TRAINING MANUAL

on Interpersonal Violence Prevention
and Stress Management in Health Care Facilities

HEALTH CARE IN DANGER IT'S A MATTER OF LIFE & DEATH

Norwegian **Red Cross**

CONTENTS

FOREWORD

Why a manual on interpersonal violence prevention and stress management?
In many contexts, the safe delivery of health care services is challenged by the lack of respect for health care personnel who face insults, threats and violence. Consequences include the disruption of health services, high staff turnover in health facilities, high levels of stress impacting the quality of the services and health care personnel being forced to flee. This manual intends to complement the existing training materials and is aimed at supporting staff in health care facilities to cope with stress and violent experiences, including how they can protect themselves by de-escalating potentially violent situations.

Specific scope of this training manual
This manual was purposefully defined around the notion of the moral integrity of the personnel in health care facilities, from the individual perspective, as opposed to a global rights-based approach that would apply for all. In other words, this manual focuses on individual protective behaviours, challenging the personnel in health care facilities to recognize their responsibility and role in situations of interpersonal tension and conflict. The development objective seeks to empower the personnel to act pro-actively through a self-protective, but still empathetic and caring attitude in order to reduce conflictual situations in the health care facility. The manual is furthermore designed to involve participants actively in the learning process and to extract practical measures for context specific situations using a participatory approach.

Our goals
The overall and long term objective of this manual is to contribute to a self-controlled behaviour and a reduction of violent incidents, the stigma and taboo that can be associated with violence and its emotional resultant. The latter being a key step in helping the personnel in health care facilities to relinquish their feeling of "helplessness" vis a vis violent incidents.

The aim is to sensitize personnel in health care facilities on the active role they can have in de-escalating or preventing tense and violent situations from arising in their workplace.

- **Goal 1:** Equip personnel in health care facilities with simple and practical skills on interpersonal conflict prevention and stress management.
- **Goal 2:** Reduce the number of threats and violent incidents in health care facilities.
- **Goal 3:** Reduce the stress level and limit the potential impact of threats and violence on the working environment in the health care facility.

Our priorities

- Improving the local, regional and international capacity to respond to situations of violence and harassment directed at staff in health care facilities.
- Develop a specific expertise in interpersonal violence and stress management for one of the most commonly observed types of violence against personnel in health care facilities[1].
- The Norwegian Red Cross (NorCross) could also envisage to assist with technical support to Movement partners requiring further guidance on how to use the manual.

Background

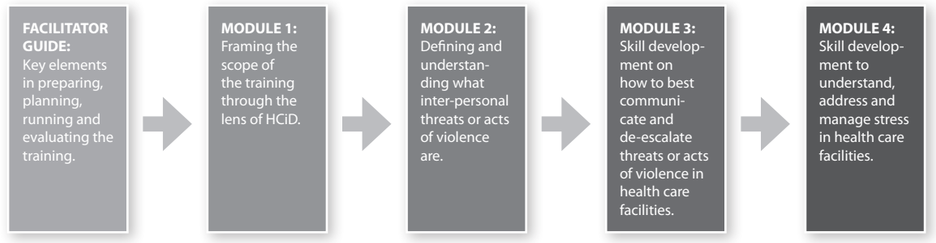
The manual was developed on the basis of a number of pilot trainings carried out in Lebanon, Colombia and South Sudan in 2014 and 2015. This unique learning experience allowed for the pedagogical approach to be elaborated empirically, based on the participants' experiences of threats and violent incidents in their working environment. The findings of several previously organized expert consultations[2], also underpin the development of this manual. Some key elements of the content as well as the approach to conflict management is borrowed with consent from the Street Mediation methodology developed by NorCross.

For whom is this training manual?

This manual has been designed for Red Cross Red Crescent facilitators to teach and sensitize personnel in health care facilities.

Learning content

The manual includes four key modules in addition to a facilitator guide. It aims to facilitate adult learning with interactive learning sessions, as well as plenary and group reflections. Its learning sequence is illustrated below:



Facilitators may decide which modules to use according to the needs, time available and the level of the participants. The facilitator guide provides key support to the facilitator in preparing the sections suggested in each module while modules 1 to 4 provides information and suggestions to interactive activities addressing the thematic content. Key principles are then elaborated by the group, drawing on observations and lessons learned from the activities and role plays. The follow up of the participants post-training is not provided here, but should be considered developed in a future manual. The participants could define individual plans of action, depending on their specific contextual environment and challenges.
A key element for the success of the training remains the participatory approach. This is necessary in order to generate the required ownership for the group to become the driving force behind the recommendations and coping measures that are generated by the training.

Output

In order to ensure concrete output that can contribute to safer delivery of health care services, the training will also result in a set of good practices that can be implemented at the health care facility. Throughout the manual tasks are specifically marked for the facilitator to compile recommendations and good practices identified by the participants. These will be consolidated into a document that the group presents to their senior management.

1 The total number of acts or threats of violence that affected at least one health care provider = 2624 cases, cf. ICRC HCiD
2 Expert workshops on HCiD held in London, April 2012, Cairo, December 2012, Ottawa, September 2013 and in Pretoria, April 2014.

FACILITATOR GUIDE[3]

The materials included in this guide are intended to support you as a facilitator as you prepare yourself for facilitating the different modules of the manual. You are encouraged to adapt any of the materials or timing of activities to the needs of your participants, as well as to your preferences and knowledge.

This guide is divided into two different parts. Firstly, it provides a pedagogic frame and support, highlighting what is important to remember when facilitating and presenting in front of a group. Secondly, it provides you with useful tips for the planning, conducting and evaluating of the training.

LEARNING OBJECTIVE

The first part of the facilitator guide focuses on soft skills and aims at helping you as a RCRC trainer to understand the importance of, and enable you to practice, the basics of the participatory approach and its specific interactivity with your audience. It aims at providing you with skills and tips to best facilitate, activate and engage your participants. You should be able to identify and select different facilitation techniques, to find your way of interacting with the participants and to replicate these techniques during the sessions in the manual. This first part of the facilitator guide is proposing the following essential levels for your preparation:

- Getting an overview of the techniques and selecting the best way to facilitate the dialogue
- Providing basic theoretical concepts on communication
- Mastering a few tips and ground rules to help you gain the necessary self-confidence as a trainer
- Understanding the basics of adult learning

The second part of this facilitators guide focuses on the structural elements of the training and aims to assist you as a facilitator to plan, prepare and conduct the training sessions systematically. It also advises on how to evaluate the training together with the participants and how to evaluate yourself (and alternatively your co-trainer) as facilitator(s).

Expected outcome

This guide will assist you in finding your way of interacting with your audience, your own training style and techniques. We hope it also will inspire to search for more information.

THE FACILITATOR ROLE[4]

Being a facilitator means that you will enter into a process of continuous learning and personal development. To facilitate workshops can at times be challenging, but also very rewarding. The facilitator role differs from more "traditional education" as the participants first and foremost are going to learn from each other. As such, your role will be primarily to facilitate constructive processes, ask good questions and summarize reflections. The more participants contribute and the more knowledge that comes from the participants themselves, the better. The quality of the workshop depends a lot on how you as a facilitator facilitate and control the process in the group. An experienced facilitator has the ability to balance between structure and flexibility of the processes.

3 Core elements of the facilitator guide is borrowed with consent from 1) the IFRC manual on Community-based health and first aid in action (2006) and 2) the Street Mediation Manual developed by the Norwegian Red Cross. If interest in the street mediation manual, please get in direct contact with the Norwegian Red Cross. The IFRC manual can be found in this URL: [21 October 15]: https://www.ifrc.org/Global/Publications/Health/145600_Facilitator%20guide%20CBHFA%20in%20action%20volume%201-LR.pdf

4 Adjusted with consent from the Street Mediation Manual.

- The facilitator is not a regular member of the group, but is present to aid the participants and primarily focused on the process.
- The facilitator is an active listener who sees both individual and group needs.
- What is being said in the group should not be addressed primarily to you. Ideally, it should be a conversation between the participants. As you get more experience as a facilitator, it becomes easier to facilitate such a group dialogue.
- Be open and honest. If you say something wrong: admit it immediately to the participants.
- Allow silence and time to think – including silence lasting several seconds.
- Summarize discussions / reflections and get participants to elaborate on important topics.
- Provide praise and recognition when participants share something difficult/personal, contributed with good reflections or finally dared to share their opinion in plenary.
- Use stimulating expressions such as " interesting", "exciting", "could you say more about it" to encourage participation.
- Observe the body language and reactions of the participants.
- Do not be afraid of feelings. If someone is crying: give the person time, calmness and attention. If the person seems to be ready and able to move on, thank him/her for sharing and continue with the process. Take the person aside in the first break and ask how he/she is. If, on the other hand, the person needs to take a break during an activity, one of the co-facilitators should follow the participant outside and follow-up, while the facilitator has the main responsibility for continuing to implement the activity with the group.
- Be confident and dare to set boundaries - refer to the working agreement (see below) when needed.
- Share from your own life and thoughts, but always with the group's learning and development in focus.

When facilitating and presenting

While speaking, try to communicate with the entire group rather than focusing on one person. Use eye contact if it is appropriate in your culture. Making eye contact helps to establish a connection with your participants. It also helps to read your audience and see whether they are confused or understand. Walk around the room as you facilitate. Use gestures and movements to make your points. Walk towards the participants as they respond to your questions or make comments. Your interest in their comments will encourage them to continue to be involved. Show enthusiasm and be passionate about the topic. Your energy and excitement will help keep your audience excited about the information that you are presenting. Your smile is your ultimate asset! The facial expression partly reflects the inner state of mind and a dynamic facial expression shows curiosity, passion, enthusiasm and happiness. It is also important to find a good position that makes you feel at ease while presenting and facilitating, though one should avoid half-seated postures and rather be firmly positioned with both feet grounded.

Controlling your breath is one way to remain physically and mentally focussed on the task, especially if you are nervous. Performing a breathing exercise before and during the training session might help you to relax and focus.

When talking, focus on your voice and make sure it is clear and distinct and easily understood by the audience. A presentation or lecture can convey information, theories or principles quickly and easily. Presentations can range from a lecture to the involvement of participants through questions and discussion. As a general rule, presentations should not be longer than 20 minutes. Tools that can be utilised during introductory presentations include videos and power point slides already available on the Health Care in Danger platform and website.

It is normal for a trainer to feel stage fright, which could potentially affect your performance.
In order to deal with stage fright:

- Prepare the session well in advance.
- Practice with colleagues.
- Get familiar with the premises in advance of the session
- Speak out loud and clear to gain confidence in the sound of your voice.
- Maintain a positive attitude towards your performance.

In the case of a troublesome and stressful situation, it is advisable that you admit your difficulty in order to gain understanding from your audience to help overcome the uncomfortable situation. Confidence on stage comes with practice.

A lively and constructive dialogue amongst participants is critical in order to learn from one another and elaborate the group knowledge. Therefore, make sure that you find the right facilitation style in order to:

Create a safe environment
Always try to make a safe and positive atmosphere in which the participants feel free to speak about their thoughts, experiences and feelings. Give positive feedback for participation and sharing of thoughts and ideas, even if the answer is not "right".

Include everyone
Always make sure to include everybody when doing exercises and encourage everyone to speak. Do not give all your attention to the ones who talk the loudest. Adapt your activities to the group – if some participants are "drowning" others (some are taking a lot of space, or others are very shy), it can be a good idea to use more work in pairs and groups, or sending a "talking stick"[5] around to make sure that everyone is heard. Do not let an exercise become a dialogue between 2 participants. Steering the discussions with good questions, avoiding technical jargon, being clear about your objectives throughout the training and getting someone to summarise what was said in the different sessions are all good ways of ensuring an inclusive dialogue.

Be time conscious
If you allow an exercise to drag out, be conscious of why you do this and how it affects your program as you will need to shorten or cut other activities. It is generally recommended to include a 15-30 minute buffer in the program to allow time for interesting reflections and discussions that arise along the way.

5 Only the person holding the talking stick is allowed to speak – see page 9.

Adult learners[6]
The participants in this training will be adult personnel working in health care facilities where inter-personal violent incidents are occurring is therefore important to ensure that you facilitate an effective, positive and constructive learning environment adapted to adult participants. The following elements are good to be aware of during the training and to include in your preparations:

- Adults prefer a learning environment where they feel valued and respected for their experiences.
- As a facilitator you should ask participants to share their stories. Make sure that you give positive reinforcement when they contribute by acknowledging and thanking.
- Adults prefer learning to be active rather than passively sitting and listening to you, although this may vary from one context to another. It is important that you give participants opportunities to take part in a variety of activities such as discussions, games, problem-solving case studies or brainstorming.
- Adults will be actively engaged in learning if they can see how the training will meet their needs.
- As a facilitator it is important to identify participants' learning needs, and to explain how the training content will be of benefit to them.
- Adults want to direct their own learning. Provide opportunities for participants to make choices so that they can decide which skills they need and want to learn.
- Adults have varied learning styles. Some adults learn best visually, others by listening and others by doing. Use a variety of training methods in order to accommodate all learning styles.
- Adults learn new content when it relates to something they already know. Link new content to existing knowledge with analogies or stories.
- Adults appreciate having an opportunity to apply what they have learned as soon as possible.
- Adults will learn and remember content when it is reinforced with repetition. Try to repeat key concepts, but vary the context to show different applications.
- Adults are motivated by encouragement. Be sure to reward participants with positive feedback and express appreciation when they participate.
- The adult attention span is between eight and twelve minutes. Follow the "90-20-8" rule. Take a break every 90 minutes. Change the activity every 20 to 30 minutes. Change the pace of the activity every eight minutes.
- Adults will remember 70 per cent of what they say and write. Encourage them to summarize newly acquired knowledge.

FACILITATOR TOOLS AND TECHNIQUES[7]

There exists a wide variation of interesting facilitation tools and techniques and it is important that you as a facilitator find the techniques that you are comfortable with and that provide the support necessary in communicating the content of the module. You may adapt and use other techniques depending on your personal preferences, as well as the context and culture potentially affecting group dynamics.

6 These paragraphs on adult learners are adjusted with consent from the IFRC manual on Community-based health and first aid in action.
7 This chapter has been inspired by and borrowed content from both the Street Mediation Manual and the IFRC manual on Community-based health and first aid in action.

Pre- and post-tests
In order to help you measure the extent to which the learning objectives of the modules have been reached, a pre- and post-test can be applied during the training. Scoring on various test questions can identify which concepts or skills were facilitated well and those that may require additional time or a different type of activity. Pre and post-tests measure information gained rather than acquired skills or attitudes. Behavioural improvement is best assessed through observation of skills and supervision in their working environment. The test results can also be used as a way to document results towards the National Society, the back donors and potential partners.

The work agreement
The work agreement, as suggested in activity 4, sets the standard for expected behaviour during the workshops. It is the participants themselves who set the rules. In this sense, throughout the workshop the facilitators are only helping the participants abide by their own rules. This gives the participants ownership to the work agreement and a sense of being taken seriously. It is an important tool that you may revisit during the training if need be.

The talking stick / microphone
The talking stick was traditionally used as an instrument of democracy in aboriginal tribal councils, where a stick or feather was passed around from member to member allowing only the person holding it the right to speak. The talking stick in a training might be a beanbag, a ball or other object which has a similar purpose – to allow the person that holds the object to speak without interruption, and no one may speak without having the object in their possession.

The gatherings
Each module could be opened and closed with a gathering, where the talking stick is passed around the circle and the participants in turn give their opinion or answer a question. The purpose is to gather the group's attention, reflect and give a common opening and closing of the module. The opening question is usually relating to the topic of the day, or thoughts that have arised since the last module. The closing is an evaluation of the day or what the participants have learned during the module. Suggestions for closing activities are also provided in the modules.

Brainstorming
Brainstorming might be a good tool in the phase of familiarisation with the topic addressed in the module as it generates ideas from the group and stimulates creative thinking. The facilitator poses a question and allows participants to call out answers. All ideas from the group should be recorded, regardless of how appropriate they are. Facilitators need to be careful not to criticize or judge anyone's contributions in a brainstorming activity. At the end of the brainstorming, if any technical information is discussed, the facilitator should confirm that participants have the correct information.

Dividing participants into small groups
In order to get participants involved in activities and discussions, it can be a good idea to divide them into smaller groups of about five participants. This allows for physical activity, gets participants engaged and allows them to socialize with different participants. You can divide the groups randomly by counting, or by using more creative ways. It is usually a good idea to assign a group leader to lead the small group through the activity. A rapporteur can also be assigned to take notes and report the group's responses to the larger group. You can assign these roles by choosing the most recent birthday, birth order, number of siblings, shortest name, etc. This is often a good way to involve and re-energize the participants.

Role-play
Role plays allow participants to act out situations that they might encounter in real life. It helps participants to practice skills, solve problems and gain insights into the attitudes, values and perceptions held by others. Role plays are often improvised but come with instructions for each of the roles and objectives in terms of what needs to be communicated. If possible, use some theatrical props are recommended such as a clipboard, a hat or name tag in order to help set the scene. It is a good idea to debrief after a role play and reflect on the experience. It is also recommended to have prepared some general questions in advance of this session to trigger reflection.

Case studies
Case studies are most useful once your audience has established a basic understanding of the topic and are ready to problematize and discuss more in depth. A case study is a written description of a situation that is used for analysis and discussion. It is a detailed account of a real or hypothetical occurrence (or series of related events involving a problem) that participants might encounter in real life. After it has been analysed and discussed, participants are often asked to develop a plan of action to solve the problem.

Simulation
A simulation of a situation might be equally useful as a case study in helping participants practice how they would respond to a previously discussed situation. Participants should take part in the simulated scenario without prior notice of what it will involve.

Review and recap
Reviewing content reinforces important information and helps participants remember information and skills. It also helps you to evaluate how well participants have understood the material. To have fun with the learning process, consider using games to review content that you want the participants to remember. Quizzes or questions and answer sessions can be especially useful in closing a session.

PREPARING, CONDUCTING AND FOLLOWING UP THE TRAINING

This second part of the facilitator guide provides a short overview of the structure of the modules and key tips for preparing, conducting and closing each module. It also provides suggestions for how you can evaluate the specific modules with the participants, as well as how you can evaluate your own performance and that of your co-facilitator.

Build-up of each module
Each module has a proposed layout and is planned to last from two to four hours. The two first modules could be facilitated in the same day. The last two modules however, are content heavy and require more time. They should therefore be given a full day each. All the modules are built up in the following way in order to assist you in preparing and performing well, which in turn will make it easier for the participants to grasp the main topics:

Preparations for the facilitator	**Practical**	Practicalities and logistics required for the module.
	Planning	Specific tips or elements that should be considered and prepared for the module.
	Resources	An overview of resources that can be reviewed in advance of the module for a more complete understanding of the thematic to be used in the module.
Structure of each module	**Introduction**	The topic of the module is introduced and the attention of the participants is focused.
	Main part	The topics of the day is presented through different methods. Here, a balance should be found between theory, practical activities and energizers. The participants should be as active as possible.
	Recap	The topics taught are summarized and the participants can share their views through an evaluation in a joint closing activity.

ORGANIZATION OF THE FACILITATOR GUIDE

Learning objectives – What the participants should know and be able to do as a result of the training and what you need to emphasize on in the module.

Suggested outline of activities and the estimated timeline to conduct the activities in each topic.

Practical – Practical preparations for the training and utensils needed for the different sections of the module.

Planning – Elements that you need to prepare before the training.

Resources available for you to find more information on the topic.

Activities – Suggested activity addressing or exemplifying the content of the section. All activities are listed in the back of the manual.

Output – The facilitator should compile input from the participants and hand this out towards the end of the training.

Tips – Pedagogic tips and tricks to ease the facilitation of the section or concrete activity.

Pre-preparations
In advance of this training, your National Society and local branch have identified a health care facility with a need and desire to increase the competency and skill set of its personnel with regard to tackling and de-escalating stressful, threatening and violent situations. Depending on your audience and contextual challenges, a certain adjustment of the different modules may be required.

If you have been delegated the responsibility of identifying health care facilities and participants for this training, do not underestimate the amount of time and effort this will take. A certain understanding and knowledge about the specific situation and context of the health care facility is recommended and can be ensured through a mapping conducted at the health care facility in advance of the training.

Data collection
The questionnaire, annexed as activity 1, is an example of how to collect data in advance of the training. Each participant should fill out and provide their response in advance of the training. The facilitator will then have a certain understanding of the threats and violent acts that take place at this specific facility. It will also provide a baseline for measuring the extent to which preventive or remedial actions have an impact on the number of incidents experienced at the facility. The training is an example of one such action.

Alternatively, the questionnaire can also be used directly in module 1, for the participants to map and reflect on the inter-personal threats and violent incidents occurring in their health care facility.

Venue
During your practical preparations, never underestimate the value of creating a comfortable learning environment where ventilation, lights, temperature, surrounding noises and seating are as optimal as possible. Also ensure the availability of necessary materials, water, snacks and restroom facilities. Make sure that interruptions during sessions are avoided.

A good location for a workshop is one that is spacious enough to allow games, movement of persons and room for group exercises. Due to the sensitivity of some of the topics in the workshop, the location should allow for privacy (the possibility of closing the door, preventing that a lot of people walk in and out).

Preparations for the facilitator
A successful training begins with thorough preparation. It is vital to have a good understanding of the content of each section in the modules and to have the necessary materials to facilitate the activities. It is therefore recommended that you take time to:

- Learn the content in the modules and be prepared to give a brief presentation on the content at the beginning of each section.
- Review the list of materials needed for each section to ensure that you have all necessary supplies.
- Think about the specific needs of your audience and the venue.
- Check that the venue is available and arranged to your liking.
- Communicate the time and location of the training to the participants well in advance.

The times suggested for each section in this manual are approximates. You will know your audience best and should be able to adjust when more or less time is needed according to their learning needs. Each module has an introduction that will provide a short summary of the sections and the learning objectives of the module as a whole. Suggestions for your preparations are also provided under each module, together with some tips on how to facilitate the interaction of the participants.

For each module you should:
- Introduce the module and its content.
- Lead group discussions and activities.
- Answer questions yourself only when the answer cannot be supplied by your participants.
- Provide clear instructions and repeat as needed.
- Encourage active participation.
- Give constructive and positive feedback.

Conducting the training

Permanently bear in mind the scope of your training and stay focused on this. Participants might address non- related concerns that cannot and should not be addressed in the training such as mismanagement, organizational issues or salary problems at the health care facility. It is therefore recommended to define the main concerns and objectives at the very beginning of the training. Do not be afraid of referring back to the work agreement established in the beginning of the training. As elaborated above, do not be afraid of feelings. If someone is crying, give the person time, calmness and attention. Bear in mind that this training might be the only opportunity for participants to openly talk about their experience. Your goal as a facilitator is to get the participants to elaborate their own recommendations. Ownership of the recommendations coming out of the training is key to a change in behaviour.

Reflection rounds

All practical exercises, role plays and games with thematic content should end with a reflection round in plenary where you sit back and analyse what one can learn from these exercises and how the participants can use the skills demonstrated. You can also challenge the participants to formulate their ideas and plans, including how they personally plan to utilise these skills. Reflection rounds are an important source for learning and the activity will be incomplete without it.

Evaluation of each module

Towards the end of each module, the participants get the opportunity to provide feedback on what they think about the content of the module and/or what they have learned. During this session, it can be useful to make reference to the learning objectives. However, it is not only important to evaluate what the participants have learned. It matters even more to inquire how participants will be transferring these skills and using them in their daily work. Ask the participants to explain the coping strategies that they plan to implement in order to better manage in potentially violent situations.

Closing activity

This could be a short practical activity that aims at making the participants leave the room with a positive feeling. Even though you may have addressed some difficult issues during the session, the goal is that the group will experience closure on a positive note before ending the workshop. Different suggestions for the above-mentioned elements are provided concretely in the modules.

HEALTH CARE IN DANGER: USEFUL RESOURCES[8]

Web-based platforms

- Public website: http://www.healthcareindanger.org/
- Online platform for the HCiD community of concern: http://www.healthcareindanger.ning.com/
- These resources feature a wide variety of public documents, tools and events produced by the ICRC and National Red Cross or Red Crescent Societies, as well as by MSF, the World Medical Association and the International Council of Nurses, among others.

Main publications and reports (available on the online platform)

- Promoting military operational practice that ensures safe access and delivery of health care
- Ambulance and pre-hospital services in risk situations
- Health care in danger: The responsibilities of health-care personnel working in armed conflicts and other emergencies
- Health Care in Danger – Making the case
- Recommendations from expert workshops and Council of Delegates workshops for the consideration of National Societies

Incident-gathering reports and context-related reports

- Violent incidents affecting health care (2013)
- Violent incidents affecting the delivery of health care (2014)
- Health Care in Danger: A sixteen-country study (2011)

Videos

Available at https://www.icrc.org/en/resource-centre
Search under titles:
- Health Care in Danger – The Human Cost
- Health Care in Danger – Insights Series

Magazines

- "Health Care in Danger", International Humanitarian Law Magazine, Australian Red Cross, Issue 1, 2013, available at http://www.redcross.org.au/health-care-in-danger.aspx"
- Violence against health care (I): The problem and the law", International Review of the Red Cross, Vol. 95, No. 889, Spring 2013
- Other resources not produced as part of the HCiD project
- British Medical Association, Ethical decision-making for doctors in the armed forces: A tool kit, 12 May 2014, available at http://bma.org.uk/ethics

8 This list of resources is provided in the ICRC Position Paper entitled "Health Care and Violence: the need for effective protection" Danger 24.09.2014: [27. Oct.15] URL: www.icrc.org%2Fen%2Fdownload%2Ffile%2F1194%2Ficrc-hcid-position-paper-2014-09-24-english.pdf&usg=AFQjCNFawhMx79JTRNlWN8dlHkBFn3UR5Q&sig2=Yf3Ycz8oy5ouNO9QX0sUaw

EVALUATION[9]

Being a facilitator and holding workshops is a continuous learning process. In order to make the most of this learning, to improve our selves as facilitators, to strengthen the facilitator team and to further improve the dynamic of the groups we are working with, we need to evaluate.

After each module

If the training is spread over several days, we strongly recommend that after completing each module, you use between 30 and 60 minutes to evaluate the session either alone, if you facilitated on your own, or with your co-facilitator. The evaluation provides a space for analysing the process in the group as well as the facilitators' performance. Draw on observations made during the sessions, the experiences from the facilitators and the evaluation with the participants. Go through each activity and reflect on what worked well and what could have been said or done differently. The lessons learned should be used to improve the next sessions and make adjustment in the program according to the needs. Try your best to set aside time to do this properly, even though you might be tired.

Suggested questions for self-evaluation

- What do you think worked well in the different activities and why?
- Which activities did not work so well and why?
- What challenges appeared during the workshop and how did you manage them?
- What are you best in, in which roles do you feel most secure?
- Where do you think you need more experience?

Suggested questions evaluating the cooperation between facilitators

Method: Start with your individual reflection and then reflect jointly with your co-facilitator, answering one question at a time.

- In which activities do I feel secure/insecure?
- What are my/your strong sides (e.g. who is good at spreading humour and energy?
- Who is good at keeping the focus of the group and facilitating progress? Do I like the role play?
- How can we supplement each other?
- Is it ok for me that the co-facilitators jump in with their comments during a reflection led by me?
- Is it fine with me that co-facilitators use more time than planned for their activity if the reflection in the group is well? Is it ok for me to drop other activities (e.g. the one s that I have prepared) because of this? Or should we talk about this first?
- How can we make changes during a workshop?
- Is it ok to disagree in front of a group?
- What should a co-facilitator not do when I lead the activity?
- What should I not do when my co-facilitator leads an activity?
- How do we communicate in a good way during the sessions?
- How do we give the feedback/evaluation to each other?

After the training

After the whole training has ended, a report should be filled out to document the facilitation of the training. The report format should be agreed on with your local branch and would include important data which are reported on to donors and partners. The facilitator team should meet within reasonable time after the training to make an evaluation of the implementation of the training sequence, including successes and challenges, the group dynamic, the cooperation between the facilitators (if you were two or more), and what can be improved.

9 Adjusted with consent from the Street Mediation Manual

MODULE 1:
INTRODUCTION TO HEALTH CARE IN DANGER (HCID)

LEARNING OBJECTIVE

This first module will assist in establishing a good group dynamic and provide giving the participants with a basic understanding of HCiD. It intends to frame the training and its goal: the sensitization and skill development of health facility personnel facing violence and stress in their work environment. In addition, the module will sensitize participants to the global scope of attacks against health care services and the existence of recommendations and good practices.

- The participants will have a basic understanding of HCiD and its practical implications

SUGGESTED OUTLINE OF MODULE 1

I.	**Introduction to the training**	Introduction and setting the frame for the training	20 min
II.	**Introducing Health Care in Danger**	Explaining the concept behind Health Care in Danger	60 min
III.	**Understanding the concept through examples**	Participants will discuss the concept	30 min
IV.	**Recap**	Group understanding of HCiD challenges and issues at stake	15 min
TOTAL MODULE TIME			**Approx. 2 h**

Module Summary

In section 1, the facilitator will give an introduction to the training and set the scope, the methods and the main objectives of the training.

In section 2, the facilitator will provide an overview and introduction to the HCiD as global issue, setting the frame and focus for the rest of the training.

In section 3, the participants will further refine their understanding of the issue through discussions.

In section 4, the participants will summarise the module session.

For this module, it is important the facilitator(s) are familiar with the main content of the existing HCiD literature, that they have identified their preferred resources and selected the most appropriate mode of presenting the issue.

Practical

- Registration form so that participants can list their name, address and contact information
- Access to the technical devices if needed and available
- Access to internet, if available, to present online HCiD resources
- Prepare the seating in advance
- Utensils and snacks

Planning

- Make your self familiar with the activities and energisers and ensure sufficient preparations for these. For suggestions see activity 2, 3 and 4.
- Arrive at the training room 15 minutes before the scheduled training start time.
- Ensure the training room is set up as planned. Prepare the facilitator materials.
- As participants arrive, instruct them to complete the participant registration form with their name, address and contact information. It is suggested to use a Power Point presentation with pictures to illustrate the topic and better visualise examples of violations. Try to make the presentations interactive.
- Identify type of activities to trigger the discussions and prepare questions that are able to move the debate if need be.
- One possible activity to review the model is the cabbage ball, which requires some preparations. Please refer to activity 5.

Resources

- For more information, see the following report: International Review of the Red Cross (2013), 95 (889), 83–127. Violence against health care: giving in is not an option, doi:10.1017/S1816383114000137, p.87
- Check facilitator guide for additional support material.

SECTION 1: INTRODUCTION TO THE TRAINING

Introduction

After the registration of participants, start by introducing yourself, followed by a brief introduction to the training and its objectives.

Initiate an activity for participants to introduce themselves to each other, for example through pair presentations where they get two minutes to get to know each other in pairs, after which they will introduce each other in plenary. A short name game could also be an option, a suggestion for which can be found in activity 2.

Make sure to present any practical issues such as available facilities, breaks etc.

A positive environment can be generated by selecting a few energisers that encourage the participants to share information about themselves. The energiser "the sun is shining on" in activity 3 is one example.

A short introduction to HCiD: The problem of insecurity and violence affecting the delivery of health care is more than the sum of single incidents; it is a complex humanitarian thematic, a problem to which the solutions lie not exclusively with health-care professionals but also in the domain of law and politics, in humanitarian dialogue, and in appropriate preventive measures devised and implemented by a variety of stakeholders.

Group expectations

Seek input from the group about what they hope to gain from the course. This can be done by writing 2 hopes and 2 fears for the course and ask them to read them out individually.

The responses can be put on a whiteboard or flip chart and then re-visited towards the end of the training.

Aims and outcomes of the training

- Explain the main goals and the skills that the participants will acquire.
- Emphasize the importance of the participatory approach and participant ownership in the process.

The aim is to sensitize health-care personnel on the active role they can have in de-escalating or preventing tense and violent situations from arising in their workplace.

- **Goal 1:** Equip personnel in health care facilities with simple and practical skills on interpersonal conflict prevention and stress management.
- **Goal 2:** Reduce the number of threats and violent incidents in health care facilities.
- **Goal 3:** Reduce the stress level and limit the potential impact of threats and violence on the working environment in the health care facility.

Ground rules and working agreement

Develop ground rules for the group related to the use of mobile phones, presence during the training, listening to one another, etc.

Establishing a working agreement – please see activity 4 for more information. This would be valid for the whole training and helps to establish unity and confidence in the group. It is important that everybody can support all the rules included in the agreement. The agreement then becomes an objective point of reference for authority, something you and others can refer to outside of their subjective authority if it becomes necessary for the group process. At the same time, the working agreement also becomes an illustration of the values that are important for everybody in the group.

SECTION 2: INTRODUCING HEALTH CARE IN DANGER

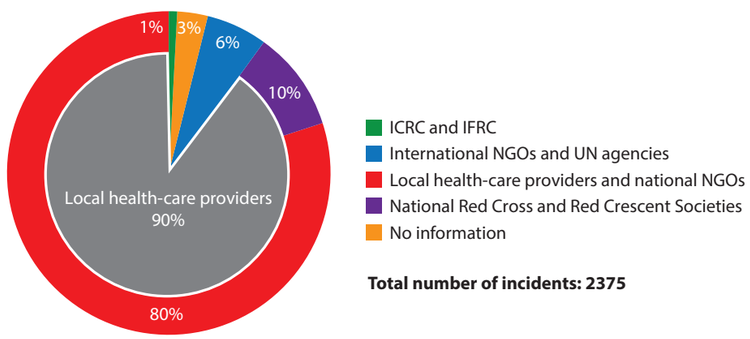
Providing an overview for the participants on the Health Care in Danger can take many forms and it is up to the facilitator to introduce this the way she or he deems most effective. It could be an idea to start the session by asking the participants openly what they know about Health Care in Danger.
The following bullet points can support the facilitator in his or her explanations.

Legal framework

- In Solferino in 1859, Henry Dunant started the work that resulted in international law asserting the right of combatants and civilians alike, to be spared further suffering during armed conflict and to receive assistance.
- To assure this in practice, health-care facilities, health care personnel, and medical transport, had to be protected: attacks upon them are forbidden as long as they are not used to commit, outside of their humanitarian function, acts harmful to the enemy.
- Protective symbols such as the red cross, red crescent and red crystal were introduced to clearly identify medical installations, vehicles and personnel as protected entities.
- These provisions, enshrined in the four Geneva Conventions of 1949, in their Additional Protocols and in customary international law, match the right to receive health care with an obligation on all parties to a conflict to search for and collect the wounded after battle, and to facilitate access to health care services.
- Human rights law protects health care at all times, including during internal disturbances. These laws are binding on all States and parties to conflicts around the world, but they are not always respected [10].

Current issues

- In armed conflict or other emergencies, violence disrupts health-care services at a time when they are most needed. Violence against the wounded and the sick, medical transport, health-care facilities and personnel is a crucial yet overlooked issue of great humanitarian concern.
- The knock-on effects of such violence can go way beyond the individual attack. For example, an attack on a hospital will have direct casualties, but even more people may suffer or lose their lives as a result of the hospital they depended on no longer being operational.
- Data compiled by the ICRC highlights that local health-care workers, including staff of National Red Cross and Red Crescent Societies and local NGOs, are the category of providers most affected by violence, falling victim to 91% of the incidents recorded.



Source: ICRC data collection between 2012-2014[11] Health care facility personnel

10 ICRC Health Care in Danger Making the Case. August 2011. [26. Oct. 15] URL: https://www.icrc.org/eng/assets/files/publications/icrc-002-4072.pdf
11 ICRC, Violent incidents affecting the delivery of health care: Health Care in Danger, January 2012 – December 2013, [April 2014] URL : https://www.icrc.org/fre/assets/files/publications/icrc-002-4196.pdf

Health care facility personnel

- Whether intentional or not, attacks against or inside health care facilities often result in the disruption of services. Such violent interferences naturally also affect health care personnel in their daily work and may result in an aggravated level of stress unless measures are put in place to protect staff and prepare them for such situations[12].
- Sometimes it is the patients and their families who are behind threats or violent acts. Family members may target health care personnel for a variety of reasons, including but not limited to the facility's capacity not matching expectations, frustration with the prioritization of treatment, the outcome of the treatment or the perception that the health services are an extension of the authorities. While incidents of this kind are not confined to conflict areas, the risk of their occurrence increases during armed conflict or other emergencies. Such incidents are infrequently reported.
- It is important to note that the majority of registered incidents relating to health care personnel, involved threats rather than direct violence against them[13]. It is important that personnel can defuse threatening situations before they turn violent.
- Capacitating personnel at health care facilities on how to deal with potentially violent situations and stress represents one measure that the facility can take in order to increase the safety of the staff and reduce interference with the services provided. Other measures include but are not limited to: capacitation on their rights and responsibilities, improving passive security of the facility and improve coordination and communication with the local community and other actors.

SECTION 3: UNDERSTANDING THE CONCEPT OF HCID THROUGH EXAMPLES

The aim of this section is to further widen the participant's understanding of the scope of HCiD. In order to visualize some of the practical issues, pictures from the HCiD campaign can be used to generate discussions with the participants.

This could be further facilitated by dividing the participants into smaller groups to solve a case that can be presented and discussed in plenary with the help of questions like:

- What do you see?
- What is the HCiD issue?
- What preventive measures were/could be implemented?
- What actions could potentially make the situation worse?

SECTION 4: RECAP

The objective of this section is to summarize the main content of the module and provide an opportunity for the participants to jointly reflect. A recap can be done in many ways and one suggestion is activity 5.

12 ICRC, Ensuring the preparedness and security of health-care facilities in armed conflict and other emergencies (2015), [26. Oct. 15] URL: https://www.icrc.org/eng/assets/files/publications/icrc-002-4239.pdf
13 ibid.

MODULE 2:
VIOLENCE MAPPING

LEARNING OBJECTIVE

This module aims at establishing an understanding of violence against staff in health care facilities. The participants will have a better understanding of what type of assaults are most commonly experienced and whom the perpetrators are. They will also have a deeper understanding of how threats and violent incidents impact the medical personnel in their working environment not only physically, but also mentally.

- Participants have a common understanding of the term "violence".
- They are able to outline the impact that violent incidents have in the environment in which they work.
- They can place different violent incidents into separate categories including verbal, physical and armed violence.
- The participants have a basic understanding of who the perpetrator of a violent act might be and why a violent act might occur under certain circumstances.
- The participants have a basic understanding of how violent incidents can affect a person both physically and mentally.

The common understanding of the group will remain the thread to be used throughout the session when referring to coping solutions.

Note: Cases of extreme armed violence will not be discussed. This module only focusses on violence that can be addressed using basic interpersonal skills. As such, even though armed violence or sexual violence are no less important, the skills provided by this training do not aim at equipping participants to deal with such extreme situations.

SUGGESTED OUTLINE OF MODULE 2

I.	**Mapping of violence**	Group work to map and categorise violent incidents in medical facilities	40 min
II.	**Presentation of the mapping**	Groups presenting their work	40 min
III.	**Defining violence**	Guided discussion on the definition of violence	40 min
IV.	**Recap**	Summarise the group understanding of threats and violent incidents occurring in health care facilities.	10 min
TOTAL MODULE TIME			**Approx. 2 h**

Module Summary

In section 1, the participants will map out the different types of violence that they have knowledge or experience of and identify who the perpetrators of the violent acts might be.

In section 2, the participants will present their group work in a plenary session.

In section 3 the participants will through joint discussions in the group establish a common understanding of what the term «violence» entails.

Practical

- Print outs of the questionnaire in activity 1
- Ten to fifteen sheets of flipchart paper
- 3-4 sets of post-its per group
- Assorted coloured markers
- Small pieces of notepaper
- Tape or wall pins
- In order to ensure good time management, consider assigning a time keeper among the participants

Planning

- Familiarize yourself with the definitions and decide how detailed you want to go into the different definitions during the sessions.
- Ensure enough time for all groups to present.
- Prepare some guiding questions in case the participants need support to get started or to reflect from a different angle.
- Choose one activity to evaluate the module, see suggestion in activity 6.
- Choose one activity to round off and close the module ensuring that you all leave in a positive spirit. See activity 7 for suggestions.

Resources

- Read through the manual well in advance and read up on the elements that are new to you. You can find resources on the HCiD project in the Facilitator guide.

SECTION 1: MAPPING OF VIOLENCE

In this section, the participants are divided into smaller groups and tasked to do a mapping of violence they are aware of, have observed or even have experienced. The aim of this exercise is to identify violent incidents that can occur at different levels in a health care facility.

One option here is to give the participants 10 minutes to reply to the questionnaire presented in the facilitator guide. You can also decide whether you want to gather the questionnaires afterwards in order to establish a baseline for a follow up training or an evaluation.

- Decide how you want to divide the groups and make sure all participants are included actively in the group work.
- Decide whether you want to use the questionnaire presented in the facilitator guide as part of this section.
- Encourage the timid to also take part.
- It might be good to circulate among the groups and ask questions if you see the group has stagnated or is taking to long on one question.
- Ensure each group have one person that will report in the plenary session outlined in section 2 and that the input from the groups are written onto post-it notes.

The groups are tasked to discuss the following questions:

- What types of incidents take place in the health care facility?
- Where in the facility did the violent incidents or threats against the staff take place? Precisely locate the mentioned incidents.
- Were the perpetrators of the threats or violent incidents identified? Why did the violent incidents occur?
- How do these types of violent incidents affect the daily work of the health care facility staff?
- Could the health care facility staff have done something to prevent the incidents from happening?

The rapporteurs should place their post-its on flip-charts under the following categories:

- WHAT (type of incidents takes place)
- WHERE (in the health facility does the threatening or violent incidents take place)
- WHO (are the perpetrators) – WHY (did the violent incidents occur)
- HOW (do these types of violent incidents affect the daily work of the health care facility staff)
- COULD (anything have been done to prevent the incidents – give examples)

The flip charts will then present a full picture of the violence experienced in the health care facility.

The responses to the above should then be compiled by the facilitator and presented again to the group in the last session of the training – section 4 – Module 4. It will work as a basis upon which participants can build in order to develop recommendations for their health care facility. The participants should also get a sense that they have aquired more useful information throughout the training that can strengthen this mapping.

SECTION 2: PRESENTATION OF THE MAPPING OF VIOLENCE

Each group is given five minutes to present their work.

SECTION 3: DEFINING VIOLENCE

Establish a consolidated definition of violence covering the different elements identified in the previous group work.

This could be facilitated through plenary discussion or smaller group discussions. If there is a need to help kick-start the process, present the following definition and ask the participants what should be added, removed or altered.

Additionally, the facilitator can make use of the HCiD definitions below to guide the discussions.

Violence means the intentional use of physical force or power – threatened or actual – against oneself, another person, or against a group or community that results in or has the likelihood to result in injury or death, psychological harm, mal development or deprivation.

(General definition provided by WHO)

Important definitions in the Health Care in Danger project[14]:

Health care means the facilities and services provided in the contexts under consideration and includes: hospitals, clinics, first-aid posts, ambulances and support vehicles.

Personnel working in the above facilities or in the community in their professional capacity; staff of the International Red Cross and Red Crescent Movement, including volunteers working in the delivery of health care; State armed forces' health-care facilities and personnel; health-oriented NGOs.

Health-care facilities mean premises (buildings and other installations) and vehicles used in the delivery of health care.

Insecurity, with regard to health care, means the very real dangers to which the wounded and the sick, health-care workers (professional or not), are exposed. It includes:

- death, injury, rape, kidnapping, arrest, harassment of and threats to health-care personnel, the wounded and the sick, and other people in health care;
- material damage, such as the physical destruction of, or damage to health-care facilities or medical vehicles, or cutting of electricity and water;
- preventing access of the wounded and the sick to health care;
- removing wounded or sick people, against their best interests, from health care.

Also included are threats to commit the acts mentioned above, launching attacks from health-care facilities and using, carrying or storing weapons within such facilities. This definition includes violent acts that unintentionally affect health care.

People committing violence refers to the party responsible for the violence or threat of violence against the delivery of health care. People committing violence are classified according to categories such as "State armed forces," "police," "armed groups," "others" (civilians, relatives of the wounded and the sick, and the wounded and the sick themselves, who commit violence), and criminals. Another such category is "conflict parties" in relation to events in which the reported impact on health care could not be attributed to any one side, party or faction engaged in armed conflict.

SECTION 4: RECAP

Summarising, evaluating and rounding off module 2 might be assisted by the suggested activities 6 and 7.

14 ICRC, Health Care in Danger, A sixteen-country study – report (2011), p. 4 [28. Oct.15] URL: https://www.icrc.org/eng/assets/files/reports/4073-002-16-country-study.pdf

MODULE 3:
THE DYNAMICS OF ESCALATION AND DE-ESCALATION OF CONFLICT

LEARNING OBJECTIVE

This module provides the participants with a basic understanding of how violence and the threat of violence can affect personnel in health care facilities. The module aims at developing relevant inter-personal communication skills to de-escalate and prevent conflictual situations. The use of examples and role plays is the starting point for participants to learn how to identify the essential human emotions that can trigger violent behaviour.

These communication skills would not apply in situations of extreme danger such as armed or sexual violence. The skills provided by this training do not aim at equipping participants to deal with such extreme situations, but only focusses on violence that can be addressed using basic interpersonal skills.

This module provides some elementary notions to understand:

- The human basic needs and the importance to meet these needs
- The four human emotions and strategies to address them
- The vital space
- Empathetic listening skills

- The participants have a basic understanding of the essential needs of human beings and what could be the emotional triggers for violent acts and threats.
- They also understand the principle of empathetic listening and how to de-escalate a violent verbal exchange.
- They have elaborated a set of good practices for dealing with violent behaviours.

SUGGESTED OUTLINE OF MODULE 3

I.	**Introduction**	Rationale of the module	10 min
		Human needs and the four basic emotions	50 min
II.	**Conflict and communication**	Understanding what conflict is and how it can be deescalated	50 min
III.	**Role plays**	Preparing and conducting the role play	40 min
		Plenary debriefing of the role play	30 min
IV.	**Vital space**	Conceptual presentation of the vital space	30 min
		Performing a simple role play (face to face)	
V.	**Listing the good practices and the coping behaviors**	Group work on good practices, best coping behaviours and key messages	30 min
TOTAL MODULE TIME			**Max. 4 h**

Module Summary

In section 1, the facilitator will give a short introduction to the module, its main aims and expected outcome. In order to start deconstructing why and how situations escalate, the group is then introduced to the basic human needs and the four basic emotions, including how these might manifest themselves in human behaviour.

In section 2, the concept of conflict is presented through group work and provides the participants with the basic understanding that conflict is an energy that can be used constructively to find solutions. Training on active listening skills and an introduction to different ways of communicating will be provided.

In section 3, the participants will conduct a role-play exemplifying the key elements of how we can communicate. They will also facilitate a de-escalation or prevention of a potentially threatening or violent situation. The group will have the opportunity to evaluate the different situations and re-play them in order to find the best way of handling them.

Section 4 will give an introduction to the "vital space" and opportunities to experience its significance in practice.

In section 5, the group will summarize coping behaviours and good practices and in de-escalating or preventing violent acts.

Practical
- Participant registration form
- Ten to fifteen sheets of flipchart paper
- 3-4 sets of post-its per group
- Assorted coloured markers
- Small pieces of notepaper
- Tape or wall pins
- Props needed for the role plays

Planning
- Read carefully through the module and prepare each section.
- Pick the activities and role plays that you would like to use and make sure that you have enough time for each activity. You are also free to adjust the different sections to your liking.
- If possible, practice with your co-facilitator in advance.

Resources
- A useful resource is the Education For Peace website (educationforpeace.com). It provides a wide variation of activities, role plays, and background information.
- For more information about non-violent communication developed by Marshall E. Rosenberg, please see http://www.psncc.org/compassionate_communication.html.
- non-violent communication centre, https://www.cnvc.org/
- Abraham Maslow's hierarchy of needs.
- The Norwegian Red Cross has developed a manual on street mediation that much of this module is based on. Norwegian Red Cross can provide you with this street mediation manual, as well as training if this is of interest.

SECTION 1: INTRODUCTION TO HUMAN NEEDS AND THE FOUR BASIC EMOTIONS

Use the opening of the section to present the topic and the objectives of this module, as well as information about any practicalities that should be communicated before starting. Remember also to give the participants the opportunity to ask questions in order to further clarify the topic of the workshop, the program, or anything else. If you find it necessary, re-visit the working agreement established in module 1.

Needs[15]

Broadly speaking, people have the same needs, from the fundamental needs such as food, water and safety, to higher level needs such as recognition and a sense of belonging. When we think that one of these important needs in life is threatened, we react automatically and often unconsciously, to protect what is important to us.

- Physiological needs: Food, drink, sleep, warmth
- Need for assurance and structure: Security, protection
- Social needs: Belonging, care
- Acknowledgement: (self)respect, responsibility, status
- Self-awareness: Personal development, challenges, creative expression

A link could also be made to Maslow´s hierarchy of needs.
We are only partly aware of these needs and many are fearful of acknowledging them. Often we lack the courage to identify and express our needs, values, requests and dreams. In difficult and stressed circumstances, this might lead to conflictual situations expressed through physical or verbal threats and violence. In order to prevent and de-escalate a threatening situation, it is important to identify what needs are not met and try to understand how these can be met. In theory, we all have four basic human emotions. Simplified, these emotions are expressions of our needs.

As an exercise you can ask the participants to brainstorm about the different emotions that arise when our needs are and are not met. See activity 8[16] for inspiration and support in facilitating this activity. The activity can be done by using post-its and sorting them on two flip charts ; one for met needs and one for unmet needs.

Emotions

After mentioning all the different emotions related to unmet and met needs, the next step is to identify the four basic emotions. Here, you can use the results from the previous brainstorming session and ask participants to sort the words into the following groups:

- Anger
- Fear
- Sadness
- Happiness

The third step is to highlight ways in which these emotions can be expressed.

If we are in pressed situations where our needs are not met, then conflictual situations might occur. It is important that we have a basic understanding of what conflict is and how to de-escalate it through the way we communicate.

SECTION 2: CONFLICT AND COMMUNICATION[17]

In order to generate understanding for what a conflict is, use the activity as described in activity 9. For this exercise, it is important that the facilitator understands the chapter below. It will help her/him to trigger in-depth reflection with the group.

What is conflict?

Conflict may be defined as a struggle between people with opposing needs, ideas, beliefs, values, or goals. The results of conflict are not predetermined. It might escalate and lead to non-productive results or it might be resolved in a mutually beneficial manner. More often than not, conflicts occur due to miscommunication between people with regard to these needs, ideas, beliefs, goals or values. The conflicts can then build up, brick by brick, until a whole wall of negative feelings and unaddressed differences separates the parties from each other.

Negative associations with conflict are reinforced by the fact that we usually best remember those for which no solution was found. However, when a conflict is resolved, the relationship between the parties will often be strengthened as a result. The majority of conflicts are, in this way, constructive. When handled in a constructive manner, conflicts have the capacity to be an important source of learning, development

15 This sub-chapter on needs is borrowed and adjusted with consent from the Street Mediation Manual.

16 The list in activity 8 can also be found on the web-page of Center for Non-violent communication [28. October 15]
URL: https://www.cnvc.org/sites/default/files/feelings_inventory_0.pdf

17 The major part of section two of this module is based on the Street Mediation manual developed by NorCross. If you would like to learn more about the Street Mediation methodology and program, please contact NorCross directly.

and growth. Conflict management is the principle that all conflicts cannot necessarily be resolved, but learning how to manage conflicts can decrease the odds of non-productive escalation.

There always exists an opportunity for change in conflicts. If we think that:

> Conflict = Energy

Based on this definition of conflict we can say that conflict work is largely about taking care of the energy that exists in a conflict situation and transforming it into constructive energy in the form of collaboration, learning and development. Violent acts or threats of violent acts are in practice energy gone awry. This energy may come from cumulated frustration that stems from a lack of understanding and/or unmet needs.

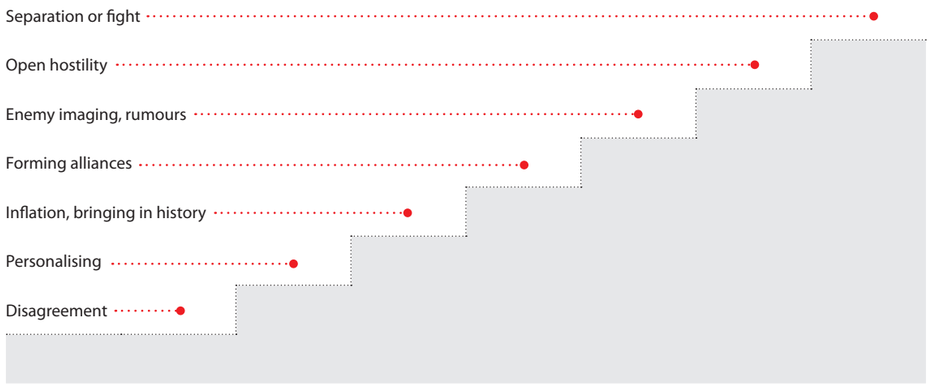
The conflict staircase
No conflicts are equal. Every single conflict changes gradually as it develops. Nonetheless there are many similarities in conflicts' dynamics. The conflict staircase shows how conflicts escalate and also what is needed to de-escalate them. Each step in the staircase represents a level of escalation of the conflict. Escalation from disagreements to open conflict with destructive actions may occur very rapidly. Other conflicts are inherited differences and stereotypes that have been perpetuated through generations. Correspondingly, it often takes less time to de-escalate a conflict that has flared up quickly than one that has gradually built up over months, years or generations.

The conflict staircase (see below) can help us to analyse conflicts and more effectively identify the strategies best suited for specific conflicts. Our demeanour and actions (attitude, choice of words, tone, body language and timing) can contribute to conflicts escalating or de-escalating. At the same time, based on insight into the conflict staircase, outside parties can prevent further escalation of the conflict with strategic interventions.

The activity described in activity 10[18] is a role play giving the participants a further understanding of the importance of de-escalating a conflict before it develops to the higher levels of the conflict staircase. This activity might take up to 45 minutes, and it is advisable that you as a facilitator determine ahead of time what kind of activities will be included, in order to best manage the time available.

18 This role play is borrowed from the Street Mediation manual, but can also be found on the web-site of Education for Peace: www.educationforpeace.com

Conflict staircase



Communication
A good activity to visualise the challenge that lies in dialogue and finding good solutions is the «4 words about communication» – found in activity 11. This activity lasts approximately 20 minutes.

Active listening
Active listening is a communication skill that is about being present in the conversation and giving full attention to the person who is talking by showing openness, interest and respect. The ability to actively listen can help to strengthen personal relationships by creating understanding, improving cooperation and reducing conflicts.

Active listening has its origins in the theories and practice of the psychologist Carl Rogers. Later the tool has become important within education, health and conflict work. In Rogers' own words, active listening "means giving one's total and undivided attention to the other person and tells the other that we are interested and concerned… we listen not only with our ears, but with our eyes, mind, heart and imagination as well… We listen to the voice, the appearance, and the body language of the other… We simply try to absorb everything the speaker is saying verbally and nonverbally, without adding, subtracting or amending" (Rogers, 1980).

When interacting with others, we often do not listen properly. Perhaps you are distracted by your own thoughts or by something else that is happening in the room (TV, mobile phone, other patients). We sometimes start sharing our own thoughts, interpretations, conclusions and suggestions for solutions, before the other person has had time to finish telling their story. Alternatively, we "steal" the story by starting to talk about something similar that has happened to us – we think that our story is bigger, worse or more significant.

How the listener listens may have a large effect on how well the speaker speaks. The person who is listening gives both verbal and nonverbal signals that affect the person who is talking and even the message that is conveyed. The attitude, the way we stand or sit, our gaze, facial expressions, gestures, touch and physical distance, are all involved in signalling to others how we feel and how much attention we are giving to what is being said. This nonverbal communication often takes place unconsciously.

An active listener should:

- Maintain eye contact
- Be aware of body language (e.g. nodding, facial expressions, posture, sitting position)
- Make noises and give feedback (e.g. "mmm", "oh", "exactly", "oh really?", "how interesting")
- Think about vocalisation and tone of voice
- Avoid judging, criticising, interrupting or bringing your own prejudices/interpretations.
- Ask questions
  …about something that you are not sure that you have understood.
  …to have the speaker go into greater detail and talk more about the topic.

Active listening is important in all communication and especially in stressed and conflictual situations. When working in a health care facility, it is important to remember that patients and relatives are particularly aware of your communication with other individuals. Fortunately, active listening is a skill that can be improved with training.

In order to experience the effects of active listening, go to the activity described in activity 12 and try to relate the situations to an interaction between a relative or patient and someone working at the health care facility.

Non – violent communication

The American psychologist Marshall Rosenberg is the creator of "non-violent communication" (NVC) and has written several books on this communication model. The model addresses how we communicate when we are in a conflict, and how different communication strategies can either escalate or de-escalate a conflict. NVC is now used across the world[19].

Rosenberg distinguishes between two characteristic ways of speaking that can affect the development of a conflict either towards an escalation or a de-escalation:

You-language: contributes to the conflict becoming more ardent and to escalating it. One (negatively) evaluates the other person, accuses and makes the other responsible. You-language often contains requirements about what the other shall or shall not do, demands changes, shouts and threatens. The You-language analyses people, judges them, blames them and labels them. We all know this language well and we have learned to use it. This language blocks productive communication and the recipient often becomes defensive and naturally enough starts a counterattack.

I-language: works to de-escalate conflicts and can contribute to an exchange and closeness that increases the chance of a common solution. You take responsibility for your own feelings and actions. I-language does not include a negative evaluation of the others (nor implied). This does not harm the relationship with the others, and can promote the desire to change. Empathy is fundamental in the I-language.

In stressful situations we are often unable to have an overview of what is happening before we feel that we are being heard and understood. If we find that the other person has heard or understood what we need, then we can relax and be willing to hear about what is important for them as well. In a conflict in which one person is more upset than the other (for example, the father with an injured son, who thinks that the nurse is not doing his or her job properly), the most effective method can be to first listen and allow the upset individual to feel that he/she is being understood. This person will then often calm down, making it possible to conduct a dialogue.

19 There are very many resources online that can further explain NVC and can provide activities and energizers based on this methodology.

If you are well trained in NVC you will also be able to clearly hear the other person's feelings and needs. Before you have advanced that far, always remember that it is very easy to return to using the You-language.

In the next section, the participants are to train on the active listening skills and modes of NVC.

SECTION 3: ROLE PLAYS

The main aim of this section is for the participants to act in role-play scenarios in which they are faced with situations of stress, threats and potentially (simulated) physical violence. The participants will feel how this affects them emotionally and will have the opportunity to be an active listener and use the I-language.

Divide the participants into two groups. Task one group with using I-language in their communication with patients and relatives and the other with using You-language. An example for a scenario is provided below, but the participants can be encouraged to develop their own role play-scenario based on the incidents that they are faced with at their health care facility. Alternatively, the facilitator may also develop role-plays that is tailor made to the groups needs, based on the incident mapping done the first day of the training.

The participants will observe the role plays and take notes, focusing on the role-players' **behaviour, attitude, emotions, and arguments**. The role play should not last more than 10-15 minutes.

In the debrief of the role play (using You-language), the participants will reflect on how the situation could have been handled and solved differently by the personnel of the health care facility. How could the situations have been de-escalated or even prevented? How could the personnel have ensured their own safety in the different scenarios? After this, the second group will act the other scenario (using I-language) and a similar debrief is held by the facilitator, with an emphasis on how the use of I-language affected the potential for the situation to escalate and the safety of the personnel.

Role-play – activity 13
Suggested issue or scenario to be explained to participants: a patient has just died from a lethal illness and the family has gone to the health care facility, in order to understand what happened. The family members are all shocked and upset. They meet with health care personnel.

In the verbal exchange, the family does not seem to listen much to the health care personnel and starts arguing, threatening and insulting them. Any attempt by the doctor to provide the medical explanation is being challenged by the family.

Make sure that the role plays do not pose any emotional concern to anyone. Do not force any participants to take part, try also to have participating medical staff play angry patients instead.

SECTION 4: THE VITAL SPACE

The aim of this section is to understand the principle of the vital space as a sort of "sphere" around us. This sphere may change size according to our mood and whom we interact with. The intrusion into our vital space can be perceived as interference, violation and lack of respect.

One practical exercise for participants: Ask all participants to freely move in the room and let them find the place where they feel most comfortable. Then ask them individually why they specifically chose this place. The goal is to make one realize that we tend to position ourselves at a comfortable distance from other persons and in a way that provides us with a better overview.

A second practical exercise for participants: Ask participants to face each other from a 5-10 metre distance. They should then move very slowly towards each other. They will stop moving when they feel that they have reached their comfort zone. The participants will then explain his or her decision to stop, by providing details about the emotions involved. The facilitator will define this border or threshold as the limits of their "vital space".

SECTION 5: LISTING THE GOOD PRACTICES AND THE COPING BEHAVIOURS

The main aim of this section is for the participants to reflect on and summarise the good practices and coping behaviours in a stressed and challenging situation.

A flip chart can be used to list the "does & don'ts".

The facilitator will guide the participants in their identification of the behaviour, the arguments, the body language and wording that can be used by health care personnel when facing stressing, threatening and/or violent situations in the interaction with others.

The facilitator should collect the good practices listed by the participants and write them up so that they can be handed out on the last day of the training. These can be used to inform the development of personal measures and recommendations in the last activity of module 4.

MODULE 4:
BASICS ON STRESS MANAGEMENT

LEARNING OBJECTIVE OF THE MODULE

The aim of this module is for the participants to understand the basics of stress and propose simple solutions to help master stress at an individual level.

This module should provide the elementary notions required in order to understand:

- The different manifestations of stress
- The impact of stress
- Dealing with and channel stress
- Suggested means to help reduce stress level

SUGGESTED OUTLINE OF MODULE 4

I.	**What is stress?**	Defining "stress"	20 min
II.	**Stress mapping**	Mapping out of the symptoms of stress	40 min
III.	**Stress coping mechanisms**	Coping solutions	40 min
IV.	**Key recommendations for reducing conflict and stress**	Identifying personal measures and key recommendations for the health care facility	80 min
TOTAL MODULE TIME			**Max. 3 h**

Module Summary

In section 1, the group will jointly identify different signs of stress and try to find a definition of stress that they can all agree on.

In section 2, the group will, based on their definition, do a more thorough mapping of stress symptoms and have a group discussion on stress detection.

In section 3, the group will identify appropriate stress coping mechanisms.

In section 4, the group will identify and agree upon a set of recommendations to reduce the stress and conflict within the health care facility.

Practical
- A couple of coloured marker pens
- Flip charts

Planning
- Ensure that you have a good overview of potential symptoms of stress and how to best manage stress.
- Prepare reflective questions (approximately one per participant) to assist the participants in actively taking part in the sessions, or during the final reflecting session to conclude the module.

Resources
- It is especially recommended to read through the ICRC report Ensuring the preparedness and security of Health-Care Facilities in Armed conflict and other Emergencies (2015, pp. 25-34) [4.nov.15] URL: https://www.icrc.org/eng/assets/files/publications/icrc-002-4239.pdf
- You can also visit the web site of the Red Cross Red Crescent Reference Centre for Psychosocial Support: http://pscentre.org
- Centres for Disease Control and Prevention have some useful guides on stress: http://psychcentral.com/blog/archives/2011/07/11/10-practical-ways-to-handle-stress/
- Information on mental health and well being can be found here : http://www.helpguide.org/articles/stress/stress-management.htm

SECTION 1: WHAT IS STRESS?

The main aim of this section is for the participants to reach a joint understanding of the concept.

It could be a good idea to start this session with an open discussion on what "stress" is. Decide whether the most optimal is then to divide the group into smaller groups or if a plenary discussion is more suitable. Summarize the discussion and propose a definition for stress. For example: "a physical, mental, or emotional factor that causes bodily or mental tension" or "a coping reaction to an external unbalancing factor". Stress would usually generate the "fight or flight" response.

> One of the most commonly accepted definition of stress (attributed to Richard S Lazarus – 1966) is that *stress is the feeling experienced when someone perceives that "demands exceed the personal and social resources the individual is able to mobilize."*

Short about stress[20]
- For health care personnel to be able to carry out their work and care for others to the best of their abilities, their own basic physiological and safety needs must be met. Every effort must therefore be made to create a supportive environment that is conducive to them performing their duties effectively.
- In many cases, health care personnel are the only service providers working for all parties in a conflict zone. They often find themselves pulled in all directions as they try to meet demands for their services from conflicting parties, to manage the expectations of patients and their relatives, and sometimes also having to provide adequate and timely information to the media or other stakeholders.
- Staff stress can originate from a number of sources ranging from the responsibilities of their job and their work environment to their personal situation. Staff members are as likely to be affected by a crisis as the people they are treating.

20 More detailed information in the ICRC report Ensuring the preparedness and security of Health-Care Facilities in Armed conflict and other Emergencies (2015) p. 26-29 [4.nov.15] URL: https://www.icrc.org/eng/assets/files/publications/icrc-002-4239.pdf

- Common stress reactions include a decrease in alertness and performance, poor judgment, strain in personal relationships and psychosomatic problems such as backaches, lethargy, a decrease or increase in appetite and/or sleep.
- Experiencing" burnout" is another common consequence of working in stressful situations over an extended period of time without practicing adequate self-care. A "burnout" is an emotional state characterized by chronic emotional exhaustion, depleted energy, impaired enthusiasm including motivation to work, reduced work efficiency, a diminished sense of personal accomplishment, pessimism and cynicism.
- There are at least three factors that pose a challenge to providing psychosocial support to health-care personnel and patients in conflict situations.
  - Firstly, in the face of patients' immediate needs and life-and-death situations, the provision of basic psychological support for staff can easily be overlooked.
  - Secondly, since stress is seen as a mental health issue, it is taboo in many cultures.
  - Thirdly, very few staff and supervisors are trained in psychosocial support techniques.
- Training for staff in managing changing demands and dealing with different people, can help to prepare them for challenging situations and thus reduce their stress levels. There are also a number of practical steps that can be taken to help reduce stress and tension for staff, such as organizing the reception area of the health care facility in such a way as to ensure that access is properly managed and security measures are applied to control and reduce unwanted intrusions.

SECTION 2: STRESS MAPPING

The aim of this section is to provide a comprehensive description of the impact of stress on the human body.

Working groups can be tasked to discuss the following topics:

- How can stress be detected? What are the symptoms?
- What are the main causes of stress in your specific working environment?

The list of signs of stress does not need to be exhaustive, but the more examples that are given, the better. The aim is for participants to acknowledge how stress and its negative impact can eventually have serious effects.

SECTION 3: STRESS COPING MECHANISMS

Stress coping mechanisms: there is no magical solutions to completely eradicate stress. In some cases, stress can be an accumulation of several factors.

Divide into three groups and assign them the following tasks:

- Identify what you as an individual can do to manage your own stress.
- Identify what you as a team member can do to reduce stress in your work unit.
- Identify what measures can be implemented in the health care facility to reduce stress levels among all staff.

The following elements can be used as a support to assist the participants in their reflection[21]:

Teams:
There are many benefits to developing peer-support systems, including the prompt provision of support and assistance to staff in need by someone who knows the situation well. Peer support at an early stage may prevent further problems from arising, as it helps people to develop personal coping skills. By forming supportive groups, peers can pool their knowledge, perspectives and experiences for the benefit of one other.

A peer-support group can provide:
- informal support both during and after work
- a formal framework for discussing work and solving problems together
- space to talk, describe your thoughts and share your feelings with someone with whom you feel at ease
- an opportunity to listen to others and share insights with them (e.g. what do you/they think about a particular stressful event?)
- a chance to encourage and support your colleagues and be available in a non-intrusive way
- confidentiality (the cornerstone of all support)
- non-intrusive follow-up and referral to professional care if someone expresses the desire to harm him/herself or another person.

Individuals:
Health-care personnel have a major role to play in managing their own stress. Often people do not pay attention to their psychological reactions to stressful situations because of a lack of time or awareness. It is recommended that staff members be trained in basic self-care.

The following tips may be helpful:
- take special care of yourself, eat well, limit your intake of alcohol and tobacco, and stay fit
- do not try to hide your feelings
- share your feelings with trusted peers or your supervisor whenever you experience troubling incidents and after each work shift
- do not self-medicate
- continue to carry out routine tasks, such as going to work, cooking, bathing and spending time with family and friends
- look for a healthy outlet, such as sharing your feelings with friends, exercising or expressing yourself through writing
- go easy on yourself
- seek professional advice
- talk openly and share your problems without fearing the consequences
- take a break when you feel your tolerance levels diminishing
- stay in touch with family and friends
- avoid perfectionism, i.e. striving to do everything perfectly, as this often leads to disappointment and conflict.

This list does not intend to be exhaustive, but proposes some measures that anyone could put into practice.

21 The list of stress management for teams and individuals is borrowed from the ICRC report Ensuring the preparedness and security of Health-Care Facilities in Armed conflict and other Emergencies (2015) p. 26-29 [4.nov.15] URL: https://www.icrc.org/eng/assets/files/publications/icrc-002-4239.pdf.

SECTION 4: IDENTIFYING KEY RECOMMENDATIONS FOR REDUCING CONFLICT AND STRESS WITHIN THE HEALTH CARE FACILITY

In order to ensure concrete outputs that can contribute to the safer delivery of health care services, the facilitator has throughout the training compiled key outputs of recommendations and good practices produced by the participants. These should be handed out.

Our aim is to sensitize personnel working in health care facilities, on the active role that they can have in de-escalating or preventing tense and violent situations from arising in their workplace.

Before the below listed activities, spend five minutes re-visiting the three objectives of the training.

- **Goal 1:** Equip health care and management staff with simple and practical skills on interpersonal conflict prevention and stress management.
- **Goal 2:** Reduce the number of threats and violent incidents in health care facilities.
- **Goal 3:** Reduce the stress level and limit the potential impact of threats and violence on the working environment in the health care facility.

Bearing in mind the context in which they work, the participant should develop measures and recommendations that can be realistically implemented to reduce stress and potential for inter-personal conflict at their facility.

- Give participants 5 minutes to individually write down a minimum of three personal measures to reduce stress and the potential for inter-personal tensions or conflicts with patients, their relatives or others at the health care facility. If people feel comfortable in sharing their three points in plenary they are welcome to do so.

- Divide participants into groups of 5 or less. Give the groups 20-30 minutes to develop a minimum of three key recommendations for addressing stress and interpersonal conflict at their health care facility. Depending on the context, the recommendations might vary from structural changes to informal improvements that the workshop participants as a group, upon returning to the health care facility.

- Ask each group to present their recommendations, followed by a plenary discussion.

- The outcome should be a consolidated list of agreed-upon recommendations that can be presented to the health facility´s senior management. Revise the mapping of violent incidents conducted on the first day to see if these recommendations would adress the main issues experienced at the facility. If new issues arose throughout the training, consider complementing the mapping.

- To evaluate the training, revisit the flip-chart and do a round on whether the training has met the expectations of the participants. An option here is to also do an evaluating activity as suggested in activity 14.

ACTIVITIES

FACILITATOR GUIDE

ACTIVITY 1: Questionnaire for health care facility personnel exposed to inter-personal violence in their work place[22]

Health Care Facility: .....

Date if visit:. .....

Title of interviewee (name can remain confidential): .....

1. Personally, have you ever faced repeated incivility, verbal aggression or bullying, while working at the health care facility?

☐ Never
☐ Once in my life
☐ Once a year
☐ Every month
☐ Every week
☐ Everyday

2. Personally, have you ever faced physical intimidation or violence, while working at the health care facility?

☐ Never
☐ Once in my life
☐ Once a year
☐ Every month
☐ Every week
☐ Everyday

3. Personally, have you ever faced armed violence or intimidation with arms, while working at the health care facility?

☐ Never
☐ Once in my life
☐ Once a year
☐ Every month
☐ Every week
☐ Everyday

4. In case of a positive answer to question 3, where did it happen?

☐ Inside the building
☐ At the entrance/gate
☐ In the waiting room
☐ In the doctor office
☐ A reception/registering desk
☐ Outside the building
☐ Elsewhere, please specify where .....

22 The questionnaire was developed by the Colombian Red Cross in the frame of the Mision Medica & HCiD initiative

5. Do you report incidents?

☐ All the time
☐ Sometimes
☐ It depends
☐ Never

6. In case of no reporting, why did you decide not to report (or what prevented you from reporting)?

☐ No available reporting mechanism
☐ Too complicated reporting mechanism
☐ Fear for reprisals
☐ Fatigue, tiredness or disillusionment
☐ The incident is "too minor" to be reported
☐ Other reasons, please specify.....

7. Following a case of violence or aggression, which follow-up or action would you recommend?

☐ A dialogue with your superior or a manager
☐ Improvement of the security measures to prevent intrusion
☐ Psychological support
☐ Time off work
☐ Transfer to other department or facility
☐ Training
☐ Other .....

8. To which extend has the contribution of the Red Cross local branch and its training encouraged you to report the cases of violence that you encounter?

☐ Moderately
☐ Slightly significantly
☐ Significantly
☐ Definitely has influence me to report
☐ It depends, please explain:.....

9. What support would you like to receive from Red Cross volunteers if possible?

☐ Be able to talk to them about the cases of violence
☐ Receive some support to "encourage" me to report the cases of violence
☐ Receive training and advice on how to better cope with violent people (at least the verbal violence).
Please explain if that already took place: .....
.....
.....

☐ To learn about organizational setup at my health care facility and how to improve efficiency
☐ To learn how to deal with personal stress
☐ To learn about how to improved team work
☐ Other

MODULE 1

ACTIVITY 2: My Name[23]
15–20 minutes)

Purpose
- Learning the names of each other in an unconventional way
- Learning more about the participants

How to do it
Everyone comes up, one at the time, writes his/her name on a flip chart, and says **what it means, where it comes from and why they got exactly that name**.

For example: My name is Ellen. This name comes from the name Helena, who was a Greek goddess. The name means "shining". My parents gave me this name because as my mum is Norwegian and my dad is English they needed a name that is easy to pronounce in both languages.

Tip
Use Google to find out the symbolic meaning of the names of the participants, before the session starts. Many people do know the meaning of their name, and think it is nice and surprising to receive this information. Does the name suit the person – is the characteristic the name gives him/her correct?

ACTIVITY 3: The sun is shining on…[24]
(10 minutes)

Purpose
- Energizer
- Begin to communicate also about difficult topics

How to do it
- Everybody sits on chairs in a circle, with one person standing in the middle of the circle. There is a chair less than the number of participants, and the person in the middle is supposed to get a chair to sit on during each round, making another person become the one standing in the middle.

- The person in the middle says something that must be true about her/himself and starts the sentence with 'The sun is shining on me and everybody else who is'. Everybody for whom this statement is also true, for instance 'who is also wearing jeans', must change chairs. It is not allowed to jump to the nearest chair, everybody must stand up and go to another chair.

The game should start easily about appearance, for instance with 'The sun is shining on me and everybody else who is wearing black shoes', and later move towards more personal topics, for instance what people like and dislike, what the participants have experienced in a conflict or threatening situation and so on. In a playful way, the participants can start communicating about more challenging topics.

Take a lead as a facilitator and say for instance: 'The sun is shining on me and everybody else who have taken part in a fight' or something similarly 'difficult' you yourself have experienced and would like to share with the group.

23 This activity is borrowed with consent from the Street Mediation Manual developed by the Norwegian Red Cross
24 This activity is borrowed with consent from the Street Mediation Manual developed by the Norwegian Red Cross

Other examples
"And everybody else who…

- Have been in a conflict
- Wants to learn more about conflict/communication/conflict management
- Sometimes think that it is scary to talk in front of a lot of people
- Likes to write a journal or diary
- Had an argument with someone they care about during the last year
- Have lost a friend

Movement and games can make it less frightening for the participants to show new sides of themselves. This game fits well in the beginning of a course, to start movement into more difficult topics.

ACTIVITY 4: Working agreement[25]
(15 minutes)

Purpose
Establishing a common framework for the group work through a working agreement.

How to do it
Ask the participants which rules they find necessary for everybody to feel secure to speak about personal things, difficult experiences and conflicts.

Which rules are needed for the group to become what the participants would like it to be? The working agreement differs from group to group, but often includes some of the following rules:

- We listen to each other, and speak one at a time.
- Talk for yourself.
- Participate actively.
- It is allowed to say 'pass'.
- Show respect. We do not speak negatively about ourselves or others.
- Confidentiality – personal information stays within the workshop/group.
- Turn off your cell phone.
- Be on time.
- Have fun.

It is important that everybody can support the agreement and its specific rules (remember to ask if everyone agrees before each rule is validated). The agreement then becomes an objective point of reference for authority, something you and others can refer to outside of their subjective authority if it becomes necessary for the group process. At the same time, the working agreement also becomes an illustration of the values that are important for everybody in the group.

Tip
If the participants do not mention "confidentiality" or "pass" themselves, the instructors should introduce these rules and ask if the participants agree to them. Avoid including too many rules, as this can easily cause confusion – four or five is often enough. It could be beneficial to form the rules positively, namely through encouragements or demands rather than prohibitions (what the participants should not do).

25 This activity is borrowed with consent from the Street Mediation Manual developed by the Norwegian Red Cross

ACTIVITY 5: The cabbage ball
(10 minutes)

Purpose
- Evaluation
- Summary

Preparations
- Count the number of participants. You are recommended to prepare one review question for each participant.
- Refer to the topic summary and main learning points to create your questions.
- Write a single review question on each piece of paper.
- Crumple the paper into a ball.
- Write a new single question on a single sheet of paper. Cover the first crumpled ball with this second paper.
- Continue writing one review question on a new sheet of paper each time.
- Add each sheet to the ball.
- When you have finished, you will have a small ball or "cabbage" with layers of questions

How to do it
- Ask participants to stand and form a circle.
- Gently toss the cabbage ball to a participant.
- Ask the participant to peel the top sheet from the cabbage ball and read the question aloud. If the participant can answer the question correctly; s/he should do so. If the participant is NOT able to answer the question, ask the group if someone else can answer.
- Once the question is answered, ask the participant to toss the cabbage ball gently to a new participant who has not yet correctly answered a question. The participant receiving the cabbage ball will peel off the top sheet, read the question out loud, and answer it to the best of her/his ability.
- Continue until all review questions have been answered.
- Congratulate everyone for their participation and round off the module.

MODULE 2

ACTIVITY 6: What did I learn today?[26]
(15 minutes)

Purpose
- Evaluation
- Summary

How to do it
All participants sit on chairs in a circle. Give each of the participants the task of finding one sentence, and only one, which expresses what he or she has learned from module 2. The participants get one minute to think and to put together a sentence, and then everyone shares it with the group.

Tip
Make sure that everyone gets that one minute to think, even though someone might be ready soone. Some need more time than others.

26 This activity is borrowed with consent from the Street Mediation Manual developed by the Norwegian Red Cross

ACTIVITY 7: Confirmation Pyramid[27]
(5 min)

Purpose
- Closure of the session
- To provide positive confirmation and strengthen the group's internal cohesion

How to do it
Everyone stands together in a tight circle. The facilitator starts by saying a positive word about the group and extends his hand to the middle of the circle. A participant then follows suit and says a positive word about the group and put his hand on top of the instructor's hand. Continue until everyone has said something positive about the group and have their hands on top of each other. Lastly the instructor puts his other hand on top of all the hands, and bending down so that all the others follow suit with his hands. Then lift all hands up toward the ceiling.

MODULE 3

ACTIVITY 8: Feelings Inventory[28]
(20 min)

The following are words that we use when we want to express a combination of emotional states and physical sensations. This list is neither exhaustive nor definitive. It is meant as a starting point to support anyone who wishes to engage in a process of deepening self-discovery and to facilitate greater understanding and connection between people.

There are two parts to this list: feelings we may have when our needs are being met and feelings we may have when our needs are not being met.

Feelings when your needs are satisfied						
AFFECTIONATE compassionate friendly loving open hearted sympathetic tender	ENGAGED absorbed curious engrossed enchanted entranced fascinated interested intrigued involved spellbound stimulated	HOPEFUL expectant encouraged optimistic	CONFIDENT empowered open proud safe	EXCITED amazed animated aroused astonished dazzled eager energetic enthusiastic giddy invigorated lively passionate surprised vibrant	PEACEFUL calm clear headed comfortable cantered content fulfilled mellow quiet relaxed relieved satisfied still tranquil	REFRESHED enlivened rejuvenated renewed rested restored revived
GRATEFUL appreciative moved thankful touched		JOYFUL amused delighted glad happy jubilant pleased tickled	EXHILARATED blissful ecstatic enthralled exuberant radiant thrilled			INSPIRED amazed wonder awed

27 This activity is borrowed with consent from the Street Mediation Manual developed by the Norwegian Red Cross
28 This list can be found on the web-page of Centre for Non-violent communication [4. Nov. 2015] URL: https://www.cnvc.org/sites/default/files/feelings_inventory_0.pdf

Feelings when your needs are not satisfied						
AFRAID apprehensive dread foreboding frightened mistrustful panicked petrified scared suspicious terrified wary	ANNOYED aggravated dismayed disgruntled displeased exasperated frustrated impatient irritated i rked	ANGRY enraged furious incensed indignant irate livid outraged resentful	AVERSION animosity appalled con- tempt disgusted dislike hate horrified hostile repulsed	CONFUSED ambivalent baffled bewildered dazed hesitant lost mystified perplexed puzzled torn	DIS- CONNECTED alienated apathetic bored cold detached distant distracted indifferent numb removed uninterested withdrawn	DISQUIET agitated alarmed disconcerted disturbed perturbed rattled restless shocked startled surprised troubled turbulent turmoil uncomfortable uneasy unnerved unsettled upset
EMBARRASSED ashamed chagrined flustered guilty mortified self-conscious	FATIGUE beat burnt out depleted exhausted lethargic listless sleepy tired weary worn out	PAIN agony anguished bereaved devastated grief heartbroken hurt lonely miserable regretful remorseful	SAD depressed dejected despair disappointed discouraged disheartened forlorn gloomy heavy hearted hopeless melancholy unhappy	TENSE anxious cranky distressed distraught edgy fidgety frazzled irritable jittery nervous overwhelmed restless stressed out	VULNERABLE fragile guarded helpless insecure leery reserved sensitive shaky	YEARNING envious jealous nostalgic pining

ACTIVITY 9: What is conflict?[29]
(25 minutes)

Purpose
- Start reflection around the concept of 'conflict'
- Uncover the purpose of learning about conflict management – that we can choose how we relate to conflicts, that we can transform conflicts into cooperation, learning, and development.

How to do it
- Write 'conflict' in the middle of an empty sheet of flipchart paper. Ask the participants what they think of when they hear the word 'conflict', and write down all the words that are mentioned until the flow of words stops. Alternatively, put the sheet of paper on the floor and let the participants write themselves.

- Ask the participants:
  – How many of the words that are on the paper are negative?
  – Are there more negative words, or more positive words?

29 This activity is borrowed with consent from the Street Mediation Manual developed by the Norwegian Red Cross

It is common for people to have more negative thoughts when hearing the word 'conflict'. This is because there are negative and hard feelings involved when we are in conflicts. Furthermore, conflicts that are handled in a bad way or remain unresolved can cause bigger problems, and stay with us for a long time.

- Discuss one or more of the negative words, and look closer if there can be situations where these words can be positive. Can "argument" or "confrontation" also be something positive in certain situations?

- Inform the participants: that most words can be both negative and positive, depending on the context in which they are expressed and how we relate to them. The same is true for 'conflict' – it is of itself neither positive nor negative. The way we treat and manage the conflict determines its effect. Mention the possibilities of change and development that exist in conflicts.

  Here it might be suitable to suggest the definition "Conflict = Energy", and that this energy can both destroy or be channelled in a constructive way through creativity, learning, and development.

  The goal then is not to avoid all conflict, but to find a way to manage the conflicts that arise in a positive and constructive manner. Conflict work and conflict management is often about taking care of the energy that lies in the conflicts, and changing it into constructive energy. The personal and interpersonal learning we obtain from our experiences with well managed conflict, we take with us further in life.

ACTIVITY 10: Conflict staircase, role-play[30]
The Conflict Stairs
(45 minutes +)

Purpose
- Exercise in conflict mapping and analysis
- Look at the feelings and needs that can lie behind the actions of a person in conflict, and use this knowledge to find alternative ways of reacting in a conflict situation

How to do it
- Analysis of the conflict stairs in plenary: In this exercise, we shall analyse how conflict situations may escalate. We look at both different types of behaviour that escalates or increase the conflict, and at actions that could de-escalate the conflict.
- Draw the eight-step stairs on a board/flip chart with enough space to write on each side of the steps ("escalation" on one side, "de-escalation" on the other).

Tip
To make the exercise more interesting you can stage a conflict where the instructors start arguing in the beginning of the activity. The participants do not know the argument is staged. Then analyse what happened and explain the first step of the conflict stair. Continue the acting of the different stages, analysing each one in turn, until stage five or six, where for natural causes the act stops (we do not want anyone to actually get harmed just to make our point), but the analysis continues.

These types of role-plays are usually very popular and make the theory more visual and exiting. Alternatively, you can prepare an example to show how a conflict can escalate.

30 This activity is borrowed with consent from the Street Mediation Manual developed by the Norwegian Red Cross

The Conflict Stairs

Step	Escalation	Strategy for de-escalation
1	**Contradiction, disagreement** • Focus on the content • Still belief that a solution is possible	• Talking together • Creativity
2	**Personification** • There is something wrong with the other, other person's fault	• Open dialogue • Give room for emotions • Go back to the matter/the original problem/the root conflict • Take responsibility
3	**Polarization and debate** • Stronger inner cohesion • Brings others into the conflict • Positions and stereotypical images of the other • Remembering past events – appears to be an ancient conflict	• Trying to see how the other one sees the situation • Seek advice and help with somebody you trust. • Look for possibilities to approach the other
4	**Conversation is given up** • The relationship becomes a problem, the original 'matter' disappears from view • Stereotypes • Attempts to dominate the other • Non-verbal communication (not saying hello, rolling ones eyes when the other says something in class/ reunion etc.)	• Re-establish contact • Process guidance from a neutral third party • Mediation
5	**Enemy images** • Strong, bad feelings • Separation of the world into two: • One good (oneself) • One evil/stupid/crazy etc (the others) • Ridicule, denial • Mental/physical violence is justified through the images of the other	• Mediation • Grand meeting
6	**Open hostility** • Threats, violence • 'Either you are with me, or you are against me' – no room for middle positions • Attempts to hurt the other	• Dialogue with a neutral third party, each party separately (pre-mediation) • Grand meeting, mediation
7	**Polarization and trench warfare** • "Either you or me needs to be destroyed: I will make sure it will be you!" • The parties try to win over the other • Spiral of violence • Alliances, more people are involved	• Police, external observers • Ceasefire/stopping hostilities • Peaceful co-existence • Dialogue with a neutral third party, each party separately (pre-mediation), grand meetings
8	**Together into the abyss** • Hate against the other results in hate towards oneself • Willingness to die to kill the other • Everybody loses	• Police • Physical separation • Dialogue with impartial third party • Shuttle mediation • Grand meeting

ACTIVITY 11: 4 words about communication[31]
(20 minutes)

Purpose
- Introduce the topic of communication.
- Create consciousness about how easy it is to move from curiosity and dialogue to defending own points of view, debate or even verbal fighting.
- Encourage discussion, participation, exchange of opinions and respect for other's opinions.
- Improve group communication and explore which roles we take in groups.

How to do it
- Ask all the participants to find four words that answer the question: 'What are the most important elements of good communication?' Ask the participants to write each of the four words on a different post-it note. Let everybody know that they have three minutes to find the four words.

- As soon as everybody has written down four words, ask the participants to find a partner. Based on the eight words they have in total, they should now make a new list consisting of only four words. No new words can be added, and it is not allowed to change the words or put two words together. Let them know that they have three minutes to complete the task.

- The process continues in the same manner: each pair goes together with another pair to make groups of four, and together they spend three minutes to find a new combination of four words from these two lists. The groups of four then go together in groups of eight to make a new list of four words. The process continues until the whole group has made a mix of all the lists, ending with one list with four words common for all participants.

Tip
- Be strict with time, and make the participants aware of how much time they have left at different intervals, such as "two minutes left", "one minute left", and "15 seconds left".
- Observe the groups during the exercise – how do the different participants react? What role do they take in the process? Leading, pulling out, clarifying and dominating are examples of positions you may potentially identify. Share these observations during the reflections but ask the participants to reflect on their role themselves without concluding on their behalf.

Reflections
Explore how the participants felt when they again and again had to make compromises:

- Was it difficult to come to agreement with the others?
- Did this change as the number of participants in the groups increased?
- Did the participants feel like the others heard and saw them during the whole process?
- Is everyone happy with the end result? Does everyone agree?
- Did they use the four "elements of good communication" in the process? (Did they listen, show respect and so on?)
- How did it feel having to let go of own words that they thought were important?
- What were the consequences of the allocated time being so short?
- Do they think that the end result would have been different if they had been given more time?
- What did the participants learn about communication during this exercise?

31 This activity is borrowed with consent from the Street Mediation Manual developed by the Norwegian Red Cross

ACTIVITY 12: Active listening[32]
(25 minutes)

Purpose
- To test how different ways of listening have different effects on the one being listened to.
- Think through what is required in terms of trust and security, for one to be able to talk about personal difficulties.

How to do it
- Go together in pairs. One person tells a short story while the other person puts all his/her effort into NOT paying attention. The listener should actively try not to listen or show any interest in what is being said. The instructor stops them after 1-2 minutes and asks them to change roles.

- When both have told their story to a "bad listener", they are told to tell their story again. This time the listener should be very empathetic and show a lot of interest in what is being communicated. Use active listening by nodding, confirming and following-up with questions . Let them talk for 3-5 minutes before switching roles.

Tip
If you are short on time the first one that tells her/his story can have a "bad listener", while the second can have an active listener.

Reflection
- How did it feel not being listened to?
- How did you know that you were not being listened to? (body language, eyes and so on)
- What effect did the other's lack of attentiveness and response have on the story you were trying to tell, both in terms of content and form?
- How did you feel being listened to actively?
- How did you know that you were being listened to?
- How did the active listening affect the story you were telling?
- For how long do you think that you were talking? Did the time seem longer with an active or a "bad listener"?
- Was this familiar to any previous experience that you have had?

32 This activity is borrowed from the Street Mediation Manual developed by the Norwegian Red Cross

ACTIVITY 13: Role-play – Disorder at a health care facility
(70-90 min)

Purpose
- Go through a real case of disorder that is generating verbal violence between staff working in health care facilities and the relatives of a patient.
- Identify the relational and communication dynamics between the two parties.
- Draw the lessons learned and list do´s and don´ts.
- •Tentatively outline HCiD key messages.

Preparations: Chairs, tables and any additional prop that you find relevant. Each group should have 15 minutes to prepare. You also need flip-charts for debriefing and conclusion.

Section Outline
The section is aimed at bringing to life a fictional case of verbal violence that may occur between health care personnel and the family of a patient. Participation in the role play must be voluntary.

The group acting will choose to use either the I-language or the You-language in their mode of communication, without informing the others. The remaining participants will observe and take part as patients in the waiting room.

When the role-play is over, reflect jointly and discuss what could have been done differently – see key questions below. Then, swap and act using the language form not yet used.

Introduction: Presentation of the case
A patient has just died from a lethal illness and the family has gone to the health care facility, in order to understand what happened. The family members are all shocked and upset. They meet with health care personnel.

In the verbal exchange, the family does not seem to listen much to the health care personnel and starts arguing, threatening and insulting them. Any attempt by the doctor to provide the medical explanation is being challenged by the family.

Objectives
Draw the lessons for a good and bad behaviour between patients' relatives and the personnel at the health care facility. Understand the underlying reasons and triggers that led to the situation becoming chaotic.

The dynamics are observed and analysed from a medical point of view, but also from an interpersonal point of view (characteristics of the interaction and emotions involved on both sides).

During the debriefing, participants should list on the flip chart the do's and don'ts for such situations (mainly for the medical and administrative staff because that is where the training intends to have an added value).

Suggestion for organization and group setup

- Establish a group of 2 persons = a father and his young son
- Establish a group of 4 people = health care workers
- Establish a group of 3-5 people = other patients in the waiting room

Make sure that the role play does not pose any emotional concern to anyone. Do not force the participants. The role play should take up to 10-15 minutes until the facilitator ends the role play. There is no right or wrong behaviour in the role play, but playing the role genuinely matters the most.

For everyone's safety, it is important to brief the players that it is not allowed to materialize the violence physically.

Create a space that includes the waiting room with a few chairs and the ward where the patients are being pre-examined, registered and checked-in.

Give the 2 groups their respective scenario[33] and ask them to leave the room for 15 min to prepare their role play.

The remaining participants will be observers and other patients waiting. They will be asked to listen and to take notes focusing on: **behaviour, attitude, emotions, and arguments**.

Debriefing and observations
The facilitators get the entire group back to their seats in order to conduct the debriefing.

They guide the discussion with the following questions:

- How did each player feel in his/her role?
- Was the interaction threatening or violent? When did the situation escalate?
- What triggered the escalation? Which emotions were obviously present?
- How did the health care group manage the situation?
- Did the patient and father behave properly? Was it understandable that they were impatient?
- Did the medical staff restore order? If so, how? Which arguments and behaviours did they use?
- Did both groups listen to each other? What language did they use?
- How would the situation have been different if the other language form was used to communicate?
- Did the medical staff speak on their own behalf or as health care personnel?
- Did you see group coherence among the medical staff?
- Did the patient/father express their feelings sufficiently/not sufficiently/too much?
- Did the medical staff listen sufficiently to the patient/farther?
- Did the medical staff propose ways forward? Was that a constructive exchange?

Attention is to be drawn to what should have been done or said to de-escalate the threatening or violent situation and restore order.

Key questions
- What should be emphasized?
- What was missing?
- What would be the right behaviour for the staff to protect themselves?

33 Each group will have a guiding scenario telling them how to play their role and which behaviour and attitude they should emphasize. The aim is to bring forward the typical behavioural tendencies (fear, anger, confusion and sadness)

Activity 14: Evaluation diagonal
(10 minutes)

Purpose
- Evaluation
- Examine the participants' assessment of what they have learned and what this might mean to them.

How to do it
- Ask the participants to imagine a line going diagonally through the room, from one corner to the other. The end points of this line are the corners.

- The facilitator gives a statement, for instance: "I believe that what I now learn about conflict management will change the way I interact with patients," or "I believe I can actively contribute to reducing the stress level at work". One corner represent denial of this statement ("not at all") while the other corner represents confirmation of the statement ("totally agree"). The participants should then position themselves at the point along the line that reflects the extent to which he or she agrees or disagrees with the statement. The participants are encouraged to talk with each other to find out if they are placed correctly in relation to each other, what makes them stand where they do and so on.

- When all the participants have found their place, the facilitator asks some of the participants questions to hear more about what they think about the position they have found on the evaluation diagonal. The dialogue with each of them can trigger further reflection.

- If there is time, repeat the activity with other statements.

Other statements the facilitator could use, include:
- "I think my life will change after this conflict workshop."
- "My interaction with patients and their relatives will improve as I now know better how to read their needs and understand their reactions."
- "This course as taught me a lot about conflict management."
- "After this workshop, I will deal better with threatening situations and conflicts."