider the centre a safe space to express themselves • Relations between staff members is overwhelmingly positive • Space is more welcoming and friendly • Individual users engage in dialogue and start to share experiences • Bridging gap between communities

While the LCRP considers provision of healthcare services a (potential) source of tension primarily because people compete over resources, there are other equally important factors that contribute to this tension. As reported by all staff members, the centres were spaces of interaction at the beginning of the crisis where negative attitudes and scepticism towards the 'other' were generated and displayed. Perceived socio-cultural differences, concerns over hygiene, overcrowded waiting rooms and long waiting times all combined to create an unfriendly atmosphere. "The tension was mostly felt in the waiting rooms. Some Syrians were very tired and used to sleep on couches, which offended the Lebanese," recalled a staff member.[10] Some Lebanese started to voice their complaints in the waiting rooms of the centres where many of them "started to cover their noise".[11]

Conversely, Syrian users who were asked about their first experience in the centres felt "uncomfortable" because the Lebanese looked down on them and considered themselves "people who should have the priority to access the centre's services". In sum, Syrian refugees perceived that they were not treated "equally" and "were not comfortable", as narrated in various FGDs.[12]

The tension also arose in the centre's immediate and neighbouring environment: "Syrians used to come in numbers and wait on the street or even have breakfast there in front of the centre. Our neighbours were not happy at all and this put a lot of pressure on us [the centre's staff], as they started to criticise us."[13]

10 Interview with a staff member, Bourj El Barajneh, 16 July 2019
11 Interview with a staff member, Tyre, 17 July 2019
12 FGD, Mashghara, 9 August 2019; and FGD, Tyre, 8 August 2019
13 Interview with a staff member, Tyre, 17 July 2019

It should be noted that these dynamics were not visible in the case of the Mashghara centre, partly because the facilities are bigger and more space is available (waiting rooms, etc.), but mostly because the centre opened after 2011 and the "common perception is that it targets the Syrians".[14] In other words, and unlike the two other centres of Bourj El Barajneh and Tyre, there was no discernible difference before and after the crisis, as the Lebanese who go to the centre already know that they will encounter Syrians.

Centres' ability to mitigate tensions and relations between staff and users

Due to the integration of a conflict-sensitive approach in the PHCs, considerable changes have taken place, leading the centres to be able to alleviate emergent tensions. Significant efforts have been made to improve management in the centres, specifically by developing the skills to deal with tensions and grievances, as well as by more efficiently and fairly organising the doctors' schedules. This action research shows that the service provision is based on an inclusive approach, which has been reinforced by the project. In fact, as clearly stated by a frontline staff member (receptionist), the training she received in the framework of this project has made her "more aware of her responsibility towards the users", and she realises "how important it is not to differentiate between anyone".[14] In fact, this shows not only the importance of introducing a conflict-sensitive approach into healthcare provisions, but also that it reaches out to all staff members, including – and perhaps more importantly – frontline workers.

In general, this was echoed during the FGDs when some participants highlighted problems that they used to face (such as perceiving that they were deprioritised) and stated that this is no longer the case. "I once faced a problem with a staff member … I never face this kind of problem again."[15]

In fact, after following the training with Amel's trainers and coaching by Alert, Amel's staff members have created new ways to address the many challenges they used to face on a daily basis. For instance, in one of the centres, staff members have dedicated a special room for breastfeeding, as breastfeeding in communal spaces made some Lebanese patients uncomfortable. This measure responds to the needs of users – both Syrian and Lebanese – without necessarily compromising anyone's freedom.

In addition to Alert's efforts to train and coach staff, a parallel process was taking place, which also contributed to a significant improvement in the services. Amel is working in close coordination with the MoPH for the implementation of the accreditation of its centres,[16] which according to a recent study is a "first step towards improving the quality of PHC delivery arrangement system" in Lebanon,[17] which ultimately benefits all users of different nationalities. This underlines the importance of state institutions as actors in promoting better services. In other words, national institutions are accountable to ensure the right to health and play a major role in improving the quality of the services, which positively impact on the satisfaction of the individuals, and therefore on their wellbeing and social stability.

14 Interview with a staff member, Tyre, 17 July 2019

15 FGD, Tyre, 8 August 2019

16 Republic of Lebanon, MoPH: "Within the vision of the Ministry of Public Health in Lebanon to pursue excellence and improve the quality of health care, the Ministry of Public Health in Lebanon established in 2010 a partnership with Accreditation Canada, an affiliate of the Health Standards Organization (HSO) to abide by PHC Accreditation Standards." For more information, please see https://www.moph.gov.lb/en/Pages/6/755/accreditation-primary-health-care-centrecentres.

17 F. El-Jardali et al, The impact of accreditation of primary healthcare centers: Successes, challenges and policy implications as perceived by healthcare providers and directors in Lebanon, BMC Health Services Research, 14(1): 86, 2014, https://doi.org/10.1186/1472-6963-14-86

Relations between users of different backgrounds

While the quality of healthcare service provision is important in building a healthier community, it does not on its own imply that people interact and, therefore, contribute to reducing the tension between different communities. In fact, it is ensuring access to health with a conflict-sensitive approach – simultaneously targeting staff members and centre users from different communities through dialogue – contributes the most to social stability.

This is clearly reflected in the demand for and importance of awareness sessions. Almost all participants in FGDs who took part in them requested additional sessions. Participants in an FGD "believed that the psycho-social support provided by the centre would contribute to the public's health and would reduce conflict between members of the two communities".[18] While healthcare service provision remained the most important component for those users who did not take part in the awareness sessions cycles (who requested more services and additional specialised doctors), participants of dialogue-focused awareness-raising sessions felt that dialogue and communication between communities was as important as the healthcare services provided by the centre.

The awareness sessions and everyday support provided by the centres' staff members to the users have led to visible changes in the individual behaviours of centre users. According to a medical doctor at one of the centres, "I have noticed a huge improvement; now they have more appropriate general conduct and do indeed take more care of their health."[19]

To conclude, to a great extent, the project improved the atmosphere in the centres and the relations between centre users and staff members, and the awareness sessions positively influenced individual perceptions of the 'other' community. This is clearly reflected in the working environment and by the centre becoming a friendly space for positive interactions, where respect, equality and humanitarianism prevail. The relations between the healthcare users and centres' staff members became overwhelmingly positive. Indeed, staff members have become very aware of and vigilant about the role they play in social stability. Moreover, the project opened the space for positive interaction between different communities through introducing dialogue sessions, health campaigns, and other community events and services. All of this was carried out with an inclusive and participatory approach, which has made the centre a friendly facility, providing engaging social events and activities. Beneficiaries who participated in the awareness sessions cycles were positively affected and admitted that the sessions changed their behaviour and perceptions towards the 'other', not only setting the foundation for resilient individuals but also bridging the gap between different communities. If it is capitalised upon, this change at the individual level can contribute to more social stability.

Hypothesis 2: Social stability and conflict sensitivity, once integrated in a community-based centre's strategy and services provision, have the potential to transform the centre from a 'healthcare and protection services provider' to facilitating a **higher level of social engagement**, so it in effect becomes an 'active agent of change' contributing towards social stability in the area.

18 FGD, Baajour, July 2019

19 Interview with medical doctor, Baajour centre, Baajour, 16 July 2019

Table 2: Situation pre-crisis, and changes before and after intervention

Before the crisis	Before the intervention	During and after the intervention
• **Lebanese users visit the centres to receive services (exception is the centre that opened in 2011)**	• Number of Lebanese users decreased • Centres seek the accreditation of the MoPH and improve services • Tension depends on external factors • Centres are mostly used by refugees	• Lebanese citizens come back to the centres to receive health services as a result of MoPH support and introduction of equally subsidised consultation fees for Lebanese and Syrian users • Dialogue sessions are organised in the centres • A number of visits are organised and joint activities are conducted between participants in awareness sessions • Friendships are consolidated outside the centres • A number of sessions are organised in partnership with local stakeholders • Outreach sessions are organised by the centres • Lack of coordination mechanisms

According to the interviews with PHC staff members, and based on FGDs with Lebanese non-users, Lebanese users stopped frequenting the centres for numerous reasons, ranging from their fear of disease transmission to their lack of a sense of ownership, as well as the general high number of users, etc. For instance, in one of the FGDs with non-users in Tyre, at least four out of six Lebanese stated that they do not go to the centre because they "are afraid of contracting viruses and because centres have become very crowded and one has to wait for longer hours".[20]

Amel's staff members in the three centres confirmed that many Lebanese have started to visit the centres again because of the new programmes introduced in the process of the MoPH accreditation, which provide 'free tests' to the Lebanese (blood, diabetes tests, etc.). This suggests that this category of Lebanese is likely to belong to the 'most vulnerable population' who only came back because the services and medical tests are now free or are subsidised compared to other potential providers (PHCs or private clinics).

20 FGD, Tyre, 18 July 2019

During a medical consultation carried out by Amel staff © Amel Association International

Challenges

While the study revealed several areas of good practice and successes, there were still a number of challenges to integrating a social stability approach.

Involving Lebanese users in awareness sessions

For various reasons, social workers were not always able to recruit and secure a balanced representation of different nationalities and cultural beliefs in awareness sessions, which were the main activity designed to facilitate dialogue between Lebanese and Syrians. This might also contribute to compromising the objectives of social stability. Lebanese participants constituted only 29% of all participants in the sessions, most of whom were part of the Tyre centre activities. Staff members noted that the Lebanese did not seem interested in taking part in such activities.[21] One explanation for their lack of participation is employment (i.e. not being available for sessions due to working hours), which points to the potential for activities held outside working hours to attract more participants.

21 Interview with a staff member, Bourj El Barajneh, 16 July 2019

Involving men in awareness-raising sessions

Awareness sessions primarily targeted women. Due to the centres' working hours and holding sessions in the mornings and early afternoons, and the participatory selection of topics by female participants in attendance, sessions became almost exclusively focused on the priorities presented by women. While these became safe spaces for women (see below), this focus left out a key demographic. Future awareness-raising sessions should engage men, especially as they often have more of a role in decision-making. For example, according to the head of one centre, "women we meet and train respond in a great way to training and sessions; however, they do not have enough agency as it is the men or the mothers-in-law who are the ones to make the decisions at home."[22]

Recruitment process for awareness sessions

The survey revealed that there are two main channels through which people learn about the centres: 1) word of mouth or informal networks, and 2) international organisations (specifically UN agencies in the case of the Tyre centre). Those who did participate in the sessions were recruited individually or through social networks. This raises an important point that needs to be addressed: it is most likely that the most vulnerable people (those who do not benefit from social connections) are not being reached by such cycles and risk losing a great opportunity to express themselves and participate.

To address this, staff deployed different strategies to reach out to those who do not come to the centres. In Tyre, for instance, further to the Mobile Medical Unit helping with outreach, staff members conducted awareness sessions inside participants' houses in order to ensure the participation of both nationalities and to save them the travel fees. Similarly, staff in the Bourj El Barajneh centre drew on their networks to reach out to people (specifically those who do not often visit the centre) and organised outreach in collaboration with local NGOs and local actors (such as the municipal PHC and the family planning centre of the municipality).

Coordination mechanisms at the local level

In order to receive accreditation, the centres need to be part of coordination committees involving local stakeholders (municipalities, etc.). These efforts, however, are not strictly limited to the willingness or capacities of Amel's centres to organise such structures and oversee their activities. According to Amel, the main problem in establishing these local coordination structures is that "municipalities are not often mobilised and NGOs show a 'fatigue', or they have different priorities for social stability (football pitches)".[23] In previous phases of the project, Alert had supported the facilitation of such coordination sessions; however, in subsequent phases (including the ones assessed in the study), these activities were developed and contextualised directly by Amel in order to reinforce their local ownership.

22 Interview with a staff member, Bourj El Barajneh, 16 July 2019
23 Interview with Amel programme manager, 11 July 2019

A woman attending social awareness session in one of Amel's centres in Bourj Al Barajneh, Lebanon © Amel Association International

Conclusion

While a better and more high-quality primary healthcare system leads to better health outcomes and eventually a healthier society, this study shows that integrating a conflict-sensitive approach to health and protection services does contribute to better outcomes at the individual level of healthcare staff and users and at the level of the healthcare centres. This dynamic eventually contributes to institutional improvement and, therefore, consolidates the position and role of the healthcare centres at the local level. It is also clear that the MoPH accreditation is an important step towards improving the quality of the PHC delivery arrangement system, the expansion of coverage and the increase in the number of users. The coaching model was found to be effective, and staff should continue to receive cycles of training in order to equip them to deal with a potential increase in the number of users due to the worsening economic situation, to prevent a repeat of the challenges faced by frontline services in the first two or three years of the Syrian crisis.

Activities organised by the centres have succeeded in engaging communities. Health campaigns and outreach organised by staff and volunteers informed Lebanese and Syrian refugee members about available services, and, in some areas, managed to recruit participants for mixed-nationality awareness sessions. Overall, however, the *impact of community engagement is more limited when it comes to change at the community and wider systemic levels*. Even though social stability and conflict sensitivity have been integrated successfully into the centres' strategies, they do not necessarily transform the centres from 'healthcare and protection services providers' to 'active agents of change' who could have an impact at the country level on social stability. This requires more systematic efforts engaging local and national stakeholders with wider mandates, such as the relevant line ministries, the municipalities and other local associations. Additional actions are needed to turn healthcare centres into 'active change agents for social stability' through (re)activating coordination mechanisms and conducting wider outreach to community members of different nationalities and socio-economic backgrounds. Finally, funding should provide for further integration of conflict sensitivity and social stability objectives in healthcare and protection services, as well as other sectors.

Opportunities for integrating social stability outcomes in healthcare and protection services

Based on lessons learned from good practice in this project, this section identifies a number of good practices and opportunities to integrate social stability into healthcare and protection services.

Building a friendly environment within the centres

All three centres faced immense pressure during the first years of the crisis, largely due to the high number of new users, most of them Syrians. This significantly contributed to tensions between different users, whether because of reasons related to presumed lack of hygiene, fear of epidemics spreading or cultural sensitivities. As one social worker in Tyre stated: "at the very beginning it was really difficult to manage the crowd". However, with this programme and other major quality initiatives, such as the MOPH accreditation, these problems are no longer highlighted by staff or users. In all FGDs conducted, participants expressed how satisfied they are with the services and their relationship with the staff. The study finds that there are clear improvements in the attitude of the staff towards the patients. Four FGD participants confirmed that they were challenged at some point and encountered angry staff but that was at the very beginning and no longer happens. "Now they are very organised, they respect everyone and treat everyone equally."

Partnership and coordination

Partnerships between healthcare and protection providers and peacebuilding organisations are 'mutually beneficial' and allow for the gradual integration of conflict sensitivity and social stability into health, protection and social activities. They also highlight the importance of – and the need for – organisations working on different sectors related to the Syrian crisis to collaborate and explore how rights-based approaches can be complemented by peacebuilding efforts.

Relevant health topics as entry points for social stability

This study finds that the topics presented in the dialogue-based awareness sessions were very well received by the participants. Indeed, topics were chosen in an interactive manner. As reported, FGDs were conducted from the outset in order to identify topics that might be of interest to the participants. Participants, therefore, in some cases proposed some topics, which were taken on board by the facilitators. This raised their sense of ownership of the process.

Outreach to potential beneficiaries and tailoring activities

The use of volunteers, Mobile Medical Units and collaboration with other organisations resulted in more successful recruitment of participants in activities aimed at enhancing social stability. As demonstrated by the Tyre centre, which collaborated with UN agencies in recruitment of participants, awareness sessions had a better balance between nationalities, which is an important precondition for strengthening acceptance and solidarity between groups. Centres can increase their chances of working with different communities when they schedule activities outside working hours and design sessions based on specific interests (i.e. of working men). Furthermore, parallel activities for children could both provide an additional incentive for mothers to participate in the sessions and reduce their level of stress and distraction.

Be part of a larger project and vision

The project success on a more systematic level is also dependent on the integration of the project in a larger vision for the complementarity of healthcare, protection and social stability objectives, whether that of Amel or Alert. This collaborative and equal partnership between Amel and Alert helps to establish a trust relationship and mutual contribution to the project's output. Another success is that the centres are now deploying efforts in order to receive the accreditation of the MoPH: "the ministry has asked us to meet these criteria". Hence, the conflict-sensitive approach is coupled with serious efforts to improve the work at the centres. The organisations working in unison contributed to make the PHCs more professional and a catalyst for stability.

Rights-based approach

Social rights, including right to health and protection, are ensuring dignity for all the populations. This approach relates to the universality aspect of those human rights. Hence, Amel's vision is non-discriminatory and contributes to social cohesion, while ensuring access to social services for all populations.

Sessions have empowered women

The study finds that the awareness and dialogue sessions also play a major role in empowering women, helping them to find a better place for themselves in society: "I now know how to defend my rights, and express my needs. I know how to defend the others. At some I stood up for my neighbour's rights who was continuously bullied by the landlords." Additionally, women are more aware of their peers' socio-economic conditions, which has helped to stop the prejudice against them: "I used to see a Syrian woman holding the gas cylinder on her head and walking home. I used to judge her for being mistreated. But now I understand that she's a strong woman and fulfilling a big role; something that I don't do."

Key elements of a centre, which support social stability

Proximity: Where 'staff and patients share a same territory' is very conducive for cooperation and mutual understanding. Social workers and heads of centres are part of the social fabric and play a role in bridging the gap between the centre and the community (visits to people, paying condolences, etc.).

Centres as 'socialising space': Centres that act as a space to socialise beyond their primary service delivery functions support social stability goals (such as excursions, exercise or other recreational activities).

Collaborative practices among staff members to manage stress: These include formal and informal coordination mechanisms and peer learning from each other at centre level.

Work with management as well as frontline staff: What is important about this project is that it also expanded the scope of training beyond the social workers (who conduct the awareness and dialogue sessions) to include medical and administrative staff.

Centres have more equal and less hierarchical structures valuing different roles: Training and coaching involved all staff and was structured in a way to support and empower different staff members and highlight different expertise as complementary and of equal value to social stability, far from a hierarchical division of responsibility. As one doctor noted: "A social worker's role is complementary to ours … they help us a lot preparing the group through the social and psychological training they provide to patients."

Amel staff providing medical care in a Mobile Medical Unit, Lebanon © Amel Association International

Recommendations

Government stakeholders:

Develop and implement a vision for contributing to social stability via the MoPH and healthcare centres. While stability, or lack thereof, is influenced by an array of factors (political, economic and security), it is clear that the MoPH accreditation and support to healthcare centres has contributed to the increase in the numbers of Lebanese accessing PHCs. This implies that national health policy and the involvement of national and public institutions are essential in supporting these centres and, therefore, contributing to turning them into spaces for interactions between different communities. There is an opportunity for the MoPH to actively support PHCs to fulfil a role not only in service provision (medicines, etc.), but also in improving the wellbeing of beneficiaries through a rights-based and conflict-sensitive approach. This can be achieved through coaching and training healthcare centres' staff, awareness raising in communities addressing both health and social needs, and dialogue sessions that enhance relations among different communities.

Encourage, support and actively participate in local coordination mechanisms and structures. These committees should involve municipalities and other relevant local stakeholders representing different sectors (health, protection, etc.) in analysing the communities' priorities and the main sources of tension, and design suitable and relevant interventions and approaches to contribute to social stability. Committees could further organise dialogue sessions between members of the community to address local needs and make referrals.

International community, including donors and international organisations:

Encourage and incentivise conflict-sensitive cross-sectoral projects. This could be done by integrating requirements for conflict sensitivity and/or cross-sectoral partnerships that combine humanitarian/development and social stability aims into calls for proposals, and assessing prospective projects for conflict-sensitivity criteria, such as ensuring that they are built on a sound context analysis. Where donors have made conflict-sensitivity expertise available to development partners, either through in-house conflict advisers or outsourced via drawdown mechanisms, this has also been shown to be beneficial. By allocating only 10–12% of the overall project budget to ensure a proper implementation of the conflict-sensitive approach, donors will be supporting 'quality' services to beneficiaries, enhancing the working environment for the partners' staff and playing a greater role in stabilising relationships between different communities. Donors can also create opportunities for cross-sectoral partnerships and synergies to develop by encouraging networking and joint idea-formulation activities between development, humanitarian and peacebuilding partners.

NGOs and PHCs (National level):

Invest in staff capacity development. Training and support should be provided to centres' staff to allow them to integrate social stability objectives into their work and to act not only as a 'service provider' but also as an 'agent of change and contributor to social stability' (training can include stress management and communication and facilitation skills). The working personnel can be empowered through coaching by experienced colleagues and partners, including from peacebuilding organisations, to help them put into practice the acquired information and skills, and extract learning.

Provide spaces for positive interaction between the centre users. This can be done by managing existing services to be more inclusive, and should include interactive, dialogue-based approaches in awareness sessions, outreach and other campaigns that aim to tackle misinformation and stereotypes, and build shared understanding and relationships between different community members.

Increase outreach to vulnerable populations, such as children, youth, elderly, people with difficult socio-economic conditions, people with disabilities and refugees. This will increase the overall number of centre patients, particularly if they experience a friendly environment and are received by personnel who are able to mitigate tensions and address their needs with adequate services and adaptable approaches to their culture.

Provide support to staff and take care of their wellbeing. Staff members are not completely immune to the crisis and are often under a lot of pressure. Therefore, there is a need to: a) organise follow-up training addressing their own well-being; like how to deal with stress and conflicts inside the centre and other team-building activities; and b) design parallel, complementary activities, such as excursions or recreational activities, that enhance their wellbeing and support their resilience at work.

Practitioners including Amel and Alert

Scale up awareness sessions to reach the most vulnerable populations and take into account gender dynamics. Awareness sessions should be expanded to reach out to those who cannot commute or visit the centres. For example, out-of-hours sessions can be held for men, many of whom work during the centres' opening hours, and alternative locations can be used for those who are not able to move freely for reasons including protection and security. Sessions could also be targeted at young people, perhaps in partnership with youth clubs and organisations, in order to reach those who are less likely to go to the centre to seek services.

Develop a systemic approach for recruiting participants in centres' activities. It is important to include the different staff departments, including medical, social, protection and livelihoods teams (if present inside the centre), and develop a strategy that helps increase the number of participants in activities contributing to social stability, such as awareness and dialogue sessions. For instance, in the pilot centres, participants of previous awareness cycles played a major role in recruiting new people by forming an Outreach Volunteer Unit consisting of two or three members each from Lebanese and Syrian nationalities. In addition, the centres should advertise for the upcoming dialogue cycles and campaigns inside the centres as well as in the mobile units and open the door for registration.

Adopt and scale up an accompaniment/coaching model to integrating conflict-sensitive methods in service provision. Building staff capacities should not rely solely on traditional forms of training but should involve accompaniment in order to follow up with staff and support them while they organise, conduct or evaluate the dialogue sessions. The accompaniment model should involve frontline staff equally. It is important to encourage peer learning and dedicate experienced staff to provide coaching on conflict sensitivity for other departments and new staff members.

Amel staff providing services for Syrian refugees in informal settlements during an outreach activity

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