**Search for Common Ground**

**Regional Cooperative Health Initiative**

**Final Evaluation of the Program**

**Submitted by**

**Arab World for Research and Development**

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**List of Tables and Charts**

**Tables**

|  |  |
| --- | --- |
| **Table 1** | Results framework  |
| **Table 2** | Category of respondents compared with type of tool used |
| **Table 3** | Scores of training participants by nationality  |
| **Table 4** | Tabulations of changes in Israeli’s perceptions of understanding and attitudes from baseline to end line |
| **Table 5** | Summary of end line results |

**Charts**

|  |  |
| --- | --- |
| **Chart 1** | Changes in attitudes from baseline to end line by nationality of junior lab technicians  |
| **Chart 2** | Percentage of junior lab technicians showing increased positive attitudes to training counterparts at project end line  |
| **Chart 3** | Change in positive attitudes from baseline to end line by gender of junior lab technician |
| **Chart 4** | Positive changes in understanding and attitudes from baseline to end line by nationality of TOTs  |
| **Chart 5** | Percentage of senior lab technicians showing increased positive attitudes to training counterparts at project end line. |
| **Chart 6** | Percentage of senior lab technicians who had positive perceptions of CM and Technical training components  |
| **Chart 7** | Change in positive attitudes of senior lab technicians by gender from baseline to project end line  |
| **Chart 8** | Self-reported changes in ability to deal with conflict and disagreement from baseline to end line by nationality |
| **Chart 9** | Self-reported changes in ability to deal with conflict and disagreement from baseline to project end line by gender  |
| **Chart 10** | Self-reported changes in CM skills between baseline and project end line by seniority of lab technician. |

**List of Acronyms**

|  |  |
| --- | --- |
| **AWRAD** | Arab World for Research and Development |
| **CORDS** | Connecting Organizations for Regional Disease Surveillance |
| **CM** | Conflict Mitigation |
| **MECIDS** | Middle East Consortium on Infectious Disease Surveillance |
| **PMOH** | Palestinian Ministry of Health |
| **RCHI** | Regional Cooperative Health Initiative |
| **SFCG** | Search for Common Ground |
| **ToR** | Terms of Reference |
| **ToT** | Trainers of Trainers |
| **USAID** | United States Agency for International Development |

**EXECUTIVE SUMMARY**

**Background**

The main goal of the Regional Cooperative Health Initiative (RCHI) is to build professional and personal understanding among senior public health officials and technicians in the Israeli, Jordanian and Palestinian public health sector. This goal was pursued by building institutional and individual cooperation among the Israeli, Jordanian and Palestinians public health sectors on biosafety and, at the same time, harmonizing biosafety levels in Israel, Jordan and Palestine. Project activities included training of trainers in biosafety techniques and conflict mitigation (CM) skills, training of lab technicians from the three participating countries to Biosafety Level 3 (BSL3), and a scenario simulation of a biosafety outbreak for senior public health officials of the three countries.

The overarching aim of this final evaluation is to capture the change brought about by the project among its target groups and beneficiaries in terms of increased professional capacities, CM skills and attitudes towards their regional counterparts. The specific objectives of the final evaluation include assessing progress towards results, assessing overall project performance against key criteria, and tabling lessons learned and recommendations for future projects of this type.

**Methodology**

The frame of reference for the evaluation was based on three of the five basic Organizations for Economic Cooperation and Development criteria of relevance, effectiveness, and sustainability. The evaluation was undertaken in three phases (i) the inception phase, to plan and scope the evaluation and develop the evaluation tools, (ii) the data collection phase, which included documentation review, baseline and end line surveys, interviews and focus groups in Jerusalem and Cyprus, and (iii) the analysis and reporting phase, during which the team analyzed and synthesized all the collected data and prepared this evaluation report.

**Analysis of Results and Key Findings**

The vast majority of findings confirm the utility of the current project. Across all evaluation criteria (effectiveness, relevance and sustainability), the project exhibits positive achievements. The scores for indicators show improvement on most fronts, with the need for improvement in some eras in the future as indicated below.

***In terms of Effectiveness*,** **findings show that** **four of the project results have been completely achieved and one has been partially achieved. The overall project goal was well achieved.**

**The professional capacities of all health technicians** (23 were trained as trainers [TOTs] at bio safety level 3 [BSL3] and 59 were trained by these trainers) trainings **were significantly increased**. On the basis of their scores in the final exam, all 82 received certification at BSL3 and four of the TOTs can now provide BSL3 training at international level. All senior public health officials involved in the simulation exercise felt that the experience of modeling a real emergency taught them essential communication and response protocols for managing common action. **This result was fully achieved**.

Trainers from the three countries trained mixed groups from the three countries. The final average scores on the exam of participants from the three countries were within the same range (82-85) indicating that **biosafety trainings of health technicians in the three countries are at the same standard. This result was fully achieved.**

**Health officials were able to coordinate and cooperate together during a modeled emergency.** The simulation exercise was highly rated by all participants and trainers. The exercise produced a common action plan for management of emergencies as an outcome. **This result was fully achieved**.

**Cooperation was built on both the individual and institutional levels among all levels of health officials and technicians from the three countries.** AllMECIDS members from the three levels claimed increased levels of communication with each other, and almost all junior lab technicians and TOTs reported a desire to ‘stay in touch with other participants’ (91.3% for juniors, 90.4% for TOTs) and a willingness to ‘work on common issues’ (93% for juniors , 96.3% for TOTs). TOTs also reported increased traction for networking on the personal level (from 67% to 92% at end line). **This result was fully achieved**.

**The CM skills of health technicians from the three countries overall decreased, although those of the Israelis increased. This result was only partially achieved.**

In general, the project succeeded in creating effective networking opportunities between health officials and technicians. MECIDS has shown that these networking opportunities can be sustained at the highest levels of the public health system. Sustaining networking opportunities at the lower levels of health technicians will, to some extent, depend on the leadership of the senior public health officials. In the public health sector, practitioners tend to stay in their jobs for life, which helps to sustain the networking.

**In terms of Relevance, the participants were in consensus that the project and its goals are relevant, although challenging in the prevailing context.**

**The public health laboratory assessment was positively welcomed by all MECIDS members.** The report gave them new knowledge about the situation in the other partner countries. As a result of the baseline assessment, the Palestinian MOH was more aware of the need for clear protocols to be followed in their laboratories and the importance of security checks on personnel entering the labs. They have provided training on protocols and have installed a system of security checks. They have no resources to implement the recommendations made on the requirements for the establishment of BSL3 laboratories.

MECIDS members acknowledged the role of the project in identifying the priority public health topics of common interest for future work. **They also confirmed that the level of cooperation across the health ministries has moved to a new level and that the simulation exercise added value to the collaboration process.** All members recognize the more strategic benefits achieved through a deeper level of cooperation around academic collaboration but recognized the political obstacles involved.

**Palestinian members felt that the project has opened up and consolidated the existing professional network**. Jordanians felt that while the East Mediterranean Region Office of the World Health Organization already provided a platform for Palestinian-Jordanian regional cooperation, the simulation exercise helped formalize the working process for regional biosafety work, including the Israeli MOH.

**As for Sustainability, there has been a positive transformation in attitudes towards the ‘other’ overall and of skills. Yet, participants feel that more work needs to be carried out with the relevant institutions in their countries to create a more conducive and sustainable utilization of the new skill.**

All participants at senior levels agreed that it was important to continue working with personnel from other health ministries. At the level of lab technicians, cooperation remains at the theoretical level at this point, but there is a clear desire to keep in touch and willingness to work on common issues. **All data shows that attitudes have improved at all stakeholder level towards increased cooperation and collaboration.**

**Indicators:** Almost all participants (95%) also expressed a readiness to work with each other on common issues.

At the end of the project, training participants had gained significantly higher levels of understanding of and positive attitude to the other. The average score at end line for all training participants (junior lab technicians) combined was **59.7**, which is a **10.5 percentage point increase** over the baseline of **49.2**.

The goal indicator - *percentage of participants who agree that they have a better understanding of the other which helped to change their attitude positively* –**showed a significant increase overall of 10.5 percentage points over the baseline figure of 49.2 for junior lab technicians** and a **9.4% increase over the baseline figure of 58.1% for those Senior lab technicians who were trained as trainers (TOTs).**

Almost all participants (95%) also expressed a readiness to work with each other on common issues.

While all other findings and indicators were mostly positive, the results indicate a major area of improvement and further focus in the future. The Sub Intermediate Result 1.1 Indicator – *health officials licensed by each country’s Ministry of health have increased conflict mitigation skills –* showed an **overall decrease of 7.7 percentage points from the baseline figure of 45.4**%, **although more Israelis rated their skills higher at end line by 6.8 percentage points. In general, the focus on this element was minimal for reason explained throughout the report, which calls for either a change of objectives or a change in approach as the recommendations suggest.**

**Conclusions and Recommendations**

The Regional Health Cooperative project is fundamentally a very successful project. All project results were fully achieved with the exception of increasing CM skills, which was only partially achieved. In terms of meeting it objectives, the project succeeded in harmonizing biosafety levels at the human resource across the three countries. The process of harmonizing these levels in terms of other resources – equipment and running costs – has been pushed to the next step through the lab assessments carried out in the three countries by the project. The project also succeeded in building and further developing individual and institutional cooperation on biosafety in the three public health sectors through the joint training activities carried out and through the desk top exercise with MECIDS members, which brought additional value to the ongoing regional cooperation.

The goal of building professional and personal understanding among senior public health officials and technicians in the three countries was reached. In the deteriorating political context and climate, this is a remarkable achievement and attests to the common values held by public health practitioners and the sense of belonging to one epidemiological family.

SFCG staff felt that the project was the most successful of all the MECIDS programs to date because of its systematic planning process and monitoring and evaluation procedures in place. SFCG felt that their ability to plan the project systematically were the direct result of the significant level of USAID financing and USAID requirements for systematic M&E protocols.

The evaluation has the following six recommendations to make for future regional programming in the health sector:

1. **Integrate CM skills into technical trainings, present the skills CM skills and themes as communication skills.**

As the CM trainers attested, CM requires much more time for positive outcomes. It is a process which has its own dynamics and used in conjunction with technical training, particularly in a tight training framework, tends to distract rather than add value. This requires further thinking and decision on how to best approach it (directly and upfront, indirectly or even separately).

There is clearly a role for the concept of ice breakers and empathetic listening techniques to be introduced within the broader training process, but they could be presented as communication skills for training rather than CM. These ‘soft’ skills can be delivered by the same trainers who deliver training on technical skills to avoid the potential conflation of CM with the broader political issues. SFCG staff also felt that the ‘light touch’ of the CM modules did not have a significant impact on the undoubted successful outcomes of the project itself. It is difficult to make a distinction between CM and the implicit ‘normalization’ involved because of the conflation of military occupation with ‘conflict’.

1. **Build in sustainability to program activities by providing a broader platform or encouraging MECIDS to establish a broader platform to maintain connections and follow up with all trainers and trainees on a regular basis to track what worked well and was applicable and what could be improved in the training and networking activities.**

When participants return to their own institutional environments, the application of what they have learned and changes in their perceptions will not always be smooth. It is important that some kind of platform is established for participants to share their successes, reflect on aspects which are not working well, and discuss particularly useful biosafety messages they have used in their work environments. Such a platform will be used by those participants who are keen to maintain momentum through the opportunities that networking allows. Furthermore, for participants who agree to stay in touch and be available, the next step in consolidating professional networking post training is to provide the tools for participants to engage. An essential link in this is a simple contact sheet which can be presented to all participants at the beginning of the workshops.

1. **Establish clear protocols for the training workshops and enforce as necessary**

It is essential that clear instructions in terms of the language to be employed in the training groups are established. Enforcing these instructions must be constantly attended to in order to provide fair and equitable access for all participants to the knowledge being shared.

Agreements on all other the protocols for the workshop, for example the turning off of mobile phones, clarifications of all points requested and a slower pace of delivery so that language competencies can be equalized, must be discussed and approved by participants at the start of all workshops. Attention to these details help to operationalize the inclusive and participatory principles guiding the project design and implementation.

1. **Ensure equity in treatment for all participants and sensitivity to different cultural customs**.

Getting this right in such a complex logistical and political context is daunting. But if it is not right, then attitudes of participants to the ‘other’ can be significantly affected. It is worth additional investment in this part of planning and implementation, even if it proves time consuming. By being responsive to requests, explaining changes to the plans and being more proactive and structured in choices of down time activities, participants will feel they are all of equal value.

1. **De-escalate potential issues up front at the right level**

For example, if a senior Israeli or even the project officials had clearly explained (or possibly apologized) to the Jordanian participants at the beginning of the workshop for their visa refusal and their perceived rather harsh treatment in the Israeli Embassy in Amman, much of the understandable resentment could have been dissipated. While it may be a common experience for Palestinians, it is not the same matter for Jordanians, who have more positive expectations as the two countries have a peace treaty.

1. **Building on the baseline laboratory assessment**

The benefits to the participating MOHs from the base line assessment are not yet clear. A repeat assessment (re-audit) would be helpful to understand how the three governments reacted to the recommendations would be helpful in understanding what follow up actions could be taken in terms of supporting any funding required for additional equipment or training for staff.

**Table of Contents**

Acknowledgements 2

 List of tables and charts 3

 List of acronyms 4

 Executive summary 5

1. Project Information 11
2. Introduction 11
3. Methodology 14

4. Findings against evaluation criteria 17

 41. Effectiveness 17

 411. Networking opportunities 17

 412. Achievement of project results 18

 42. Relevance 20

 421. Public health lab assessment 21

 422. Improvements to health sectors 21

 43. Sustainability 22

 431. Improving collaboration and synergies 23

 432. Transforming attitudes to support increased 23

 Cooperation and collaboration

 433. Transforming attitudes towards the other 23

1. Project Indicators 23

51. Goal Indicator 23

 511. Junior lab technicians 24

 512. Analysis of findings 26

 513. Senior lab technicians 27

 514. Analysis of findings 29

52. Sub-Intermediate Result 1.1 Indicator 30

 521. Analysis of findings 32

 53. Summary of end line results 33

6. Conclusions and Recommendations. 34

Annexes:

Annex 1 Methodology

Annex 2 Data gathering tools

Annex 3 List of people interviewed

1. **PROJECT INFORMATION[[1]](#footnote-1)**

The Regional Cooperative Health Initiative (RCHI) is implemented by Search for Common Ground (SFCG) through the mechanism of the Middle East Consortium on Infectious Diseases (MECIDS) which is administered by SFCG office in Jerusalem. The RCHI is a technical training and professional networking opportunity for public health officials and technicians at various levels (junior and senior lab technicians, senior managers) in Israel, Jordan, and Palestine.

Made possible by the generous support of USAID, the main goal of the RCHI was to build professional and personal understanding among junior and senior public health officials and technicians in the Israeli, Jordanian and Palestinian public health sector. This goal was intended to be achieved by building institutional and individual cooperation among the Israeli, Jordanian and Palestinians public health sectors on biosafety and, at the same time, harmonizing biosafety levels in Israel, Jordan and Palestine. Project activities included a joint training-of-trainers for 24 senior lab technicians in biosafety techniques and conflict mitigation (CM) skills, a joint training of 60 junior lab technicians in biosafety and biosecurity to Biosafety Level 3 (BSL3), an assessment of biosafety needs and standards for each country, and a scenario simulation of a biosafety outbreak with senior public health officials of the three countries. Three meetings of the MECIDS Board were also included as project activities although because of significant re-scheduling of project activities during implementation, only two Board meetings were held.

 The RCHI programme ran from September 17th, 2015 to March 31st, 2017. A baseline report which assessed the current capacities and practices of BSL-2 and BSL-3 Laboratories regarding biosafety and biosecurity in the West Bank, Israel and Jordan to benchmark training requirements was carried out in April 2016 before the training programs were designed. Trainings in Biosafety and Biosecurity for Level 3 Laboratories were held in Jerusalem in May 2016 for 23 senior lab technicians from all countries (nine from Palestine, seven from Israel and seven from Jordan). Eight of these senior lab technicians were selected as trainers for the subsequent two rounds of training for 59 junior lab technicians (20 from Palestine, 20 from Jordan and 19 from Israel) held in Cyprus in November 2016[[2]](#footnote-2) Trainings were also conducted for 19 MECIDS members and senior public health officials ( five from Palestine, seven from Israel and seven from Jordan) in Cyprus in November 2016 on how to manage a cross border outbreak of an infectious disease and develop a common action plan for use in the event of public health emergency. Two board meetings for MECIDS members were also held during the two training periods, one in Jerusalem and one in Cyprus.

**2. INTRODUCTION**

At the heart of the Israeli-Palestinian conflict is a dispute over land and borders between France, England and Russia at the beginning of the twentieth century as the Turkish Ottoman was dismembered. As a result of agreements concluded at the end of World War 1, Palestine became a British protectorate. After World War 2, the United Nations General Assembly decided in 1947 on the partition of Palestine into Jewish and Arab states, with Jerusalem to be an international city. The plan, which was rejected by the Palestinians, was never implemented. In three successive wars (1948, 1967 and 1972) Israel made massive territorial gains including the West Bank and Gaza, the Syrian Golan Heights, and the Egyptian Sinai up to the Suez Canal. The principle of land-for-peace that has formed the basis of Arab-Israeli negotiations is based on Israel giving up land won in the 1967 war in return for peace deals recognizing Israeli borders and its right to security. The Sinai Peninsula was returned to Egypt as part of the 1979 peace deal with Israel. Jordan signed a peace treaty with Israel in 1994 after the Oslo Accords were signed between Israel and the Palestinians. The Oslo Accords, under which the Palestinian Authority was created in 1994, were intended to lead to a final negotiated settlement between the parties. However, a final political settlement between Israel and Palestine has not materialized.

One consequence of the Arab-Israeli conflict is a lack of cooperation - and sometimes outright hostility - between the Israeli, Jordanian, and Palestinian governments. In the public health sector the conflict has created an environment of mistrust among professionals in the three Ministries of Health, leading to lack of harmonization of information, standards and professional coordination. This presents a public health risk to the three populations.

In this context, the Middle East Consortium on Infectious Disease Surveillance (MECIDS), administered by Search for Common Ground (Search) has consistently worked to improve cross-border efforts on public health between the Israeli, Palestinian, and Jordanian governments over the past thirteen years. MECIDS has served as the only mechanism through which key players in the participating Ministries of Health have conducted joint trainings, shared information, and coordinated cross-border responses on a variety of infectious disease issues.[[3]](#footnote-3) MECIDS was formed in 2003, when health professionals from the Ministries of Health and academia of Jordan, Palestinian Authority and Israel, convened together by the US Search for Common Ground, to fulfill the goal of facilitating trans-border cooperation in response to disease outbreaks. In January 2007, MECIDS formed an Executive Board with rotating chairmanship to each country each year. The first targets for MECIDS work were food-borne diseases and avian and pandemic influenza. Food imports and exports from the three countries may provide means for transmission of foodborne diseases in the whole region. Despite the volatile shifts in the political situation MECIDS has responded to the Avian flu outbreak in 2005 through collaborative diagnostic techniques and culling of poultry, to the swine flu epidemic in 2009 through containment and control, and put in place a common action plan for managing any future flu pandemic in 2008.

The RCHI is based on the following theory of change: **If** large numbers of public health professionals from Israel, Jordan, and the Palestinian Authority are brought together in the context of capacity-building activities on biosafety (trainings, scenario exercises) which will benefit them professionally and serve their societies, **then** they will be more willing to meet their peers on the other side of the conflict in other contexts. This is because currently, many Palestinians and Jordanians avoid contact with Israelis that might be deemed ‘normalizing’ [[4]](#footnote-4)and could lead to negative actions by their fellow citizens against them.

**If** these activities build up the biosafety capacities of health laboratories licensed by the three Ministries of Health to the same level, **then** it will also build confidence among professionals in the laboratories where standards were lower and will enable cooperation that was not possible before. Under these conditions, **if** we introduce capacity building **and** conflict mitigation skills, **then** public health officials will be more willing to meet, build trust, resolve tensions, and ultimately improve coordination among the three public health sectors.

This program logic is represented below as the Results Framework[[5]](#footnote-5) below, Table 1.

**Goal:** Professional and personal trust among senior public health officials and laboratory technicians in the Israeli, Jordanian, and Palestinian public health sectors is built.

**Intermediate Result 2:** Biosafety trainings of health officials in Israel, Jordan and the Palestinian Territory are at the same standard.

**Intermediate Result 1**: Cooperation built on both the individual and institutional levels among health officials licensed to work in the three ministries of health.

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**Sub- Intermediate result 2.1:** Health officials licensed by the three ministries have increased professional capacities.

**Sub-Intermediate result 1.1:** Health officials licensed by each country’s ministry of health have increased conflict mitigation experience.

**Sub- Intermediate result 1.2:** Health officials licensed by each country’s ministry of health are able to coordinate and cooperate together in case of an emergency.

**Activities:**

Assess biosafety needs and standards of each country; Train 24 Health officials to become trainers of biosafety and biosecurity; Train 60 lab technicians in biosafety and biosecurity.

**Activities:**

Hold conflict mitigation exercises during the trainings.

**Activities:**

Hold 3 MECIDS executive board meetings; Design the 3 day ‘scenario run-through’ with key public health officials; Hold a 3-day “scenario run-through” simulation exercise for senior public health officials.

**3. METHODOLOGY**

There are three specific objectives for the evaluation:

1. Evaluate the project against the criteria of effectiveness, relevance and sustainability

2. Measure the change of the project’s indicators after implementation of the activities

3. Extract lessons learned and recommendations from this experience to inform future programming for supporting regional health initiatives.

Quantitative and qualitative research was conducted during the implementation period at key points in the implementation of activities by both AWRAD and SCFG staff to capture adequate and useful data that can be used to provide an overall evaluation of the project. The surveys and monitoring carried out by SFCG during implementation are designed to measure project progress against project indicators. SFCG managed the assessment of biosafety needs and standards or each country, which was implemented by a consultant from SFCG’s partner Connecting Organizations for Regional Disease Surveillance (CORDS). SFCG also carried out a USAID-designed survey to test post training and participation attitudes of participants towards their training counterparts, and analysed the test results of all participants, including junior and senior lab technicians. Further SFCG also surveyed the MECIDS members involved in the board meetings as to their perceptions of to what extent the objectives of their meetings had been achieved. SCFG has shared with AWRAD the data from their own monitoring work to enable the holistic evaluation of the project.

Target Groups

All program participants - junior and senior lab technicians, MECIDS board members -were included in both SFCG and AWRAD surveys in which they self-assessed their changes in attitudes to and understanding of their training and networking counterparts, their changes in conflict mitigation experience, the relevance and applicability of what they had learned, and their expectations of future networking. AWRADs survey were baseline and end line surveys which enabled changes over time to be measured, while SFCG were post training/activity surveys.

AWRAD also conducted in-depth semi structured interviews with other key stakeholders including the conflict mitigation trainers, the international trainers who trained the trainers in May, and the two expert consultants from CORDS. AWRAD conducted separate focus groups with Israeli, Palestinian and Jordanian participants to surface common issues and harvest recommendations for future projects of this type.

All survey tools were administered in English. Although all participants had a high level of English, in order to facilitate a clear and consistent understanding of the survey questions, SFCG and AWRAD staff with fluency in Arabic, Hebrew and English administered the surveys and were able to answer any questions from participants in their mother tongue. All training and activities were run in English and all interviews were conducted in English.

 The research tools are linked to the targets as detailed in the following table:

 **Table 2: Category of respondents compared with type of tool used**

|  |  |
| --- | --- |
|  | **Number of data gathering tools used by type** |
| **Category of respondent** | **Baseline survey**(AWRAD) | **End line survey**(AWRAD) | **Post-training or activity survey**(SFCG) | **Interviews**(AWRAD) | **Focus group**(AWRAD) |
| **Senior lab technicians** | 23 | 23 | 23 | 2 | 0 |
| **Junior lab technicians** | 59 | 59 | 59 | 0 | 4 |
| **Trainers** | 0 | 0 | 0 | 4 | 0 |
| **Desk top simulation participants** | 0 | 0 | 1 | 0 | 0 |
| **MECIDS board members** | 0 | 0 | 4 | 4 | 0 |
| **SFCG staff** | 0 | 0 | 3 | 3 | 0 |
| **Total** | 82 | 82 | 90 | 13 | 4 |

The surveys assessed the impact of the joint trainings on participants on their increase in CM skills, technical knowledge, and to what extent each nationality’s attitudes towards participants from other countries changed. Interviews and focus group data were used to provide additional context and to explore causal linkages (the ‘why’ and the ‘how’) of any changes registered in the survey.

The baseline study[[6]](#footnote-6) investigated the attitudes and skills perceptions of laboratory technicians before they participated in the training activities. The end line survey was then conducted to measure the progress achieved towards the program’s objectives. The selection of participants for the baseline and end line study was guided by the program hypothesis, that if public health professionals are brought together in the context of capacity-building activities on biosafety which will benefit them professionally and serve their societies, then they will be more willing to meet their peers on the other side of the conflict in other contexts.

Data collection tools: The tools (surveys, focus group and interview guidelines) used by AWRAD were developed by AWRAD and approved by SFCG. They were absolutely standard across the different nationalities, junior and senior health professionals and other stakeholders to allow for comparison across indicators. SFCG used a combination of tools, some designed by USAID and others designed by SFCG staff in collaboration with the trainers.

Data analysis: Data gathered was tabulated by SFCG and AWRD and was analyzed by AWRAD. The data from the baseline and end line surveys were tabulated and disaggregated using the SPSS statistical package. Focus groups and interviews were analyzed by themes of relevance, effectiveness and sustainability. Overall trends in the data were noted as well as variations by nationality, gender and seniority. Qualitative data was used to explain and contextualize the quantitative results.

Evaluation team: The AWRAD team comprised 3 people – 2 women (one Palestinian and one British) and 1 man (Palestinian). Both Palestinian team members have complete fluency in Arabic and English, and the British team member has working knowledge of Arabic.[[7]](#footnote-7) The implications of gender and nationality were fully considered. When working with educated professionals especially in the public health field, women are significantly more highly represented than men.

Limitations: The only challenge experienced during implementation was the time allocated for completion of the baseline and end line surveys. As a result, the administration of these was a little rushed and may have impacted the quality of data gathered.

The ToR specified the use of three evaluation criteria and detailed the evaluation questions of interest under each of the criteria as detailed below:

**Effectiveness**:

1. To what extent did the project create effective and sustainable networking opportunities between health officials in the three countries?
2. To what extent did the project reach its expected results in each of the three targeted countries?

**Relevance:**

1. To what extent did the three health ministry’s benefit from the public health lab assessment?
2. To what extent do participants believe that the knowledge and networking opportunities gained through participation in the program improve the health sectors in their countries? If so, how? If not, why not?

**Sustainability**:

1. To what extent did the project allow for greater collaboration and the creation of synergies between the participants from the three different countries?
2. To what extent has the project enabled transforming target beneficiaries’ attitudes towards an increased support for cooperation and collaborations amongst the three countries?
3. To what extent has the project transformed the views of the participants towards the “other”.

**4. FINDINGS**

We present the findings in three separate sections below corresponding to the criteria of relevance, effectiveness and sustainability and addressing all stakeholder groups. We draw on both quantitative and qualitative data gathered by both AWRAD and SFCG.

***4.1 Effectiveness***

1. **To what extent did the project create effective and sustainable networking opportunities between health officials in the three countries?**
2. **To what extent did the project reach its expected results in each of the three targeted countries?**

4.1.1. Networking opportunities and future personal contact between health professionals in Israel, Jordan and Palestine

The project created positive networking potential at all stakeholder levels: junior lab technicians, senior lab technicians and senior managers in the public health systems of the three countries.[[8]](#footnote-8) Positive increases were registered across all participants in The effectiveness and sustainability of these opportunities were different for each group of stakeholders based on quantitative data from the surveys conducted and the data from interviews and focus groups.

At the level of the junior lab technicians, the survey data shows that while the project created little appetite for increased contact between participants in the three countries on the personal level, **there is almost total agreement on the desire to ‘stay in touch with other participants’ – 91.3%, and ‘willing to work on common issues’ – 93%.** The interviews done over the project period illustrate that despite the political and cultural issues which divide them, all agree that cooperation at the professional level is important and essential for reaching public health objectives in their own countries.

At the level of senior lab technicians, survey data shows that the project created additional traction for continuing contact on the personal level (**from 67% to 92% at end line**) as well as the professional level. There is near complete agreement on the desire to **‘stay in touch’ – 90.4%, and ‘working on common issues’ – 96.3%.** Seniors also now have a **more positive view of the other with 96.3% feeling this.** Interviews carried out show that, despite the rather mixed reaction to the CM elements of the project, there was a clear desire to keep in touch, particularly now that they knew the faces of their counterparts and had positive experiences working together during the training.

At the most senior levels of the public health administrations in the three countries within the MECIDS framework, relationships are already excellent and networking is ongoing at the professional level. Alex Leventhal, the outgoing chair of MECIDS and other MECIDS members explained that all three countries recognize the need for cooperation at the level of public health to be able to achieve their own objectives in their own countries. Although there is a long history of cooperation, the political situation can make it difficult to be public about the levels of cooperation. The MOH of the three countries have previously collaborated on food borne diseases and avian flu. There are direct and open lines of communication between the three MOH for consultations and support is provided for diagnosis. The surveys showed that MECIDS members unanimously agreed on the importance of cooperation and the willingness to continue the work with public health officials from the three countries. The board meetings of MECIDS held during the project was used to sustain the relationships at the professional and personal level.

The project succeeded in creating effective networking opportunities between health workers and officials. MECIDS has shown that these networking opportunities can be sustained at the highest levels of the public health system. Sustaining networking opportunities at the lower levels of health workers will, to some extent, depend on the leadership of the senior public health officials. In the public health sector, practitioners tend to stay in their jobs for life, which suggests the networking connections will be long lasting.

4.1.2. Achievement of project results

The following section presents the extent of achievement of the project results as assessed by the evaluation team.

* **Intermediate result 1: Cooperation built on both the individual and institutional levels among health officials licensed to work in the three ministries of health.**

Assessment: **This result has been fully achieved**. All MECIDS members (strongly agreed and agreed) that they learned through this workshop how to communicate with the personnel from the other health ministries. Junior lab technicians reported almost total agreement on the desire to ‘stay in touch with other participants’ – 91.3%, and ‘willingness to work on common issues’ – 93%. Senior lab technicians reported similar high levels of agreement on the desire to ‘stay in touch’ – 90.4%, and ‘work on common issues’ – 96.3%. Senior lab technicians also reported that the project had created additional traction for continuing contact on the personal level with their training counterparts (**from 67% to 92% at end line**). Interviews with senior public health officials from all countries involved underlined the difficulty of translating personal connections into formal institutional linkages as a result of the lack of progress in the Middle East peace process and the lack of any enabling environment to support further institutionalization.

Evidence from the survey also shows that over the period of the project, there was an overall decrease among both junior and senior lab technicians who felt that cooperation on solving regional health problems, would help in the creation of a more favorable environment’.[[9]](#footnote-9)

* **Intermediate result 1.1:** Health professionals (senior lab technicians/ToTs) licensed by each country’s ministry of health have increased conflict mitigation skills**.**

Assessment: **This result has been partially achieved**. Although the self-perceived CM skill levels of both Palestinian and Jordanians have not increased, those of Israelis have increased by 6.7 percentage points.

* **Sub- Intermediate result 1.2: Health officials licensed by each country’s ministry of health are able to coordinate and cooperate together in case of an emergency**.

Assessment: **This result has been fully achieved**. The simulation exercise[[10]](#footnote-10) - River Jordan -which simulated a biosafety emergency affecting the three participating countries was rated as highly successful by both participants and trainers. Participants felt it was a successful model in that it provided practical and realistic experience of how to deal with emergency issues, how to coordinate and share public health problems in order to control an outbreak of disease with biosafety implications. A collective debrief was held at the end of the exercise to share the most important elements to be incorporated into the manual (common plan of action) and future focus for MECIDS.[[11]](#footnote-11) A number of commonalities emerged including:

For the Manual:

* A clear communication plan which would provide a clear framework for explaining the public health emergency on a national and international level
* The need to identify clear roles and responsibilities for decision-making, technical collaboration in managing the emergency
* Mechanism for communication within and between respective MOHs during the emergency.
* Draw on previous Standard Operating Procedures in drafting the manual

Possible future MECIDS focus

* Need for expanded capacity building in biosafety and biosecurity for lab technicians
* Workshops on diagnostic tools in use
* Risk management training needed
* Physical capacity of laboratories in Palestine needed up to BL3 level.
* Operationalize the platform established for communities of practice for exchanging ideas and best practice
* Expand MECIDS to Lebanon, Syria and Egypt

The MECIDS Board Meeting held after the simulation exercise was completed, reviewed the input received for the manual and future priorities for MECIDS. The common elements were used as a minimum basis for the development of the manual, with already existing standard operating procedures incorporated. The manual was further developed with the help of the International Supervisor Dr Robert Spencer who had, together with Nigel Lightfoot from CORDS, developed and facilitated the simulation exercise. The common action plan manual on how to deal with an infectious disease outbreak that could affect all three countries is now available in English, Hebrew and Arabic.

* **Intermediate result 2: Biosafety trainings of health officials in Israel, Jordan and Palestine are at the same standard.**

Assessment: **This result has been fully achieved**. Trainers from the three countries trained mixed groups from the three countries. The final average scores on the exam of participants from the three countries are within the same range as shown in table 3 below, indicating that the up-take of knowledge and the training provided was at the same level.

 **Table 3: Scores of training participants by nationality**

|  |  |
| --- | --- |
| **Country** | **Average final score** |
| Israel | 82 |
| Jordan | 80 |
| Palestine | 85 |

* **Sub-Intermediate result 2.1: Health officials licensed by the three ministries have increased professional capacities**

Assessment: **This result has been fully achieved.** The scores achieved on the final exam detailed in Table 3 provide significant evidence of increased professional capacities. In addition, four of the trainers have been chosen as on a level to provide international trainings in bio safety with trainers from Public Health England. All junior and senior lab technicians have received certification at BSL3.

***4.2 Relevance***

The following evaluation questions are addressed:

1. **To what extent did the three health ministry’s benefit from the public health lab assessment?**
2. **To what extent do participants believe that the knowledge and networking opportunities gained through participation in the program improve the health sectors in their countries? If so, how? If not, why?**

4.2.1. Public health lab assessment

Three BSL 2 and BSL 3 laboratories were assessed with regard to biosafety and biosecurity three in the West Bank, three in Israel and four in Jordan over the period 11 – 18 April, 2016. The assessment was conducted by Dr Robert C Spencer, a CORDS Consultant in Clinical & Environmental Microbiology, Technical Expert for Microbiology in the fields of ISO 15189 and ISO 17025, with Logistical & Secretarial Support from Wajdi Bkeirat, Project Manager, SFCG. The assessment team met with Directors of laboratories, who were often also responsible for quality control and education.

The lab assessment was a clear and detailed joint baseline report on the levels of biosafety and biosecurity in the main public health labs of the three countries with recommendations for improvement in human and physical resources for use by all three ministries. The reaction of MECIDS board members to the report was positive. The report gave them knowledge about the situation in the other countries. It has not been possible for the evaluation team to fully[[12]](#footnote-12) assess at this point to what extent the three health ministries benefitted from the public health lab assessment. The lab assessment made the Palestinian MOH was more aware of the need for clear protocols to be followed in their laboratories and the importance of security checks on personnel entering the labs, as a result they have provided training on protocols and have installed a system of security checks. They have no resources to implement the recommendations made on the requirements for the establishment of BSL3 laboratories.

4.2.2. Improvements to the health sectors in participating countries

The RCHI project was able to build technical skills, knowledge and professional relationships in the public health sector across countries at all levels and was also able to deepen knowledge, develop and build on professional relationships within each country sector on the common issue of biosafety and biosecurity The scope of the outputs and outcomes supporting improvement in the health sector are very impressive. SCFG staff feel that the scope and scale of the project, as a result of USAIDs generous funding, was unprecedented in terms of their MECIDS work as evidenced by both the quantitative outputs (numbers and variety of participants, tangible outputs in the form of 8 certified biosafety and biosecurity trainers in each country, 59 lab technicians certified at BSL3 across labs in the region, a baseline laboratory assessment providing recommendations for improvements on biosafety and biosecurity levels for all participating MOHs and a common action plan for managing public health emergencies) and qualitative outcomes (levels of participant engagement, increased understanding of regional counterparts and overall positive changes in attitudes towards them). All these elements create the basis for sustainable effects provided the cross border connection is continuously encouraged.

Another unique feature of the RCHI project was that it provided detailed and evidence-based findings of its successes and areas where improvements could be made through a systematic monitoring evaluation approach. This will inform future planning of similar projects in support of cross border public health work. The SFCG Director reported that this was the first time that properly documented outcomes of the project including the strengths, weaknesses and opportunities provided by introducing a CM element into the program had been possible.

MECIDS members reported through the SCFG administered surveys that the board meetings held as part of the project helped to identify and begin to work on public health topics of common interest to all three countries. MECIDS members also confirmed that the inter-regional cooperation had moved to a higher qualitative level within their respective health ministries as a result of the development of the common action plan for managing public health emergencies. They also reported that the simulation exercise carried out during the project added great value to the collaboration process as it helped to reveal the current gaps in procedures and process for effective regional collaboration. However, Israelis feel that the level of cooperation is still superficial and they would like to deepen the relationship through academic collaboration and collaboration at the level of research. This, they feel, would bring more strategic benefits to the health sectors in all countries, but it is impossible to move forward on this because of the political situation. In the context of the deteriorating political situation in the region, one senior Israeli official felt that the MECIDS collaboration was ‘almost like a fairy tale’ because it looks better than the reality.

Palestinian public health practitioners at all levels report that the Jordanians and Israelis already support the Palestinian health sector through the provision of diagnostic support for diseases that the Palestinian system does not have the capacity to deal with. One Palestinian senior staff felt that although they know who to contact within the Israeli system when they need help, the joint working with seniors from other countries during the training and meeting with the MECIDS members during the project (who represent the highest levels of public health management in Israel and Jordan) has opened up and helped to consolidate the existing professional network. Jordanians regularly provide technical assistance to Palestinian counterparts for free and there is very open communication at all levels between the two systems. Palestinian MECIDS members concur that research and academic cooperation would bring strategic benefits to the Palestinian health sector, but this is compromised by popular political attitudes and positions.

Jordanians reported that the East Mediterranean Regional Organization of the World Health Organization grouping within had already provided a professional network with Palestinians in the region for collaboration on joint projects of mutual public health concern like the tracking of food borne diseases across the borders of the two countries. However, the simulation exercise helped to formalize and experience what the working process for regional biosafety control would look like, including the Israeli ministry of health. The possibility of joint research with Israelis is heavily compromised by the political situation in the region, but the professional relationships at the most senior levels are ‘remarkable’.[[13]](#footnote-13)

***4.3 Sustainability***

The following evaluation questions are addressed in this section:

1. **To what extent did the project allow for greater collaboration and the creation of synergies between the participants from the three different countries?**
2. **To what extent has the project enabled transforming target beneficiaries’ attitudes towards an in increased support for cooperation and collaboration amongst the three countries?**
3. **To what extent has the project transformed the views of the participants towards the ‘other’**?

4.3.1. Improving collaboration and creation of synergies

In terms of sustainability and the continuity of cooperation between participants from the three countries, at the most senior levels**, all** participants agreed (strongly agreed and agreed) to continue working with personnel from the other health ministries. In addition, **all** participants agreed (strongly agreed and agreed) that the cooperation between the three ministries of health (Israel, Palestine, Jordan) is important. The increase in collaboration and the creation of synergies was most obvious in practice at the most senior stakeholder level. At the lab technician level both senior and junior, opportunities for and examples of collaboration is still only theoretical, but the first steps have been taken to form those relationships, confirmed by the reported desire to keep in touch, the willingness to work together, and the recognition of the importance of regional cooperation in both quantitative and qualitative data.

4.3.2. Transforming attitudes to support increased cooperation and collaboration

Survey data and interviews and focus group data show that attitudes at all stakeholder levels have improved towards increased cooperation and collaboration, as elaborated in section 4.1.2 and 4.2.2. above.

4.3.3. Transforming attitudes towards the other

This has been achieved to a very large extent. The quantitative and qualitative evidence is presented in sections **5.1.2.** and **5.1.3.** below

**5. PROJECT INDICATORS**

We present the overall findings by comparing the baseline status against the end line of each indicator.

***5.1.******Goal Indicator***

**Percentage of participants who agree that they have a better understanding of the other which helped to change their attitude positively (disaggregated by gender)**

This indicator was assessed using four statements [[14]](#footnote-14)with which respondents ranked their level of agreement. A six point likert scale [‘strongly agree’, ‘agree’, ‘neither agree nor disagree’, ‘disagree’, ‘strongly disagree’ and ‘don’t know’] was used by respondents to self-assess their degree of agreement with the statements, which explored issues of shared values, knowledge of context, motivations, and future behaviors. The percentage of ‘strongly agree’ and ‘agree’ responses was tabulated for all statements and the average of all 4 percentages calculated.[[15]](#footnote-15) The higher the score, the higher the level of understanding of - and positive attitude to -the other. We present the figures for junior and senior lab technicians separately.

5.1.1. Junior lab technicians (trainees)

The average score at end line for all training participants (junior lab technicians) combined was **59.7**, which is a **10.5 percentage point increase** over the baseline of **49.2**. This means that on average, training participants had gained significantly higher levels of understanding of and positive attitude to the other. The Israelis’ levels of understanding of and positive attitude to the other increased by **24.1%,** very significantly more that either Palestinians, who showed an increase of **8%** or Jordanians whose understanding and attitudes remained the same. An example of the tabulations for changes in attitudes of Israeli junior lab technicians against the four statements is provided below in Table 4. Similar tabulations were carried out for Jordanians and Palestinians and the average of the changes inserted into the Chart 1 below.

|  |  |  |
| --- | --- | --- |
| **Table 4: Tabulations of changes in Israeli’s perceptions of understanding and attitudes from baseline to end line** |  |  |
|  | **Baseline** | **End line** |
| Jordanians have different values from me (reverse scoring) | 17.7 | 65 |
| Palestinians have different values from me (reverse scoring) | 11.0 | 55 |
| Jordanians know how the current economic and political situation affects me | 5.9 | 20 |
| Palestinians know how the current economic and political situation affects me | 0.0 | 20 |
| Jordanians are cooperating in this project because there is a risk to peoples’ health | 33.0 | 65 |
| Palestinians are cooperating in this project because there is a risk to peoples’ health | 38.9 | 60 |
| I will welcome an opportunity to meet with the Jordanian trainees in a non professional context | 87.5 | 95 |
| I will welcome an opportunity to meet with the Palestinian trainees in a non professional context | 87.5 | 95 |
| **Overall scores at base line and endline** | **35.2[[16]](#footnote-16)** | **59.3** |
|  |  |  |

The Israeli’s positive perceptions of both Palestinians and Jordanians increased in particular in the area of shared values from baseline to end line. Israelis also had a stronger belief at the end of the project that Palestinians were cooperating in the project for altruistic reasons. Although on average the understanding and positive attitudes of the Jordanian participants did not change overall from baseline to end line, they increased towards the Palestinians and decreased towards the Israelis. The Palestinians understanding and positive attitudes increased by 8% overall. This increase was almost all in favor of Jordanians and decreased towards the Israelis including a reduced willingness to meet Israelis in a social context.

**Chart 1: Changes in positive attitudes from baseline to end line by nationality of junior lab technicians**

The results ofSFCG’s own surveys at the end of the training period confirm the trend of positive changes in attitude to the other across the three groups at junior level as a result of the project. At junior level, both Jordanians and Palestinians expressed very positive attitudes about each other, but they were less positive about their attitudes towards Israelis, although a majority of both of them said they were felt more positive about Israelis. All Israelis by contrast were more positive about both Jordanians and Palestinians. Chart 2 below illustrates this point. Almost all participants (95%) also expressed a readiness to work with each other on common issues.

**Chart 2: Percentage of junior lab technicians showing increased positive attitudes to training counterparts at project end line.**

5.1.2. Analysis

Qualitative data from focus groups and interviews provides some context for these findings. All groups involved said that they kept the conversation away from politics as they all felt that they would feel the conflict and the tension. As a result, they intentionally kept interactions at the professional and personal levels. The training was originally intended to be held in Jerusalem but the Jordanians had been refused visas by the Israeli Embassy in Amman. Cyprus was chosen as a ‘neutral’ location.

However, while the Israelis said that they felt very comfortable in this atmosphere, Jordanians in particular, who had never met with Israelis before, felt a lack of sensitivity on behalf of the Israelis to their customs and ways of working. The Jordanians said they were treated very harshly by the Israeli Embassy officials over their visa denial. They mentioned the fact that during group work Israelis used Hebrew, despite being requested to use English; Israeli trainers were not patient with requests for clarifications, they spoke very fast and in a heavy accent, which was difficult for Jordanians to understand. Both Jordanians and Palestinians felt very certain that their technical competencies and abilities were on a par with Israelis although they did not have the same resources.

Some Jordanians and Palestinians felt that Israelis received preferential treatment outside of the trainings. For example, the restaurants that they were taken to outside of the hotel served alcohol, and the Jordanians and Palestinians were not consulted about their preferences. Jordanians said that the Israelis were provided with a choice of kosher meals from other restaurants, but the Jordanians were not offered a halal option.

During their focus group, Israelis reflected their surprise that ‘despite all they were told and read in the newspapers’, Palestinians and Jordanians were ‘very similar to them’. They commented on how ‘well prepared’ the Jordanian trainers were and how ‘intelligent and serious’ the Palestinians were.

Lack of familiarity with the other can account for most of these reactions and attitudes. The Palestinians, who were mostly from Jerusalem, interact with Israelis on a daily basis and are very aware of the differences in customs and have learnt to deal with the reality. Israelis, who had not met with either Jordanians or Palestinians, were very positively affected by their personal experience. Jordanians, who also had not met Israelis before, were more negatively affected by their personal experience and by the visa denial for Jerusalem.

Gender

When end line results are disaggregated by gender, there is no statistically significant difference[[17]](#footnote-17) in attitudes and perceptions across gender from baseline to end line with men showing an increase of **7.5%** in positive attitudes and women a **5.8% increase.** The difference between these two increases of 1.7% is not statistically significant. Chart 3 below illustrates.

**Chart 3: Change in positive attitudes from baseline to end line by gender of junior lab technician**

5.1.3 Senior lab technicians

The average score at end line for all TOTs combined was **67.5%**, which is a **9.4 percentage point increase** over the baseline of **58.1%.** This means that, overall; trainers had gained significantly higher levels of understanding of - and positive attitude to - the other. The biggest overall increase in positive attitudes was the Jordanian participants at **25%** followed by the Israelis at **5.6%.** Palestinians showed a decrease in understanding and positive attitudes of **2.4%.**

The Israelis showed an increased willingness to meet in a social context with both Jordanians and Palestinians and also has an increased belief in shared values with both. Jordanians too were more willing to socialize with both Israeli and Palestinians, but they exhibited a decrease sense of shared values with Israelis and slightly less trust that the Israeli motives for participating in the project were altruistic. Palestinians understanding and attitudes remained essentially unchanged. Chart 4 below illustrates these points.

**Chart 4: Positive changes in understanding and attitudes from baseline to end line by nationality of TOTs**

At senior levels, almost all participants reported that they were more positive about the other, with only Palestinians showing a slightly less positive attitude to both Israelis and Jordanians. Chart 5 below illustrates these points.

**Chart 5: Percentage of senior lab technicians showing increased positive attitudes to training counterparts at project end line.**

The results ofSFCG’s own surveys at the end of the training period illustrate the overall comparison in satisfaction between the CM and the technical training (See Chart 6 below). Palestinians are the least satisfied with this component and Israelis the most satisfied. However, 100% of all Palestinians and Israelis expressed a continued willingness to work on common issues.

**Chart 6: Percentage of senior lab technicians who had positive perceptions of CM and Technical training components**

**pa**

5.1.4. Analysis of findings

The training was held in Jerusalem, which was clearly a source of much satisfaction for the Jordanians, most of whom had never visited before. However, most Israelis went home in the evening, restricting the opportunities for more social interaction. The technical training was assessed very positively by all groups according to the SCFG survey.

All the groups were to some extent uncomfortable with the introduction of intentional CM into the training modules and all felt it should be separated from the technical training. Israelis felt it was ‘too intense’ in a 5 day period. In particular, Palestinians said they felt ‘abused’ by its inclusion. They were only aware of this component 3 days ahead of the training and felt it was a ‘very bad idea’ and made them feel ‘very uncomfortable’. Israelis felt that the inclusion of CM ‘put us in a corner where we don’t want to be’ but they also recognized that the tools for CM can be used in any context. Jordanians did not comment on the inclusion of the CM element. During the focus group, the issue of ‘normalization’ was raised but in relation to the overall purpose of the project rather than to any specific element.

Palestinians felt that they were not given enough time to plan for what they needed for the training, and that the setting of tables for lunch (in a row rather than circles) was not conducive to social interaction. In common with their junior colleagues, Israelis, who had never met Palestinians or Jordanians before, expressed frank astonishment at the professional status of their Palestinian and Jordanian training counterparts: ‘it is an eye opener for me that women in scarves (hijab) have senior positions in the region!’.

Positive changes in attitudes of Israelis can be accounted for by lower levels of familiarity with their training counterparts. The slightly negative changes in attitudes of the Palestinians can be accounted for by their very negative reaction to the CM training and the lack of time for proper preparation. The very positive change in the attitudes of Jordanians could party be accounted for by the fact that they were present in Jerusalem for the first time in their lives and this was for them a highly spiritual and symbolic time,[[18]](#footnote-18) but also by the prior lack of familiarity with both their Israeli and Palestinian counterparts.

Gender

Overall, more women have more positive attitudes to the other than men by almost the same margin of difference at base line (6.7%) and end line (5.5%) as Chart 7 below illustrates.

**Chart 7: Change in positive attitudes of TOTs by gender from baseline to project end line**

***5.2. Sub-Intermediate Result 1.1 Indicator***

This indicator was assessed using seven statements with which respondents ranked their level of agreement.[[19]](#footnote-19) A four point scale [‘always’, ‘often’, ‘sometimes’, ‘never’] was used by respondents to self-assess their degree of agreement with the statements, which all expressed good practices in CM. The percentage of ‘always’ responses was tabulated for all statements and the average of all seven percentages calculated. For full details of the questions asked, please see Annex 2.

The average end line score for all training participants combined was **37.6%** which represents a decline of **7.7** percentage points from baseline. However, more Israelis rated their CM skills higher at end line – 47.6% compared to 40.8% at baseline. This is an increase of **6.8** percentage points. More Palestinians and Jordanians rated their CM skills lower at end line by **13.5** and **16.3** percentage points. Chart 8 below illustrates:

**Chart 8: Self-reported changes in ability to deal with conflict and disagreement from baseline to end line by nationality**

When the results are disaggregated by gender, it is clear that more men now rate their CM skills higher than at baseline (42.8% compared to 40.3%). More women, however, feel that their CM skills have declined (from 56.4% at baseline to 35.7% at end line). Chart 9 below shows this.

**Chart 9: Self-reported changes in ability to deal with conflict and disagreement from baseline to project end line by gender**

The TOTs were divided into senior managers and lab technicians to assess the level of conflict mitigation skills at the two levels of the TOTs. Despite the overall decrease in CM skills overall (see graph 6 above), as at baseline, more senior managers still felt that their CM skills were higher than those of lab technician as chart 10 below shows.

**Chart 10: Self-reported changes in CM skills between baseline and project end line by seniority of lab technician.**

5.2.1. Analysis of findings

As section 414 above suggests, CM was not the most popular element of the training provided to the senior lab technicians. In addition, many felt it disrupted the technical elements of the training. Interviews with the CM trainers after the training was completed provide some insights into the reasons for a perhaps less successful part of the project.

The trainers had agreed with SFCG to teach participants tools for mediating conflict in general so that they could use them in any other contexts. On day 3 of the training, in agreement with SFCG, they pushed the envelope a little to ask questions like: what pressures did you face not to come to this training? Where do you come from? What is the importance of you being here? The reactions were mixed. Some who had been in this context before were more open, but others were much more reserved, particularly the Jordanians, who questioned why only the Israeli/Arab conflict was being addressed. Trainers said that one Israeli Arab[[20]](#footnote-20) who tends to have more fluid identities said that ‘there was nothing to it: I face it/do it every day’.

However, the discussion soon began to go down the road of different narratives, so the trainers pulled it back to effective listening skills and empathetic listening. The trainers felt that they should have had much more time as when you begin to focus on the ‘conflict’, a ‘psychological shift happens inside you and you cannot focus on anything else’. Participants and observers felt that the team building ice breakers at the beginning of the training were useful: ‘the ice breakers skills were used in the training workshops for junior lab technicians’. But participants wanted to focus on the technical elements of the training and found the CM elements as ‘distracting’ and ‘uncomfortable’.

SFCG staff reported that this was the first time CM had been added to MECIDS workshops. The subject of health is normally enough to build connections between participants working in this field. SCFG staff felt that while some parts of the CM skills building was appreciated, at the same time for lack of time or reluctance to add tension to the atmosphere, the CM sections had a ‘light touch’. As a result, SFCG staff felt that it didn’t have a profound effect on the successful outcomes of the project.

The international trainers who provided the technical training in biosafety felt that the time for the training was very tight and there were ‘too many side shows’. For them, the purpose of the project was to create an opportunity for dealing with the common issue of biosafety. They judge the success of the project by the trainer’s ability to take messages on biosafety and grow them in their own environments and contexts. The change in CM skills of trainees at end line could be influenced by several factors including the frequency of use of these skills in a training environment after the training is completed, and a tendency to overrate the status of skills at baseline, the subsequent use of the skills during training which may have provide much more difficult in practice, leading to a more realistic evaluation of skills status at end line. Israelis commented during the focus group that ‘it was much more difficult in practice’ to use these skills. ,.

None of the trainees had had prior experience with CM training and, based on their practical experience of using CM skills, may have rated themselves more realistically later. One Israeli trainer noted in the closing session for the training workshop that ‘it was good to know how to deal with conflict in the workplace’. There were no positive comments from their Jordanian or Palestinian counterparts. To the contrary, one Jordanian opined in the focus groups at the end of the training that ‘the goals from such a training program is normalization, I knew that from the beginning from the first exercise. We understood that quickly when we read the survey that they gave us.’

In the context of the deteriorating political environment in the region and in Palestine, the conflict mitigation element of the training was, for many of the participants, not well received. Part of the reason for this is the connotation that CM has acquired over the past few decades and the lack of outcomes from its application in terms of a strategic political settlement. The CM trainers themselves felt that there was insufficient time to roll out the process in a proper way and recognized that it may have been more of distraction than an added value. In addition, the participants did not feel well prepared for such an activity. For some of the participants, the addition of the CM element was a distinct surprise. Despite the fact that SFCG staff confirmed that a detailed description of the project and the workshops was sent to the TOTs some months before the activities commenced, the coordinator of the Palestinian trainers relates: ‘We were not told about the CM until 3 days before the event. When I got the schedule, I did not circulate the agenda to the other members in case they decided not to come. This is not the way it should be. It’s not comfortable. This issue should be separate from technical training.’

***5.3 Summary of end line results***

The table below presents a summary of baseline results against targets set.

**Table 5: Summary of baseline results**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Indicator** | **Baseline** | **End line** | **Target** | **Comment** |
| % of senior lab technicians with increased skills in conflict mitigation | **45.3%** | **37.6%** | 50% | Israelis reported an increase in skills of 6.8 percentage points. |
| % of target participants who say they have a better understanding of the other that helped in changing attitudes positively | Senior lab technicians | **58.1%** | **67.5%** | 30%-40% | 9.4% increase over baseline |
| Junior lab technicians | **49.2%** | **59.7%** | 30%-40% | 10% increase over baseline |

1. **CONCLUSIONS AND RECOMMENDATIONS**

The RCHI is fundamentally a very successful project. All project results were fully achieved with the exception of increasing conflict mitigation skills, which was still partially achieved. In terms of meeting it objectives, the project succeeded in harmonizing biosafety levels at the human resource across the three countries. The process of harmonizing these levels in terms of other resources – equipment and running costs – has been pushed to the next step through the lab assessments carried out in the three countries by the project. The project also succeeded in building and further developing individual and institutional cooperation on biosafety in the three public health sectors through the joint training activities carried out and through the desk top exercise with MECIDS members, which brought additional value to the ongoing regional cooperation.

The goal of building professional and personal understanding among senior public health officials and laboratory technicians in the three countries was reached. In the deteriorating political context and climate, this is a remarkable achievement and attests to the common values held by public health practitioners and the sense of belonging to one epidemiological family.

SFCG staff felt that the project was the most successful of all the MECIDS programmes to date because of its systematic planning process and monitoring and evaluation procedures in place. SFCG felt that their ability to plan the project systematically were the direct result of the significant level of USAID financing and USAID requirements for systematic M&E protocols.

The evaluation has the following six recommendations to make for future regional programming in the health sector:

1. **Integrate CM skills into technical trainings, present the skills CM skills and themes as communication skills.**

As the CM trainers attested, CM requires much more time for positive outcomes. It is a process which has its own dynamics and used in conjunction with technical training, particularly in a tight training framework, tends to distract rather than add value. This requires further thinking and decision on how to best approach it (directly and upfront, indirectly or even separately).

There is clearly a role for the concept of ice breakers and empathetic listening techniques to be introduced within the broader training process, but they could be presented as communication skills for training rather than CM. These ‘soft’ skills can be delivered by the same trainers who deliver training on technical skills to avoid the potential conflation of CM with the broader political issues. SFCG staff also felt that the ‘light touch’ of the CM modules did not have a significant impact on the undoubted successful outcomes of the project itself. It is difficult to make a distinction between CM and the implicit ‘normalization’ involved because of the conflation of military occupation with ‘conflict’.

1. **Build in sustainability to program activities by providing a broader platform or encouraging MECIDS to establish a broader platform to maintain connections and follow up with all trainers and trainees on a regular basis to track what worked well and was applicable and what could be improved in the training and networking activities.**

When participants return to their own institutional environments, the application of what they have learned and changes in their perceptions will not always be smooth. It is important that some kind of platform is established for participants to share their successes, reflect on aspects which are not working well, and discuss particularly useful biosafety messages they have used in their work environments. Such a platform will be used by those participants who are keen to maintain momentum through the opportunities that networking allows. Furthermore, for participants who agree to stay in touch and be available, **provide a list of participants phone numbers and e-mails to all those attending**

The next step in consolidating professional networking post training is to provide the tools for participants to engage. An essential link in this is a simple contact sheet which can be presented to all participants at the beginning of the workshops.

1. **Establish clear protocols for the training workshops and enforce as necessary**

It is essential that clear instructions in terms of the language to be employed in the training groups are established. Enforcing these instructions must be constantly attended to in order to provide fair and equitable access for all participants to the knowledge being shared.

Agreements on all other the protocols for the workshop, for example the turning off of mobile phones, clarifications of all points requested and a slower pace of delivery so that language competencies can be equalized, must be discussed and approved by participants at the start of all workshops. Attention to these details help to operationalize the inclusive and participatory principles guiding the project design and implementation.

1. **Ensure equity in treatment for all participants and sensitivity to different cultural customs**.

Getting this right in such a complex logistical and political context is daunting. But if it is not right, then attitudes of participants to the ‘other’ can be significantly affected. It is worth additional investment in this part of planning and implementation, even if it proves time consuming. By being responsive to requests, explaining changes to the plans and being more proactive and structured in choices of down time activities, participants will feel they are all of equal value.

1. **De-escalate potential issues up front at the right level**

For example, if a senior Israeli or even the project officials had clearly explained (or possibly apologized) to the Jordanian participants at the beginning of the workshop for their visa refusal and their perceived rather harsh treatment in the Israeli Embassy in Amman, much of the understandable resentment could have been dissipated. While it may be a common experience for Palestinians, it is not the same matter for Jordanians, who have more positive expectations as the two countries have a peace treaty.

1. **Build on the baseline laboratory assessment for sustainability**

The benefits to the participating MOHs from the base line assessment are not yet clear. A repeat assessment (re-audit) would be helpful to understand how the three governments reacted to the recommendations would be helpful in understanding what follow up actions could be taken in terms of supporting any funding required for additional equipment or training for staff.

**Annex 1: Methodology**

The frame of reference for the baseline study was the projects Results Framework, which delineates the causal linkages and provides an M&E implementation plan which details the timeline, tools and responsibilities for the overall monitoring and evaluation envisaged.

The work was undertaken in three phases (I) the inception phase, to plan and scope the assignment and develop the data gathering tools which included a documentation review, (ii) the data collection phase, surveys, interviews and focus groups in both Jerusalem and Cyprus (iii) the analysis and reporting phase, during which data has been analyzed and synthesized and a report prepared.

**3.1 Documentation review**

AWRAD team reviewed the following documents for RCHI program including:

* Program description[[21]](#footnote-21)
* Performance Management Plan
* Baseline Assessment Report of BSL-2 and BSL-3 Laboratories regarding biosafety and biosecurity in the West Bank, Israel and Jordan, April 2016

Information obtained from these documents helped in developing the survey’ methodology.

**3.2 The Questionnaire**

The questionnaire was devised by AWRAD team with close consultations with SFCG team. AWRAD developed a standard questionnaire to Regional Cooperative Health Initiative (RCHI) and to measure its potential impact from the perspective of citizens. The following indicators were assessed through the questionnaire:

* % of participants who agree that they have a better understanding of other which helped to change their attitude positively (disaggregated by gender) **(Goal)**
* % of senior lab technicians with increased experience in conflict mitigation (disaggregated by gender, nationality, seniority in the public health system) **(Sub-IR 1.1)**

The questionnaire included 5 closed-ended questions designed to measure the indicators in addition to the 5 demographic questions that included organizational affiliation, nationality, sex, and job title. Respondents were asked to rank their level of agreement with a series of statements presented in the questions concerning their training counterparts from the other two countries. For example, if the trainee was a Jordanian, s/he would be asked the question in relation to Palestinians and also to Israelis, generating multiple answers for analysis. Respondents were also asked to rate their ability to deal with conflict and disagreement against a separate series of statements.

For Sub-IR 1.1, respondents were asked to rate their current ability to deal with conflict and disagreement in relation to the following questions:

|  |
| --- |
| * I can listen patiently to what another person has to say even when I don’t agree with it
 |
| * Actively acknowledging what a person has to say does not mean that I agree with it
 |
| * When I get angry, I know what to do without losing control of myself of damaging a relationship
 |
| * Even in a situation of conflict I am able to understand my needs and the needs of other parties
 |
| * Using violence to solve a conflict means that everyone involved loses
 |
| * I anticipate the other persons reaction to what I say before I say it
 |
| * When a conflict is resolved non-violently, I understand more about how to achieve my own goals without undermining others
 |

For the Goal indicator, the answers to the following statements were considered to establish a measure for the indicator at base line for participants from each participating country

* (Palestinian/Jordanian/Israeli) have different values from me (this was reverse scored)
* (Palestinian/Jordanian/Israeli) know how the current economic and political situation affects me
* (Palestinian/Jordanian/Israeli) are cooperating in this project because there is a risk to peoples’ health
* I will welcome an opportunity to meet with the (Palestinian/Jordanian/Israeli) trainees in a nonprofessional context

**3.3 The Sample:**

All 59 junior and 24 senior lab technicians were included in the survey.

**3.4 Field Work and Interviewing:**

The survey was carried out through three sets of face-to-face interviews with laboratory technicians. The baseline survey was included in the program of activities for the training program and was allocated a time slot of 30 minutes for each of the three sets of interviews. The baselines were conducted at three different times during the project. The baseline for the senior lab technicians was in May, and the two baselines for the two groups of junior lab technicians were in November.

 **Table 2: Timetable for research**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Category of participants** | **Date of training** | **Location of training** |
| 1 | **Senior Lab technicians** | 19-22 May, 2016 | Jerusalem |
| 2 | **Junior Lab Technicians** | 7-9 November, 2016 | Cyprus |
| 3 | **Junior Lab Technicians** | 21-23 November, 2016 | Cyprus |
| 5 | **Key project stakeholders** | n/a | Jerusalem and Cyprus |

AWRAD staff completed the face to face surveys with the three groups with the logistical support of SFCG staff, who ensured that everyone registered for the training was surveyed and helped in answering questions that the respondents had on the questionnaires.

**Annex 2: Data Collection Tools**

**Search for Common Ground Survey questionnaire for Regional Health Cooperation Project**

**Introduction**

The Arab World for Research and Development (AWRAD) is conducting research on the effectiveness, relevance and impact of the joint training activities that you will be involved under the project Regional Cooperative Health Initiative. The project is designed to build professional and personal understanding among public health officials and laboratory technicians in the Israeli, Jordanian and Palestinian public health sectors. This short survey questionnaire which we will be asking you to complete is designed to help us understand what your current personal attitudes are to your training counterparts. It is also designed to help us understand how you rate your own skills in dealing with conflict.

At the end of the project, we will be asking you the same questions again to see how the project activities have impacted your current attitudes and your skills in dealing with conflict and disagreements.

We can answer any questions that you may have on this. **Once you complete filling the questionnaire please hand it to Ms. Kirsty Wright/Reem Ghattas from AWRAD.** Thank you for your time. It is much appreciated.

Please indicate your answers by circling the appropriate responses.

**A1 Questionnaire #**

**A2 Organizational affiliation**

1. Palestinian Ministry of Health
2. Jordanian- Ministry of Health
3. Israeli Ministry of Health

**A3 Nationality**

1. Palestinian
2. Jordanian
3. Israeli

**A4 Sex**

1. Male
2. Female

**A5 Job Title:**

**A6 How were you selected to participate in this training?**

1. Self -selected
2. Through a competitive process
3. Assigned by supervisor

**When you compare the capabilities of your public health system to deal with cross-border health threats, how do you compare it to the system of the…..? (please tick the appropriate box )**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Answer #** |  | **1.Much better** | **2.better** | **3.worse** | **4.Much worse** | **5.Don’ t know**  |
|  | A8 Jordanian |  |  |  |  |  |
|  | A9 Palestinian |  |  |  |  |  |

* **To what extent do you agree with the following statements characterizing your training counterparts?** Please indicate your agreement by circling the appropriate responses in the two

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **1.Strongly Agree**  | **2.Agree** | **3.Neither agree nor disagree** | **4.Disagree** | **5.Strongly disagree** |
| B1 Jordanians have different values from me |  |  |  |  |  |
| B2 Jordanians know how the current political and economic situation affects me |  |  |  |  |  |
| B3 Jordanians are cooperating because there is a risk to people’s health  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **1.Strongly Agree**  | **2.Agree** | **3.Neither agree nor disagree** | **4.Disagree** | **5.Strongly disagree** |
| B4 Palestinians have different values from me |  |  |  |  |  |
| B5 Palestinains know how the current political and economic situation affects me |  |  |  |  |  |
| B6 Palestinians are cooperating because there is a risk to people’s health  |  |  |  |  |  |

**How do you rate your current ability to deal with conflict and disagreement? Please assess your own skills in relation to the following statements below by ticking the appropriate box (‘always’, ‘often’, ‘sometimes’, ‘never’ ) opposite the statements.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Answer #** | **Statement** | **1.Always** | **2.Often** | **3.Sometimes** | **4.Never** |
|  | B10 I can listen patiently to what another person has to say, even when I don’t agree with it |  |  |  |  |
|  | B11 Actively acknowledging what a person has to say does not mean that I agree with it |  |  |  |  |
|  | B12 When I get angry, I know what to do without losing control of myself or damaging a relationship |  |  |  |  |
|  | B13 Even in a situation of conflict, I am able to understand my needs and the needs of the other parties |  |  |  |  |
|  | B14 Using violence to solve a conflict means that everyone involved loses |  |  |  |  |
|  | B15 I anticipate the other person’s reaction to what I say before I say it |  |  |  |  |
|  | B16 When a conflict is resolved nonviolently, I understand more about how to achieve my own goals without undermining others. |  |  |  |  |

**Please indicate your level of agreement with the possible expected outcomes of the joint activities phrased as a statement below.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Answer #** | **Statement**  | **1.Strongly agree** | **2.agree** | **3.nether agree nor disagree** | **4.disagree** | **5.strongly disagree** |
|  | C1 If we improve our ability to cooperate on solving a regional health problem, it will help create a more favorable environment for an Israeli/Palestinian peace agreement |  |  |  |  |  |
|  | C2 I will welcome an opportunity to meet with Palestinian trainees in a non-professional context |  |  |  |  |  |
|  | C3 I will welcome an opportunity to meet with the Jordanian trainees in a non-professional context |  |  |  |  |  |
|  | C4 The training will be useful on a technical level, but it will not improve my current attitude towards Jordanians |  |  |  |  |  |
|  | C5 The training will be useful on a technical level, but it will not improve my current attitude towards Palestinians |  |  |  |  |  |

**Annex 3: List of people Interviewed**

|  |  |  |
| --- | --- | --- |
| **Name** | **Nationality** | **Position** |
| Ziad Abdeen | Palestinian | Researcher at Al Quds University (MECIDS Board member) |
| Alex Leventhal | Israeli | Director of Public Health Services, Israeli Ministry of Health (Outgoing Chair of MECIDS) |
| Robert C Spencer | UK | Consultant with CORDS |
| Abdallah Abdallah | Jordanian | Director of Laboratories, Jordanian Ministry of Health (Incoming Chair of MECIDS) |
| Nigel Lightfoot | UK | Consultant with CORDS |
| Wajdi Bkeirat | Palestinian | Project Manager, SFCG |
| Daniel Cohen | Israeli | Head of School of Public Health, Tel Aviv University (MECIDS Board Member) |
| Sharon Rosen | Israeli | Co-Director, SFCG Jerusalem Office |
| Sari Husseini | Palestinian | Executive Director, MECIDS |
| Dror Rubin | Israeli | Conflict Mitigation co-trainer |
| Faten Zinaty | Israeli | Conflict Mitigation co trainer |
| Heather Sheeley | UK | Expert Trainer, Public Health Organization, UK  |
| Jane Shawcross | UK | Expert Trainer, Public Health Organization, UK |
| Noa \_\_\_\_\_\_\_\_\_ | Israeli | Manager of Operations Room at the Israeli Ministry of Health |
| Rania Samman | Palestinian | Coordinator of Palestinian Group and new MECIDS Board member |
| Muwayed Ghoul | Palestinian | Trainer |

1. Taken from Attachment B, Search For Common Ground Cooperative Agreement Budget, September 17, 2015 through March 31, 2017 [↑](#footnote-ref-1)
2. Full details of the timing of all activities can be found in Annex 1. [↑](#footnote-ref-2)
3. Participants from the Palestinian Ministry of Health (PMOH) are under pressure to not engage officially with MECIDS, including this project, because of popular feeling against normalizing relationships with Israel. The project still found opportunity to engage with PMOH staff, with lab assessments were also completed in Nablus, Beit Jala, and Ramallah, and with the inclusion of Junior Staff from PMOH. [↑](#footnote-ref-3)
4. According to SFCG , normalization is considered as any activity or initiative that brings together Palestinians and Israelis. [↑](#footnote-ref-4)
5. Taken from the Performance Management Plan [↑](#footnote-ref-5)
6. This is the subject of an earlier report entitled baseline study [↑](#footnote-ref-6)
7. The SFCG design and monitoring expert was a female Palestinian, who had complete fluency in English, Arabic and Hebrew. [↑](#footnote-ref-7)
8. Junior and Senior Laboratory technicians are defined by their length of experience in bio safety work. Senior Laboratory Technicians who were selected to be trainers of trainers from the first round of trainings are designated as Trainer of Trainers (TOT). Senior managers in the public health systems of each country are Directors of Laboratories , Public Health and Emergency Services, or Planning within their respective Ministries’ of Health. [↑](#footnote-ref-8)
9. The survey question is phrased as: Please indicate your level of agreement with the possible expected outcomes of the joint activities phrased as a statement below: ‘If we improve our ability to cooperate on solving a regional health problem, it will help create a more favorable environment.’ [↑](#footnote-ref-9)
10. [↑](#footnote-ref-10)
11. [↑](#footnote-ref-11)
12. Email requests for this information have been sent to the MECIDs coordinators in each country. [↑](#footnote-ref-12)
13. Interview with Alex Leventhal, outgoing Chair of MECIDS, Cyprus, November 2016. [↑](#footnote-ref-13)
14. The statements are detailed in the survey tools which are attached as Annex [↑](#footnote-ref-14)
15. The exception to this was statement #1, which was reverse, scored using percentages of those who responded ‘disagree’ and ‘strongly disagree’. [↑](#footnote-ref-15)
16. This figure is presented in Chart 1 above under ‘Israel’ at baseline. The percentage of Israeli participants whose attitudes has increased positively from base line to end line is therefore 24%. [↑](#footnote-ref-16)
17. The changes are not significant . A less than 5% change either way means – in statistical terms – that there was no change that could not be accounted for by natural variance.i.e. the changes registered in positive attitudes between women and men were only 1.7% (7.5% - 5.8%) [↑](#footnote-ref-17)
18. “It is my first time to this holy place in my life. It is such a precious thing to be able to pray in Al Aqsa”; “It is a life time dream to be in Jerusalem!” [↑](#footnote-ref-18)
19. For details of statements, see questionnaire appended in Annex XX [↑](#footnote-ref-19)
20. Israeli Arab is the term often used to denote those Palestinians who were incorporated into the State of Israel in 1948 by virtue of living in the areas that became Israel during the partition of Palestine in 1948. [↑](#footnote-ref-20)
21. Contained in Attachment B, Search for Common Ground Cooperative Agreement Budget, September 17, 2015 through March 31, 2017, USAID West Bank and Gaza [↑](#footnote-ref-21)