Peacebuilding Education and Advocacy Programme
Case study of volunteers during the Ebola response in Liberia

Ingrid Gercama & Juliet Bedford
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Acknowledgements

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Executive summary

Background and aim of the study

In Liberia, UNICEF’s Peacebuilding Education and Advocacy (PBEA) programme supported the National Youth and Sports Programme (NYP) led by the Ministry of Youth and Sports, Ministry of Internal Affairs/Peacebuilding Office, and the Ministry of Education. The NYP is an integrated peacebuilding and development programme that provides recent graduates from universities, colleges and technical schools with the opportunity to serve as teachers, administrators and managers in conflict-affected communities.

The PBEA programme built upon the Government of Liberia’s Strategic Roadmap for National Healing, Peacebuilding and Reconciliation 2013-2030. This outlined the need to build the capacity, provide livelihood opportunities and ensure the political inclusion of children, and young men and women. The four-year PBEA programme (2012-2015) was an innovative, cross-sectorial initiative that aimed to mitigate the key conflict drivers that posed a threat to national security. The PBEA programme supported three groups of volunteers: National Volunteers; National Junior Volunteers; and Community Peace Committees.

In August 2014, President Ellen Johnson-Sirleaf declared a national state of emergency due to the unprecedented outbreak of Ebola in Liberia. It quickly became clear that all available resources should be diverted to support the Ministry of Health to eradicate the Ebola virus. In October 2014, UNICEF Liberia redirected the scope of the PBEA programme. Under the revised programme, NVs and JNVs were deployed to Ebola-affected communities to support the Ministry of Health’s Ebola awareness activities, conduct contact tracing and provide psychosocial support.

This study evaluates the effects of the volunteers’ interventions as part of the Ebola response from the perspective of the volunteers themselves and other key stakeholders. It focuses on five key areas: relevance, efficiency, results and effectiveness, partnership and sustainability.

Methodology

The methodologies used were designed to be relevant and proportional to the scope of the study, to be flexible and to correspond to continuing development and good practice. Data were collected in Montserrado, Nimba and Maryland Counties in April 2016 through a combination of the following methods: desk review of data and literature, both qualitative and quantitative; in-depth interviews with key informants and stakeholders; focus group discussions with key informants and stakeholders; participatory workshops with key informants and stakeholders; roundtable workshop and direct feedback with UNICEF and other stakeholders. Key stakeholders participating in the evaluation included NVs, JNVs and CPC members; community members and community leaders (teachers, elders, women and youth groups, religious leaders); community health workers; social mobilisers; trainers of NVs and JNVs; government officials (at local, county and national levels); and UNICEF programme implementing staff. The study included a total of 112 participants across 43 data collection sessions: 26 people were interviewed; five focus group discussions were held (with between eight and 15 participants in each); and three participatory workshops were conducted (with between nine and 11 participants in each). Sound recordings were made of each data-collection session. These were fully transcribed into English to enable cross-referencing and rigorous thematic analysis.

Relevance

This chapter examines why there was a need for peacebuilding and education activities during the Ebola outbreak and identifies key conflicts and bottlenecks that the programme aimed to address. The overall goal of the PBEA programme was acutely relevant during the emergency as tensions increased and the structure of the programme provided a ready platform to strengthen social cohesion and resolve conflicts. By training and deploying volunteers to undertake critical tasks, the programme was able to contribute skilled human resources to the response. The volunteers brought their approach to peacebuilding and
education to bear on their new activities, and were therefore able to directly address key conflict areas and potential flashpoints during the outbreak. Given the operational context, however, a severe strategic limitation of the programme was that it did not do more to mitigate the risks volunteers faced. Similarly, activities should have been revised to fit the changed needs of affected PBEA communities (and the volunteers) over time.

Efficiency

This chapter explores the extent to which the volunteer initiatives were suited to the Ebola response. It addresses how the PBEA volunteers were different from other social mobilisers and identifies ways in which the volunteers added value to the wider response. Quickly deploying educated volunteers to target areas was a strategic use of the programme’s key resources. The level of education that both the NVs and JNVs had obtained prior to their deployment was seen to be advantageous and set them aside from other community-based social mobilisers. The skills and experience that the NVs gained pre-Ebola proved essential for their work during the outbreak, and the JNVs and their CPC members benefited from their previous work as peacemakers in the PBEA programme. JNVs and CPC members were able to use their understanding of social structures and cultural practices to their advantage, however when NVs were deployed to communities with which they were unfamiliar, their lack of language skills and local knowledge hampered their levels of efficiency and effectiveness.

Results and effectiveness

This chapter assesses the effectiveness of the volunteers as part of the Ebola response and analyses the results of three key activity streams: social mobilisation and contact tracing; conflict resolution and peacebuilding; and psychosocial support. It also addresses factors that limited the effectiveness of the volunteers and considers some of the unintended consequences that resulted from their interventions. The volunteers were able to successfully conduct their key activities and support communities to implement IPC measures. By March 2015, they had reached over 28,000 people through door-to-door campaigns; organised over 150 social mobilisation events focusing on Ebola; traced 1,626 contacts; and had resolved 2,279 Ebola-related and other conflicts across the 45 PBEA communities. Despite their fear and the adverse challenges they faced, the majority of volunteers retained their morale and motivation and were dedicated to their work through a sense of duty to help the country fight Ebola. Community members concluded that the volunteers’ presence fostered a sense of solidarity and Ebola-affected families and survivors benefited from the psychosocial support volunteers provided. However, the perception of volunteers as Ebola response workers (rather than peacebuilders) made their work significantly more challenging. Although attitudes changed during the course of the outbreak and response, volunteers were often stigmatised, feared and distrusted by the communities in which they worked, and also by their family members and friends who were wary of their work and potentially elevated risk levels. The operational environment, plus lack of resources, such as transport to access remote communities, hampered the effectiveness of the volunteers. Volunteers appeared to have been less effective was in the registration of orphans, particularly because they were unable to offer any practical assistance or support.

Partnership

This chapter assesses how partnerships with the CPCs and other community members and groups supported the work of the volunteers. When community consultation was done well and the tasks assigned to the volunteer decided in collaboration with community leaders, the PBEA programme was more likely to contribute to youth empowerment, conflict resolution and peacebuilding, and effective Ebola response work. JNVs and CPC members who were recruited from their own communities were better placed than NVs to develop respectful and trusting relationships, but the CPC members were not given the incentive structures of the other volunteers or the same training opportunities and this was a source of frustration. The leaders of some beneficiary communities did not see (initial) value in the PBEA
programme and placement of volunteers, and were sceptical that outsiders (NVs) were recruited in favour of their own youth who would have directly benefited from the employment opportunity. A strong sense of partnership between the PBEA volunteers and a number of NGOs and CBOs was developed across programme sites (particularly in Maryland and Nimba), but this required active Programme and Liaison Officers to fulfil a vital programme management role, nurturing effective and mutually beneficial partnerships over time. Where there were no designated Programme and Liaison Officers (as in Montserrado), collaboration and coordination across organisations was more limited. Although the NYSP had cross-ministerial support, it did not involve the Ministry of Health and stakeholders were frustrated that they had not been included in the re-formulation of the volunteers’ terms of reference during the Ebola response. Volunteers highlighted that the lack of resources and limited supportive supervision was detrimental to their work and the programme more broadly, and there was consensus that the lack of transport restricted the scope and coverage of their work.

Sustainability

The fieldwork for this case study was conducted in April 2016, after Liberia had been declared Ebola-free and the PBEA programme was winding down towards its official end date of 30 June 2016. It was therefore possible to explore the extent to which components of the volunteers’ interventions were likely to be sustained after the end of their engagement, and assess whether knowledge and skills introduced by volunteers were still evident in the communities they had supported. There was general agreement that the volunteers had been a positive force in the community and both volunteers and community members suggested that their knowledge about IPC measures had improved through the Ebola response, although it was not clear how key healthy behaviours such as hand washing and improved sanitation were being maintained at the community level. The programme increased local capacity and community leaders continued to invite volunteers to support their community meetings and participate in local decision-making post-Ebola. This was a positive indication of the value of individual volunteers, and of the programme more broadly. Volunteers wanted their work to be recognised and affirmed publically and by the institutions they were engaged with. Accountability to the volunteers and to affected communities was weak during the Ebola response and volunteers suggested that the duty of care extended to them fell short, particularly in terms of psychosocial support. Limited incentives and a sense of under-appreciation undermined the programme.

Conclusion and recommendations

Due to the complex nature of the Ebola outbreak and response, and the limited timeframe to conduct this case study, it is difficult to fully evaluate the impact of the PBEA volunteers or the outcomes of their work over time. The communities to which they were assigned were the recipients of multiple interventions, and the activities of one programme should not be viewed in isolation. Rather, this case study has analysed the relevance, efficiency, results and effectiveness, partnerships and sustainability of the PBEA programme from the perspective of the volunteers themselves and the communities they served.

The following recommendations focus on operationalising the lessons learnt from deploying PBEA volunteers during the Ebola response. They are drawn from the evaluation of the programme and include suggestions made by volunteers, community members and other stakeholders who participated in the case study.

• Identifying gaps in the volunteers’ knowledge, capacity and skill sets will determine areas that require the programme to provide enhanced training.

• If volunteers are to be deployed to another emergency, it is essential that they be provided with refresher training and that mechanisms for supportive supervision are improved.

• When possible, volunteers should be deployed to communities with which they are familiar. They should be able to speak the local language. Locally recruited volunteers are likely to be more effective
in achieving behaviour change and less prone to marginalisation, discrimination and stigmatisation by the host community.

- To maximise the impact of NVs and JNVs in terms of community mobilisation, it is recommended that they be deployed to affected communities in pairs, and continue to collaborate with the CPC members.

- The duties of the volunteers and the resources available should be realistically matched so that activities can be facilitated in a timely manner. When volunteers’ workloads or tasks are revised, support mechanisms and resources should be appropriately updated (transport, material supplies, psychosocial support etc.).

- Community consultation is critical and the role and responsibilities of volunteers should be negotiated with community leaders to ensure their support and buy-in. The placement and duties of volunteers should be regularly evaluated as the situation develops and their activities should be modified accordingly.

- The expectations of both the volunteers and the communities to which they are deployed should be carefully managed.

- The involvement of the Ministry of Health during the recruitment, training and deployment of volunteers during public health emergencies would increase their credibility, enhance the quality of their work and provide opportunities for supervision and medical guidance at the local level.

- Mutually beneficial partnerships with organisations at the local level should be developed in advance and strengthened over time.

- Volunteers should be offered longer-term psychosocial support and institutions that deploy volunteers should adopt a greater duty of care.

- Stronger accountability mechanisms must be introduced for both volunteers and the communities to which they are deployed.

- County-level supervisors should be deployed to all counties where the programme is active to ensure clear line management and supportive supervision. Supervisors should advocate on behalf of the volunteers and be able to negotiate with community leaders in situations of conflict.

- Volunteers must be recognised for their work, particularly by the institutions that engage them and higher authorities. They should be provided with a certificate or diploma to acknowledge their service, and included in community-based appreciation ceremonies.
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABE</td>
<td>Alternative Basic Education</td>
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<tr>
<td>ADC</td>
<td>Africa Development Corps</td>
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<td>ALP</td>
<td>Accelerated Learning Programme</td>
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<tr>
<td>CCC</td>
<td>Community Care Centre</td>
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<tr>
<td>CEO</td>
<td>County Education Officer</td>
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<tr>
<td>CHO</td>
<td>County Health Officer</td>
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<tr>
<td>CO</td>
<td>Country Office</td>
</tr>
<tr>
<td>CPC</td>
<td>Community Peace Committee</td>
</tr>
<tr>
<td>DEO</td>
<td>District Education Officer</td>
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<tr>
<td>DHO</td>
<td>District Health Officer</td>
</tr>
<tr>
<td>DRC</td>
<td>Danish Refugee Council</td>
</tr>
<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
</tr>
<tr>
<td>ETU</td>
<td>Ebola Treatment Unit</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GNI</td>
<td>Gross National Income</td>
</tr>
<tr>
<td>IPC</td>
<td>Infection Prevention Control</td>
</tr>
<tr>
<td>JNV</td>
<td>Junior National Volunteer</td>
</tr>
<tr>
<td>MIA</td>
<td>Ministry of Internal Affairs</td>
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<tr>
<td>MoE</td>
<td>Ministry of Education</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MoYS</td>
<td>Ministry of Youth and Sports</td>
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<tr>
<td>NV</td>
<td>National Volunteer</td>
</tr>
<tr>
<td>NYSP</td>
<td>National Youth and Sport Programme</td>
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<tr>
<td>PBEA</td>
<td>Peacebuilding Education and Advocacy</td>
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<tr>
<td>PBO</td>
<td>Peacebuilding Office</td>
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<tr>
<td>PIH</td>
<td>Partners in Health</td>
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<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
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<tr>
<td>PSS</td>
<td>Psychosocial Support Services</td>
</tr>
<tr>
<td>RTP</td>
<td>Right to Play</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations International Children’s Emergency Fund</td>
</tr>
<tr>
<td>VLA</td>
<td>Volunteer Living Allowance</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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</table>
Introduction

In Liberia, UNICEF’s Peacebuilding Education and Advocacy (PBEA) programme supported the National Youth and Sports Programme (NYSP) led by the Ministry of Youth and Sports (MoYS), Ministry of Internal Affairs (MIA)/Peacebuilding Office (PBO), and the Ministry of Education (MoE). The NYSP is an integrated peacebuilding and development programme that provides recent graduates from universities, colleges and technical schools with the opportunity to serve as teachers, administrators and managers in conflict-affected communities.

In August 2014, President Ellen Johnson-Sirleaf declared a national state of emergency due to the unprecedented outbreak of Ebola in Liberia. It quickly became clear that all available resources should be diverted to support the Ministry of Health to eradicate the Ebola virus. In October 2014, UNICEF Liberia re-directed the scope of the PBEA programme. Under the revised programme, NVs and JNVs were deployed to Ebola-affected communities to support the Ministry of Health’s Ebola awareness activities, conduct contact tracing and provide psychosocial support. During the Ebola outbreak the numbers of NVs and JNVs were significantly scaled-up to respond to the emergency. By January 2016 (when the PBEA programme in Liberia officially ended), UNICEF had trained 300 recent university graduates as NVs and 75 secondary school graduates as JNVs. The NVs were deployed to 105 institutions in 12 countries and the JNVs deployed to 75 communities across 5 countries to work with 750 Community Peace Committees (CPCs) (UNICEF 2015). This case study evaluates the effects of the volunteers’ interventions in these communities as part of the Ebola response.

Aim of the case study

In June 2015, the UNICEF Country Office in Liberia documented the role of NVs and JNVs in resolving conflict and building peace during the Ebola epidemic. The purpose of the current case study is to complement previous documentation with a rapid evaluation of the volunteers’ interventions from the perspective of the volunteers themselves and other key stakeholders.

Data were collected in Montserrat, Nimba and Maryland Counties in April 2016 to assess the relevance, efficiency, effectiveness and sustainability of utilising JNVs and NVs as ‘agents of change’ during the Ebola outbreak. Because of the unique mandate of the JNVs/NVs as peacebuilders and promoters of social cohesion, these volunteers were considered to be uniquely placed to respond to conflicts that emerged during the Ebola outbreak (UNICEF 2014).

To evaluate the results of the programme, the case study addresses the accountability, motivations and rewards of the volunteers’ work (following Boesten et al. 2011) as well as the characteristics (e.g. skills, education and knowledge) that set the volunteers aside from other social mobilisers. The analysis reviews how the PBEA programme responded (action) to key conflict drivers (problems), and documents the reaction of the benefiting communities over time.

The study focuses on five key areas: relevance, efficiency, results and effectiveness, partnership and sustainability. Key definitions for these areas are presented in Table 1 below.

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1 The use of ‘volunteers’ refers to all PBEA supported volunteers (i.e. NVs, JNVs and Community Peace Committee members) as a collective group.
Table 1: Key definitions for this case study

<table>
<thead>
<tr>
<th><strong>Relevance</strong>*</th>
<th>The extent to which the objectives of the intervention are consistent with recipients’ requirements, country needs, priorities and policies.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Efficiency</strong>*</td>
<td>The extent to which resources/inputs (e.g. people, experience, skills, equipment, etc.) are used in a programme to convert activities into results.</td>
</tr>
<tr>
<td><strong>Results</strong>*</td>
<td>Positive and negative primary and secondary long-term effects produced by the intervention, whether directly or indirectly, intended or unintended.</td>
</tr>
<tr>
<td><strong>Effectiveness</strong>*</td>
<td>The extent to which the intervention’s objectives were achieved, or are expected to be achieved.</td>
</tr>
<tr>
<td><strong>Partnership</strong></td>
<td>Voluntary and collaborative relationships between various parties in which all participants agree to work together to achieve a common purpose or undertake a specific task.</td>
</tr>
<tr>
<td><strong>Sustainability</strong>*</td>
<td>The continuation of benefits from the intervention after development assistance has ceased. Sustainability addresses the probability of continued long-term benefits.</td>
</tr>
</tbody>
</table>

* UNICEF Office of Research - Innocenti 2014  
** UNICEF CSO 2015

UNICEF posed specific research questions for each area of investigation:

1. **Relevance**  
   Why was there a need for peacebuilding and education during the Ebola outbreak and how relevant was the PBEA programme?

2. **Efficiency**  
   In what ways did using PBEA volunteers add value to the Ebola response? How were the volunteers different from other social mobilisers?

3. **Results and Effectiveness**  
   How effective were the volunteers as part of the Ebola response and did they achieve the objectives of their activities? What were the factors that limited the effectiveness of volunteers and the unintended consequences that resulted from their interventions?

4. **Partnership**  
   How did partnerships with the Community Peace Committees and other community members and groups support the work of the volunteers?

5. **Sustainability**  
   To what extent were the results of the volunteers’ interventions sustained after the end of their engagement?

**Structure of the report**

The case study is an important record of the how the PBEA programme and the national volunteers contributed to the Ebola response.

The report outlines the methodology used in the study, including the study sites and sampling. This is followed by a background situational analysis of the historical and cultural context of Liberia, the PBEA programme and national volunteers, and the Ebola outbreak. The five subsequent chapters focus on relevance; efficiency; results and effectiveness; partnership; and sustainability. The final chapter presents the study’s conclusions and recommendations.

This is the final report and incorporates comments and feedback provided by UNICEF. An accompanying PowerPoint presentation summarises the evaluation and highlights key findings and recommendations.
CPC members participating in a Focus Group Discussion, April 2016.
Methodology

Study design

The methodologies used were designed to be relevant and proportional to the scope of the study, to be flexible and to correspond to continuing development and good practice. Our evidence-based approach draws on the theory of applied social research, defined as using knowledge acquired to contribute directly to the understanding and assessment of specific issues, in this case the use of volunteers as first responders in the Ebola outbreak in Liberia. Throughout the study, the methods adopted ensured that the quality and quantity of material gathered was maximised and that multiple perspectives were considered. Data were gathered through a combination of the following methods:

- Desk review of data and literature, both qualitative and quantitative
- In-depth interviews (IDIs) with key informants and stakeholders
- Focus group discussions (FDGs) with key informants and stakeholders
- Participatory workshops with key informants and stakeholders
- Roundtable workshop and direct feedback with UNICEF and other stakeholders

The study was completed in four stages.

Phase 1 – Document and literature review
Phase 2 – Fieldwork preparation
Phase 3 – In-country data collection
Phase 4 – Analysis

Phase 1 – Document and literature review

Undertaken at the start of the consultation process, the review of background documents, programmatic material and related literature provided a solid foundation for the study. Key documents reviewed included: PBEA annual reports (2012, 2013a, 2014); programme reports from the MoYS, MIA and other PBEA implementing partners (e.g. RTP, ADC); programmatic material from UNICEF (ToRs JNVs/NVs); and the PBEA baseline study (by Indevelop 2013). On the basis of the review of these documents, a web search was conducted for additional material focusing on: i) the Ebola outbreak in West Africa; ii) deployment of volunteers during public health emergencies; iii) conflict prevention; and iv) the use of public health volunteers in previous Ebola outbreaks (as in Uganda for example).

Phase 2 – Fieldwork preparation

Based on the document review and desk analysis, the team designed a topic guide that was the platform for the design of specific tools for in-country data collection (in-depth interview frameworks; focus group discussion frameworks; participatory workshops, see Appendix 1). A mapping exercise highlighted key informants and stakeholders at national, district and community levels. This preliminary list of relevant stakeholders and interlocutors was shared with the country office.

Phase 3 – In-country data collection

Each data collection session was conducted with as much privacy as possible, after full consent had been given (see consent forms in Appendix 2) and in the presence of the research team only. Data collection included the following activities.
a) In-depth interviews were held with a range of stakeholders at national, district and community levels. Interview questions were reviewed and refined during fieldwork in response to themes arising during the course of interviews conducted. The direction and content of each interview was determined by the interviewee and focused on issues they self-prioritised, although all components of the topic guide were covered to ensure thematic comparison. This structure ensured the empowerment of participants.

b) Focus group discussions were held with selected community-level stakeholders. As with the key informant interviews, the group discussions were structured by the prepared framework, but allowed for flexibility and the co-production of knowledge.

c) Participatory workshops were held with the NVs and the JNVs, CPC members, Ebola response trainers of the JNVs/NVs, and service providers in the community. The workshops used appropriate terminology and participatory methods in line with ethical good practices.

d) Building upon the key informant interviews, focus group discussions and workshops, detailed case studies were completed. These included in-depth narratives, sections of which have been used in the final reporting.

At the end of the data-collection period, a workshop with UNICEF and other key stakeholders was scheduled, but had to be cancelled due to a number of participants being unavailable. A debrief meeting was held with UNICEF, and feedback on preliminary findings was secured from the MoYS, MIA, MoE, MoH and other stakeholders via email and telephone in late April.

Phase 4 – Analysis

Sound recordings were made of each data-collection session. These were fully transcribed into English to enable cross-referencing and rigorous analysis. Analysis was conducted throughout: all data, interview, focus group and workshop notes, and other material was regularly reviewed by the team. Thematic analysis developed specifically for analysing data generated through applied qualitative research was used for the material generated through qualitative methods. Dominant themes occurring in the data were drawn out. This involved systematically sorting through the material, labelling ideas and phenomena as they appeared and reappeared. The trends that emerged were critically analysed in line with the study’s key objectives.

Study sites

Data collection for the case study took place between 26 March and 9 April 2016 in three counties that were purposively selected (see schedule in Appendix 3). To take into account the role that the NVs recruited in November 2014 played during the Ebola outbreak, data was collected in Montserrado (the most affected county in Liberia). To measure the role the JNVs/NVs played in already existing PBEA communities, data was collected in Maryland Country (one of the most remote counties in Liberia with limited road access and only a small number of confirmed Ebola cases) and Nimba County (a county with one of the highest number of confirmed Ebola cases). In Nimba and Maryland counties, two field sites were visited: Cavalla and Harper in Maryland; and Sanniquellie and Bahn in Nimba. In Monsterrado, activities were conducted in central Monrovia, and two communities, Day Break Mouth Open and 1405 Community. Map 1 below depicts the study sites.

Sampling

Key stakeholders participating in the evaluation included NVs, JNVs and CPC members; community members and community leaders (teachers, elders, women and youth groups, religious leaders); community health workers; social mobilisers; trainers of NVs and JNVs; government officials (at local, county and national levels); and UNICEF programme implementing staff.
A comprehensive mapping of stakeholders was conducted prior to the start of data collection. National-level stakeholders were purposively selected for key informant interviews based on their individual/institutional position related to the PBEA programme, and included representatives from UNICEF, the Ministry of Education, Ministry of Health, Ministry of Internal Affairs/Peacebuilding Office, and the Ministry of Youth and Sports. Interviews were also held with county-level officials from the Ministry of Health and Ministry of Education staff, and programme staff (County Liaison Officers and Programme Officers). To gain a more in-depth understanding of the volunteers’ work in the communities, key informant interviews were conducted with a selection of JNVs and NVs to reflect maximum variation (i.e. variety of ages, genders, assigned communities, length in post etc.). Three participatory workshops were also held with JNVs and NVs, one in each county. Five focus group discussions were held with community stakeholders including town chiefs, commissioners, women and youth leaders and religious leaders, teachers, community-level service providers (members of the community Ebola Task Force and community health workers) and CPC members. Due to the limited time in each site, convenience sampling was used, so although each stakeholder group was engaged in each county, there was some variation in the number of activities and participants.

The study included a total of 112 participants: 26 people were interviewed; five focus group discussions were held (with between eight and 15 participants in each); and three participatory workshops were conducted (with between nine and 11 participants in each). Each interview lasted for around 45 minutes and the focus group discussions and participatory workshops were an average of three hours long. Table 2 below presents the number of participants per activity in each county.
Table 2: Total numbers of respondents per county

<table>
<thead>
<tr>
<th>County</th>
<th>Site</th>
<th>Type</th>
<th>No. of sessions</th>
<th>No. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montserrado</td>
<td>Monrovia</td>
<td>IDIs with NVs</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IDIs with MoH/External trainers of NVs/JNVs</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IDIs with national level stakeholders (government officials,</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>service providers, programme staff UNICEF/MoYS/MIA/PBO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participatory workshop with JNVs/NVs</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Day Break Mouth Open</td>
<td>FGD with community stakeholders</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>1405</td>
<td>IDI with community leader</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nimba</td>
<td>Bahn</td>
<td>FGD with community stakeholders</td>
<td>1</td>
<td>9</td>
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<tr>
<td></td>
<td></td>
<td>FGD with community stakeholders</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IDIs with NVs/JNVs</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IDI with County Liaison Officer</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Saniquellie</td>
<td>IDI with NYSP Programme Officer</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IDI with the County Education Officer</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IDI with NV/JNVs</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participatory workshop with JNVs/NVs</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Maryland</td>
<td>Cavalla</td>
<td>FGD with community stakeholders</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FGD with community stakeholders</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IDIs with NV/JNVs</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Harper</td>
<td>IDIs with JNVs/NVs</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participatory workshop with JNVs/NVs</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IDI with District Health Officer</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IDIs with County Liaison Officer/NYSP Programme Officer</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>43</td>
<td>112</td>
</tr>
</tbody>
</table>
Using stones to represent food items, participants demonstrate tensions between people in quarantine and other community members due to the distribution of Ebola response materials.
Background

Historical and cultural context

Liberia was founded in 1822 by the American Colonization Society as a ‘free state’ where liberated American slaves could be resettled. A small minority group descended from freed slaves dominated the country, whilst the rest of the population enjoyed little economic development. The exploitation of the governing elite led to economic collapse under the regime of Samuel Doe and Liberia was embroiled in two civil wars between 1989 and 2003 resulting in over 200,000 deaths and 700,000 displaced Liberians (Stanturf et. al. 2015). The war exacerbated already existing land-based and inter-ethnic tensions and many Liberians fled the country to becoming refugees in neighbouring countries. Those who were internally displaced, gravitated towards the capital city, Monrovia.

Liberia’s recent history of conflict continues to have significant ramifications. The war not only destroyed much of Liberia’s physical infrastructure but also had a significant impact on the country’s social fabric. Many Liberians witnessed their family and friends brutally killed or raped during the 14 years of civil war and the violence had major long-term effects on social cohesion and the population’s psychological and physical well-being. The Carter Center estimates that of Liberia’s 3.4 million population, 40% have experienced post-traumatic stress disorder (The Carter Center 2015). There is only one practicing psychiatrist in the country and access to psychiatric medicines remains limited (Ibid).

In 2013, however, Liberia celebrated 10 years of uninterrupted peace and progress. Assisted by a stable government and with support from the UN and other development partners, Liberia achieved remarkable progress in its immediate post-conflict period, including improving access to basic health services and primary education, water and sanitation facilities, social welfare and protection from violence, abuse and exploitation (UNICEF 2013b). The government of Liberia relied heavily on foreign aid for the development of the country: between 2007 and 2011 official development assistance accounted for 175% of the Gross National Income and foreign direct investment for 46% of the Gross Domestic Product (UNDP 2013).

Although the country reported an economic growth rate of 7.5% in 2014 (World Bank 2015), poverty remains widespread with 64% of the population living in poverty and 48% in extreme poverty (UN 2013). More than 75% of the population is under 35 years of age, and with limited access to education, skills training and livelihood opportunities, youth unemployment (or non-formal employment) is a major concern. One in every three young people is unemployed and half of those working do not earn sufficient income to sustain a basic standard of living (Ibid).

Liberia’s population faces multiple other challenges including persistent food insecurity, urban-rural disparities in access to health and education, and high levels of sexual and gender-based violence (UN Liberia 2013). The long-term impact of the war is clearly visible in post-conflict Liberia and manifests itself through weak national pride and citizenship values; nepotism; corruption; inadequate transparency and public accountability; limited access to basic services and lack of human resources available to offer basic services, particularly education; low levels of trust within communities; disrespect for African traditional values; and the use of violence, including against girls and women, as an expression of power. The participation of youth and women in the decision-making processes is limited and unclear relationships

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2 The emigration of black slaves was a solution to slavery for many politicians in the United States of America. The settlers (or locally called ‘Congos’ or Americo-Liberians) established a stronghold in the Liberia and rapidly started to govern using methods learnt in the United States to control the local population (referred to as the ‘country’ people). Until 1980, the Americano-Liberians (a small minority of descendants of the free black colonists) were in total control of the country’s economic resources. In 1985 Sergeant Samuel Doe seized power through a coup. Although Doe’s regime was initially seen by many to be positive, attitudes quickly changed when Doe abused his power, using excessive violence against the Gio and Mano tribal groups.

3 According to studies by the WHO (2004, 2005, 2006) the majority of Liberian women experienced sexual violence during the war and sexual violence against girls and women has persisted in the post-conflict era. Liberia has one of the highest incidence rates of sexual violence against women globally (Samuels et. al. 2015).
exist between informal/traditional systems and formal systems of governance and leadership (UNICEF 2012).

Political leaders are often polarising and public spaces characterised by intolerance, mistrust, and hostility (UNICEF 2012). The limited access to basic services continues to create a severe lack of trust between government and communities (UNICEF 2013a). In the education sector, for example, enrolment steadily increased at all educational levels during recent years, but gender equality (particularly at the secondary level) has not. The failure in 2013 of all 25,000 University of Liberia applicants to pass a standard university entrance exam used by other countries in the region prompted President Ellen Johnson Sirleaf to declare the deteriorating quality of education a national emergency (ibid).

PBEA programme in Liberia

UNICEF implemented the Peace Building Education and Advocacy Programme (PBEA) in fourteen countries: Pakistan, Myanmar, Yemen, Ethiopia, Somalia, Democratic Republic of the Congo, Chad, South Sudan, Burundi, Uganda, Sierra Leone, State of Palestine, the Ivory Coast and Liberia. Its central goal was to strengthen resilience, social cohesion and human security in conflict-affected contexts, including countries at risk of experiencing or recovering from conflict. The Liberian PBEA programme was created in 2011 by integrating various components of earlier reconciliation interventions funded by the Peacebuilding Fund (e.g. UNDP’s project ‘Volunteers for Peace’, UNICEF’s project ‘Youth Empowerment Skills for Peace’ and UNHCR’s Community Empowerment Project) (UN 2013).

The PBEA programme built upon the Government of Liberia’s Strategic Roadmap for National Healing, Peacebuilding and Reconciliation 2013-2030. This outlined the need to build the capacity, provide livelihood opportunities and ensure the political inclusion of children, and young men and women (Government of Liberia 2013). Youth Empowerment was one of the three key thematic areas in the Roadmap. Recognising its critical importance, the PBEA programme supported the Government to develop Youth Empowerment into a full programme of interventions, and leveraged over USD1.5 million of funding under the Peacebuilding Fund from 2012 to 2015 (UNICEF 2012).

The programme was launched in Liberia in 2012, with the aim of mitigating key conflict drivers that posed a threat to national security (UNICEF 2012). The four-year programme (2012-2015) was an innovative, cross-sectoral initiative focusing on education and peacebuilding, and was designed as a partnership between the national Government (Ministry of Internal Affairs, Ministry of Education and the National Peace-building Office), UNICEF, the Government of the Netherlands, and INGO implementing partners Africa Development Corps and Right to Play. Save the Children was also part of the consortium between 2012 and 2014.

The programme was developed following extensive desk reviews and an in-depth conflict analysis in 2012. In line with the Roadmap, it was designed to addresses five key conflict drivers in the country and structured around five key outcomes and (UNICEF 2012).

Key conflict drivers:
1. Poor governance and misuse of power and resources at the central and local levels.
2. Lack of trust between government and communities.
3. Discrimination and lack of participation of local populations in political decision hampering social cohesion.
4. Inadequate access to education for children and limited job opportunities for youth.
5. Lack of transparency in decision-making and accountability for results.
Key outcomes:

1. Increased inclusion of education into peace-building and conflict reduction policies.
2. Increased institutional capacities to supply conflict-sensitive education.
3. Increased capacities of children, parents, teachers and other duty bearers to prevent, reduce and cope with conflict and promote peace.
4. Increased access to quality and relevant conflict-sensitive education that contributes to peace.
5. Contribution to the generation and use of evidence and knowledge in policies and programming related to education, conflict and peacebuilding.

The PBEA programme covered a wide range of beneficiaries including children participating in its Early Childhood Development (ECD) programme; out-of-school children and adolescents participating in Accelerated Learning Programme (ALP), Alternative Basic Education (ABE) and recreational programmes; government officials and young university and high school graduates supporting the Government by implementing conflict-sensitive education services at community level; teachers delivering new conflict-sensitive curricula in schools; and community members taking active roles in conflict resolution and peacebuilding initiatives.

Volunteer initiatives supported by the PBEA programme

The PBEA programme supported three groups of volunteers: National Volunteers; National Junior Volunteers; and Community Peace Committees. Table 3 outlines the characteristics of the volunteers.

Table 3: Comparison NVs/JNVs characteristics in Liberia

<table>
<thead>
<tr>
<th>Education level</th>
<th>National Volunteers</th>
<th>Junior National Volunteers</th>
<th>Community Peace Committees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision structure</td>
<td>University degree</td>
<td>High-school diploma</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Ministry of Youth and Sports</td>
<td>Ministry of Internal Affairs</td>
<td>Ministry of Internal Affairs (via the JNVs)</td>
<td></td>
</tr>
<tr>
<td>Focus pre-Ebola</td>
<td>Work in health centres, schools, youth centres and Land Commission to support the Ministry of Education, Ministry of Agriculture and Ministry of Health. Contributed to C4D activities.</td>
<td>Conflict resolution, mediation, peace-building and early warning activities at the community level. Contributed to C4D activities.</td>
<td>To support JNVs with conflict resolution, mediation, peace-building and early warning activities at the community level. Contributed to C4D activities.</td>
</tr>
<tr>
<td>Focus during Ebola</td>
<td>Contact tracing; Ebola awareness raising; Community mobilisation; Promotion of IPC measures; Monitoring school supplies provided by UNICEF.</td>
<td>Contact tracing; Ebola awareness raising; Community mobilisation; Promotion of IPC measures; Conflict resolution.</td>
<td>To support JNVs in Ebola response activities.</td>
</tr>
<tr>
<td>Geographical coverage during the Ebola response (counties)</td>
<td>Grand Bassa Grand Gedeh Grand Cape Mount Maryland Nimba Bomi Bong Gbarpolu Lofa Margibi Montserrado Sinoe</td>
<td>Grand Bassa Grand Gedeh Grand Cape Mount Maryland Nimba</td>
<td>Grand Bassa Grand Gedeh Grand Cape Mount Maryland Nimba</td>
</tr>
</tbody>
</table>
UNICEF’s PBEA programme directly supported the government’s National Youth and Sports Programme (NYSP). The primary aim was to fill key human resource gaps and provide quality essential services to Liberian children in the sectors of education, health, social welfare and agriculture. In the education sector, NVs were recruited to teach in primary and secondary schools, and on youth literacy courses. In the health and social welfare sectors, the programme focused on providing clinics with medically trained NVs who worked as clinical assistants delivering sexual and reproductive health services and psychosocial counselling. The agricultural sector organised NYSP rural livelihoods projects, including youth farming cooperatives and swamp rehabilitation projects, and NVs also supported the resolution of land cases through their work at the Land Commission. The Ministry of Youth and Sports established youth centres where NVs were deployed to assist with resource management and operations, deliver computer literacy training, and cascade peacebuilding and leadership skills (UN 2011). In addition to their core work within these sectors, NVs were also required to support UNICEF during C4D activities and awareness-raising campaigns. Overall, the programme aimed to provide young people with valuable work experience that would prepare them for future employment.

**Junior National Volunteers and Community Peace Committees**

The main goal of the Youth Led Social Cohesion Programme directed by the Ministry of Internal Affairs was to build peace at the community level. They recruited JNVs to lead peacebuilding, early warning and conflict-response activities, and to apply advanced mediation skills when conflicts arose in their communities. In turn, the JNVs recruited CPCs to voluntarily support the peacebuilding and conflict resolution activities in their catchment areas. CPC members were respected community residents including traditional chiefs, elders, teachers, youth and women leaders.

**Ebola in Liberia**

On the 28th of December 2013 a two-year-old child, Emile, died of an unidentified haemorrhagic fever in the town of Guéckédou in Guinea, followed by his mother, sister and grandmother. The family organised a traditional burial for the grandmother and in so doing, inadvertently spread the virus to others in nearby villages. Emile became known as ‘Case Zero’ – the first case in the 2013-2016 West Africa Ebola outbreak. By the 29 March 2016 (the end of the Public Health Emergency of International Concern), more than 28,646 people had been infected, and 11,323 deaths reported (WHO 2016). Liberia reported its first case of Ebola in Foya, Lofa County, in March 2014 (Stanturf 2015), and on 17th of June 2014, the Ministry of Health recorded the first confirmed Ebola cases in Monrovia. The number of cases increased rapidly and all 15 countries were affected (WHO 2016). Of the West African countries that were affected by the Ebola outbreak, Liberia reported the highest mortality rate (ibid).

Denial that the virus existed, unsafe burial practices and the government’s initial lack of response intensified the spread of the virus throughout the country. Liberia lacked the capacity, systems, technical facilities nor expertise to respond to an epidemic of this scale and the growing number of Ebola cases led to the near collapse of the already weak healthcare system (UNICEF 2014). Many health workers were infected with the virus due to their higher risk profile, limited training on Infection Prevention Control (IPC) and lack of access to Personal Protective Equipment (PPE). As fear and distrust spread, health workers stopped presenting for work and government hospitals and clinics were temporary closed. Many sick and vulnerable people (including pregnant women, terminally ill or patients in need of emergency care) were left untreated (UNICEF 2014).

The Ebola Task Force was set up by the Ministry of Health and Social Welfare to coordinate the Ebola outbreak response across the country. As the epidemic spread, the number of people infected with the Ebola virus needing medical attention increased dramatically, and communities urgently requested services
from the Task Force to remove the sick and dead from their households and communities (UNICEF 2014). There was, however, a limited number of ambulances, few trained and properly equipped first responders, a lack of Ebola Treatment Units (ETUs) and insufficient safe burial teams. The Ebola Emergency Hotline ‘4455’ that was set up by the government was unable to respond to the high load of emergency calls. Communities frustrated by delays and the lack of capacity of the Task Force, lost trust in the government’s ability to assist them and often acted independently. Fear and misinformation about the disease further exacerbated tensions (UNICEF 2014).

On 6 August 2014, President Ellen Johnson-Sirleaf declared a national state of emergency. All schools were closed, public gatherings prohibited, curfews imposed, government ministries and institutions reduced to essential staff, and markets in crowded locations shut down (UNICEF 2014). As a drastic measure to stop the spread of the virus, whole communities were quarantined. Tensions in these communities were particularly raised as people lacked access to food and received little or no ‘official’ support. According to one community leader who participated in this study, the sentiment that they were ‘left to die all together’ was widespread.

Ebola halted many of the political, economic and social gains achieved by the country in its recent past (Stanturf 2015). Movement restrictions to curb the spread of the virus resulted in the decrease of economic activity and price rises for basic goods and supplies (UNICEF 2014). By the end of August 2014, with unemployment soaring and an exponential growth of Ebola cases, the government was still unable to respond effectively and community violence increased (UNICEF 2014). Citizens accused government authorities of poor governance, corruption and the mismanagement of resources set aside to combat the epidemic. How Ebola-related conflict and mistrust in the government hampered response measures will be further explored throughout case study.

**Ebola and the PBEA programme**

According to the project’s logframe, the NYSP aimed to have trained 600 NVs by 2015, providing them with work experience in 85 institutions across 54 communities nationwide. It also aimed to train and deploy 45 JNVs to collaborate with at least 54 Community Peace Committees to support peacebuilding and promote conflict prevention in all targeted communities.

In 2012, the first year of the programme, 170 NVs were deployed to 30 schools in 76 rural communities, and 54 JNVs were deployed to 54 communities where they trained 540 Community Peace Committee members (UNICEF 2012). In 2013, 175 NVs were assigned to 76 public institutions (e.g. hospital, schools) in 12 counties, and 45 JNVs were deployed to communities across five counties (UNICEF 2013). In 2014, another 45 NVs were trained and deployed, and the NYSP was in the process of training the next batch of 150 NVs when the Ebola outbreak started, and the United States Peace Corps volunteers who had been contracted to conduct the introductory training for NVs were evacuated from Liberia (UNICEF 2014).

In response to the Ebola outbreak, the PBEA programme’s objectives were revised and the terms of reference for the existing batch of NVs and JNVs amended to support UNICEF’s Ebola mobilisation activities. Against a backdrop of peacebuilding, conflict resolution and filling key human resource gaps in service provision, the primary aim of the volunteer initiatives became to protect target communities from being infected by and transmitting Ebola. Seventy-five JNVs were immediately reassigned across 75 communities in the five conflict-prone counties to help contain the spread of the Ebola virus. In November 2014, an additional 243 NVs were recruited, trained and deployed to the programmes’ 12 counties to provide additional support for the government’s Ebola awareness and prevention campaigns at the community level (UNICEF 2014). In 2015, a total of 300 NVs were deployed to 105 institutions across 12 countries (241 to teach in 83 public schools; 33 to work as clinical assistants; 24 to work as managers at youth centres; and 2 to support the Land Commission), and 75 JNVs were deployed to 75 communities across five countries to work with 750 CPCs (UNICEF 2015). The programme had been due to finish in May 2015 but was formally extended for an additional six months, and then UNICEF Headquarters agreed cover the volunteers’ payments until 30 June 2016.
Community leaders recall an occasion when community members chased Ebola response workers with sticks because they perceived there was a lack of 'benefits' for the community.
Relevance

This chapter examines why there was a need for peacebuilding and education activities during the Ebola outbreak and identifies key conflicts and bottlenecks that the programme aimed to address.

Community conflicts during the Ebola outbreak

In line with UNICEF’s model, conflict drivers in Liberia can be organised into three key factors threatening national peacebuilding and development (UNICEF 2012):

- A system (both political and behavioural) that prevents communities from participating in decisions affecting their lives (due to poor governance, discrimination and lack of participation of local populations in political decision-making, lack of transparency in decision-making and accountability for results).
- The unequal distribution of wealth, which limits most citizens’ access to basic services including land, education, and health services (due to misuse of power and resources at the central and local levels, inadequate access to education for children and limited job opportunities for youth, the misuse of natural resources).
- Lack of common Liberian values and beliefs, resulting in a lack of citizenship that hampers social cohesion (lack of trust between the government and communities).

These conflict drivers can manifest themselves in ethnic and communal tensions or land disputes, and are key flashpoints that can undermine the existing peace. During the Ebola outbreak, tensions and associated conflict drivers were intensified, and elevated risky behaviours that had the potential to increase the spread of the Ebola virus. Conflicts developed around three interrelated areas. First, the lack of information and understanding about the Ebola virus and its transmission. Insecurity and limited knowledge about how to ‘stay safe’ led to deep-rooted suspicion and mistrust. People were accused of spreading the virus through culturally specific behaviours (e.g. washing bodies, eating bush meat), Ebola survivors and response workers were ostracised from their communities because of fear of contamination, and rumours about witchcraft and allocations of blame circulated rapidly. Secondly, the Ebola response itself heightened tensions: there was conflict over the location of Ebola Treatment Units; the hiring and remuneration of Ebola response workers; and the lack or inequitable allocation of response resources. Thirdly, the socio-economic impact of the emergency caused conflicts as livelihood opportunities were strained due to restrictions on cross-border trade and mobility, and children were unable to graduate from school. Table 4 (below) outlines the contextual conflict drivers in Liberia and their Ebola-specific manifestations (UNICEF 2014, NYSP 2014).

To fight the Ebola virus effectively, government and communities had to work together (DuBois et al. 2015). Top-down government communication was needed to inform communities about how to protect themselves from the virus, and communities needed to provide the government and first responders with information about the sick and deceased (to enable the government to effectively trace contacts). The lack of trust in the government during the Ebola outbreak manifested itself strongly throughout the whole crisis and negatively influenced IPC measures. Although there were episodes of violent resistance, a more telling indicator of popular distrust was the need to convince people that Ebola was actually real and not a government scam or corrupt aid ploy (DuBois et al. 2015). Community engagement proved essential in enabling the population to protect themselves and prevent transmission; develop safe and supportive care practices for the ill or those at risk of infection; adhere to safe and dignified burial practices; and reduce fear, mistrust and resistance to health authorities. Unfortunately government action often sidelined the very communities whose engagement proved to be essential.
Table 4: Contextual conflict drivers and Ebola specific manifestations of conflict

<table>
<thead>
<tr>
<th>Key conflict drivers in Liberia</th>
<th>Ebola specific conflict manifestations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Politics and governance</strong></td>
<td></td>
</tr>
<tr>
<td>• Corruption and exclusion</td>
<td>• Centralised decisions about the location of ETUs, hiring of Ebola response workers, allocations of ambulances and IPC material etc.</td>
</tr>
<tr>
<td>a. Centralisation of power</td>
<td>• Limited transparency about the allocation of Ebola response resources</td>
</tr>
<tr>
<td>b. Limited transparency in the allocation of resources lead to lack of trust in the government)</td>
<td>• Lack of effective emergency response: lack of available care including beds, limited service provision including the collection of dead bodies, delays in action taken after national emergency number (4455) contacted etc.</td>
</tr>
<tr>
<td>c. Non-democratic decision-making in exclusionary practices in governance</td>
<td></td>
</tr>
<tr>
<td>d. Misuse of power</td>
<td></td>
</tr>
<tr>
<td><strong>Economic</strong></td>
<td></td>
</tr>
<tr>
<td>• Lack of livelihood opportunities:</td>
<td>• Lack of livelihood opportunities due to border closure, closure of markets and limited mobility (due to the ‘Ebola laws’)</td>
</tr>
<tr>
<td>a. Minimal economic diversification</td>
<td>• School closure and delay of rehabilitation and development work</td>
</tr>
<tr>
<td>b. Poor infrastructure</td>
<td>• Increased tensions over limited IPC resources and economic opportunities (Ebola response jobs, food rations)</td>
</tr>
<tr>
<td>c. Few local opportunities</td>
<td></td>
</tr>
<tr>
<td>d. Lack of relevant education</td>
<td></td>
</tr>
<tr>
<td>e. Increase tensions over limited resources</td>
<td></td>
</tr>
<tr>
<td><strong>Ethnic and religious divisions</strong></td>
<td></td>
</tr>
<tr>
<td>• Ethnic and religious divisions</td>
<td>• Lack of education and understanding about the spread of the Ebola virus (combatting rumours)</td>
</tr>
<tr>
<td>a. Grievances and inequalities between groups mobilised along ethnic and/or political lines</td>
<td>a. Ethnic and religious groups accused of spreading the virus (due to cultural specific behaviours, local stereotypes and practices)</td>
</tr>
<tr>
<td>b. Education system reinforces divisions</td>
<td>b. Stigmatisation of Ebola survivors and their families</td>
</tr>
<tr>
<td>c. Opportunities to build social cohesion through education were not realised</td>
<td>c. Stigmatisation of health workers, Ebola response workers and their families</td>
</tr>
<tr>
<td>• Gender-based identities and discrimination</td>
<td>d. Gender-based discrimination: women as ‘witches’ spreading Ebola</td>
</tr>
<tr>
<td>a. Normalisation of domestic abuse and rape</td>
<td></td>
</tr>
<tr>
<td>b. Association of masculine identities with threatening expressions of violence and force</td>
<td></td>
</tr>
<tr>
<td>c. Discrimination excludes women from decision-making roles and limits agency to act</td>
<td></td>
</tr>
<tr>
<td><strong>Environment</strong></td>
<td></td>
</tr>
<tr>
<td>• Access to land</td>
<td>• Government and NGO run ETUs constructed on land without ensuring customary practices were agreed upon</td>
</tr>
<tr>
<td>a. Competition and conflict over access to land and how land is utilised</td>
<td>• Lack of agreement with communities about land tenure for ETUs and CCCs</td>
</tr>
<tr>
<td>b. Dual systems of land tenure (customary and statutory) further exacerbate land conflicts as property rights are not secure</td>
<td></td>
</tr>
<tr>
<td><strong>Security</strong></td>
<td></td>
</tr>
<tr>
<td>• Legacy of violence (normalisation of violence)</td>
<td>• Increase of violence during national emergency situation (e.g. in West Point against government response)</td>
</tr>
<tr>
<td>a. Normalisation of violence, including rape, domestic violence, gender-based violence, assault and fighting</td>
<td>• Violence against girls increased due to school closure</td>
</tr>
<tr>
<td>b. Legacy of violence reinforced through the education system</td>
<td></td>
</tr>
</tbody>
</table>
Box 1

It was clear from the experiences shared by community leaders in Monrovia, that Ebola exacerbated already existing tensions and the pressure community leaders felt to resolve conflict increased. Scarcity of resources, misinformation about the spread of the virus and lack of government response to the increased number of Ebola cases caused conflict (or, in Liberian English, ‘confusion’) in the PBEA communities. The following narratives were representative of the views shared by community leaders participating in the case study.

'Not everyone that died during Ebola died from Ebola, but some died because the ambulance was not on time. People were afraid for their relative to go to the ETU, so they allowed them to die in the house and the community buried them. Not all of the deaths were recorded and if you ask me in public I will lie, but to tell you the truth we had to bury some bodies in the community at night... At the time of Ebola when you call the 4455 number the ambulance will not come and when they come they will request money, even up to $150 for the service they are going to render. Before they take sick persons or the dead bodies they told us to give money. We were not working, so we had to go around in the community to collect money and I told the community members that it was mandatory. This caused much confusion. There was a time I wanted a body removed from the community and I called the burial team at 8am and they did not come until 4pm. When they came I was standing at the police station waiting for them, they said we are not going to go in there and since you are the chairman you know what to do.'

Community leader, Monrovia

'Our community was highly hit and we lost seven persons. When you called the Ebola hotline 4455, it will ring endlessly. When you reach to the hospital there will be no space so they will send the patient back home. That caused the virus and fear to spread in communities. Response was slow. It was a little after the outbreak had subsided that we started seeing cars with ‘Ebola Response’ written on them, but during the heat of the outbreak there was no car and that led to the death of many people. Even when you saw an Ebola car they will tell you, ‘I am not the one that is to take this body or to carry this sick person’. This was bad so the government needs to do something about it.'

Community leader, Monrovia

The key objectives of the PBEA programme were acutely relevant during the emergency, and its structure provided a ready platform to help strengthen social cohesion and resolve conflicts, both at a micro level in terms of inter- and intra-community tensions, and also at a macro level in terms of fostering trust between communities, the government and international agencies.

The volunteers’ Ebola response tasks: peacebuilding, health education and social mobilisation

A critical gap in the Government of Liberia’s Ebola response was human resources: personnel able to do contact tracing, undertake door-to-door awareness raising and provide psychosocial to affected communities. To address this gap, the 375 JNVs and NVs were ‘reorientated’ for the Ebola response by UNICEF. The NVs were trained for three days on Ebola awareness raising strategies by the Ministry of Youth and Sports staff in Monrovia and on delivering psychosocial support (PSS) by the Ministry of Health. The JNVs were trained for three days at the county level by the Programme Officers and then supported through informal mentoring sessions. The reorientation of NVs and JNVs was designed to enable them to undertake the following key tasks (UNICEF 2014, NYSP 2014):

- Contribute to awareness campaigns on the prevention and control of the Ebola virus
- Conduct contact tracing to ensure support for sick community members and the protection of communities against infection
- Implement IPC measures in their sectors
- Act as a link between the government and the community to ensure rapid response and case management
- Assist with the registration of orphans reporting orphans identified through door-to-door assessment in the community
- Facilitate dialogue and conflict resolution sessions to help overcome communities’ lack of trust in the government’s response
- Facilitate community dialogue to remove stigma against Ebola victims and their families
• Raise awareness about psychological suffering, mental health and psychosocial support.

By training and deploying volunteers to undertake these tasks, the PBEA programme was able to contribute skilled human resources to the response. Although they task-shifted, the volunteers brought their approach to peacebuilding and education to bear on their new activities, and were therefore able to directly address key conflict areas and potential flashpoints during the outbreak. They continued to strengthen social cohesion and were well placed to build the capacity of communities to respond to the emergency and advocate for behaviour change during the outbreak. Health education and conflict resolution were critical components that led to the population developing trust in the government’s response and to achieving Zero Ebola cases in Liberia.

Strategic limitations

Despite the overall relevance of the PBEA programme during the Ebola outbreak and related response, there were several strategic limitations. The programme was not always consistent with the needs and priorities of the communities and the volunteers themselves. For example, the PBEA programme did not address conflicts arising from the inequitable distribution of resources and there was criticism that local youth did not benefit from economic or employment opportunities ceased by the response. Similarly, although the programme’s objectives were revised at the start of the emergency, activities should have been reviewed to fit the needs of the affected communities over time.

In addition, deploying volunteers during a national emergency and into potentially dangerous situations (from both a public health perspective and in terms of heightened tensions at the community level) was a high-risk policy. A severe strategic limitation of the programme was that it did not do more to mitigate the risks volunteers faced or enhance the duty of care. Had implementation been strengthened at all levels and across key areas (including programme management, supervision, training and materials, and psychosocial support, all of which are explored in greater depth in subsequent chapters), the programme may have achieved even greater relevance and maintained longer-term impact.

Key conclusions

• The overall goal of the PBEA programme was acutely relevant during the emergency as tensions increased.

• The structure of the programme provided a ready platform to strengthen social cohesion and resolve conflicts.

• By training and deploying volunteers to undertake critical tasks, the PBEA programme was able to contribute skilled human resources to the response.

• The volunteers brought their approach to peacebuilding and education to bear on their new activities, and were therefore able to directly address key conflict areas and potential flashpoints during the outbreak.

• Given the operational context, a severe strategic limitation of the programme was that it did not do more to mitigate the risks volunteers faced.

• Activities should have been critically revised and sequenced to fit the changed needs of affected PBEA communities (and the volunteers) over time.
Volunteers in a participatory workshop demonstrate how community members chased them out of the community and accused them of ‘spreading the Ebola virus’.
Efficiency

This chapter explores the extent to which the volunteer initiatives were suited to the Ebola response. It addresses how the PBEA volunteers were different from other social mobilisers and identifies ways in which the volunteers added value to the wider response.

Education

The level of education that both the NVs and JNVs had obtained prior to their deployment was seen to be advantageous in comparison to other community-based social mobilisers. To be recruited to the NYSP, an NV was required to have completed a technical school or university degree. University graduates are well regarded in Liberian society as only 1% of the Liberian population has completed a university degree. Many volunteers that were assigned to health facilities, schools or youth centres had a degree from the University of Liberia or Cuttington University in a relevant subject (e.g. medicine, education or social work). Even in normal circumstances, human resources in these sectors are scarce (due to poor public administration; limited public expenditure for education and health etc.) and the volunteers bought skills and capacity to their assigned workplaces. Indeed, the educational background of the NVs, often made them more qualified than established personnel in the institutions.

The JNVs were expected, at a minimum, to have completed secondary education and were required to demonstrate a youth leadership role in their communities, to understand the local context and speak the local dialect(s). As with the NVs, the education level of the JNVs set them aside from other social mobilisers and meant that they were more likely to contribute to the response efforts effectively. Quickly deploying educated volunteers to target areas was a strategic use of the programme’s key resources.

Previous work experience

In scaling their response, volunteers who had already graduated from the programme were redeployed, so they were able to draw on previous work experience. Many JNVs had previous experience working in the PBEA programme as mediators and ‘agents of change’ and this was highly beneficial in helping them to address and resolve Ebola-related conflicts in the community. A JNV from Maryland concluded,

‘People know that I am a peacemaker in my community. I listen to the youth and they listen to me. When I went for the training and came back, I started to create awareness in the community and I showed them pictures of Ebola survivors and how the virus treat people and from there they started to listen and they went by the preventive measures.’

Similarly, many NVs had already experienced working in schools, youth centres and hospitals or health centres, so were able to build on established relationships in both community and institutional settings. The tasks that they were assigned illustrates the level of responsibility with which NVs were entrusted, and they played significant roles in both schools and health centres. They assisted the school administration with the re-opening of schools (particularly in Maryland County) and were responsible for taking every child’s temperature as they arrived at school, isolating a child with an elevated temperature (and alerting the Ministry of Health), and monitoring the school premises. Volunteers that had served in health centres helped fill the positions left by the health professionals who transferred to serve in ETUs. Because higher incentives were paid to those working in ETUs, many positions that did not directly benefit from ‘Ebola money’ were left unstaffed. NVs with an auxiliary medical background were deployed to provide care for non-Ebola patients and to help manage the increased patient load. As a Ministry of Health representative concluded, ‘They stepped in and gave support to the health facilities – they were really helpful. Most of the staff went to the Ebola Treatment Units during the Ebola outbreak and the NVs really helped us fill some of the gaps.’
Language and cultural background – familiarity with assigned communities

Although prior work experience was seen to be a distinct advantage, even if NVs had previously worked at a community level, most were not able to speak the local languages of the communities to which they were assigned, were unfamiliar with tribal and cultural practices, and lacked a deep understanding of local social structures. According to a UNICEF PBEA staff member, this was a specific component of the programme’s design pre-Ebola as it was seen to be beneficial for peacebuilding efforts as well as personal development to send NVs to rural communities to foster intercultural learning and social cohesion between Monrovia and the counties. Supposedly, this exchange meant that it was unnecessary for the NV’s to have local knowledge in advance, but rather to absorb and integrate during their deployment. During the Ebola response, however, this hampered the effectiveness of NV’s work because they were treated with increased suspicion and in some cases resentment (discussed further below). To overcome some of these issues, the intention at the start of the Ebola response was that previously deployed NVs would be redeployed to the same communities. In practice, this was not feasible due to the geographic spread of the virus and operational priorities. For example, the PBEA programme had never deployed volunteers to Monrovia before Ebola, but during the response this was a centre of greatest need. Therefore, volunteers were deployed to communities with which they were unfamiliar, and to communities that had no previous experience of volunteer placements. At least initially, the effectiveness of NVs in both scenarios was reduced.

In contrast, JNVs were recruited from their own communities and were often put forward by community leaders for having a sound reputation as a youth leader. This provided the JNVs with multiple advantages: not only did they speak the same language as the community members they were working with, but they also had an in-depth understanding of cultural practices and traditions at the local level. With their secondary school education, and having been elected by their community, the young volunteers were respected and well placed to effectively advocate for behaviour change. According to several community leaders who participated in the study, the fact that JNVs were engaged in conflict resolution work pre-Ebola, made them more efficient peer-educators during the outbreak response.

Community Peace Committee members also played a vital role in information dissemination and uptake. The members of these Committees were recruited from the community to work alongside the JNVs during their peacebuilding and Ebola response activities. They were able to communicate IPC measures to their friends, family and neighbours and provided essential support to the JNVs. Additionally, the CPC members were able to assist the NVs by translating IPC materials into local dialect(s) and helped to identify cultural practices resulting in risky behaviours that could spread the virus. CPC members were well suited to respond to local conflicts since they came from the communities they were trying to influence, however many of them were young women who, despite the value of their work, were not always treated with respect by the wider community because of their social standing, and this limited their impact.

Key conclusions

- The level of education that both the NVs and JNVs had obtained prior to their deployment was seen to be advantageous and set them aside from other community-based social mobilisers.
- Quickly deploying educated volunteers to target areas was a strategic use of the programme’s key resources.
- The skills and experience that the NVs gained pre-Ebola proved essential for their work during the outbreak. The JNVs and their CPC members benefited from their previous work as peacemakers in the PBEA programme.
- The tasks that they were assigned illustrated the level of responsibility with which NVs were entrusted and they played significant roles in both schools and health centres.
• JNVs and CPC members were able to use their understanding of social structures and cultural practices to their advantage.

• It was not always possible to redeploy NVs to the communities they had been assigned prior to Ebola.

• When NVs were deployed to communities with which they were unfamiliar, their lack of language skills and local knowledge hampered their levels of efficiency and effectiveness.
Volunteers in a participatory workshop demonstrate how community members reacted with frustration when volunteers were not able to deliver IPC materials
Results and effectiveness

This chapter assesses the effectiveness of the volunteers as part of the Ebola response and analyses the results of three key activity streams: social mobilisation and contact tracing; conflict resolution and peacebuilding; and psychosocial support. It also addresses factors that limited the effectiveness of the volunteers and considers some of the unintended consequences that resulted from their interventions.

Social mobilisation activities and contact tracing

The volunteers’ activities sought to address two key areas: the lack of trust in the government and the government-led response; and the lack of reliable information that was trusted and communicated in a way that resulted in positive behaviour change. Contributing to awareness campaigns on the prevention and control of the Ebola virus was a major stream of work, and one of the most significant successes of the programme. By March 2015, the PBEA volunteers had reached over 28,000 people through door-to-door campaigns and had organised over 150 social mobilisation events focusing on Ebola (PBO 2015). In a country where most news is spread by community radio with limited quality control, and communities, particularly in rural areas, have limited access to reliable source of information, house-to-house education campaigns was seen to be an effective method to address negative rumours and provide information through trusted interpersonal communication.

In addition to their health communication activities, the volunteers also supported the County Health Teams to conduct contact tracing in Nimba and Montserrado. By March 2015, the volunteers had traced 1,626 people (PBO 2015). During their community monitoring visits, the volunteers also helped identify sick people and urged potential patients to present at health facilities for testing and/or treatment. Through these activities, and by helping to identify affected patients and dead bodies that were hidden from Ebola response teams, the volunteers made an important contribution to containing the spread of the virus in the communities to which they were assigned.

When the volunteers’ terms of reference and work package was reorientated to directly respond to Ebola, their level of resources did not change. In their self-evaluation of their activities, the volunteers who participated in this study concluded that they could have been more effective if they had been provided with money for transportation. They suggested that had they been more mobile, they would have been able to reach more people during the awareness-raising campaigns and community monitoring visits. Although the NVs and JNVs were asked to engage the communities that neighboured their assigned community, most volunteers were forced to limit their number of field visits due to lack of funding. As one volunteer concluded, ‘It was a challenge because we had to walk long distances to get to one community and we did not have enough money for transportation’. Other volunteers commented that the lack of transportation resulted in supervision for contract tracing being done ‘mainly over the phone’.

One activity in which the volunteers appeared to have been less effective was in the reporting of orphans to the Ministry of Gender, Children and Social Protection. The volunteers and stakeholders who participated in the case study suggested that the identification of orphans was included in their remit at the request of the Ministry, but it was not always discussed as a key activity. Although volunteers would report the orphans they came across in the course of their other activities (including social mobilisation, contact tracing and house-to-house visits), no practical assistance or support was offered to them (with the exception of psychosocial support offered in Nimba, discussed below). One volunteer in Monrovia recounted that during visits to schools in their catchment area, she and her colleague had identified several orphans.

‘We found between nine and thirteen children that had lost their parents. We met the principal and he said he needed people to help those children. I told him that I was from the Ministry of Youth and Sports and I took their record. I told him that I would send the records to the
Ministry and if there was an organisation that looks for children to help, then they would help. After Ebola, I went back to that place to pick up my boss lady, right around the same area. He [the principal] saw me. My mind was not thinking about what had happened during Ebola and at first I did not know that he recognised me. He started to shout at me, saying ‘you people can really lie’ and even threw rocks at me. I tried to explain, but they [the community] gave us information and they take us to be liars because no support went back to the orphans. It is really disheartening and made me feel sad. Now, as a result, I am afraid to go back.’

Taking a record without ‘offering benefits’ to orphans was unacceptable for many communities, raised local tensions and put the volunteers at risk. The activity contributed to community members’ suspicion of volunteers and meant that they had less community support and were unable to operate effectively. If registration of orphans or other vulnerable and marginalised groups are to be part of future programme activities, key supporting mechanisms must be put in place from the start.

Effective conflict resolution and peacebuilding in affected communities

Certain behaviours promoted as part of the IPC measures set out by the Ministry of Health and the international response, also raised the level of tension in communities and in some causes resulted in conflict. The declared national emergency prohibited public gatherings, closed borders, imposed curfews, shut markets, and prevented the eating of bush meat (PBO 2015). Resources became increasingly scarce as people’s livelihoods were curtailed. A Programme Officer in Maryland confirmed, ‘It was difficult because the people from Maryland get their goods from Ivory Coast so the closure of the border was a problem for them; they could not get rice, pepper, salt and other goods that they needed to have’. According to community leaders, scarcity of food caused increased tensions, violence at food distribution points and elevated levels of crime.

The prohibition of burial rituals, including the ceremonial washing and dressing of bodies, often resulted in anger at the community level, and the policy of imposed cremation (from August to December 2014) was abhorrent to most Liberians. A County Liaison Officer from Maryland recounted, ‘There was this man and his wife in Cassava Farm. When a close one [relative] of the man died he wanted to go to the burial in Grand Kru. The woman advised him not to go because the government said people should not go on burial. This man still went despite the warning that his wife gave him. When he came back the woman said she did not know if he ‘was infested from the burial’. So she did not let him enter the house and moved in with her family place until after twenty-one days. The CPC and the JNV in that community had to intervene and make peace between them.’

The fact that Maryland was not affected by Ebola outbreak at that time was incidental. As the County Liaison Officer continued, ‘During the time of Ebola people came from Monrovia by bus via Sinoe and when they came they started saying the people are bringing Ebola people to the County and that brought tension. Some community members were stigmatising those that came from Monrovia. This caused conflict between community members, leaders, friends and family.’

By March 2015, the volunteers had resolved 2,279 Ebola-related and other conflicts across the 45 PBEA communities (PBO 2015). Volunteers recounted specific situations in which they had intervened. For example, because of the government’s advice to fill buckets with chlorinated water and place them at strategic points in the community, water pumps became ‘dry’ and caused conflicts about ‘the right to draw water’. Similarly, the fact that families in quarantine received ‘benefits’ from the national and international response, led to many cases of conflict. Community members who were themselves living in poverty and badly affected by resource shortages, were frustrated that people in quarantine would ‘benefit’ from such
privileges, whilst they would not. Some felt that quarantined households were being positively discriminated, whilst the rest of the community was suffering. As a community leader in Monrovia explained,

‘I had to quarantine eight houses and there were thirty-seven person in those houses. The Urey Foundation promised to bring food and medicine for them but they did not. The foundation did not bring the medicine that they promised so people saw us [the community leaders] to be liars in the community which caused so much confusion [conflict] here in the community. People who were quarantine did not want to remain under quarantine and the police could not enforce it, nor could the community leaders enforce it. This meant that people who may have been sick roamed around freely through the community risking the health of other community dwellers.’

Many volunteers, particularly JNVs and CPC members who had received specific training in conflict-resolution, were able to clearly articulate the methods they used at a community level to build peace, calm disputes, reduce prejudice and promote increased tolerance for diversity. Strategies included dialogue, mediation, trust building and providing a ‘listening ear’. Responses such as ‘We made people talk to each other to stop them from becoming vexed’ were common. In contrast, the NVs had not received pre-deployment training in conflict resolution. They were less confident in discussing specific techniques and most reverted to ‘common sense’ practices to dissipate community-level tensions.

In the participatory workshops held as part of this evaluation, volunteers were asked to enact scenarios depicting their work during Ebola, including how they resolved community conflicts. Through these performances and in discussion afterwards, recurring themes were identified:

- Mediation between community members often took multiple days.
- Volunteers would acknowledge the community members’ concerns and listened to their experiences.
- Volunteers went back and forth between conflicting parties to discuss their concerns and show support.
- Volunteers often offered compromises (suggesting, for example, the option of sharing Ebola buckets, taking turns drawing water, and having community members monitor water usage).
- Volunteers provided community members with new information about Ebola that helped dissipate tension (for example, when Ebola survivors were being stigmatised and ostracised by their neighbours, the volunteers explained that the survivors were no longer contagious).

When the volunteers were unable to resolve conflicts via their own intervention, they would present the conflicting parties to community leaders for further mediation. Leaders would set up a community-based court and if agreement could not be reached, would assign appropriate punishments to the parties involved. This indicates that whilst volunteers played a significant role in resolving local conflicts through dialogue, in extreme situations they had to rely on the support of the community leaders who reverted to enforcing punitive measures.

**Solidarity and psychosocial support**

Although volunteers were unable to provide direct services, such as the transport of patients, the provision of treatment, or the removal of dead bodies, they were able to provide key information about behaviour and practices (as discussed above), and because of their longer engagement with communities, offered sustained solidarity. Community members usually perceived the volunteers to be government affiliates (working for MIA/PBO or MoYS), or aid workers with UNICEF. They often wore the campaign T-shirts issued by UNICEF, and this was how most community members identified them. Despite the distrust communities

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4 Aid-dependency remains omnipresent in Liberia and was the cause of much community conflict pre-, during and post-Ebola
had for government authorities in general, the near-constant presence of volunteers who were seemingly affiliated to the government, helped to build trust in subtle ways. As a community chairman in greater Monrovia concluded, seeing the volunteers, ‘We felt there was hope since they [the government/UNICEF] had not forgotten about us’. (Community perceptions about the volunteers are discussed further below).

The volunteers in Nimba were also trained in basic psychosocial support by the Danish Refugee Council (DRC) and the WHO in collaboration with the County Health Teams. Study participants in this county emphasised the importance of their training and the provision of psychosocial support to communities. According to the volunteers, they were often the only actors to visit Ebola survivors after they were released from an ETU, and played an important role in brokering a survivor’s reintroduction into the community. Families who had been in quarantine and Ebola survivors reported feeling more accepted after the volunteers’ interventions. The volunteers in Nimba were able to provide ongoing psychosocial support, not only to Ebola victims, orphans and affected families, but to the community more broadly, including community leaders and members of local Ebola task forces.

Limitations: betwixt and between role

One of the main objectives of the volunteers’ deployment was to build trust amongst communities, yet their very presence had fraught associations because of how community members perceived them and their role. In some circumstances, the presumed alignment of the volunteers with the government (as discussed above) actually posed a barrier to achieving their objective of building people’s trust in the government’s response.

Related to this, was the concept of volunteerism. This was complicated and does not have the same connotations in Liberia as in the global North. Although the NVs and JNVs were referred to as ‘volunteers’, they were actually paid US$275 per month, a substantial stipend (or ‘volunteer living allowance’) in a country where over 80% of the population lives under the international poverty line of $1.25 a day (UNICEF 2013b). The volunteers were often seen as ‘big men’ in the communities in which they worked: their affiliation with UNICEF and the government implied that volunteers were ‘making big money’; this was reinforced by the fact that volunteers received a large stipend and its amount was well known amongst community members; and in some cases, volunteers behaved as ‘big and important men’ in the communities to which they were assigned, sometimes monitoring rather than contributing to community-level activities.

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5 According to a UNICEF staff member who was involved with the design of the programme, the issue of remuneration was discussed in detail with the MoYS who well understood the resource limitations of the programme and its timeframe, and did not want the volunteers to assume they had guaranteed employment after its conclusion. The final stipend was determined by the MoYS in line with the financial resources of the programme and agreed by UNICEF.
A clear illustration of the tensions between volunteers and community members was linked to the distribution of IPC materials to promote basic hygiene measures. Some saw the distribution of buckets and chlorine to be ‘free hand-outs’ and many Liberians felt entitled to the items. When community members did not receive materials from the volunteers (because they were not supplied with materials to distribute, it was not part of their remit), they accused the volunteers of ‘eating their Ebola benefits’. The credibility of the volunteers was also negatively affected because they could not provide the resources that they were recommending the community use as part of Ebola prevention measures. As a community leader in Monrovia explained,

‘People expected those volunteers to bring benefits. But they were only coming to see. Next time, they should bring something like food and medicine for the quarantine families. I don’t blame him [the NV] because he was giving the information, but they were not coming in to help.’

That communities perceived the volunteers had access to the necessary materials but were not sharing them equitably, severely damaged the trust between the volunteers and community leaders. Although volunteers explained during their initial community consultations that they did not have a mandate to distribute resources and tried not to raise expectations, it was clear that many community members found this disingenuous and simply did not believe them. Rather, communities made a direct connection between material distributions and volunteers wearing T-shirts branded by organisation. Historically, the UN and INGOs have provided a high level of aid to the Liberian people, and there is widespread belief, particularly in rural Liberia, that such agencies have unlimited funding and an explicit remit to distribute resources. Because of these perceptions, volunteers were seen to lack integrity and at times were ‘not allowed back’ into the community or to specific households until they bought ‘Ebola supplies’. Furthermore, in communities with a high case load but where the government response was delayed or not available, volunteers were left frustrated and feeling ‘hopeless’ because they lacked potentially lifesaving materials to distribute.

Volunteers were also accused of spreading false information about Ebola and its transmission and communities were resistant to their awareness-raising messages prohibiting traditional practices such as eating bush meat or local burial practices. It was known that the IPC messages conveyed by volunteers were approved by the Ministry of Health and UNICEF, yet community members continued to debate their credibility against the backdrop of government mistrust, conspiracy theories and the belief that Ebola was ‘not real’. Such issues were not unique to the PBEA programme, but were challenges common to all first responders during the Ebola outbreak. As one volunteer in Montserrado County concluded, community members would ask ‘We have been behaving in this manner since forever – why was it now spreading Ebola? That was a challenge we faced’. In this context, prescribing behaviour-change to community members again placed the volunteers in a vulnerable position.

This was particularly true for the NVs, who were often regarded as ‘strangers’ (i.e. not from that community), and therefore more likely to be distrusted as the movement of people in and out of communities was so restricted during the emergency. In Nimba, for example, one NV reported having been placed in quarantine by the community leadership because he had travelled from Monrovia, an Ebola affected area. At the time, government guidance was to ‘observe strangers’ in the community to ensure that a traveller did not ‘bring Ebola’ into the locale. Only after this volunteer had been observed by the community for the prescribed 21 days was he permitted to move freely, but his relationship with them continued to be strained as he felt ‘very bad’ about how the community he had been assigned to had treated him.

Because of their new duties, communities perceived volunteers to be Ebola response workers (rather than peacebuilders) and this changed the relationship between the volunteers and their host communities. Due to fear about the virus and distrust of the government response, communities often reacted negatively to Ebola response workers in ways that were difficult to predict prior to the outbreak. A volunteer in Monrovia concluded,
If people were sick and they felt the symptoms of Ebola and you meet them and ask them - they will not admit. They will tell you it is just headache. The fear was that if they tell you that they are sick you will call the ambulance for them and when the ambulance carries them, their relatives will not see them again. They had this perception that if carried to the ETU the nurses and doctors will inject you and you will die so they did not want to go to the ETU. This made people not to trust us. They were afraid to give us information.’

The majority of volunteers who participated in the study described how they were ‘chased away’ from their assigned communities, were ridiculed, and in some cases verbally and physically abused by community members. One volunteer remembered an occasion when she had tried to speak with the community chairwoman but, ‘We were chased away – she even threw rocks at us’. Feeling unwelcome and treated with suspicion by a community where, according to the volunteers, ‘we had voluntarily come to work for the community’, was discouraging and frightening. It affected their morale and motivation, and for some, was detrimental to the effectiveness of their work. As a volunteer in Monrovia recounted,

‘Community members accused Ebola response workers of using this outbreak for money making; they said the white people gave us lots of money to poison wells so that people can get sick. So then the government can receive the money from international community.’

Another volunteer confirmed,

‘People had this perception that Ebola was all about money. They said people were paid and the nurses injected people for them to die. They even saw us to be health workers, so when we went to talk to them they did not want to listen to us because they said NGOs paid us lots of money to spread the virus around.’

The nature of the crisis and the activities conducted by volunteers meant that not only were they stigmatised, feared and distrusted by the communities in which they worked, but also by their family members and friends. Several volunteers in Monrovia, for example, recounted how they were not able to return to their own homes during the height of the outbreak because, ‘People were afraid to get in contact with us when we came back from the field’, whilst others were not allowed ‘to eat with our friends’. In the climate of fear associated with Ebola, these concerns were widespread. Volunteers reported that they felt exposed and lacked sufficient personal protection measures. Their perception of their own elevated risk levels heightened tensions and was stressful for the volunteers and their families. Volunteers explained that they were ‘afraid of getting close’ to people in the Ebola-affected communities to which they were assigned, and as an NV in Montserrado concluded, ‘We were constantly standing to not catch the Ebola virus. We were so afraid’. A stakeholder who trained NVs about Ebola prevention confirmed, ‘You could see it on their faces, they were so scared’. Limitations in the psychosocial support offered to volunteers is discussed further below.

Despite their fear and the adverse challenges the volunteers faced, it is notable that the majority of volunteers who participated in the study retained their morale and motivation and were dedicated to their work through a sense of duty to help the country fight Ebola.

Key conclusions

- The volunteers were able to successfully conduct their key activities: social mobilisation and contact tracing; conflict resolution and peacebuilding; and offering psychosocial support. Through their interventions, the volunteers were able to support communities to implement IPC measures.
- By March 2015, the PBEA volunteers had reached over 28,000 people through door-to-door campaigns; organised over 150 social mobilisation events focusing on Ebola; traced 1,626 contacts; and had resolved 2,279 Ebola-related and other conflicts across the 45 PBEA communities.
• Despite their fear and the adverse challenges they faced, the majority of volunteers retained their morale and motivation and were dedicated to their work through a sense of duty to help the country fight Ebola.

• Community members concluded that the volunteers’ presence fostered a sense of solidarity and Ebola-affected families and survivors benefited from the psychosocial support volunteers provided.

• The perception of volunteers as Ebola response workers made their work significantly more challenging. Although attitudes changed during the course of the outbreak and response, volunteers were often stigmatised, feared and distrusted by the communities in which they worked, and also by their family members and friends who were wary of their work and potentially elevated risk levels.

• The operational environment, plus lack of resources, such as transport to access remote communities, hampered the effectiveness of the volunteers. Investment in equipment and mobility would have increased the volunteers’ efficiency.

• Volunteers appeared to have been less effective in the registration of orphans, particularly because they were unable to offer any practical assistance or support.
Community leaders and volunteers reflect on the logistical challenges that the volunteers faced during the Ebola response.
Partnership

This chapter assesses how partnerships with the CPCs and other community members and groups supported the work of the volunteers.

Partnerships with CPCs, CBOs, NGOs and across Ministries

There was a strong sense of partnership between the PBEA volunteers and a number of NGOs and Community Based Organisations (CBOs), particularly in Maryland and Nimba counties. In Maryland, productive relationships were fostered with the County Health Teams, UNICEF field office, Africa Development Corps (ADC), Danish Refugee Council (DRC) and Partners in Health (PIH). These long-term partners provided material and logistical support and technical guidance through their training of NVs and JNVs. In Nimba, key partner agencies included the DRC and Global Communities (GC). They provided transport for the volunteers to access affected communities, and trained the volunteers in the provision of psychosocial support (discussed above).

In Montserrado, partly because it was a more complex urban operational environment with a proliferation of national and international actors, it was difficult to determine the formal partnerships that volunteers had with other NGOs and CBOs in the area. In addition, although the NYSP had cross-ministerial support (involving MoYS, MIA/PBO and MoE), it did not involve the Ministry of Health (MoH), and there was a critical coordination gap with the Incident Management System (IMS) led by the MoH. Stakeholders from the MoH were frustrated that they had not been included in the formulation of the terms of reference for the volunteers during the Ebola outbreak, particularly because it was the MoH that was leading the national response in collaboration with the President’s Office. As one County Health Officer explained in relation to the NVs being deployed to hospitals and health facilities,

‘Most of the supervisors at the hospital did not think they should supervise them because they were not brought in by the health sector. They just came and went at any time without covering their eight hours. This is something that needs to be worked on. There was a problem with separation of functions. I recommend that their terms of reference be brought to the County Office and we can sit and look at it together, and from there they can be assigned and then monitored by the supervisor that is responsible. It is not good to just work directly with the Ministry and not inform the County Health Team of the activities that you want to carry on. They need to look at the terms of reference and the organisations or institutions they are working with should share a memorandum of understanding, so that the volunteers’ role can be clearly defined’.

One of the main challenges for the programme, even pre-Ebola, was building relationships with community leaders and fostering their support and buy-in for the initiative. Traditionally, conflict resolution has been the remit of community leaders, and many did not see the need for a volunteer to act as a community-level mediator. Several community leaders whose communities (in Montserrado and Nimba) were rapidly incorporated into the PBEA programme during the Ebola response, suggested that the roles and responsibilities of the volunteers were not initially negotiated with them, and that they had not been properly briefed or involved in the Ebola response programme. Subsequently, NYSP and County Liaison Officers had to frequently renegotiate the position of the volunteers. In contrast, when the initial community consultation was done well and tasks assigned to the volunteers were decided in collaboration with community leaders, the PBEA programme was more likely to contribute to youth empowerment, conflict resolution and peacebuilding, and effective Ebola response work (as in longer-term PBEA communities in Maryland County).

The link between the JNVs and members of the CPCs was also beneficial in that CPC members, like JNVs, came from the communities they served. The CPCs and JNVs had collaborated on conflict resolution
activities before Ebola, and were remobilised during the response. They did not benefit, however, from the incentive structures of the other volunteers and were not given the same training opportunities. The PBO suggested that CPCs members should have received 12 days of Ebola-related training from the JNVs, however the CPCs who participated in the case study confirmed that whilst some had been informally trained by proactive JNVs and NVs, none had received formal training on Ebola response activities. This was a point of frustration for both CPC members and the community leaders. There was concern the CPC members may not have been able to convey the details of key messages accurately, and because they were expected to interact at a community level but had not been formally trained on protection measures, their risk profiles may have been elevated. In addition, because no stipend was provided to the CPC members, many were not able to fulfill the tasks expected of them.

In Maryland and Nimba counties, Programme and Liaison Officers served as local support mechanisms for the volunteers and their communities. These actors fulfilled a vital programme management role, nurturing effective and mutually beneficial partnerships, and helping to dissipate tensions between volunteers and their assigned communities by proactively resolving emerging issues. In Montserrado, the central office of the MoYS and the MIA/PBO directly managed the volunteers. Due to workload and structure it was not possible for the central office to provide the level of support to volunteers as they received from Programme and Liaison Officers in other counties, and without them to act as intermediaries, partnerships could not be developed and maintained in the same way.

**Youth unemployment and ‘benefiting your own’**

A component of the criticism levied by community leaders was that they were not involved in the recruitment of the NVs. They were frustrated that ‘strangers’ were being assigned to their communities and asked why ‘our own children’ were not recruited into the programme. In Montserrado County, community leaders argued that the ‘new’ volunteers were unfamiliar with the communities and that ‘local youth’ would have been better placed to do contact tracing and social mobilisation. They were clear in their opinion that Ebola response workers should have been sourced locally, and criticised the fact that UNICEF disregarded local labour needs in favour of ‘paying strangers’. As one community leader concluded, ‘If UNICEF had come to this community to call the youth that volunteer and appreciate them for the work that they did, things would have been better because they will always want to work’. In contrast, it was easier for the JNVS that were recruited from their own communities to build respectful and trusting relationships.

**Lack of resources**

Many volunteers highlighted that the lack of resources and limited supportive supervision was detrimental to their work and the programme more broadly. There was consensus that the lack of transport restricted the scope and coverage of their work. As discussed above, volunteers were expected to monitor and support a large number of communities, yet were not remunerated for transport costs. This was particularly problematic in Monrovia where the cost of transport was higher and the distances between communities greater. When volunteers tried to support communities remotely and were unable to work ‘hand-in-hand’ with community members and leaders, the partnership component of the PBEA programme was strained and not conducive to high quality, sustained engagement. Volunteers and other stakeholders who participated in the study concluded that either transport costs should have been provided to the volunteers, or their workload adapted so that they could have built stronger partnerships with a smaller number of communities distributed over a more accessible area.
Key conclusions

- When community consultation was done well and the tasks assigned to the volunteer decided in collaboration with community leaders, the PBEA programme was more likely to contribute to youth empowerment, conflict resolution and peacebuilding, and effective Ebola response work.
- JNVs and CPC members who were recruited from their own communities were better placed than NVs to develop respectful and trusting relationships, but the CPC members were not given the incentive structures of the other volunteers or the same training opportunities and this was a source of frustration.
- The leaders of some beneficiary communities did not see (initial) value in the PBEA programme and placement of volunteers, and were sceptical that outsiders (NVs) were recruited in favour of their own youth who would have directly benefited from the employment opportunity.
- A strong sense of partnership between the PBEA volunteers and a number of NGOs and CBOs was developed across programme sites (particularly in Maryland and Nimba), but this required active Programme and Liaison Officers to fulfil a vital programme management role, nurturing effective and mutually beneficial partnerships over time. Where there were no designated Programme and Liaison Officers (as in Montserrado), collaboration and coordination across organisations was more limited.
- Although the NYSP had cross-ministerial support, it did not involve the Ministry of Health and stakeholders were frustrated that they had not been included in the reformulation of the volunteers’ terms of reference during the Ebola response.
- Volunteers highlighted that the lack of resources and limited supportive supervision was detrimental to their work and the programme more broadly, and there was consensus that the lack of transport restricted the scope and coverage of their work.
During a participatory workshop, a volunteer leads a discussion about the psychosocial issues that volunteers continue to face as a result of their work.
Sustainability

The fieldwork for this case study was conducted in April 2016, after Liberia had been declared Ebola-free and the PBEA programme was winding down towards its official end date of 30 June 2016. It was therefore possible to explore the extent to which components of the volunteers’ interventions were likely to be sustained after the end of their engagement, and assess whether knowledge and skills introduced by volunteers were still evident in the communities they had supported.

Knowledge and practices

When asking community members to reflect on the work and impact of the volunteers, there was general agreement that the volunteers had been a positive force in the community. Both volunteers and community members suggested that their knowledge about IPC measures had improved through the Ebola response, and they were therefore in a stronger position in terms of preparedness for and resilience to future (public health) emergencies. What was less clear, however, was the extent to which key healthy behaviours such as hand washing and improved sanitation were being maintained at the community level.

Working in the Ebola response taught the JNVs and NVs valuable skills that could be positively transferred to other situations and work environments. This increase in local capacity had been recognised by some community leaders who continued to invite volunteers to support their community meetings and participate in local decision-making. The fact that they maintained such roles after the Ebola response (and in some cases, despite their Ebola-related work) and had been incorporated into the hierarchy of community leadership (usually positions reserved for elders rather than youth) was a positive indication of the value of individual volunteers, and of the programme more broadly.

Motivation and rewards

When volunteers feel motivated, appreciated and rewarded, the quality of their work increases, whereas lack of economic benefits reduces motivation and curtails the capacity of volunteers to work effectively (see Boesten et al. 2011). Although they were provided with a substantial monthly stipend (discussed in detail above), many volunteers felt that it was too low (a marked contrast to the perception of community members). As one NV in Nimba explained, ‘I am now sustaining two families – my wife and children in Monrovia and myself here in Nimba. I have to pay rent and feed two different households’. Volunteers reported that due to their financial situation, they often had to engage in side jobs during their deployment, and the situation was more extreme for CPC members who did not receive any incentive.

Many NVs and JNVs confirmed that part of the reason they were volunteers was to gain work experience, with the expectation that they would be more likely to find formal employment. Across the country, 68% of all employed people are in the informal sector, and 79% are classified as having ‘vulnerable’ employment (LISGIS 2010). The programme was able to secure job placements for some volunteers (as teachers in Maryland for example), but for many the lack of job opportunities after completing two years of volunteering with ‘limited remuneration’ was a significant disappointment.

Many volunteers in Montserrado and Maryland also suggested that they felt a lack of ‘appreciation’ for the work they did during the Ebola outbreak. It was important to them that their work be recognised by the institutions they engaged with and by national authorities. Volunteers agreed, ‘We are not talking about money, but some recognition by the Government or UNICEF is very much needed’. They were disappointed that during the national appreciation ceremony held by the government and attended by the President, health workers had been formally recognised and thanked for their service, but they had not. The sense of under-appreciation undermined the relationship that volunteers had with the institutions they were
engaged with, reduced the level of effort and commitment they were willing to make, and risked their willingness to participate in similar programmes in the future, or recommend them to their peers. In contrast, NVs and JNVs in Nimba County affirmed that they had been appropriate appreciated for the work they did. Here, volunteers were part of a remembrance ceremony hosted by the County Health Team in partnership with the Danish Refugee Council, and each volunteer received an official certificate from the Ministry of Health.

**Box 3**

Community members also felt that their role in fighting Ebola had not been sufficiently recognised by the government and UN agencies. The following dialogue between three community leaders during a focus group discussion in Monrovia was representative.

Community leader 1: *What is making me angry is that after the work that we did, NGOs and other organisations and the government did not come back to say thank you to the community members for the work that they did. Some people in the community paid their own money to help eradicate Ebola from the community. This is the reason I asked when the government will come to say thank you for the work that we did in communities. Even though we do not want money from them, but just the appreciation for the work that we did.*

Community leader 2: *The volunteer was coming, but the Ministry of Youth and Sports did not send someone to monitor and after Ebola this Ministry did not come back to say thank you for the work that we did. There was no support brought to this community from the recommendation that we gave to the NVs assigned here. All that they do is bring people to come and ask questions and write books that will not benefit us and now they brought you guys to get information from us to write the same book that will not benefit us. We are tired of giving information and we are hoping that when you carry this report something should come from out of it.*

Community leader 3: *We may not want money but just some recognition for the works that we did and when this is done other young people will be encourage to be a part of the volunteer work within their communities*. 

Community leader 2: *When the volunteer called to tell me to mobilise people I was furious, and I asked him why is he calling me now because since the end of Ebola he did not call to say thank you for the work that you did. His institution did not call us to say thank you.* 

**Accountability to communities and volunteers**

Accountability to the volunteers and to affected communities was weak during the Ebola response and an aspect of programme management that was lacking. As one community leader rightly concluded, ‘*Any recommendation that come from the community should be addressed or fed back*’. In addition, volunteers suggested that the duty of care extended to them fell short, particularly in terms of psychosocial support. Many reported that they continued to have nightmares, and the sentiment that ‘*We were the foot soldiers that risked our lives*’ was often emphasised by volunteers. One volunteer in Maryland recounted,

> The work that I was doing was a sacrificial job. We did not have the Ebola materials to distribute and people did not understand the danger of the Ebola virus. We did not receive PPE but we managed to take people to the hospital using plastics. We put plastics on our hands and took the sick persons to the hospital and the hospital refused them. This was terrible. I was always lonely at night because I always thought about those people that died during the time of Ebola.

A volunteer in Monrovia concluded, ‘*It takes a man to go in those dangerous areas to work. There should be psychosocial counselling provided for the volunteers*’. 
Key conclusions

• There was general agreement that the volunteers had been a positive force in the community and both volunteers and community members suggested that their knowledge about IPC measures had improved through the Ebola response, although it was not clear how key healthy behaviours such as hand washing and improved sanitation were being maintained at the community level.

• The programme increased local capacity and community leaders continued to invite volunteers to support their community meetings and participate in local decision-making post-Ebola. This was a positive indication of the value of individual volunteers, and of the programme more broadly.

• Volunteers wanted their work to be recognised and affirmed publically and by the institutions they were engaged with. Limited incentives and a sense of under-appreciation undermined the programme.

• Accountability to the volunteers and to affected communities was weak during the Ebola response and volunteers suggested that the duty of care extended to them fell short, particularly in terms of psychosocial support.
Community leaders discuss how community members should have been consulted during the recruitment and deployment of national volunteers
Conclusion and recommendations

Due to the complex nature of the Ebola outbreak and response, and the limited timeframe to conduct this case study, it is difficult to fully evaluate the impact of the PBEA volunteers or the outcomes of their work over time. The communities to which they were assigned were the recipients of multiple interventions, and the activities of one programme should not be viewed in isolation. Rather, this case study has analysed the relevance, efficiency, results and effectiveness, partnerships and sustainability of the PBEA programme from the perspective of the volunteers themselves and the communities they served. Table 5 (below) presents a summary of the key conclusions.

Table 5: Summary of key conclusions

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<th>Positive</th>
<th>Negative</th>
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| **Relevance** | • The overall goal of the PBEA programme was acutely relevant during the emergency as tensions increased.  
• The structure of the programme provided a ready platform to strengthen social cohesion and resolve conflicts.  
• The PBEA programme was able to contribute skilled human resources to the response by training and deploying volunteers.  
• The volunteers were able to directly address key conflict areas and potential flashpoints during the outbreak. | • Given the operational context, a severe strategic limitation of the programme was that it did not do more to mitigate the risks volunteers faced.  
• Activities should have been critically revised and sequenced to fit the needs of affected communities over time. |
| **Efficiency** | • The volunteers’ level of education was seen to be advantageous and set them aside from other community-based social mobilisers.  
• Quickly deploying educated volunteers to target areas was a strategic use of the programme’s key resources.  
• The skills and experience that the volunteers had gained pre-Ebola proved essential for their work during the outbreak.  
• JNVs and CPC members were familiar with local social structures and cultural practices and were well-respected members of their communities. | • It was not always possible to redeploy NVs to communities they had previously been assigned to prior to Ebola.  
• When NVs were deployed to unfamiliar communities, their lack of language skills and local knowledge hampered their efficiency and effectiveness. This made them less efficient than the JNVs/CPCs. |
| **Results & effectiveness** | • Volunteers retained their morale and motivation and were dedicated to their work through a sense of duty to help the country fight Ebola.  
• Volunteers were able to successfully conduct their key activities: social mobilisation and contact tracing; conflict resolution and peacebuilding; and offering psychosocial support.  
• Community members concluded that the volunteers’ presence fostered a sense of solidarity and Ebola-affected families and survivors benefited from their psychosocial support. | • The perception of volunteers as Ebola response workers made their work significantly more challenging.  
• Volunteers were often stigmatised, feared and distrusted by the communities in which they worked, and by family members and friends wary of their potentially elevated risk levels.  
• Registering orphans was challenging, and volunteers were unable to offer practical assistance or support.  
• The operational environment was challenging and lack of resources, such as transport, restricted the scope and coverage of their work. |
<table>
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<th>Partnership</th>
<th>Sustainability</th>
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<td>• JNVs and CPC members who were recruited from their own communities were better placed than NVs to develop respectful and trusting relationships. Some community leaders did not see the value of the programme, and were sceptical that outsiders (NVs) were recruited in favour of their own youth.</td>
<td>• Although levels of knowledge about IPC measures had improved through the Ebola response, it was not clear if key healthy behaviours were being maintained.</td>
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<td>• A strong sense of partnership between the PBEA volunteers and a number of NGOs and CBOs was developed across the programme sites. CPC members were not given the incentive structures of the other volunteers nor the same training opportunities, and this was a source of frustration.</td>
<td>• Limited incentives and a sense of under-appreciation undermined the programme. Volunteers wanted their work to be recognised and publically affirmed.</td>
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<tr>
<td>• When community consultation was done well and the tasks assigned to the volunteer decided in collaboration with community leaders, the PBEA programme was more likely to contribute to youth empowerment, conflict resolution and peacebuilding, and effective Ebola response work. Where there were no Programme and Liaison Officers, collaboration and coordination across organisations was limited.</td>
<td>• Accountability to the volunteers and to affected communities was weak, and volunteers suggested that the duty of care extended to them fell short, particularly in terms of psychosocial support.</td>
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The following recommendations focus on operationalising the lessons learnt from deploying PBEA volunteers during the Ebola response. They are drawn from the evaluation of the programme and include suggestions made by volunteers, community members and other stakeholders who participated in the case study.

• Identifying gaps in the volunteers’ knowledge, capacity and skill sets will determine areas that require the programme to provide enhanced training.

• If volunteers are to be deployed to another emergency, it is essential that they be provided with refresher training and that mechanisms for supportive supervision are improved.

• When possible, volunteers should be deployed to communities with which they are familiar. They should be able to speak the local language. Locally recruited volunteers are likely to be more effective in achieving behaviour change and less prone to marginalisation, discrimination and stigmatisation by the host community.

• To maximise the impact of NVs and JNVs in terms of community mobilisation, it is recommended that they be deployed to affected communities in pairs, and continue to collaborate with the CPC members.

• The duties of the volunteers and the resources available should be realistically matched so that activities can be facilitated in a timely manner. When volunteers’ workloads or tasks are revised, support mechanisms and resources should be appropriately updated (transport, material supplies, psychosocial support etc.).

• Community consultation is critical and the role and responsibilities of volunteers should be negotiated with community leaders to ensure their support and buy-in. The placement and duties of volunteers should be regularly evaluated as the situation develops and their activities should be modified accordingly.
• The expectations of both the volunteers and the communities to which they are deployed should be carefully managed.

• The involvement of the Ministry of Health during the recruitment, training and deployment of volunteers during public health emergencies would increase their credibility, enhance the quality of their work and provide opportunities for supervision and medical guidance at the local level.

• Mutually beneficial partnerships with organisations at the local level should be developed in advance and strengthened over time.

• Volunteers should be offered longer-term psychosocial support and institutions that deploy volunteers should adopt a greater duty of care.

• Stronger accountability mechanisms must be introduced for both volunteers and the communities to which they are deployed.

• County-level supervisors should be deployed to all counties where the programme is active to ensure clear line management and supportive supervision. Supervisors should advocate on behalf of the volunteers and be able to negotiate with community leaders in situations of conflict.

• Volunteers must be recognised for their work, particularly by the institutions that engage them and higher authorities. They should be provided with a certificate or diploma to acknowledge their service, and included in community-based appreciation ceremonies.
Annex 1 – Research tools

TOPIC GUIDE

Relevance, effectiveness, efficiency, sustainability

- **Relevance**: extent to which JNVs/NVs were suitable to the response.
  - Key conflict areas in Liberia/during Ebola (see below)
  - Contributions of JNVs/NVs (see below)
  - Assigned tasks and job descriptions:
    - Case management
    - Social mobilization
    - Awareness raising
    - Conflict resolution
    - Psychosocial support
  - Successes and challenges
  - Results of JNVs/NVs intervention:
    - Direct consequences
    - Indirect consequences
    - Intended consequences
    - Unintended consequences

- **Effectiveness**: extent to which the volunteers’ activity attained their objectives
  - Contributions of JNVs/NVs
  - Assigned tasks and job descriptions
  - Successes and challenges
    - Success stories (e.g. effective social mobilization, case management, PSS support, awareness raising) and challenges (e.g. dangerous behaviour, mental health issues, conflict, lack of collaboration with MoH staff etc.)
  - Influencing factors:
    - Knowledge, support and safety (e.g. training, monitoring)
    - Tools and material support (e.g. transport and material goods)
    - Receptiveness of community (e.g. community support)
    - Motivation (e.g. moral obligation, rewards and incentives)

- **Efficiency**: extent to using volunteers for the Ebola response was a value added to the response
  - Comparison with other social mobilisers (positive and negative)
  - Knowledge, support and safety (e.g. training, monitoring)
  - Tools and material support (e.g. transport and material goods)
  - Receptiveness of community (e.g. community support)
  - Motivation (e.g. moral obligation, rewards and incentives)

- **Sustainability**: extent of results of the volunteers’ intervention continue after the end of their engagement
  - Existence of knowledge and skills in the community they supported
  - Partnership with existing structures (CPCs, community structures)
  - Success factors and challenges
Conflict drivers and contributions

Conflict area 1

Politics and governance
• Corruption and exclusion
  - Centralisation of power
  - Limited transparency in the allocation of resources lead to lack of trust in the government
  - Non-democratic decision-making in exclusionary practices in governance
  - Misuse of power

Specific conflict areas during the Ebola outbreak
• Centralised decisions about placements ETUs, hiring of Ebola response workers, allocations of ambulances and IPC material etc.
• Limited transparency of allocation Ebola response resources
• Lack of effective Ebola emergency response: delay in response to national emergency number (4455), lack of beds available in the response etc.

Contributions JNVs/NVs
• Dialogue sessions: communities lost trust in government’s response (conflict management and mediation) and conflict erupted around:
  - Allocation of Ebola response material (both IPC and food)
  - No transparent communication about location of ETUs
• Awareness raising about infection prevention measures and PSS (community based advocacy)
• Contact tracing and data collection: mapping out needs and at risk individuals and communities (to aid the government to respond to the outbreak)
• Early warning – early response through community mobilization

Conflict area 2

Economic
• Lack of livelihood opportunities:
  - minimal economic diversification
  - poor infrastructure
  - few local opportunities
  - lack of relevant education
  - increase tensions over limited resources

Specific conflict areas during the Ebola outbreak
• Lack of livelihood opportunities due to border closure, short closure of markets and limited mobility (due to the ‘Ebola laws’)
• School closure (national emergency situation) and delay of rehabilitation and development work (e.g. on schools)
• Increased tensions over limited IPC resources and economic opportunities (Ebola response jobs, food rations)

Contributions JNVs/NVs
• School construction/maintenance work to improve poor infrastructure before school reopening
• Conflict resolution: missing out Ebola out rations and hygiene material (aid division), theft of property and land (due to reallocation families etc.)
• Community mobilisation of youth – due to school closure and lack of economic opportunities (due to loss of mobility and border closure)
Conflict area 3

Social
• Ethnic and religious divisions
  - Grievances and inequalities between groups mobilized along ethnic and/or political lines
  - Education system can reinforce divisions
  - Opportunities to build social cohesion through education have not been realized
• Gender-based identities and discrimination
  - Normalisation of domestic abuse and rape
  - The association of masculine identities with expressions of threat, violence and force;
  - Discrimination excludes women from decision-making roles

Specific conflict areas during the Ebola outbreak
• Lack of education and understanding about the spread of the Ebola virus (combatting rumours)
  - Ethnic and religious groups and ethnic groups accused of spreading the virus (due to cultural specific
    behaviours – e.g. local stereotypes and practices - Kissi tribe has a practice of eating dog meat, Muslims
    thought to have the habit of extensive burial rituals)
  - Stigma for families of and Ebola survivors themselves
  - Stigma of health workers, Ebola response workers and their families
  - Gender-based discrimination: women as ‘witches’ spreading Ebola, women as caregivers, women selling
    ‘Ebola salt’.

Contributions JNVs/NVs
• Awareness raising and community dialogue: to remove stigma against Ebola victims and their families, to
  promote IPC procedures, to stop the spread of rumours that spread fear

Conflict area 4

Environment
• Access to land
  - competition and conflict over access to land, as well as control over how land is utilized
  - in some cases dual systems of land tenure (customary and statutory) further exacerbate land conflicts
    as property rights are not secure

Specific conflict areas during the Ebola outbreak
• Government run and NGO run ETUs constructed on the land without ensuring customary practices where
  agreed upon
• Lack of agreement with communities about land tenure for ETUs and CCCs

Contributions JNVs/NVs
• Conflict resolution over land disputes (during the Ebola outbreak)
• Awareness raising and community mobilization to get support for the Ebola response

Conflict area 5

Security
• Legacy of violence (normalization of violence)
  - Normalization of violence, including rape, domestic violence, gender-based violence, assault and
    fighting
  - Legacy of violence reinforced through the education system
Specific conflict areas during the Ebola outbreak

- Violence against girls increased due to school closure (during the national emergency situation)
- Increase of violence during national emergency situation (e.g. in West Point against government response, lack of livelihood opportunities and school closure etc.)

Contributions JNVs/NVs

- Conflict resolution: community mobilization, peacebuilding against conflicts that increased due to National Emergency Situation, Ebola aid and lack of trust in government
- PSS support for victims of Ebola related violence
PARTICIPATORY TOOLS

The problem ‘plum’ tree

Objective: Problem tree analysis helps to find solutions by mapping out the anatomy of cause and effect around an issue in a similar way to a Mind map, but with more structure.

Session with JNVs/NVs

During this session the JNVs and the NVs will be asked to reflect on their work during the Ebola outbreak. They will be asked to write (on post-it’s) the key problems that existed in the communities to which they were assigned during the Ebola outbreak. They will be asked to note the different types of conflict they identified in the communities and then post it next to the box ‘focal problem’. After identifying the key problems the group will be asked to reflect on the causes of these conflicts in the community and post these below next to the box of ‘causes’. Links will be drawn between the focal problems and the causes. After having identified the key problems and causes the group will be asked to reflect on their actions to mitigate the problems in the community. Again, the group will past their notes next to the box ‘action’ and draw links to the previous work done.

Then participants will be asked to reflect on the effects of their intervention: what happened because of their intervention? The group will be asked to cluster the effects by indirect, direct, intended and unintended consequences and reflect on the short and long term effects of their work. To close the session, the group will be asked to reflect on challenges and recommendations for the future (or for other settings where this model could be used to respond to crisis situations).
Session with service providers / CPCs

Service providers that were deployed in the communities where a JNV/NV was based, will be asked to reflect on community-based conflict that existed during the Ebola outbreak in their communities. They will be asked to write (on post-it's) the key problems that existed in the communities to which they were assigned during the Ebola outbreak. They will be asked to note the different types of conflict they identified in the communities and then post it next to the box ‘focal problem’. After identifying the key problems the group will be asked to reflect on the causes of these conflicts in the community and post these below next to the box of ‘causes’. Links will be drawn between the focal problems and the causes. Having identified the key problems and causes, the group will be asked to reflect on the work the JNVs and the NVs did to mitigate the problems in the community. Again, the group will post their notes next to the box ‘action’ and draw links to the previous work done. The service providers will also be asked to review the quality of the work the JNVs/NVs did during the Ebola outbreak: what type of interventions were done well and which one not do well? And why did some of the work of the JNVs/NVs went better than other?

Then participants will be asked to reflect on the effects of their intervention: what happened because of the intervention? How did they build the peace of their communities? The group will be asked to cluster the effects by indirect, direct, intended and unintended consequences and reflect on the short and long term effects of their work. To close the session, the group will be asked to reflect on challenges and recommendations for the future (or for other settings where this model could be used to respond to crisis situations).
Drama and community walks

**Objective:** to enact Ebola related conflict mediation sessions and to better understand community based conflict resolution during community mobilisation practices.

**Session with JNVs/NVs**

The JNVs/NVs will be asked to enact a community-based conflict during the Ebola outbreak (most likely one of the conflicts they have named in the ‘plum tree’ sessions that will be scheduled to take place before the drama session). The group will be told that they need to enact a real situation that happened in the past and that there will be no right or wrong in the way they resolve the problem during this session. They will be asked to take on the role of: community member, service provider, JNV/NV, concerned family member, community leader etc. (or another actor that features in this story). The group will then be asked to act out the conflict and the assigned person to ‘play’ the JNV/NV will be asked to intervene in the conflict and show how they resolved the conflict.

**Session with service providers / CPCs**

The group of service providers or the group of CPCs will be asked to reflect on a situation in the past where they encountered a conflict in the community they were assigned to. They will be asked to reflect on a real live situation and identify instances when a JNV/NV intervened in a positive manner. They will also be asked to reflect on a situation where the response of the NV/JNV could have been better. They will enact at least one situations and then reflect on the successes and the challenges of the JNVs/NVs.
IN-DEPTH INTERVIEW FRAMEWORKS

Interview framework – JNVs/NV’s

• Introductory/demographic questions
  - Gender: (male/female)
  - How old are you?
  - Are you married?
  - Where do you live?
  - How many people are there living in your household?
  - What level and kind of schooling do you have?
  - How many children do you have?
  - How old are they? Boys / girls?
  - How many additional children do you care for under your care?
  - What is your tribal affiliation?
  - Which religion do you adhere to?

• Relevance
  - What was the situation in this community/area during the Ebola outbreak?
  - What kind of conflict existed in the community?
  - What where they key problems and needs that existed during the Ebola outbreak?
  - What was missing in the Ebola response?
  - Do you feel like you helped fill the gap? And how?
  - How do you think you were suitable to respond to this crisis situation? In comparison with other social mobilisers?
  - How did you help resolve some of the conflicts that existed in the community you were assigned to?
  - Was your work important during the Ebola outbreak? And why/how?
  - What happened as a result of your work?

• Effectiveness
  - Were you able to help community members during the Ebola outbreak?
  - What tools did you get to help you carry out the assigned tasks?
  - What was the goal of your work? And do you feel like you were successful in achieving this result? Why or why not?
  - What helped you to be successful in your work?
  - What would have helped you to be more successful in your work?

• Efficiency
  - What enables you to do your work efficiently?
  - What could have helped you doing your work better?
  - How could you have reached out to more people?
  - How could you have provided better information in a cost effective way?
  - How could you have better helped people suffering from mental health issues?
  - Did you feel safe doing the work you did?

• Sustainability
  - Do people still benefit from your work? And how?
  - In case of a new Ebola emergency, would you recommend using JNVs/NVs again?
  - What should the programme know about the impact of your work?
  - What lessons can we learn from your work?
  - How do you think the communities still benefit from your work?
  - And what recommendations would you provide if the programme continues?
Interview framework – Community members and CPCs

• Introductory/demographic questions
  - Gender: (male/female)
  - How old are you?
  - Are you married?
  - Where do you live?
  - How many people are there living in your household?
  - What level and kind of schooling do you have?
  - How many children do you have?
  - How old are they? Boys / girls?
  - How many additional children do you care for under your care?
  - What is your tribal affiliation?
  - Which religion do you adhere to?

• Relevance
  - What kind of problems existed in the conflicts in the community during the Ebola outbreak?
  - Did the JNV/NV assigned to your community get involved in the conflict?
  - How did they respond to the conflict?
  - What were the consequences of their actions?
  - Did this mean to happen? And what happened afterwards?
  - What did you think they did well? And what could they have done better?
  - Do you think the NV/JNV was the right person to do the work they were doing?

• Effectiveness
  - Did the JNV/NV assigned to your community carry out their tasks?
  - What do you think their tasks were?
  - Can you share some of the successes of the JNV/NV in your community?
  - Did the NV/JNV change the behaviour of community members/protect the community from contamination with the Ebola virus?
  - Where there situations wherein the JNV/NV was not very effective? And what happened?
  - What were some of the challenges that the JNVs/NV faced?
  - Where they supported by the community? And what about the government? Others?
  - How was the partnership between the NV/JNV and the CPC?

• Efficiency
  - Were there other Ebola response workers assigned to your community?
  - What was the difference between these response workers and the JNV/NV assigned to the community?
  - In what way were the JNVs/NVS more successful in changing the behaviours than other social mobilisers? And in what way were they less successful?

• Sustainability
  - Do you still know what the JNV/NV taught you?
  - If there would be an opportunity to have another NV/JNV assigned to your community – would you want them to be redeployed in community?
  - What are some of the recommendations you have if the NV/JNVS are reassigned to your community?
Interview framework – Service providers

• Introductory/demographic questions
  - Gender: (male/female)
  - How old are you?
  - Are you married?
  - Where do you live?
  - How many people are there living in your household?
  - What level and kind of schooling do you have?
  - How many children do you have?
  - How old are they? Boys / girls?
  - How many additional children do you care for under your care?
  - What is your tribal affiliation?
  - Which religion do you adhere to?

• Relevance
  - What kind of existed in the conflicts in the community during the Ebola outbreak?
  - Did the JNV/NVs get involved in the conflict?
  - How did they respond to the conflict?
  - What were the consequences of their actions?
  - Did this mean to happen? And what happened afterwards?
  - What did you think they did well? And what could they have done better?
  - Do you think the NV/JNV was the right person to do the work they were doing?

• Effectiveness
  - Did the JNV/NV assigned to your community carry out their tasks?
  - What do you think their tasks were?
  - Can you share some of the successes of the JNV/NV in your community?
  - Did the NV/JNV change the behaviour of community members/protect the community from contamination with the Ebola virus?
  - Where there situations wherein the JNV/NV was not very effective? And what happened?
  - What were some of the challenges that the JNVs/NV faced?
  - Where they supported by the community? And what about the government? Others?
  - How was the partnership between the NV/JNV and the CPC?

• Efficiency
  - Were there other Ebola response workers assigned to your community?
  - What was the difference between these response workers and the JNV/NV assigned to the community?
  - In what way were the JNVs/NVS more successful in changing the behaviours than other social mobilisers? And in what way were they less successful?

• Sustainability
  - Do you still know what the JNV/NV taught you?
  - If there would be an opportunity to have another NV/JNV assigned to your community – would you want them to be redeployed in community?
  - What are some of the recommendations you have if the NV/JNVs are reassigned to your community?
Interview framework – National level actors

• **Introductory/demographic questions**
  - Gender: (male/female)
  - How old are you?
  - Are you married?
  - Where do you live?
  - How many people are there living in your household?
  - What level and kind of schooling do you have?
  - How many children do you have?
  - How old are they? Boys / girls?
  - How many additional children do you care for under your care?
  - What is your tribal affiliation?
  - Which religion do you adhere to?

• **Relevance**
  - What kind of challenges existed in the country during the Ebola outbreak?
  - How did the JNVs/NVs respond to conflicts emerging from this situation?
  - How did the NV/JNV change the behaviour of community members/protect people from contamination with the Ebola virus?
  - What were the consequences of their actions?
  - Did this mean to happen? And what happened afterwards?
  - What did you think they did well? And what could they have done better?
  - Do you think the NV/JNV was the right person to do the work they were doing? (and if so why? And if not, why?)

• **Effectiveness**
  - What do you think the tasks of the JNVs/NVs were?
  - Did the JNV/NVs manage to attain their objectives?
  - Can you share some of the successes of the JNV/NV intervention?
  - Where there situations wherein the JNV/NV was not very effective? And what happened?
  - What were some of the challenges that the JNVs/NV faced?
  - Where they supported by the community? And what about the government? Others?
  - How was the partnership between the NV/JNV and the CPC?

• **Efficiency**
  - Were there other Ebola response workers assigned during the crisis?
  - What was the difference between these response workers and the JNV/NV?
  - In what way were the JNVs/NVS more successful in changing the behaviours than other social mobilisers? And in what way were they less successful?

• **Sustainability**
  - What, do you think, is the long-term and short term impact that the JNVs/NVs had?
  - If there would be an opportunity re-deploy the JNVs/NVs in a different public health crisis – do you think that this would be suitable?
  - What are some of the recommendations would you have for other programme implementers looking at implementing the JNV/NV model?
Interview framework – IPC trainers

• Introductory/demographic questions
  - Gender: (male/female)
  - How old are you?
  - Are you married?
  - Where do you live?
  - How many people are there living in your household?
  - What level and kind of schooling do you have?
  - How many children do you have?
  - How old are they? Boys / girls?
  - How many additional children do you care for under your care?
  - What is your tribal affiliation?
  - Which religion do you adhere to?

• Specific questions about the training
  - When did the training session take place? For how long?
  - Where did the training take part?
  - Who were present at the training? And who was not?
  - Where there any other follow-up training sessions?
  - What topics were discussed during the training?
  - Did you have enough to talk about all the topics you had in mind?
  - What are your qualifications and who trained you?
  - Did you feel that the training provided the JNVs/NVs with enough knowledge to respond in this emergency situation?
  - How was the training perceived by the participants?
  - What are some recommendations you have for future training sessions?

• Relevance
  - What kind of challenges existed in the country during the Ebola outbreak?
  - How did the JNVs/NVs respond to conflicts emerging from this situation?
  - How did the NV/JNV change the behaviour of community members/protect people from contamination with the Ebola virus?
  - What were the consequences of their actions?
  - Did this mean to happen? And what happened afterwards?
  - What did you think they did well? And what could they have done better?
  - Do you think the NV/JNV was the right person to do the work they were doing? (and if so why? And if not, why?)

• Effectiveness
  - Can you share some of the successes of the JNV/NV intervention?
  - Where there situations wherein the JNV/NV was not very effective? And what happened?
  - What were some of the challenges that the JNVs/NV faced?
  - Where they supported by the community? And what about the government? Others?
  - How was the partnership between the NV/JNV and the CPC?

• Efficiency
  - Were there other Ebola response workers assigned during the crisis?
  - What was the difference between these response workers and the JNV/NV?
  - In what way were the JNVs/NVS more successful in changing the behaviours than other social mobilisers? And in what way were they less successful?
• **Sustainability**
  - What, do you think, is the long-term and short term impact that the JNVs/NVs had?
  - If there would be an opportunity re-deploy the JNVs/NVs in a different public health crisis – do you think that this would be suitable?
  - What are some of the recommendations would you have for other programme implementers looking at implementing the JNV/NV model?
Annex 2 – Consent forms

JNVs and NVs – Case study Liberia – interviews and group discussions

Background
This study seeks to improve our understanding of the contributions of the NVs and JNVs to peace building and social cohesion during the Ebola epidemic. The volunteers were deployed to Ebola affected communities during the national emergency situation to help stop the spread of the virus by raising awareness on infection prevention control measures, contact tracing, conflict resolution and community mobilization. This study will use information gathered from community members, service providers and the JNVs and NVs themselves to better understand the effectiveness, relevance and sustainability of the work they did during the Ebola outbreak.

FGD/Workshops/KII
For this purpose, we would like to talk to you about matters relating to your work during the Ebola outbreak. Specifically:
- Your perceptions and experiences of the role you played during the Ebola outbreak
- The challenges you faced and the support you enjoyed
- The way you were perceived by the community, your colleagues and other social mobilisers

The interview / focus group discussion will last for approximately 30/60/120 minutes (cross out what is not relevant). Participation is voluntary. You have the right to withdraw from the discussion at any time without reason and without penalty. There is no cost associated with your participation. We believe there is no risk to you in participating.

We will ensure that your information, opinions and experiences are kept confidential and will only be used for the purpose of the study outlined. We will not use your name. You may ask any questions related to the study and we will answer these questions to your satisfaction. With your permission, we may make an audio recording of our discussions for our records. This will be destroyed at the end of the study. With your permission, we may also take photographs during the interview / focus group discussion. These may be used for the purpose of the current study and may be included in academic publications and other material for UNICEF or Anthrologica. If your photograph is published, you will not be identified by name and confidential processes shall be followed.

In regard to collecting information for this study, we would greatly appreciate your help and therefore seek your consent and cooperation. If you have any questions about this study, you may contact John Weah, Child Protection Specialist at UNICEF Liberia at 0770267656.

INFORMED CONSENT
I have been informed in detail about the purpose and nature of this study. I have received satisfactory answers to all my questions relating to this study. I have decided that my child can participate willingly and can withdraw at any time for any reason. I agree to his/her workshop being recorded. I give my informed consent to my child participating in this study and having his/her photograph taken as part of the study.

_________________________________________  ____________________________  ______
Name of participant  Signature  Date

_________________________________________  ____________________________  ______
Name of witness  Signature  Date

As a witness of this letter, I ensure that I have the above information has been accurately conveyed to the participant. I also ensure that they have decided to participate in this study freely and willingly.
**JNVs/NVs – Case study Liberia – interviews and group discussions**

**Background**

This study seeks to improve our understanding of the contributions of the NVs and JNVs to peace building and social cohesion during the Ebola epidemic. The volunteers were deployed to Ebola affected communities during the national emergency situation to help stop the spread of the virus by raising awareness on infection prevention control measures, contact tracing, conflict resolution and community mobilization. This study will use information gathered from community members, service providers and the JNVs and NVs themselves to better understand the effectiveness, relevance and sustainability of the work they did during the Ebola outbreak.

**FGDs/KII/Participatory workshops with youth under 18**

For this purpose, we would like to talk to your child about matters relating to their work during the Ebola outbreak. Specifically:

- Their perceptions and experiences of the role the JNVs/NVs played during the Ebola outbreak
- The challenges they feel the JNVs/NVs faced and the support these actors got
- The way the JNVs/NVs were perceived by the community, their colleagues and other social mobilisers

The workshop will last for approximately 120 minutes. Participation is voluntary. Your child has the right to withdraw from the discussion at any time without reason and without penalty. There is no cost associated with him/her participation. We believe there is no risk to him/her in participating.

We will ensure that your child’s information, opinions and experiences are kept confidential and will only be used for the purpose of the study outlined. We will not use their name. You and/or your child may ask any questions related to the study and we will answer these questions to your satisfaction. With your/their permission, we may make an audio recording of our discussions for our records. This will be destroyed at the end of the study. With your/their permission, we may also take photographs during the workshop. These may be used for the purpose of the current study and may be included in academic publications and other material for UNICEF or Anthrologica. If your child’s photograph is published, they will not be identified by name and confidential processes shall be followed.

In regard to collecting information for this study, we would greatly appreciate your help and therefore seek your consent and cooperation. If you have any questions about this study, you may contact John Weah, Child Protection Specialist at UNICEF Liberia at 0770267656.

**INFORMED CONSENT**

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I have received satisfactory answers to all my questions relating to this study.
I have decided that my child can participate willingly and can withdraw at any time for any reason.
I agree to his/her workshop being recorded.
I give my informed consent to my child participating in this study and having his/her photograph taken as part of the study.

_________________________  _________________________  ______________
Name of parent/caregiver  Signature  Date

_________________________
Name of youth participant

_________________________  _________________________  ______________
Name of witness  Signature  Date

As a witness of this letter, I ensure that I have the above information has been accurately conveyed to the participant. I also ensure that they have decided to participate in this study freely and willingly.
JNVs and NVs – Case study Liberia – interviews and group discussions

Background

This study seeks to improve our understanding of the contributions of the NVs and the JNVs to peace building and social cohesion during the Ebola epidemic. The volunteers were deployed to Ebola affected communities during the national emergency situation to help stop the spread of the virus by raising awareness on infection prevention control measures, contact tracing, conflict resolution and community mobilization. This study will use information gathered from community members, service providers and the JNVs and NVs themselves to better understand the work they did during the Ebola outbreak.

FGD/ Participatory workshops for adults

For this purpose, we would like to talk to you about matters relating to your work during the Ebola outbreak. Specifically:

• Your perceptions and experiences of the role the JNVs/NVs played during the Ebola outbreak
• The challenges you feel they faced and the support they got
• The way they JNVs/NVs were perceived by the community, your colleagues and other social mobilisers

The interview / focus group discussion will last for approximately 30/60/120 minutes. Participation is voluntary. You have the right to withdraw from the discussion at any time without reason and without penalty. There is no cost associated with your participation. We believe there is no risk to you in participating.

We will ensure that your information, opinions and experiences are kept confidential and will only be used for the purpose of the study outlined. We will not use your name. You may ask any questions related to the study and we will answer these questions to your satisfaction. With your permission, we may make an audio recording of our discussions for our records. This will be destroyed at the end of the study. With your permission, we may also take photographs during the interview / focus group discussion. These may be used for the purpose of the current study and may be included in academic publications and other material for UNICEF or Anthrologica. If your photograph is published, you will not be identified by name and confidential processes shall be followed.

In regard to collecting information for this study, we would greatly appreciate your help and therefore seek your consent and cooperation. If you have any questions about this study, you may contact John Weah, Child Protection Specialist at UNICEF Liberia at 0770267656.

INFORMED CONSENT

I have been informed in detail about the purpose and nature of this study.
I have received satisfactory answers to all my questions relating to this study.
I have decided that my child can participate willingly and can withdraw at any time for any reason.
I agree to his/her workshop being recorded.
I give my informed consent to my child participating in this study and having his/her photograph taken as part of the study.

_________________________  ___________________  _____________
Name of participant       Signature                  Date

_________________________  ___________________  _____________
Name of witness           Signature                  Date

As a witness of this letter, I ensure that I have the above information has been accurately conveyed to the participant. I also ensure that they have decided to participate in this study freely and willingly.
## Annex 3 – Schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
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</thead>
<tbody>
<tr>
<td>24 March</td>
<td>International travel</td>
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<tr>
<td>25 March</td>
<td>In-country preparation work, briefing research team</td>
</tr>
<tr>
<td>26-27 March</td>
<td>In-country preparation work</td>
</tr>
<tr>
<td>28 March</td>
<td>Briefing, UNICEF Country Office Liberia</td>
</tr>
<tr>
<td>29-30 March</td>
<td>Data collection Monrovia</td>
</tr>
<tr>
<td>31-1 April</td>
<td>Travel to Maryland County</td>
</tr>
<tr>
<td>2-3 April</td>
<td>Data collection Maryland County</td>
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<tr>
<td>4 April</td>
<td>Data collection Maryland County. Travel to Nimba County</td>
</tr>
<tr>
<td>5 April</td>
<td>Travel to Nimba County. Data collection Nimba County</td>
</tr>
<tr>
<td>6-7 April</td>
<td>Data collection Nimba County</td>
</tr>
<tr>
<td>7 April</td>
<td>Travel to Monrovia</td>
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<tr>
<td>8 April</td>
<td>Preliminary analysis. Validation workshop and debrief</td>
</tr>
<tr>
<td>9 April</td>
<td>Report writing</td>
</tr>
<tr>
<td>10 April</td>
<td>International travel</td>
</tr>
<tr>
<td>16 May</td>
<td>Submission of draft report</td>
</tr>
<tr>
<td>30 June</td>
<td>Comments on draft report returned by UNICEF</td>
</tr>
<tr>
<td>11 July</td>
<td>Submission of final deliverables</td>
</tr>
</tbody>
</table>
References


Education Policy and Data Center (2014). *Liberia National Education Profile.*


[https://www.internews.org/sites/default/files/resources/Liberia_Reports/Liberia_Media_Newsletter_18.pdf](https://www.internews.org/sites/default/files/resources/Liberia_Reports/Liberia_Media_Newsletter_18.pdf)


[http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0137208](http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0137208)


*[All weblinks accessed 9 July 2016]*