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Ebola: beyond the health emergency

Summary of research into the consequences of the Ebola outbreak for children and communities in Liberia and Sierra Leone

The first phase of the research is available at http://plan-international.org/ebolareport

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Part I: Introduction

1 Introduction

The 2014 outbreak of the Ebola Virus Disease in West Africa was declared an international public health emergency on 8 August 2014 (WHO, 2014). Plan International, who commissioned this research, undertook a rapid assessment of the situation among Plan staff in the three most affected countries, Liberia, Sierra Leone and Guinea; staff reported that, whilst Ebola trailed sickness and death in its wake, the outbreak had implications that reached far beyond this direct impact on people's health. This was confirmed by reports from other NGO's and the international press about how the Ebola outbreak was causing wider problems such as the closure of schools, restrictions on movement, food shortages and economic downturn. In a rapidly-changing situation, media coverage was an important source but tended to give a one-dimensional picture, presenting issues as separate headlines.

What was evident is that there is a lack of empirical research investigating the wider effects of a large-scale Ebola outbreak, and in particular the indirect impacts on children and young people. To address this gap, Plan International commissioned this qualitative study in late October 2014.

Fieldwork was carried out by community based organisations in Liberia and Sierra Leone. Teams of researchers visited a sample of twenty (20) communities in each country. Selective sampling was used, to represent urban and rural communities, different regions of the countries, as well as locations where there were high and low case numbers of Ebola. Female and male children and adults took part in focus group discussions, in one-to-one interviews and case studies. This qualitative methodology allowed people to tell their own stories and encompassed views from children, families and the wider community. In total, 1,836 children and adults participated in the study.

Selective (purposive) sampling was used: the sites were chosen to represent both urban and rural communities, different regions of the countries, as well as locations where there were high and low case numbers of Ebola. Children and adults took part in small group discussions and one-to-one interviews. This qualitative methodology allowed people to tell their own stories, building up from the impact of the outbreak on the child to those experienced by the family and wider community. In total, 1,836 children and adults chose to participate in the study.

The safety issues surrounding fieldwork in countries at the height of an Ebola outbreak are substantial, as are the practical difficulties of fieldwork when people are afraid of contact, public gatherings are banned, travel restrictions are in place and areas have been quarantined. In such circumstances it was the presence of local community-based organisations and Plan staff already active amongst affected communities that made the research possible.

This report therefore describes the range of impacts that Ebola has on children and families looking beyond the immediate health effects and exploring the cause and effects, as described by those living through the crisis. It finds that beyond those infected with the virus there are a large number of children and families whose survival and development is threatened by the loss of already precarious health services, the loss of community cohesion and the loss of basic needs such as food. Many children are placed at risk by a breakdown in the protective environment usually provided by families and the wider community. Almost all children and adults, even communities with no Ebola cases, feel the hurt of bereavement and experience the loss of what gives them confidence and self-esteem; education, employment and social ties with family and community. Children's lives have been comprehensively harmed by the wider consequences of the Ebola outbreak.

It is important to bear in mind that an Ebola outbreak of this scale has never been seen before, and as a result all actors involved – from the international community, to the national governments, to civil society and communities - have been learning as the crisis escalated. Therefore, the findings, conclusions and recommendations should not be seen as a critique on what didn't work, but as a basis to draw on the learning for what to improve if a similar emergency occurs in the future.

The report is organised as follows: Chapter 2 gives a description of the research method. Chapter 3 is a review of the Ebola outbreak and response, based on published sources and with the aim of providing a context for the research findings. Chapters 4 to 9 set out the findings of the research under each of the main topics of enquiry; health, food security, livelihoods, child protection, education and community cohesion. Chapter 10 contains conclusions and recommendations for relieving the immediate impacts of Ebola's wider consequences, supporting the longer-term process of recovery and increasing resilience to such a crisis. The report is accompanied by two appendices. Appendix 1 is a book of case studies collected from children during the study. This provides first-hand and powerful accounts of the multiple ways in which children are affected by the side-effects of the Ebola outbreak. Appendix 2 contains the research tools and training guide.

2 Research method

2.1 Research aims

The research was commissioned as a qualitative study, to investigate the consequences of Ebola for children, young people and families in Liberia and Sierra Leone.

The specific objectives of the research were to:

1. Identify the immediate needs of children, young people and families with particular regards to education, livelihoods, child protection and well-being, and food security and nutrition.
2. Based on the findings from the study, initiate a broad set of recommendations which can be used to inform programming and advocacy for when the outbreak ends and with regards to a health outbreak of a similar nature and scale in the future.
3. Advise on further research needs, to improve understanding of the consequences of the outbreak.

2.2 Research challenges and general approach

2.2.1 Gathering personal perspectives on a broad agenda

An emphasis was placed in the research brief on understanding how children, parents and others view the wider consequences of the Ebola outbreak. A challenge for the research was therefore to reconcile the need to give people the time and open agenda to express their own views, with the need to minimise contact and conduct research quickly and efficiently. There was also a challenge to reconcile the exploratory aims of the research, across a wide agenda, with the desire for deep insights and the ability to make comparisons between countries and types of site.

To balance these different needs a semi-structured interviewing method was used. This employed a core set of topics and prompts to guide the discussion, but was sufficiently open and flexible to enable the participants to shape the discussion. The use of a core set of topics and prompts within the semi-structured agenda, created a data set that is a rich source of qualitative data as well as being sufficiently large and consistent to allow a simple numerical analysis and comparison between different categories of sites.

This method was chosen in preference to a more rigid questionnaire. Whilst this would have produced answers that were easier to quantify, closed questions tend to pre-set the agenda. It is also very time-consuming or resource intensive to deliver closed questions to a large number of people when they cover multiple topics.

2.2.2 Safety and ethics

Safety of participants and researchers during the research was a primary concern and a major influence on the approach. In addition to the risk of contracting Ebola there was the possibility of a hostile reception from people in communities. Attacks on visiting health teams, were reported in the international press, for example, including a fatal attack in Guinea in July 2014 (WHO, 2014g). In response to these risks, the general approach taken was to:

- **Minimise contact**; by minimising the time spent in each site, by avoiding physical contact and by avoiding the exchange of paper, pens or other research materials.
- **Minimise travel** between areas; by using different teams to cover different parts of the country, rather than a single team traveling between all the sites.
- **Maximise familiarity** with the communities; by working through Plan communities and/or through local organisations and with researchers who knew the participating communities. This helped to overcome the reluctance of people in communities to meet.

A detailed safety protocol was prepared for the research and incorporated into training for researchers, covering issues such as hand-washing, meeting in open spaces and no physical contact (see the Research Tools Appendix to this report, Appendix 2).

As children were the focus for the research it was important to include young people in the fieldwork. The child protection and ethical issues raised by this were managed by working with organisations with a track-record of carrying out research with children and with knowledge of child protection. Older children, aged 12 to 18, were invited to take part in the research instead of very young children, given the health risks and the emotional risks of discussing Ebola with children who had potentially lost their parents and loved ones to the virus. Younger children (as young as 8 years) are occasionally included in the case studies, which were researched in the presence of a parent or other adult. The inclusion of children required a shorter and simpler discussion framework to that used with adults. For child protection and safety reasons, the meetings with children and adults were held mostly in the open or in large spaces, visible to all and with space for people to avoid close contact.

The arrangements and issues described above had implications for the types of research tools used. Participatory techniques often involve the exchange of materials (for example maps) and the active (physical) engagement of participants (for example in walking transects). Such techniques were avoided in favour of methods such as focus groups and semi-structured interviews, where researchers facilitate a discussion among participants, noting down the main topics of discussion that resulted. The focus groups were a

maximum of 12 participants, for a combination of safety and research-effectiveness reasons.

The use of several research teams to minimise travel and maximise familiarity with the communities has the potential disadvantage of adding inconsistency in how the research is conducted, and hence the results. To mitigate against this, training was held for all team members, the methods were piloted and reviewed and a team leader supervised all of the sessions in a given area.

Ethical approval for this study was obtained in accordance with Plan International's Research Policy and Standards. The research adhered to Plan International's Child Protection Policy and Guidelines. In addition, the research was conducted in accordance with Plan International's safety protocol put in place in response to the Ebola outbreak. The prior and informed consent of all participants was sought, before all meetings or interviews took place (see consent form in Research Tools, Appendix 2).

2.3 Data collection

2.3.1 Selection of research sites

Research sites were purposively sampled, chosen to provide a representative sample of the demographic characteristics of the two countries and examining:

- A broad geographical spread across the countries, to encompass characteristics such as proximity to borders, trade flows and proximity to capital cities.
- Rural and urban areas.
- Areas with a high number of suspected, probable and confirmed Ebola cases and areas with a low number of suspected, probable and confirmed cases (referred to in this study as High Outbreak and Low Outbreak sites).

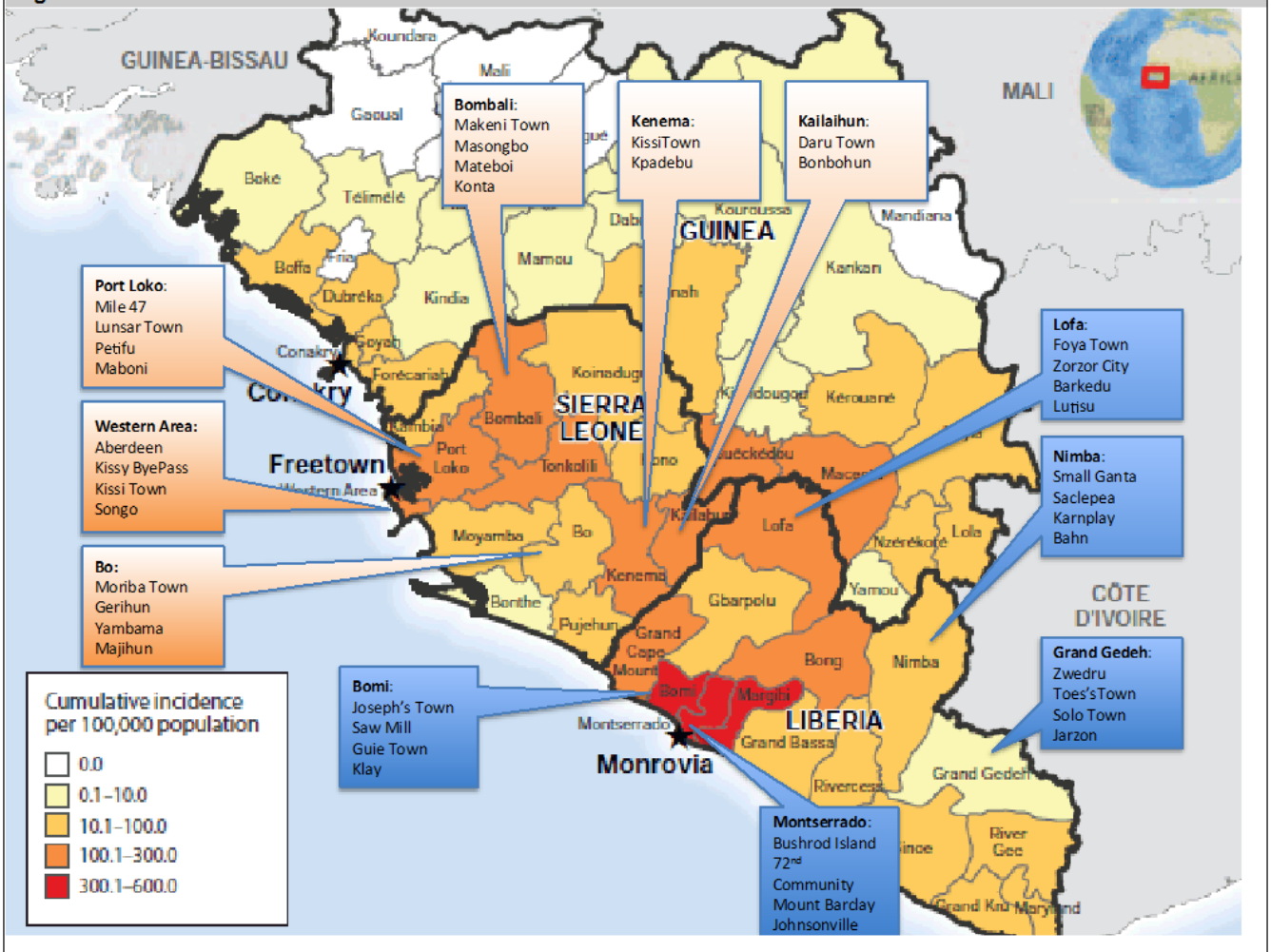
Pragmatic and programming reasons also influenced site selection. Very remote areas were not included because of time and transport difficulties. Communities where either the research teams or Plan staff had already worked and had personal contacts were favoured in order to ensure safety of the researchers.

In each country a sample of twenty (20) sites was selected. These are portrayed in Figure 2.1 and the features of the sites are summarised in Tables 2.2 (Liberia) and 2.3 (Sierra Leone). Sites were defined as high or low outbreak at the time of fieldwork according to cumulative incidence maps such as that reproduced in Figure 2.1, and research teams aimed to investigate an equal number of each type. However, the cumulative incidence maps do not give a wholly accurate guide to the status of sites because the actual numbers of suspected, probable and confirmed cases of Ebola vary from community to community (the communities being neighbourhoods of several thousand people in urban areas, or villages of a similar size or smaller for rural sites) and they change rapidly with

time. Therefore, after local knowledge was gathered during the research, the final number of high outbreak sites included in the research was 15, which was fewer than the number of low-outbreak sites included (25).

Communities themselves were usually unable to give an accurate guide to the level of outbreak as there was great uncertainty about whether cases and deaths were actually due to Ebola. Establishing accurate figures is difficult and was not an objective of this research. Nor was it essential for the method; sites that were within high outbreak counties or districts but which had relatively few cases were very aware of and affected by the events and reactions in nearby communities that had experienced a greater number of cases. Nonetheless, comparisons made in the study between high and low outbreak areas should be considered with this uncertainty in mind, and treated as indicative rather than absolute.

Figure 2.1 Research sites in Liberia and Sierra Leone



Source: Map Reproduced from CDC (2014) Cumulative incidence of Ebola virus disease — Guinea, Liberia, and Sierra Leone, November 30, 2014

Table 2.2 Research sites in Liberia			
Liberia			
County	**Site**	**Rural/Urban**	**Outbreak High/Low**
Montserrado	Bushrod Island	Urban	High
	72nd community	Urban	Low
	Mount Barclay	Rural	High
	Johnsonville	Rural	Low
Bomi	Joseph's Town	Urban	High
	Sawmill	Urban	Low
	Guie Town	Rural	High
	Klay	Rural	Low
Nimba	Small Ganta	Urban	High
	Saclepea	Urban	Low
	Karnplay	Rural	High
	Bahn	Rural	Low
Grand Gedeh	Zwedru	Urban	Low
	Toe's Town	Urban	Low
	Solo Town	Rural	Low
	Jarzon	Rural	Low
Lofa	Foya Town	Urban	High
	Zorzor City	Urban	Low
	Barkedu	Rural	High
	Lutisu	Rural	Low
Total sites	*20*		
Total Rural	*10*		
Total High Outbreak	*8*		

In Sierra Leone, the choice of districts was more heavily influenced by travel restrictions: passes had to be obtained to permit travel, which was not the case in Liberia. Roadblocks caused long delays, making it more difficult to reach remoter areas. Nonetheless, Kailahun district in the east, bordering Lofa County in Liberia, was included, particularly because it was a centre for the early stages of the outbreak in Sierra Leone and because it is a programming area for Plan International. To reduce travel difficulties, only two sites were visited in Kailahun. So instead of four sites in each district as elsewhere, the north-eastern four were split between Kailahun and the relatively accessible Kenema district.

Table 2.3 Research sites in Sierra Leone			
District	**Site**	**Rural/Urban**	**Outbreak High/Low**
Western Area	Aberdeen	Urban	Low
	Kissy Bye Pass, East III	Urban	Low
	Kissi Town, Waterloo Rural Area	Rural	High
	Songo, Koya	Rural	Low
Bo	Moriba Town, West Ward	Urban	Low

	Gerihun Town	Urban	Low
	Yambama	Rural	Low
	Majihun	Rural	Low
Kenema	Kissi Town, Gbo Kakajama	Urban	Low
	Kpadebu	Rural	Low
Kailahun	Daru Town	Urban	High
	Bonbohun	Rural	High
Bombali	Makeni Town, Banana Ward	Urban	High
	Masongbo Town	Urban	High
	Mateboi	Rural	Low
	Konta	Rural	Low
Port Loko	Mile 47	Urban	High
	Lunsar Town-Madigbo	Urban	High
	Petifu	Rural	Low
	Maboni	Rural	Low
Total sites	*20*		
Total Rural	*10*		
Total High Outbreak	*7*		

2.3.2 Selection of participants

Participants, like sites, were purposively selected and not sampled randomly. The aim was to bring together small groups consisting of children, parents and community leaders (Table 2.4). The participants were selected on arrival at the site and with the cooperation of community leaders. They are therefore largely self-selected, but within the criteria of a roughly equal gender split and a representative spread of ages between 12 and 18 in the children's groups.

Table 2.4 Groups and interviews in each site

Group and Individuals	**Participants**	**Researchers**
1. Children	8 -12 school age children, with an equal number of boys and girls and a range of ages from 12 to 18	1 lead facilitator and one note-taker.
2. Carers (Female)	8-12 female parents or carers	1 lead facilitator and one note-taker (at least one female)
3. Carers (Males)	8-12 male parents or carers	1 lead facilitator and one note-taker (at least one male)
4. Community	8-12 community representatives, including youth, woman and community leaders	1 lead facilitator and one note-taker
5. One-to-one Interviews	With community leaders (e.g. clan chief, or representatives of local government and non-government organisations)	1 interviewer and one note-taker
5. Case Studies	With children, identified through discussion groups.	1 interviewer and one note-taker

Total participants per site	*Minimum 38*	*Total team: Minimum 5*

The sampling was altered in Sierra Leone, by having two groups of children, boys and girls separately. This was done following piloting of the research tools in that country, with the aim of enabling children to have a freer discussion about sensitive topics such as sexual exploitation and gender issues more generally. To keep the total number of groups the same, the discussion group with leaders was dropped. This was considered by the research team to be the most dispensable, because the experience from Liberia was that community leaders tended in any case be included as parents/carers. Furthermore, they were specifically targeted with the 1-1 interviews that were carried out in each site, in addition to the group discussions.

In total, there were 20 children's focus groups and 60 adults' focus groups in the Liberia sample, and 40 children's focus groups and 40 adults' focus groups from Sierra Leone. There were 42 one-to-one interviews in Liberia and 80 one-to-one interviews in Sierra Leone. In total, 221 children and 599 adults were interviewed in Liberia; 473 children and 543 adults were interviewed in Sierra Leone. In total, 694 children participated in the study and 1,142 adults. A breakdown of the participants is provided in Table 2.5 below.

The intended minimum sample size was exceeded in both countries. It was greatest in Sierra Leone, mainly because more groups were at or near the maximum number planned for. Slightly more females than males took part in the focus groups and case studies. There is a significant difference in the 1-1 interviews which are predominantly male. This is because these were targeted at community leaders and the gender bias reflects the larger number of men in leadership roles.

Table 2.5 Number of participants in research

			Liberia				
	Adults	*Adults Female*	*Adults Male*	Children	*Children Female*	*Children Male*	*Total*
Focus Groups	557	*283*	*274*	184	*98*	*86*	741
1-1 Interviews	42	*16*	*26*				42
Case Studies				37	*19*	*18*	37
Liberia Totals	**599**	***299***	***300***	**221**	***117***	***104***	**820**
			Sierra Leone				
Focus Groups	463	*238*	*225*	433	*224*	*209*	896
1-1 Interviews	80	*21*	*59*				80
Case Studies				40	*21*	*19*	40
Sierra Leone Totals	**543**	***259***	***284***	**473**	***245***	***228***	**1016**
TOTAL	**1142**	*558*	*584*	**694**	***362***	***332***	**1836**

2.4 Organisation and preparation of research teams

Fieldwork in both countries was divided up amongst three teams of five researchers, covering different parts of the country as shown below (Table 2.6). A one-day training session was held with all researchers, with the research tools then being piloted in communities who were not part of the study, before being refined and then applied.

Table 2.6

Liberia				**Sierra Leone**		
South	North-West	East		West	East & South	North
Team 1 Montserrado Bomi	**Team 2** Lofa	**Team 3** Grand Gedeh, Nimba		**Team 1** Western Area	**Team 2** Kenema Kailahun Bo	**Team 3** Port Loko Bombali

2.5 Research tools

The research tools draw upon on Rapid Appraisal techniques (Chambers, 1983 and Beebe, 2001). These are quickened forms of ethnographic techniques, giving priority to the perspectives of informants and consisting of semi-structured interview checklists, observation, interviews, focus groups and case studies. Assembling views from different groups and perspectives (triangulation) is an important feature of the method.

For this study, focus group discussion, individual semi-structured interviews and case studies were chosen. Answers elicited from focus group discussions are, therefore, formed as a group and not individually. For this reason, groups have the potential disadvantage of obscuring individual viewpoints, especially if particular individuals or interests dominate the discussion. On the other hand, they allow topics to be explored through an exchange of views and reveal divergence as well as consensus. For this particular study they had the added advantage of being an open and transparent way of meeting people.

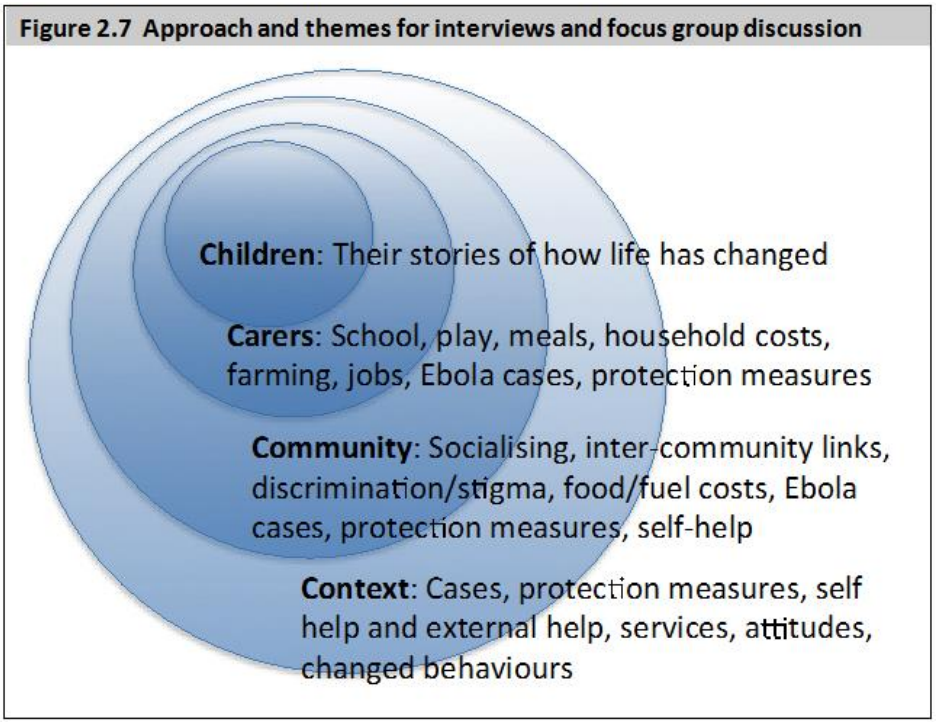
To balance the collective discussion with groups, individual interviews (with community leaders) were held and case studies of children (with carers) were researched to give more in-depth views and real-life examples of the wider impacts of Ebola. These allow for in-depth discussion of topics. Whilst the style is conversational and flexible, prompts from a checklist are used by the researcher to ensure that core topics are covered.

The tools used in this research are set out in full in a Research Method appendix (Appendix 2) and are summarised below:

- **Focus group/Interview checklists**. These were a semi-structured discussion guide, based on set topics – education, health, food security, livelihoods and community cohesion. Questions to prompt discussion for each of these topics were designed in line with the research questions and objectives of the study, and to ensure comparability of answers across the sampled sites. Different versions of the checklist were used for children and adults' groups. The same checklist was used for 1-1 interviews. Whilst each topic was introduced by the interviewer using the prompt questions, groups then led the discussions that followed, with the interviewer posing questions for clarification. This was to avoid 'leading' questions and to give groups the opportunity of engaging with the topics on their own terms.
- **Change charts**: A change chart is a simple graph on which the participants identify which aspects of their lives have changed and define how much it has changed. These were used to encourage participants to define and measure (approximately) change. They also allow the group to see that their views are being recorded.
- **Case study template**. This is a template for researching and recording case study interviews with children. It invites a story that covers what has happened to the child, what occurred in the family that contributed to that change and what occurred in the wider community that influenced the family.

The tools were designed to build up an understanding of impacts, centred on the child but encompassing the family, community and wider context, as illustrated in Figure 2.7.

Figure 2.7 Approach and themes for interviews and focus group discussion



2.6 Data analysis

2.6.1 Qualitative analysis and the quantification of results

Analysis of the fieldwork results is manual and iterative, involving an accumulation of information from the different sources and the cross-referencing of one source against the other, to identify similarities and differences and explanations for these.

The presence of a consistent set of core themes and prompting questions allowed for some basic quantification of the answers provided. Microsoft Excel was used for data entry, data analysis, and the production of simple charts. The numerical results were generated by counting the frequency with which groups (not individuals) gave specific answers. The charts and percentages referred to in this study should therefore be treated as a rough guide only: an indication of the frequency with which certain answers were given. The proportions are expressed as percentages of the total number of groups in that category. For example, 78% of adult groups in Liberia said that there were no maternal health services. This means that 47 of the 60 adult groups gave this answer.

Adults and children are analysed separately, because the children's discussion checklist was simpler and less structured. The two countries are also analysed and presented separately. This is to avoid amalgamating data from two different contexts, different sample sizes and different stages of the outbreak.

In essence, the qualitative data identifies the impacts of the Ebola outbreak and explains how they come about, whilst the simple, numerical data gives a measure of the extent to which this impact is recognised across the different groups and sites. Extensive use of quotes from the fieldwork transcripts is made in the text, to illustrate points and to give the reader a first-hand account of people's views. The case studies of children form part of the data for this analysis and they are produced separately in a Case Study Book (Appendix 1).

2.7 Comment on the robustness of the findings

This study had a number of limitations. Despite efforts to ensure that the literature search was as comprehensive as possible, the constrained timeframe in which to complete the study may mean that relevant studies and reports were unintentionally excluded.

The choice of a primarily qualitative methodology, with semi-structured tools, means that the data is not fully standardised and so is less suited for comparisons between sites and countries, and for quantitative analysis. The selective sampling of sites introduces the possibility of selection bias - although the large number of sites visited and people who participated in the research gives strong grounds for confidence in the representativeness and accuracy of the findings.

Additionally, the staggered timeline of the research meant that the research teams began the study one month apart in the two countries, although this difference was less significant than the differences in the stages of outbreak and response that are described in chapter 3.

Finally, there is the possibility of social desirability bias, where respondents tell the interviewer what they think they should say, rather than what they really believe. This is a particular risk in crisis situations where people are looking for financial and other forms of help. To guard against this, the research teams gave introductory information that included explaining that the research brought no financial rewards. Nonetheless the possibility that people answered tactically should be acknowledged.

2.8 Definition of terms

The terms used in this report are often defined in the text by explaining what the informants meant by the use of that particular word. Nonetheless, there are several terms that are frequently used and for which it is helpful to provide a definition up-front, as follows:

- **Children:** Young people aged 18 and under. The CRC defines children as under 18, whereas our research included young people aged 18. Focus groups were with children aged between 12 and 18
- **Adolescents:** Young people under 18 but who are mature enough to take on serious caring roles or work roles in the family home and also outside of the household. Typically in this research, this is children aged 14-18, who would normally be attending school or higher education. WHO defines adolescents as aged 10-19 so here we are adopting a narrower definition (WHO, 2015d). The term youth is used with the same meaning as adolescents.
- **Young people**: Used interchangeably with children to mean any child under 18 years old.
- **Child labour**: The engagement in paid employment by children under the age of 16, the legal minimum age for employment, but also those up to age 18 who would otherwise be engaged in education. It includes arduous physical labour and work that may be harmful to health.
- **Neglect**: A lack of care so that the child is not adequately protected from harm or provided with its basic needs, such as food and shelter.
- **Sexual exploitation:** A situation in which the exploited child engages in sex for food, money or protection.

3 Outbreak and response: international overview

This section provides an overview of the outbreak and the response in Liberia and Sierra Leone. Reference is also made to the situation in Guinea, so that the relevance of findings from the other two affected countries can be considered. The review is largely based on published sources but because of the fast-moving situation it relies heavily on media reports and announcements or updates by the many organisations that are involved in tackling Ebola. The focus of the review is on:

- Identifying features of the outbreak and response that create wider socio-economic impacts
- Understanding the similarities and differences in the outbreak and response between the three countries, so that the relevance of evidence or lessons from one area to other areas can be judged.

3.1 Pattern of outbreak

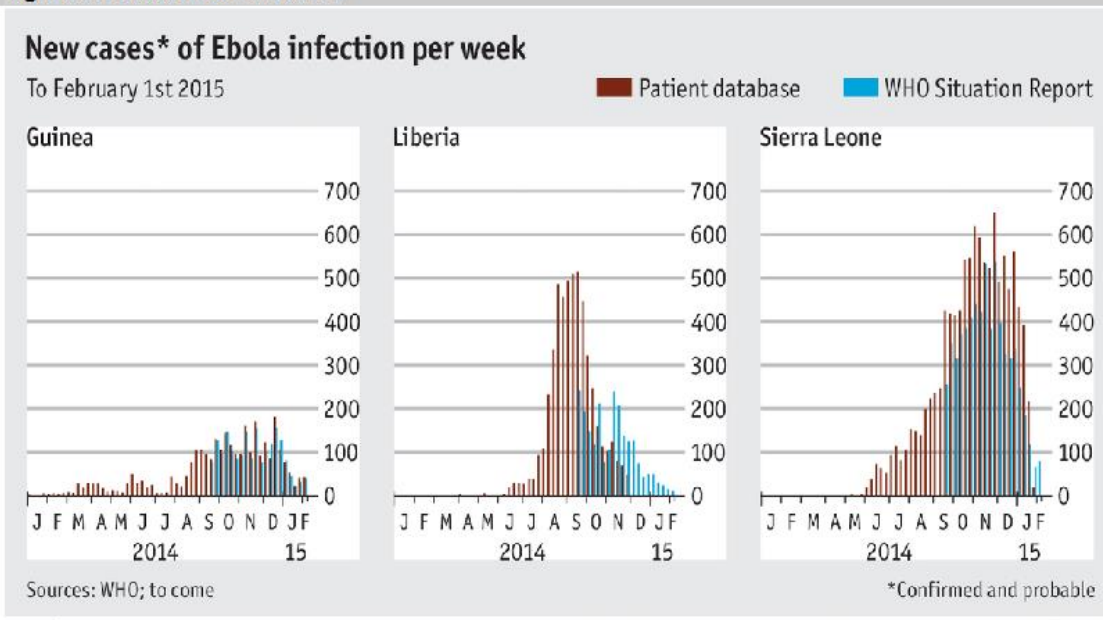
The current outbreak in West Africa began in Guinea in December 2013 and became the most widespread and deadly Ebola epidemic since the virus was first recognised in 1976. Unlike the previous 24 outbreaks, it spread beyond isolated rural villages to urban centres and from country to country; from Guinea to Liberia, Sierra Leone and Mali by cross-border travel and then to Nigeria, Senegal, USA, UK, Spain, Italy, Switzerland, Germany, France, Netherlands and Norway by air travel, including cases where patients received treatment in Europe and the United States. At the same time, an unconnected outbreak occurred in the Democratic Republic of the Congo (WHO, 2014).

In Liberia, Sierra Leone and Guinea the outbreak became widespread and intense, whereas in the other countries it was largely contained and has been declared over. The WHO issued its first report on the Ebola outbreak in March 2014 and declared a public health emergency of international concern in August after the virus had travelled from the countryside to the crowded capital cities of the three most affected countries. As the charts reproduced in Figure 3.1 describe, the severity of the outbreak was different in the three countries, both in terms of the number of people becoming infected and the timing of peak periods in new cases. The graph also shows the considerable uncertainty that exists about actual numbers, with large discrepancies between two official sources of data.

3.1.1 Liberia

The first cases of Ebola were confirmed in Liberia in late March 2014. Despite a confirmed case in the capital city Monrovia in April, the situation in Liberia remained relatively calm,

Figure 3.1 Pattern of new cases



Source: The Economist, Ebola in graphics, February 5 2015

with the outbreak apparently being largely confined to Lofa county in the north, where the virus had crossed from neighbouring Guinea. By the end of June, Liberia reported 51 cases, compared with 390 in Guinea and 158 in Sierra Leone. Following the first confirmed deaths in Monrovia on 17 June, the infection spread rapidly and overwhelmed the government's response capacity. As case numbers grew, Liberia's president closed schools and borders in July and declared a state of emergency on 6 August, 2014.

By September, the country had witnessed nearly 2000 cases, more than 1000 deaths and almost 200 infections among health care workers, the highest number among the three countries (WHO, 2015a). As of 11 February 2015, Liberia has had 8881 confirmed cases and 3,826 confirmed deaths (WHO, 2015b)

3.1.2 Sierra Leone

In Sierra Leone, the outbreak began slowly, building up to a flurry of cases in late May and early June. The first case in the capital, Freetown, was reported on 23 June and then cases increased rapidly in the last quarter of the year. By 15 October, the last district in Sierra Leone untouched by the disease had declared Ebola cases and November saw a dramatic increase in new case numbers (WHO, 2015a).

The outbreak in Sierra Leone also dipped and spiked, albeit later than in Liberia. The May funeral of a traditional healer in a remote village was reportedly responsible for around 365 deaths that were subsequently traced back to that one funeral (WHO, 2015a). Authorities declared a local state of emergency in the affected district of Kailahun and closed schools and businesses, followed by a national state of emergency on 6 August 2014. This did little, however, to stem the rate of infection among Sierra Leone's 6.2 million inhabitants. At the close of 2014, the country's Ministry of Health was reporting

2,435 confirmed Ebola deaths out of 7,458 confirmed cases (Ministry of Health and Sanitation, 2014 and 2015). By 11 February 2015, the WHO put the number of confirmed deaths in Sierra Leone at 3,341. (WHO, 2015a)

3.1.3 Guinea

Guinea, with a population of 11 million people, did not witness the scenes of bodies left in the streets of its capital that played out in Monrovia in September and Freetown in November and December. However, the size of the country along with the population's resistance to assistance posed added challenges to controlling Ebola there. Where the other two affected countries saw sharp rises in transmission, Guinea's outbreak intensified and then petered out several times between April 2014 and the end of the year.

The first cases of Ebola in the West Africa outbreak were confirmed in Guinea in March 2013. By April 2014, reported cases had dropped to zero and health officials thought the outbreak might be over, such that Médecins Sans Frontières (MSF) closed its treatment centre. The virus returned in May and subsequently spread to the capital, with a peak of over 300 cases per week in August and September 2014, said to be caused by people returning from Liberia or from Sierra Leone (MSF, 2014). By late January 2015, Guinea reported only 30 cases per week, a significant decline. On 19 January, the government began its "Zero Ebola in sixty days" campaign and by 11 February, the country had recorded 3,044 cases and 1,995 deaths (WHO, 2015b).

3.2 Impact on health services

As the outbreak evolved, vulnerabilities in the health care systems of the three countries were exposed. Before Ebola, the health systems were already extremely weak. Liberia, for example, had only 50 doctors and about 1000 nurses for 4.3 million people (BBC, 2014a).

Patients with Ebola symptoms were initially admitted to hospitals and other health centres. Without sufficient staff, facilities, triage or infection control capabilities, these services quickly became overwhelmed and closed, or health workers fled (WHO, 2015e). Subsequently, patients presenting with Ebola symptoms found facilities closed or were turned away because of insufficient staff and beds. They returned, infectious, to their homes and communities (WHO, 2015e).

The situation was aggravated by the high death rate amongst health care workers. By January 2015, a total of 830 health worker infections had resulted in 488 deaths in the three countries (WHO, 2015a). An investigation conducted from June to August by the CDC and Liberia's health ministry into the risks for health care workers found that in addition to the closure of health facilities and the loss of other medical services, health care worker deaths also undermined the Ebola response by discouraging people from seeking treatment (CDC, 2014). The report concluded that strengthening infection control

infrastructure was a main priority in order to decrease the transmission rates among health personnel.

From the start of the outbreak, MSF supported local health services with expertise and frontline medical staff. It ran medium scale Ebola Treatment centres in Liberia, Sierra Leone and Guinea, such as the 70-bed treatment centre in Kailahun, Sierra Leone. By July 25, however, as case numbers rose, MSF warned that the virus was “out of control” and reported they could not provide sufficient assistance. (MSF, 2014). By September, the situation facing health services was summed up as follows:

> *"Six months into the worst Ebola epidemic in history, the world is losing the battle to contain it. In West Africa, cases and deaths continue to surge. Riots are breaking out. Isolation centres are overwhelmed. Health workers on the front lines are becoming infected and are dying in shocking numbers. Others have fled in fear, leaving people without care for even the most common illnesses. Entire health systems have crumbled. Ebola treatment centres are reduced to places where people go to die alone, where little more than palliative care is offered. It is impossible to keep up with the sheer number of infected people pouring into facilities. In Sierra Leone, infectious bodies are rotting in the streets." (2 September, Joanne Liu, International President of MSF)*

Recognising that health services were unable to cope and that therefore Ebola patients would inevitably be cared for at home, the WHO and international aid agencies tried to relieve pressure on hospitals and stem secondary transmissions by encouraging care at home through the distribution of thousands of infection prevention and caregivers kits (MSF, 2014).

International health organisations also recognised that patients presenting with other illnesses would be untreated and experts became concerned that non-Ebola related deaths would result. In response, programmes were directed at providing care for other, common diseases such as malaria, outside of the usual health centres. For example, in October 2014, MSF distributed antimalarial drugs to 300,000 people in Monrovia. In early December, health workers in Sierra Leone gave out 1.5 million antimalarial treatments to people and another mass distribution was planned for January (MSF, 2014). Because those suffering from malaria present with the same symptoms as those suffering from Ebola in the early stages, the objective was also to reduce the numbers of malaria patients ending up in Ebola centres.

3.3 Responses: national, international and local

3.3.1 Government emergency measures

In March 2014, Guinea's president declared a national health emergency and instituted strict measures to control the spread of Ebola, including quarantining homes, border control, travel restrictions, and hospitalization for individuals suspected to be infected

until cleared by laboratory results. There was also a ban on transporting the dead between towns (The Tech Times 2014).

Liberia's president announced on July 27 that the country would close its borders but would keep a few crossing points open, such as the airport, where passengers would be screened. The country also took other preventive measures, like closing schools and universities, banning large gatherings like football games, and placing affected areas under quarantine, including West Point, one of the largest slums in Monrovia. In August, the Liberian government ordered corpses of those that died from the Ebola virus disease to be cremated. This highly unpopular order was relaxed in December 2014, when the Government allowed people to return to the practice of burying their dead, albeit with the instruction that bodies should not be touched (CCTV, 2014). Compulsory cremation was said to have led to people refusing to send family members to Ebola treatment centres and burying them at home instead (CCTV, 2014). Unlike Liberia, Sierra Leone did not make cremation compulsory (The Guardian, 2014). All the country's beaches were closed from 29 November, until Liberia is declared free of Ebola (BBC, 2014c).

Sierra Leone declared a state of emergency on August 1 but had already moved to shut its borders for trade with Guinea and Liberia in June. It closed cinemas, nightclubs and some schools in the most affected areas in an attempt to slow the spread of the virus (WHO, 2015a). Quarantines, enforced by the military, were imposed on the areas and households hardest hit. Also in August, the government passed a law imposing a jail sentence of up to two years on anyone found to be hiding a suspected Ebola case.

On 12 December, Sierra Leone banned all public festivities for Christmas or New Year, because of the outbreak (BBC, 2014e). By December (the month when fieldwork for this research was carried out) six districts and around half the total population was "locked down", under strict travel restrictions that prevented people from entering or leaving these districts without special permission (Mail Online, 2014)

Emergency restrictions were lifted at the end of 2014. Sierra Leone declared that it would ease district and chiefdom-level travel restrictions on 23 January 2015, explicitly linking this act to the aim of supporting economic activity (Times Live, 2015).

3.3.2 Closure of schools

Guinea's government announced that schools would reopen across the country on January 19, the same day the country began the "Zero Ebola in 60 days" campaign. This was five months after schools were closed and some eleven months after the first case of Ebola was confirmed.

As in Guinea, Liberian schools did not open in September after the summer holiday. After six months of closure, schools were set to reopen on 2 February, but the government announced a delay until 16 February to enable more than 5,181 schools to be outfitted with protocols and supplies. In preparation for the reopening, UNICEF provided more

than 7,000 school infection prevention and control kits with thermometers, soap, buckets, gloves and chlorine to help teachers, students, community members, and parents keep schools safe. UNICEF is distributing these kits to all 98 school districts across Liberia using barges, helicopters, trucks and other vehicles. (Ministry of Health and Social, 2015). There is concern that students whose parents have lost jobs and livelihoods won't be able to return to fee-paying schools (Ministry of Health and Social, 2015).

Sierra Leone's Ministry of Education announced that schools would reopen on March 30, after an 8-month shutdown. As in the other countries, measures are to be taken to help ensure the schools are a safe environment, checking the temperatures of everyone with thermometers, providing chlorinated water for hand-washing and generally cleaning the buildings (BBC, 2015).

3.3.3 International response

On 18 September, the United Nations Security Council declared the Ebola virus outbreak in the West Africa sub-region a "threat to international peace and security". A large international response began, coordinated by the United Nations Mission for Ebola Emergency Response (UNMEER). In October the Recovery Road Map was produced, with the immediate objectives of isolating at least 70% of cases and safely burying more than 70% of the dead within 60 days.

This led to the construction of a large number of Ebola Treatment Centres (ETCs or ETUs) in the most affected countries in the months of November and December. A 92-bed ETC in Kerry Town, Sierra Leone was opened in early November 2014, the first of six constructed by the British government. (DfID, 2014). In early December, the International Medical Corps opened 50-bed ETUs in two high-outbreak districts to the north of the capital; Lunsar in Port Loko District, and Makeni, the country's fourth largest city (IMC 2015). These were both in districts visited during the research.

From October, the US Government began constructing 17 large (100-bed) ETCs in Liberia, across the worst affected counties. This added to the new Island Clinic ETC in Monrovia (Also a site for the research), opened on 21 September with 120 beds, and the 240 beds already available in Monrovia in centres run by WHO and others (WHO, 2014f). New ETCs were still opening in late December; for example a German government 50-bed ETC opened on 23 December. Specialist services began to appear by the start of the new year, such as the 33-bed treatment unit for pregnant women, opened by MSF in their treatment centre in Kissy, Freetown, opened in January 2015 (MSF, 2015).

By mid-January 2015 it was being reported that ETCs in Liberia and Sierra Leone were being underused, with new case numbers having dropped to around 1 per day just at the time when the largest number of beds had been made available and more were under construction. By January there were seven ETCs in greater Monrovia, mostly completed

after the epidemic had started to decline, indeed newly opened centres were starting to close by February 2015 (The Washington Post, 2015).

Community Care Centres

In response to the shifting nature of the outbreak a network of Community Care Centres (CCCs) began to be established from November onwards. These were also a response to the way in which the larger ETCs were found to be inaccessible to many communities and were also unpopular, because they separated patients from their families. The CCCs were intended to complement ETCs by providing a rapid diagnostic, isolation and referral facility, but they also represented a shift of care back towards communities.

CCCs were promoted as part of a comprehensive and more community-based approach, including isolating patients, contact tracing, organising safe burials, disinfecting contaminated areas, and community mobilisation. MSF attributed this grassroots approach, rather than the large ETCs, as being the main factor in the reduction in case numbers in Liberia from late summer (MSF, 2014c). The first community care centre opened in Liberia in late November 2014, with a further 64 planned (Save the Children, 2014). Sierra Leone also led the way with the construction of some 46 community care centres from November onwards, with the aid of UNICEF, Plan International and others.

One strand of the international response was the development of effective Ebola treatment and vaccination drugs. The decline in case numbers has made trials impossible. For example, the trial of the drug brincidofovir in Liberia was halted in January 2015 (MSF, 2015b). Looking ahead to possible future outbreaks, the significance of this is that there is still no established cure for Ebola or vaccination against it.

3.3.4 Community level responses

Distrust and resistance

In all three countries, communities initially showed a high level of distrust in the information on Ebola provided by governments and NGOs, and resistance to infection control measures. This diminished in time but remained an issue, especially in Guinea.

Community resistance led to fatal encounters with security forces and health workers in all three countries:

- On 27 August, Liberian troops opened fire on protesters in the quarantined community of West Point, Monrovia, killing a 15 year old boy (New York Times, 2014)
- On 18 September, 8 members of a health team were killed by residents of Wome, in Guinea. The previous month saw rioting in the regional capital of Nzerekore, where it was reported that locals believed health workers spraying a market were spreading the disease (BBC, 2014f)

- On 22 October two protesters in Sierra Leone's Kona district were reportedly shot dead by police during a riot provoked when health teams tried to remove the bodies of suspected Ebola cases (Reuters, 2014)

Less dramatic but more prevalent was the reported reluctance amongst communities to receive and act upon the Ebola prevention messages communicated by governments and NGOs. This problem greatly diminished during the height of the outbreak in Liberia and Sierra Leone, when the danger of Ebola became evident to people in almost all areas of the countries. However, the latest situation report from the WHO describes an ongoing problem: "*engaging effectively with communities continues to present a challenge in several areas. Each of the three countries reported an increase in security incidents related to the Ebola response compared with the previous week*" (WHO, 2015b). Security incidents refer to breaches of infection control procedures, unsafe burials, failure to report sicknesses and death to the authorities, and non-cooperation with contact tracing.

The explanations for non-cooperation reported usually involve rumours and false information, or the reluctance to abandon traditional burial practices. They include:

- Fear that the government wants to sell the blood of Ebola patients, or that it will remove patients' limbs for ritual purposes.
- Fear that health workers are injecting them with Ebola or spreading it with disinfectant sprays
- Fear that the virus is an invention by government so that it can profit from foreign donations.

As the last point indicates, the lack of trust is related to a history of corruption and mis-governance (The Economist, 2014).

Acceptance and Action

By the end of 2014, media reports were describing a widespread effort by communities to defend themselves against the virus and to stop the spread of infection. In Liberia, educated youth have worked with community elders to form their own neighbourhood watchdog groups; quarantining infected households and restricting visitors to and from their communities. People adapted their own protective clothing from plastic bags and other materials so they could care for the sick with less risk. In Sierra Leone it was reported in the new year that similar community-protection arrangements were being put in place and that government leaders and traditional leaders had cooperated to make bylaws forbidding communities from hiding those who were sick, obstructing health workers or carrying out traditional burials. These local actions were being credited with having a great effect on the reduction in case numbers (New York Times, 2015).

3.4 The wider impacts of Ebola and the response to the outbreak

A broad overview of the wider impacts of Ebola noted in the press and in early studies is given below. More specific references are made in the subsequent chapters on research findings, to place the results from fieldwork in the context of information from other sources.

3.4.1 Impact on children

An interagency response plan on child protection and education, led by UNICEF and Save the Children, identified five issues of particular concern (GEC, 2014):

i. Unaccompanied and separated children: loss of caregivers due to death of parents, being sent to relatives in less affected areas or out of fear of contamination.

ii. Mental health and psychosocial distress: due to fear, bereavement and loss of support.

iii. Lack of education and development opportunities: Due to closure of schools and confinement of children in homes.

iv. Child work and child labour: as a result of children having to earn income in hazardous ways.

v. Exclusion: discrimination through the stigmatisation surrounding Ebola.

At the time of fieldwork for this research, the situation of orphans from Ebola was dominating media coverage of the impact on children but the information was based on estimates and projections. Concern was expressed at the possibility that thousands of orphans would be rejected by relatives and communities afraid of contracting Ebola, expressed in headlines such as “thousands of orphans shunned” (BBC, 2014g). By 2015, a more informed picture was starting to emerge, with UNICEF suggesting that less than 97% of Ebola orphans were being cared for by relatives or other community members. UNICEF’s January estimate for the number of orphans in the three countries was nearly 3,600 children who had lost both parents to Ebola and 16,600 registered as having lost at least one parent (UNICEF, 2015).

The closure of schools and the loss of education also received considerable press coverage, but as with the situation with orphans there has been a lack of reliable information with which to judge impacts. The Global Partnership for Education estimated that across the three countries, 100,000 schools did not open after the 2014 summer holidays, leaving more than 2 million children out of education (no figures were found for higher education establishments). The already weak education and school systems in these countries was highlighted, meaning that the gains being made in children’s

education before Ebola were in danger of being set back, and meaning that the education system was poorly prepared to cope with such a crisis, so may recover with added difficulty. Efforts by Liberia and Sierra Leone to provide alternative classes via radio were recognised, as was the variable quality of these programmes (GPE, 2014).

In general, information from published sources on the impact on children from 2014 is very limited and largely based on estimates, rather than empirical data.

3.4.2 Impacts on economic activity and food security

The financial costs of the Ebola outbreak for Liberia, Sierra Leone and Guinea were estimated at over $113 million for 2014, plus a further $359 million from economic activity forgone because of Ebola in 2014, followed by a further $1.6 billion in 2015. The effect of this on the economies of the three countries was described as "crippling" (World Bank, 2014, 2015). Studies vary in their estimates of which country has been worst affected economically: however, all agree that Guinea has been least affected, because of its larger size and the more limited spread (and scale) of the outbreak.

The consequences for households were an increase in prices, most seriously of food, and a reduction in employment. A telephone-based household survey in Liberia in October 2014 found that around half of the Liberian population was out of work. Salaried employment was halved and those who were self-employed in the informal economy – a large majority of the population – were hardest hit, largely as a result of the closure of markets (LISGIS, 2014). The government of Sierra Leone announced a 30% deflation of the national economy in August 2014 and identified the agricultural sector as the most affected, the majority of the working population being farmers. The likelihood of food shortages, increased prices and future food insecurity as a result of farmland becoming abandoned was predicted (BBC, 2014c).

A study of the socio-economic impacts in all three countries conducted by the UNDP, using economic modelling, concluded that: "*The Ebola epidemic has been a social catastrophe of vast dimensions.*" Whilst acknowledging that reliable measurements of this impact were largely missing, the study makes a number of observations. Coping strategies were noted such as the sale of assets, eating less and consuming less, as was a drastic reduction in the uptake of health and education services (with the widespread closure of health facilities and schools). It suggests that the epidemic had a disproportionate effect on women, because they make up the majority of local traders and producers of food. The study did not identify significant socio-economic differences between the three countries, although it did conclude that rural areas, isolated from health care and other services and cut off from centralised food supplies, were particularly vulnerable (UNDP, 2014)

Concerns over food insecurity led, in October, to the World Food programme in Sierra Leone, with help from the World Bank, delivering food to more than 1.7 million in the

three most affected countries, targeting those receiving treatment or in isolation (WFP, 2014)

3.5 Country differences in the outbreak and response

The three countries share similar socio-economic characteristics. They are all least developed countries, recovering from armed conflict, with relatively weak health and other services. Yet as the brief review above shows, there are some substantial differences in both the outbreak and response:

- The timing and severity of the spread of the virus has been different, with Sierra Leone experiencing the greatest peak in cases several months after Liberia, and with Guinea experiencing a longer, ongoing outbreak but at a relatively low level.
- The strictness of infection control measures has been varied and apparently most strict in Sierra Leone in terms of the quarantining of large areas.
- The pace and extent to which communities have accepted Ebola information and changed their behaviour in response has been varied, with Guinean communities appearing to be particularly reluctant to change.

Yet published sources neither discuss nor reveal substantial differences. There is the broad finding that Guinea is less affected economically, but this tells us little about the consequences for those people and places in Guinea who have been affected seriously by the virus. It is noticeable that reporting, and especially research, from the three countries is quite uneven. Coverage in the UK is strongly biased towards Sierra Leone. The situation in Liberia is well covered through a combination of USA and UK media and development organisations, and by the UN organisations. The coverage of Guinea by contrast is relatively thin. This is not just a language issue; for example, MSF's French-language sources do not reveal more or offset the predominance of Sierra Leone and Liberia information in their English-language reports. Given some potentially important differences, such as the greater community resistance reported from Guinea, this is a matter to be addressed by organisations with an interest in the recovery from Ebola.

The review helps to place the fieldwork conducted for this research, in Liberia in November and Sierra Leone in December, into context and to anchor it, time-wise, within the ebb and flow of the outbreak and response. In summary, the fieldwork took place:

- **Before** the large scale construction of Ebola treatment centres had been completed and had taken effect in Liberia.
- **Before** effective community-led infection control measures were becoming established in Liberia, but also Sierra Leone to come extent
- **During** the time when schools were closed in all countries and had been closed for three to four months.
- **During** the peak of the outbreak in Sierra Leone. The outbreak peaked in November/December and fieldwork took place in early December.

- **After** the peak of the outbreak in Liberia, which occurred around August/September whereas fieldwork happened in November.
- **After** the initial denial and resistance by communities had been replaced (largely) by acceptance of the reality of Ebola and their cooperation in enforcing infection control measures.

Part II. Impacts on children, families and communities

4 Health and survival

The Declaration of Alma-Ata affirms that health is a fundamental human right, stating that health should not only be defined as the absence of disease, but also needs to consider social well-being (WHO, 1978). Subsequent human rights standards have drawn on this approach, including the People's Charter for Health (PHM, 2000). A child's right to health, as stated in the UN Convention on the Rights of the Child, is a broad right covering not only access to effective health services, but also the right to grow and live in conditions that enable attainment of the highest standards of mental and physical health (UNCRC, 1989). This includes the environment in which children live and grow, comprising the nutrition they receive from their food intake, their education, access to water and sanitation, and supportive family and community systems.

The direct health impact on children and adults who contract Ebola is well documented; this study describes the indirect effects upon a much larger population who, even without having contracted Ebola, have their health and survival put at risk. In this chapter, the research illustrates the serious effects of the outbreak on health services, including maternal and child health services, malaria and routine healthcare and disease prevention. Later chapters of the report detail the impact of the Ebola outbreak on the underlying determinants of health including food security, education, livelihoods and community cohesion.

In interpreting the child's right to health in the UNCRC, the UN Committee on the Rights of the Child has emphasised the need to eliminate discrimination and exclusion from health, particularly gender-based discrimination and the exclusion of those in poverty (UNCRC, 2003). The Committee recognises the particular importance of mothers, whose health and role, with other carers, is crucial in a child's early development and hence future prospects. The concerns of the Committee in relation to mothers and the right to health have materialised in Liberia and Sierra Leone as a result of the outbreak, as this research confirms. There are, consequently, issues that need to be addressed in the response and recovery phases. The findings that follow also need to be seen in the context of precarious health services in both countries, even before the outbreak occurred (Edelstein, Angelides & Heymann, 2015).

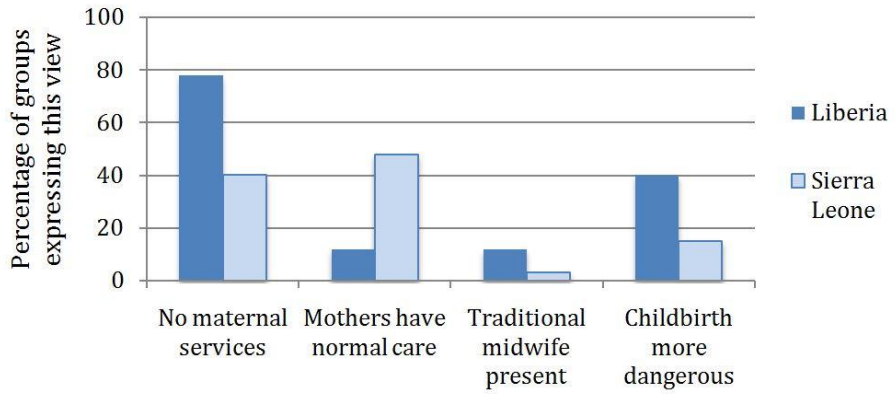
4.1 Maternal and infant health services

Infant and maternal mortality was already high in both Liberia and Sierra Leone, falling short of Millennium Development Goal targets. Infant mortality rates were 182 deaths per 1,000 births in Sierra Leone and 75 deaths per 1,000 births in Liberia. Prior to Ebola, maternal mortality was particularly high at 890 (Sierra Leone) and 770 (Liberia) mothers dying for every 100,000 births. Before the Ebola outbreak, 46% of births in Liberia were

attended by skilled health workers, while in Sierra Leone 60% of births were attended by skilled health workers (WHO, 2014b and WHO 2014c). A recent UN study has estimated that 120,000 women in Liberia, Guinea and Sierra Leone could die of complications if emergency obstetric care is unavailable (UNFPA, 2014). In the majority of the research sites in Liberia, and in just less than half of those in Sierra Leone, the figure for births attended by skilled health workers had fallen to zero, according to the groups consulted. This has immediate implications for the health and survival of mothers and babies and potential implications for infant and maternal mortality rates.

Even before birth, children are placed at grave risk by Ebola. Published sources describe a near 100% mortality rate amongst pregnant mothers in Ebola care centres in all of the most affected countries (MSF, 2014). This research finds that the health of a much larger number of non-infected mothers and babies was also put at risk by the widespread closure of clinics and hospitals.

Figure 4.1: Maternal services: Views of adults



Source: Adults focus groups (n=60 in Liberia and n=40 in Sierra Leone.)

The scale of this problem is illustrated by Figure 4.1. The graph shows the percentage of all adult groups who took part in the research, in each country, who expressed these particular views. In Liberia, a large majority of the adults consulted said that the maternal services that existed before Ebola were no longer available. Usual (pre-Ebola) maternal care was said to be available by only 11% of the groups consulted in Liberia (seven of the 60 groups visited), in sites where clinics had remained open or health workers were willing to attend mothers and babies outside of the clinic. In Sierra Leone the proportion of communities who said that mothers had access to routine maternal services was higher, because more clinics and hospitals were open. The reason for this is mainly due to timing: when fieldwork was carried out in Sierra Leone (December), there had already been a concerted push by Government to re-open clinics. Communities described how, two months earlier, all clinics and hospitals were closed to all but Ebola patients and hence mothers were in a similar situation as that encountered in Liberia in November.

Prior to the Ebola outbreak, less than half of all births in Liberia's rural regions were attended by a skilled birth attendant (who is typically without formal medical training) (Lori & Starke, 2012). In Sierra Leone in 2008, this figure was reported to be at 42 % of births (Oyerinde et al, 2013). According to the communities that participated in the research, during the Ebola outbreak, traditional midwives played a role in supporting mothers and pregnant women, but only in a minor way in Liberia and scarcely at all in Sierra Leone. In Liberia, traditional midwives, like other health professionals, were avoiding attending to patients out of fear of contracting Ebola. In Sierra Leone, maternal services were being provided exclusively by the government hospitals and clinics and expectant mothers were encouraged to attend.

The reduction and/or closure of maternal health services in both countries, initially by order of the state and then through the reported reluctance of health practitioners to treat patients, denied mothers the maternal services that they benefitted from before the outbreak during most of the period of the epidemic. The Liberian communities that participated in the research described women giving birth at home, outside closed clinics and elsewhere, and they gave examples of complications and consequent deaths of infants and mothers.

> *The closing of hospitals and clinics is making it difficult for pregnant women to give birth and also killing some of them, while others have given birth in the street in search of a hospital. Mothers are still breast feeding their children but they are always hungry (Mother, Bushrod Island, Liberia 20 November)*

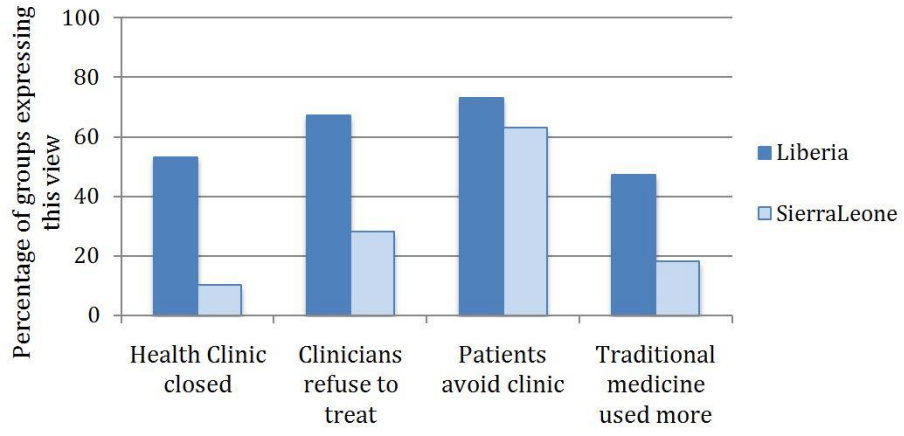
4.2 Treatment for routine illnesses

Evidence from the research suggests that the treatment of routine sicknesses and injuries has significantly diminished. Reports indicated that children and adults were denied routine treatment by the closure of medical facilities. This was compounded by the loss of medical workers, through death and reported refusal to come to work or refusal to treat patients. It was further compounded by the reluctance of people to visit clinics or hospitals. In addition, the ability of families to provide the care for routine illnesses that they would ordinarily provide at home was diminished as a result of the Ebola outbreak.

4.2.1 The use and availability of health services

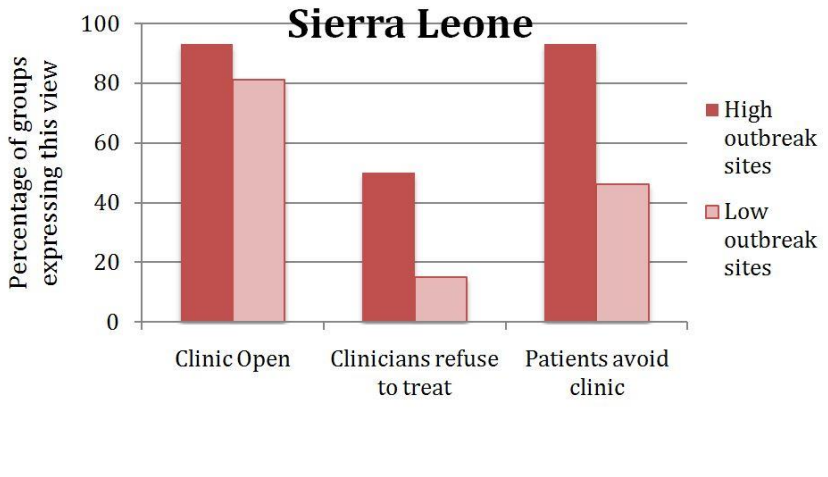
A large majority of those interviewed for this research reported that health services were unavailable to them as a result of the Ebola outbreak, suggesting this occurrence was widespread across Ebola affected areas (Figure 4.2). In Sierra Leone, far fewer clinics were said to be closed and fewer health workers were reported to be refusing to see patients, compared to Liberia.

Figure 4.2 Availability and use of health services



The exact combination of reasons provided for why health services were unavailable varied from country to country and site to site: most people in both countries stated that they were without health services either because the clinics were closed or because communities were unwilling to attend.

Figure 4.3 Access to health services in high and low outbreak areas



Source: Adult focus groups (14 of the 40 adult groups were in high-outbreak areas)

4.2.1.1 Reluctance to attend health services

In both countries, most communities reported that people who were ill were avoiding health centres. This was particularly so in areas with a high incidence of Ebola. In Sierra Leone, 14 of the 40 sites we visited had a relatively high level of outbreak. In these, nearly all (93%) of the groups said that they were avoiding clinics (Figure 4.3). The equivalent figure from the low outbreak sites was 46%. In Liberia, 79% of the groups in high outbreak sites said people were avoiding clinics, 69% in low outbreak sites. These findings suggest that only a minority of Ebola patients are being cared for in proper health care facilities, and illnesses are being diagnosed and treated at home (including Ebola cases,

potentially). This is in line with published sources, which estimate that case numbers of Ebola and other diseases are heavily under-reported (MSF, 2014_b).

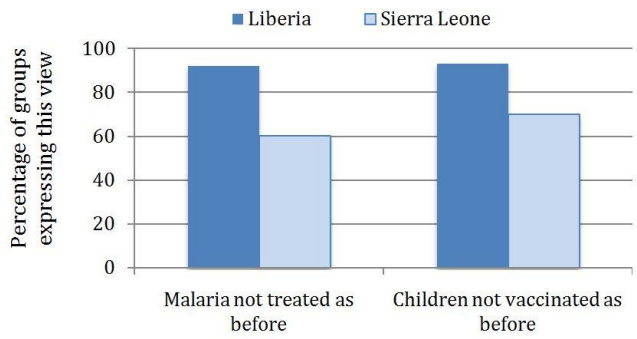
The main reasons given for why people were reluctant to visit clinics or hospitals, was that all sicknesses were treated by medical staff as potential Ebola cases. People described how a fever of any sort, even a headache, would be assumed to be a symptom of Ebola and the patient promptly quarantined for a minimum of 21 days.

> *Now if you are sick our parents treat us at home because they said the doctors will say that you are Ebola patient. In fact all clinics and hospitals are closed and all the doctors do not treat any patients because they too are afraid. (Child, Saclapea, Liberia, 22 November)*

The fact that the early symptoms of Ebola are similar to other illnesses such as malaria and cholera explains why health care workers (and members of the community) were cautious. Thus the lack of an effective diagnostic for Ebola meant quarantining was applied to all, whatever their ailment. Obviously, for nursing mothers or any parent of dependent children, for workers living hand-to-mouth and for adults and children in general, the prospect of detainment for 21 days was something they wished to avoid. This is particularly so when confinement in a health centre was widely considered to be a 'death sentence' - not simply a major inconvenience. There was a common view amongst adults and children that they would contract Ebola if they visited a health centre. It should be noted that this study did not speak with medical professionals, and therefore the findings should be regarded as only reflective of the views of community members.

4.2.1.2 The effect of a loss of health services on routine illnesses and treatment

Figure 4.4 Malaria treatment and vaccinations



Source: Adult focus groups (n=60 Liberia; n=40 Sierra Leone)

The longer term consequences of the loss of health services (and community reluctance to visit them) are sharply illustrated in the case of vaccinations. According to national health statistics, in Sierra Leone, 84% of infants were vaccinated before Ebola and in Liberia this figure was 77% (WHO, 2014c and 2014b). As a result of the outbreak, vaccination programmes appear to have come to almost a complete stop in the areas of Liberia included within the study. The situation in Sierra Leone is better, but still 70% of communities say that children are no longer being vaccinated as they were before the outbreak (Figure 4.4). This represents a complete reversal of the level of vaccinations achieved pre-Ebola: these findings are supported by a recent article in the Lancet by Edelstein, Angelides & Heymann (2015) detailing vaccination coverage in the affected

countries. The finding suggests that the Ebola outbreak may have serious long-term consequences for public health.

> *Children are not vaccinated like before. We all are afraid to take our children to any clinic. Health workers are not going around giving vaccine because of Ebola. (Male carer, Jarzon, Liberia, 27 November)*

When asked about who was most vulnerable because of the outbreak, the focus groups in both countries frequently mentioned that the elderly, disabled and long-term sick lost their access to health care when clinics closed and were also less likely to be cared for at home because of the fear amongst community members of touching others, especially when ill.

> *"If Ebola could affect people with eye sight, what about blind boys like me? If I am not mistaken, I am the worst affected person. I survive from the remnants of the sighted people." (Joseph, Boy, Konta, Sierra Leone, 10 December))*

The closure of health facilities and the reluctance of communities to seek out health services has meant that routine sicknesses such as malaria are treated at home, or are left untreated. This was the case amongst almost all of the Liberian communities visited. The situation was less dramatic in Sierra Leone, because more communities had access to a clinic and those in less affected areas were willing to seek treatment (Figure 4.3). Nonetheless, more than half of the Sierra Leone communities interviewed said that malaria was no longer being treated as it was prior to the Ebola outbreak. Malaria was a leading cause of infant (and adult) mortality in both countries prior to the outbreak: for example, it accounts for more than a third of all out-patient visits and in-patient deaths in Liberia (WHO, 2014_d). In published sources, the prediction of health experts is that the additional death toll from malaria and other endemic diseases is likely to exceed the number of deaths from Ebola (BBC, 2014). This research supports such predictions, based on the large extent to which communities have lost their access to health services.

> *I totally believe that most of the deaths of people in this community is not by Ebola but other sicknesses. Because of the fear of Ebola people were left to die. (Male carer, Daru Town, Sierra Leone, December 8)*

4.2.2 The ability of families to provide care has been diminished

Given the weak health services that existed in Liberia and Sierra Leone before the Ebola outbreak, people were used to treating illnesses such as malaria at home. However, Ebola diminished the capacity of families to provide such care, as the closure of public health centres cut off supplies of free medicine and so people were forced to turn to private clinics and drug stores instead. Groups in Liberia explained that medicines had become unaffordable as prices rose and household incomes dropped.

A few clinics are open but they are private clinics so if we don't have money we can't go there. (Mother, Johnsonville, Montserrado, 14 November)

Some communities reported that they had turned to traditional medicines. They explained that although the use of traditional healers to prepare or administer treatments had stopped, out of fear of Ebola on the part of both patients and healers, the use of herbal remedies continued. This finding clearly exemplifies the dilemma faced by carers. Communities reported that, whilst they were aware of the warnings against traditional medicine, they had no alternative but to use it (government health officials in both countries have warned against treatment by traditional healers, but the research did not find an official message against such medicines). In some communities, adults explained that traditional medicine was their main cure, because other medicines for routine illnesses were not available. Given that the popular Ebola prevention messages included "There is no cure for Ebola", it is perhaps not surprising that a substantial proportion of people turned away from health services and looked instead to traditional medicines to cure or prevent Ebola itself.

In Sierra Leone, adults in the communities interviewed explained that traditional medicine had been banned by government, and that this was reinforced by the community with a system of fines; 200,000 Leone for those found using traditional medicines and 500,000 Leone for traditional healers caught practicing their craft (approximately £30 and £80 GBP respectively). Despite this, almost a fifth of the communities in Sierra Leone said that use of traditional medicines had increased. In Liberia, this proportion was higher (47%). It is worth noting that this is not a behaviour that is found just in rural sites; the proportion of urban and rural sites where adults said they were home-treating with traditional medicines was similar in both countries. The issue of traditional medicine use is important because of what it reveals about people's understanding or adoption of Ebola prevention messages, and as an example of how poverty and the shut-down of government-run medical services pushes people towards alternative solutions for managing routine illnesses.

The overall impact of the loss of care in health facilities is likely to be an increase in health spending for families and an increase in sickness, morbidity and mortality amongst children and adults unable to access or afford care.

4.3 Stigma and segregation of quarantined households

There is a complete rejection for any family member who falls sick of any kind. No compassion for sick persons any more, they immediately become an outcast. (Mother, Ganta, Liberia, 11 November)

The communities interviewed described how the lack of medical services and proper isolation facilities forced them to adopt the crudest of isolation measures for community members suspected of having Ebola. In effect, suspected cases were isolated and often

left to die. This applied to anyone expressing any symptoms, as well as to all their family members. Sometimes whole communities were isolated. Just as clinics treated every illness as a suspected Ebola case, communities did the same and were even more rigorous in their isolation of the sick.

> *We normally help to care for sick people by sponge-bathing them, feeding and giving them medications. But since the Ebola outbreak, sick people are only encouraged by words; telling them to take their medications and to eat some food by themselves (Mother, Solo Town, Liberia, November 28)*

Those isolated in their homes were said to often lack adequate clean water, food, shelter or care. Parents or carers reported that they avoided touching or coming close to their sick children or relatives. Their accounts included extreme examples of families being boarded up in their houses without food or water, and communities being divided into Ebola and non-Ebola sections, with suspects being denied access to the village well and other facilities. For example, adults from 'high-outbreak' sites in Liberia; Ganta in Nimba and Guie Town in Bomi, described how suspected families had been enclosed in their houses without adequate food or water.

> *People are quickly quarantine in their house when any member of their family show sign of any sickness. In some cases the doors and windows are sealed up by community authorities with nails and hammers. These people will stay in there with little or no food for days. Most people in this community died in that situation. Some of their children were later taken to the ETU and some survive. (Parent, Ganta, Nimba, 20 November)*

> *Children and adults that are suspected of Ebola are treated badly by community members. Less attention is given to them, sometimes they lock door on them without food and drinking water for a week, causing death. (Female carer, Guie Town, Bomi, 19 November)*

Adults in Scalapea, in Nimba county, described how a nearby refugee camp was quarantined for 21 days after 2 people there died of Ebola (after returning from Monrovia). The town authorities then decided to isolate the camp for a further 10 days, causing great hardship amongst the confined population.

The stories from Sierra Leone were less extreme, although enforced isolation and stigmatisation happened, as illustrated by a quote from a boy in Masongbo.

> *I was quarantined in a home where four people died. When we were released, my own friends avoided me until the sensitisation team came and explained to the community about the way to treat survivors (Boy, Masongbo, Sierra Leone, 7 December.)*

The adults in Sierra Leone that we interviewed were much more likely than those in Liberia to say that Ebola suspects were not stigmatised or maltreated. They had clearly received the non-discrimination messages being put about by "sensitisation teams" and accepted this as the way in which they should behave, although the examples ongoing discrimination that they gave suggested that stigmatisation remained.

The dramatic examples of abandonment from Liberia make a more general point: suspected cases, individuals, families and communities were at real risk of being isolated in a way that denied them their basic needs. This finding corresponds to media reports of instances in both Liberia and Sierra Leone when people broke out of quarantine in order to obtain food (Telegraph, 2014).

A second point that can be taken from the findings of the study is that the case-identification and contact-tracing systems of the Ebola response were weak. Especially in Liberia, but also in Sierra Leone, sick people were being isolated in their homes, apparently without the knowledge of the authorities.

> *People are now hiding their sickness because when they are taken to government Ebola centres they will die (Community Leader, Montserrado, Liberia, 15 November)*

4.4 Attitude to health services and Ebola prevention messages

Discussions around traditional medicines revealed much about the receptiveness of adults to Ebola prevention messages. Communities interviewed tended to respond initially by explaining that traditional medicine is banned. Follow-up questions with the research respondents then revealed that they were still being used and communities explained this by referring to the non-availability and high cost of modern medicines. This suggests that prevention messages are reaching communities and being understood but without proper health care services in place, people are often ignoring the messages.

Acceptance of prevention messages, however, requires a level of trust in those delivering such messages and trust in government health services was low in both countries (IRIN, 2014). This can be seen in the high proportion of communities who reported that they are avoiding using clinics (73% in Liberia and 63% is Sierra Leone, see Figure 4.2). This mistrust in government and government services has been noted in published sources and related to a history of corruption, incompetence and civil conflict (IRIN, 2014). Whilst Liberian communities who participated in this research were united in their criticism of the health services, communities in Sierra Leone had less negative attitudes towards health services. The governments of both countries had instructed hospitals and clinics to re-open around the same time, in August-September 2014. This had been more effective in Sierra Leone (hence the higher proportion of groups saying that clinics were open) and communities appear to have played an important role by asserting their own rules about sick people and even pregnant women having to report to health services.

> *There is a law in this village that all deliveries should be done in the health centre. Any woman who delivers out of the health centre is fined some amount of money. (Mens group, Yambana, Sierra Leone, 12 December)*

> *The chief and counsellor have passed a law that whoever is sick should go to the hospital for treatment and no traditional healer should harbour a sick person in their homes. (Women, Makeni Town, Sierra Leone, 8 December)*

Another indicator of mistrust in health services is the spread of rumours about vaccinations causing Ebola. Several communities in both countries stated that they would not allow their children to be vaccinated because they believed it was a way to spread Ebola.

The crucial point from the findings in Sierra Leone is that trust can be rebuilt with communities to the extent that they accept health messages and then take their own action to implement these. In Sierra Leone, communities appear to have been further advanced in both accepting and acting upon guidance from government. A key factor in this, the research finds, is the attitude and role of local leaders. To a great extent, it is they, rather than government health officials or NGOs, who determine whether a community responds to health messages or not. More is said on the importance of community leaders in a later section on community cohesion (section 9).

One health message that has been interpreted in a variety of ways by communities regards breastfeeding. The Ebola virus has been detected in breastmilk and close contact with an ill mother can increase an infant's risk of catching the virus (CDC, 2015); consequently, mothers who are probable or confirmed cases of Ebola are advised to weigh the possibility of passing on the virus to their children against the risk of malnutrition and diarrhoeal disease. According to the communities we consulted, breastfeeding practices appear to have remained largely unaffected. In both countries, most groups did not even raise it as an issue but when they did they mostly said there had been no change (22 groups in Liberia and 8 groups in Sierra Leone said there had been no change). In exception to this general pattern, in Foya and Barkedu, high outbreak sites in Lofa county, northern Liberia, mothers said that they were now afraid to breastfeed. They referred to the health advice that mothers with Ebola should avoid breastfeeding for 3 months and said that Ebola survivors were doing this. In addition, in Barkedu communities reported that suspect cases who returned from isolation were avoiding breastfeeding. Interestingly, eight of the 60 adult groups consulted in Liberia said there was a difference in breastfeeding practices, in that mothers now take more care to clean their breasts before feeding. While there is no evidence to show that washing breasts before breastfeeding is beneficial, it nevertheless indicates that communities have taken on board health messaging around Ebola, hygiene, and sanitation measures.

4.5 Key points on health

As stated by the World Health Organisation, well-functioning health systems respond to a population's needs and expectations by:

Improving the health status of individuals, families and communities

Defending the population against what threatens its health

Protecting people against the financial consequences of ill-health

Providing equitable access to people-centred care

Making it possible for people to participate in decisions affecting their health and health system. (WHO, 2010)

Clearly, Ebola has caused a sharp move in the opposite direction. The right to life, survival and development is challenged on a large scale by the loss of parents' and the state's capacity to combat diseases such as malaria and provide preventative care. The obligation on the state to reduce child mortality cannot be met when there is a widespread closure of facilities or a widespread fear amongst the population of visiting those facilities. Communities have little choice or input in the implementation of quarantine and isolation measures. Families have been forced to turn to expensive private medicine for routine illnesses.

At first glance, the health impacts of Ebola on the non-infected population appear to be universal because the loss of health services and the diminished capacity for home care affects all or most children and families. However, exclusion due to stigma heightens the vulnerability of children who have the disease as well as those who don't. Fear of Ebola in communities means that suspected cases, children of suspected families, or even children who present common symptoms such as fever and diarrhoea are stigmatised. The reportedly harsh treatment of suspected Ebola cases *by communities* (emphasis added), to the extent that individuals and families face death from a lack of basic needs, illustrates how exclusion can in some cases be elevated to a loss of liberty and threat to survival.

Communities' response to the threat of Ebola brings compounded and intersecting vulnerabilities into sharp focus: the wider health impacts of Ebola particularly affect poorer families, because they are less able to afford medicines, care or preventative materials. They are more reliant on traditional medicine, with attendant health risks. This highlights the broader social and development implications of the outbreak: a lack of functioning health systems and high levels of mistrust in the government following decades of civil strife has resulted in a low level of resilience to a deadly disease.

Health Impacts: summary	
Immediate impacts	***Possible long term consequences***
• Babies and mothers are placed at risk by the loss of maternal health services. • Vaccination programmes have been halted and parents distrust inoculations because of rumoured links with Ebola, • Malaria and other routine but serious ailments are no longer treated. • Health care at home is compromised by fear of contact and lack of medicines. • Elderly, disabled and long-term sick lose health care due to a fear of contact, especially with suspected cases of Ebola. • People diagnose and treat themselves at home, therefore Ebola cases are not isolated and do not come to light until the sickness is well advanced; • Lack of free medication forces people to turn to traditional medicines or to expensive private medicine. • Trust in health services and health messages is undermined.	• An increase in maternal and neo-natal mortality • An increase in the numbers of cases of measles and other infectious diseases • Long-term health of children and adults may be compromised by a loss of treatment for malaria, TB and HIV. • An increase in health spending for families, pushing more families into poverty.
Priorities for intervention: • Investment in and restoration of maternal health services. • Rapid screening and development of a rapid test for Ebola. • Investment in and restoration of vaccination programmes. • Reconsideration of the methods of preventative messaging, including ensuring that local leaders consulted are those trusted by the communities. • Better investment in and design of emergency health responses to allow for acceptable and appropriate quarantine areas, for example, that allow communities to communicate with family members in quarantine. • Investment in health services with a view to withstanding future epidemics and improving population health, taking a health-systems approach that encompasses the key determinants of health.	

5 Food security

The children and adults interviewed in both countries described scarcity of food and the high price of food. They confirm that what started as a health emergency quickly became a food security emergency, with consequences for a range of different child rights and development issues.

The children interviewed frequently said that they did not have enough to eat. They talked about being hungry, eating less and eating fewer meals. They were specific in describing the reduction in the number of cups of rice their family were eating per day and described how they were no longer eating meat, fruits or other quality foods that they enjoyed before Ebola. As put by a number of participants, they were 'eating for survival'.

> *We are starving; we don't have enough to eat. (Girl, Kissy ByePass, Sierra Leone, 8 December)*

5.1 Food availability and prices

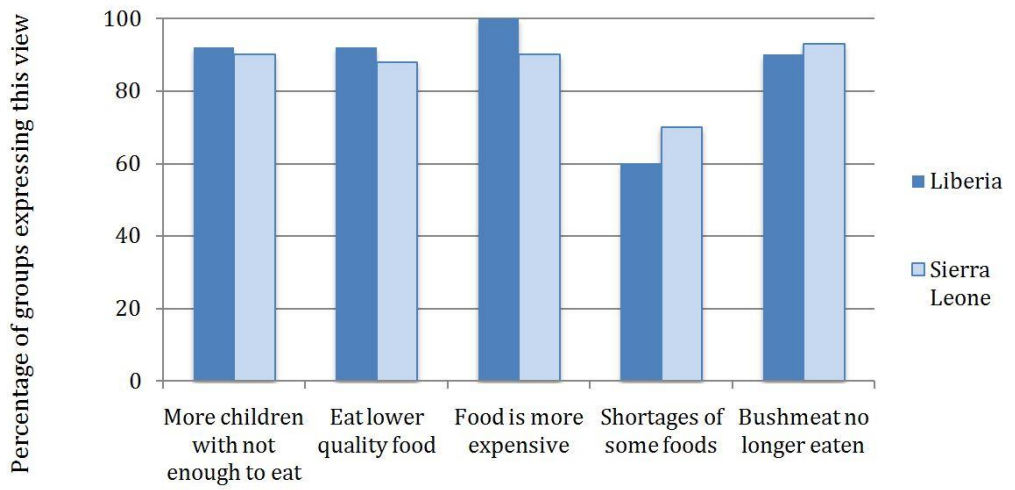
Children interviewed in both Liberia and Sierra Leone explained that they were hungry because parents were unable to obtain or afford sufficient food. The adults explained that there was a shortage of food staples such as rice, cassava, and basic ingredients such as pepper. They described how this was a result of the closure of markets, the quarantining of districts and neighbourhoods and the closure of borders with neighbouring countries to prevent the spread of Ebola. These restrictions were imposed by the authorities, but were also self-imposed as communities themselves tried to minimise contact with others.

> *The nearest market for now is 16 miles away. We walk on foot to Makeni, but how much can one buy to be going and coming for 32 miles? (Father, Konta, Sierra Leone, 10 December)*

Whilst most food shortages were an unintended consequence of the restrictions placed on people's movements, there was a specific ban on the sale and consumption of bushmeat, imposed by governments in both countries (ACF, 2014). The research confirmed that, indeed, the large majority of communities were no longer eating bushmeat (see figure 5.1). For a substantial part of the population, certainly the majority in forested areas, this meant the loss of their main source of protein. However, despite people's awareness of the ban and the link between wild animals and Ebola, in five of the forty research sites there were accounts of bushmeat still being eaten. Three of these were rural (Majihun and Petifu in Sierra Leone and Karnplay in Liberia) but two were urban (Saclapea and Zwedru in Liberia). Karnplay is a high outbreak site, while the others were low outbreak. The reason given by participants in the five sites for defying the ban was that alternatives (fish, chicken, and beef) were not readily available or affordable. So

just as poverty and the lack of alternatives forced people to disregard health measures (as described the last chapter) it also led some to disregard the ban on bushmeat.

Figure 5.1 Availability of food



Source: Adult focus groups. (n=60 Liberia; n=40 Sierra Leone)

5.1.1 Increase in food prices

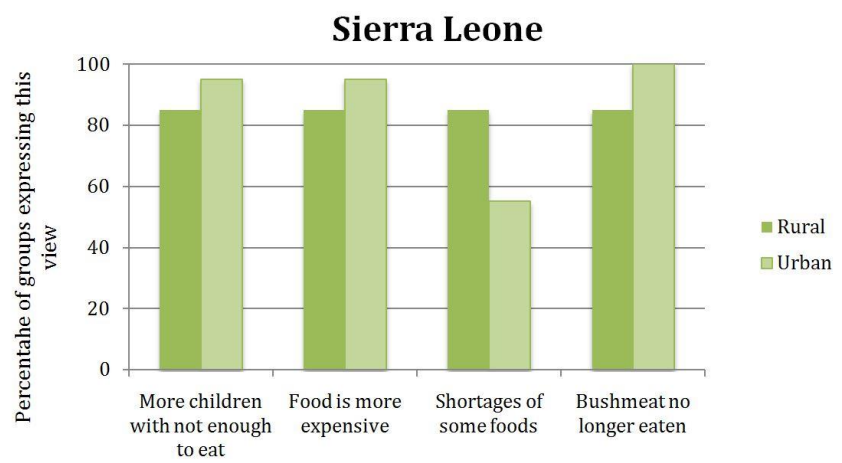
Participants commented that the limited supply of food and the restricted market had increased food prices substantially: the little food now available was not at a price that many people could afford. All groups in Liberia and almost all in Sierra Leone said that food was more expensive and they gave a detailed account of price increases in staples such as rice and cassava. The steep decline in household incomes (see next section on Livelihoods) meant that many families could not afford food, even at 'normal' prices. Those stigmatised by Ebola sometimes found that they could not buy food at any price, as demonstrated by the quote below:

> *We are out of food because of the stigma of Ebola on our community. People in the bordering market no longer want to receive our money when we try to get food for our family. (Mother, Mount Barclay, Liberia, 13 November)*

Reports of switching to lower quality food were widespread, usually meaning that people were eating plain rice or rice with palm oil, but no "soup" or "sauce" (normally a spiced stew with meat and vegetables).

Both rural and urban areas were very similar in terms of the high level of food insecurity reported. Rural areas, in general, appeared to fare slightly better because they had better access to home-grown food - but they also tended to have poorer access to imported foods because of travel restrictions and market closures, hence more shortages. This is illustrated for Sierra Leone in Figure 5.2. The pattern in Liberia is similar, with even less difference between rural and urban areas.

Figure 5.2 Availability of food – Rural and urban



Source: Adult focus groups Sierra Leone (n=20 rural; n= 20 urban)

Low outbreak sites did not fare any better in terms of food prices and appear to be worse in terms of the number of children with not enough to eat; for example 97% of the adults groups in low outbreak sites in Liberia said that there were more children with insufficient food, compared to 83% in the high outbreak sites. The equivalent figures in Sierra Leone were 92% (low outbreak sites) and 86% (high outbreak sites). The difference appears to be the result of food aid being targeted at some households in high outbreak sites. This was reported by research participants and it also fits in with the pattern of food aid distribution described in published sources. The World Food Programme distributed food to 1.7 million people in the three most affected countries, targeting people under medical quarantine, people under treatment (and their relatives) and people in communities hit hard by the outbreak (WFP, 2014). Food aid was also provided by local and international NGOs.

There were few instances where children and adults in research communities said that the food situation was no worse, or was better than this time last year (before Ebola and in the same harvest/pre-harvest period). This amounted to two sites in Liberia and two in Sierra Leone (out of a total of 40 sites) and were in communities where it was also said that food aid had been provided.

Most communities and most people, the vast majority of whom were not directly affected by Ebola, had a major problem of food insecurity and hunger. Thus almost all of the 100 groups consulted across both Sierra Leone and Liberia said that there were more children who did not have enough to eat. The results of this research support the findings of other studies, which warn that West Africa is on the brink of a major food crisis as a result of Ebola (UN News Centre, 2014). A national survey of Liberian households also found that over 70% of households said that they could not afford to buy sufficient food (LISGIS 2014).

In contrast to the views of the participants, other studies have provided a different perspective on the scale of food price rises. For example, a study of market prices in Sierra Leone in August 2014 found that there had been some very localised spikes in food prices, but that the overall picture was one of only slight increase (IGC, 2014). This research, on the other hand, found that just one of the communities visited, Yambama in Sierra Leone (a rural, low-outbreak site) reported that the price of some items had not increased. All the other 39 sites reported substantial price rises. In both Liberia and Sierra Leone, the overwhelming majority of communities included in the research described an increase in the price of staples such as rice and cassava, usually a doubling of prices and if not then a 50% increase. The difference in findings between this and other studies may be explained by the difference in timing of the research (this research was conducted in November and December 2014), as well as other potential research factors such as location, communities sampled, etc.

5.1.2 The loss of community-level food security strategies

Before Ebola, extended families and the wider community usually provided a vital safety net for households that were short of food. Children especially talked about how relatives were an important source of fresh food. Commonly, rural relatives provided food in exchange for goods from family members in the cities. Other community members, as well as relatives, typically helped hungry children or families by sharing food. Families with sufficient food would, it seems, quite normally share surplus food with children from other families who had less at that particular time:

> *Food, we used to share in common amongst friends. This used to help us but now all those things are not happening. (Child, Ganta, Liberia, 20 November)*

As demonstrated by the quote above, participants reported that much of this community safety net was eroded by Ebola, because the flow of people and food from one community to another was greatly restricted and because so many households lacked any surplus to share. Children remarked that even in their own home, food was no longer eaten from a single pot as before. Everyone now had their own plate and cup and sharing was forbibben.

Food shortages are not a new hazard for children and families in Liberia and Sierra Leone. Parents acknowledged that before Ebola, children sometimes did not have enough to eat, particularly in the lean season of June to August. Published sources bear this out; before Ebola an estimated 42 percent of children under 5 years old in Liberia were stunted by malnutrition (USAID, 2014) and 34 percent of children under five years old in Sierra Leone were stunted by malnutrition (WFP, 2011).

This research suggests that Ebola has seriously worsened the immediate and longer-term consequences of food shortages and malnutrition:

Because times are hard, the children do not have enough food to eat. They never had 100% before, but at least we could give 75% (Mother, Mount Barclay, Liberia, 15 November)

Potentially, increased malnutrition will have the knock-on effect of increasing the burden on health systems and hindering economic activity. It also compounds the risks to unborn and newly-born children identified in the earlier section regarding the loss of maternal services. Most of the irreversible damage caused by malnutrition occurs during gestation and in the first years of a child's life, the so called 'first 1,000 days' (UNICEF, 2009). In response to a general question about the effects of Ebola on childbirth and breastfeeding, 12 of the 60 adult focus groups in Liberia said that pregnant and breastfeeding mothers were not getting sufficient nourishment. This was not explicitly mentioned in Sierra Leone and further research on this issue is recommended. The underlying conditions for undernourished nursing mothers appear to be very similar in both countries: widespread food shortages and loss of health services, which might otherwise provide information and assistance to malnourished mothers.

Adult groups in both countries also suggested that hunger and the need to find food increased the spread of Ebola. This was attributed to the need for women (and men) in towns and in rural areas to travel to other settlements to buy or sell food - and hence to mix with people.

5.2 Food production

The food shortages described above are partly due to restrictions on imports and partly due to the collapse in local food production that was found to have occurred across both countries. Around 90% of the focus groups in both countries said that less farming was being done compared to the same time in the previous year (Figure 5.3). They described how farming has been seriously disrupted in a number of ways:

- Farmers could no longer travel to their farms due to travel restrictions.
- In some high-outbreak areas, substantial numbers of farmers had died.
- Communal or hired labour, which is necessary for cultivation and harvesting on larger-scale farms, was not available. This was because farm workers were reluctant to gather in groups and because farmers could not afford to pay them.
- Farmers could no longer afford other agricultural inputs such as seeds and tools, because they had spent their capital on food.

In several research sites, such as Kailahun in Sierra Leone, adults reported that the quarantining of communities and the nationwide three-day lockdown had prevented them from visiting their fields. Crops were therefore damaged by pests and weeds.

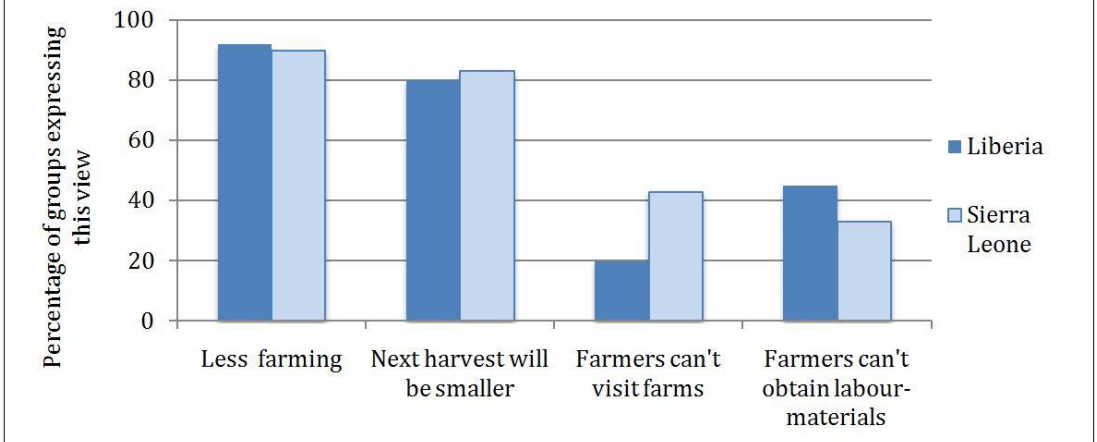
This community was quarantined so the farmers cannot go out to work on their farms and so lost many crops. (Girl, age 18, Daru Town, Sierra Leone, December 7)

Farming, food and social systems were connected in complex ways that are disrupted by the controls put in place to prevent Ebola. Farmers in Sierra Leone for example, described how the ban on bushmeat has meant that animals are no longer hunted and are damaging crops. Usually, the work-intensive parts of the farming cycle are managed with communal effort. During the Ebola outbreak, however, gathering in large groups was forbidden or avoided, and even if community members were willing to turn out, the farmers were no longer able to pay them, or reward them with bushmeat, as was common practice (see the example in the quote from Solo Town, Liberia).

> *You don't expect the harvest to be good because hunting plays a major role in farming, We use the meat to feed the people that come to help. Now no gathering so farming will be very poor (Mother, Solo Town, Liberia, 28 November)*

A larger proportion of groups in Sierra Leone reported that farmers couldn't visit their farms, compared to those in Liberia. Liberia did not have a national lockdown and the quarantining of whole districts or counties was done less rigorously, enabling greater freedom of movement. These differences did not, however, appear to have had an impact on the overall level or distribution of food shortages. This appears from the research to be fairly universal across sites in both Liberia and Sierra Leone.

Figure 5.3 Impact of Ebola on farming



Source: Adult focus groups. (n=60 Liberia; n=40 Sierra Leone)

Despite trouble on the farms, the research contradicts media reports that farming was abandoned wholesale (e.g. BBC, 2014b). In both Sierra Leone and Liberia, research participants stated that farming had continued in most communities. Indeed, farms seemed to offer a refuge, as adults in rural sites often described how they had relocated to their farms to avoid the risk of contamination in the village, and because there were no other available work options. Children too (especially boys), described how they joined their parents on the farm as opposed to being at school.

The key change indicated by the research is that the scale of farming was reduced by the side-effects of Ebola to subsistence farming and farming for local sale, rather than for

wider marketing. Communities recount how they are "gardening" rather than "farming" as the quote from the Karnplay farmer illustrates.

> *There is no real farming happening. There is only backyard gardening for eating purposes (Female Farmer, Karnplay, Liberia, 24 November)*

One consequence of this was the absence from markets of locally-produced food. For example, female participants in Liberia stated that whilst they are able to obtain imported rice at markets, they could no longer find the local (and preferred) 'forest' rice for sale.

The shift from commercial to subsistence farming has longer term consequences in that it increases reliance on expensive food imports. This is likely to manifest itself over several years to come. Farmers explained that they no longer received the cash that they needed to buy labour, seeds, tools etc. for next year's planting and talked about needing several years before they could build back up to their former level of productivity.

5.3 Key points on food security

<table>
<tr><th colspan="2">Food security</th></tr>
<tr><th>Immediate impacts</th><th>Possible long term consequences</th></tr>
<tr><td>• Closure of markets and trade routes creates food shortages and high prices.
• Families cannot afford sufficient food.
• Children and families eat less often and food of a lower quality.
• Shift from commercial to subsistence farming, with much less produce available for sale.
• Travel restrictions and fear of contact prevents extended families from sharing food resources, removing a vital safety net for families.</td><td>• Potential increase in wasting and stunting of children over and above the already high levels.
• Farm productivity is likely to be substantially lower and food insecurity higher for several years, because farmers have lost the capital to invest in next year's crops.</td></tr>
<tr><td colspan="2">Priorities for action
• Implementation of programmes for nutritional support for pregnant and nursing mothers.
• Implementation of programmes for nutritional support for children.
• Support for re-investment in agriculture, including cash-transfer programming to develop the economic capacity and livelihoods of individuals and households.</td></tr>
</table>

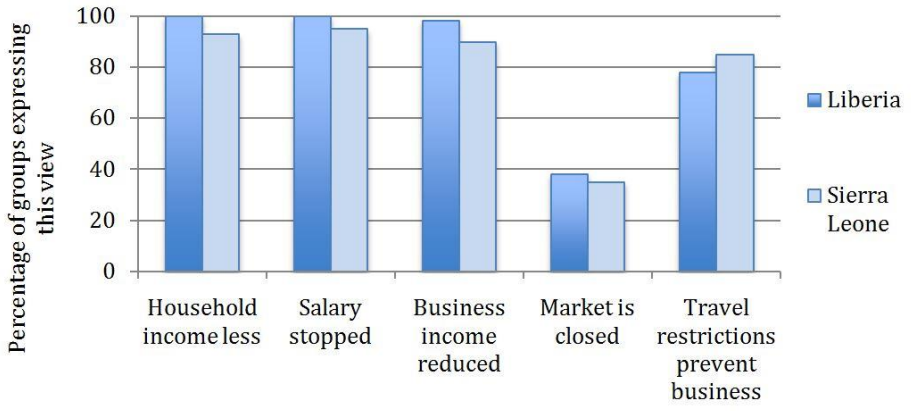
6 Livelihoods and incomes

Children who participated in the study were without sufficient food primarily because their parents had lost their livelihoods. A key finding from the research in both Sierra Leone and Liberia is that among those who participated in the study, the loss of livelihoods and household income as a result of the Ebola outbreak was widespread and very substantial (Figure 6.1).

6.1 Unemployment and loss of household income

The majority of adult respondents stated that they worked in small-scale agriculture and in the informal economy, trading food and other commodities. In one site, Makeni in Sierra Leone, mining companies were major employers but elsewhere, salaried people were few and mostly comprised of teachers or local NGO workers. This reflected the general employment profile of the two countries, as described in published sources: approximately half of the population works in agriculture and food retail (LISGIS, 2011). Many work in the informal economy as casual labourers or traders. Salaried employment is low (around 20% of the population) and unemployment levels amongst youth are particularly high in both countries, with estimates ranging from 65% to 80%, with youth unemployment being regarded as a contributory factor to historic civil unrest (LISGIS, 2010; Government of Sierra Leone, 2013).

Figure 6.1 Impact of Ebola on household income and business



Source: Adult focus groups (n=60 Liberia; n=40 Sierra Leone)

Although salaried jobs are in the minority, their significance should not be underestimated as wages support a lot of the informal economy activity, through spending and funding other businesses (LISGIS, 2014). This is very evident in the household economies described by participants in the research. Families were typically

dependent upon both adults in the family working. As they put it, the men "work" (usually as casual labour) and the women "sell" (usually in food trading).

> *All our children are hungry because our husbands are not working, we are not selling to provide food. (Community leader, Toe Town, Liberia, Nov 29).*

In both countries, nearly 100% of the groups interviewed reported that salaries had been stopped and that business income was substantially reduced, causing a collapse in household income. They described the termination of employment as being immediate in nature, without any notive or redundancy pay, and the groups decribed instances of people losing their jobs because their family members were Ebola suspects.

> *My father was a driver but he lost his job because of my sister's condition (Ebola suspect). Since then things have gone from bad to worse, you can't go to another family member to help you because everyone is affected one way or the other. My mother can't do petty trade because she doesn't have money. (Girl, Mount Barclay, Liberia, 13 November)*
>
> *All the people in Makeni that were working for African minerals have been made redundant and most of their homes are suffering from hunger now (Boy, Makeni Town, Sierra Leone, 12 December)*

Adults explained how travel bans, the closure of borders and markets, raised prices and the fear amongst people of mixing with others had severely damaged economic activity.

> *My mother used to go to villages to buy farm product to sell in Ganta city but she is no longer allowed to enter into the villages, because of state of emergency (Girl, Ganta, Liberia, 20 November)*
>
> *When the chiefs noticed that the death of people was intensified by body contact, public gathering, they passed a bye-law that all local businesses be closed forthwith. (Mother, Kissi Town, Sierra Leone, 10 December)*

In their view, the cost of transport as well as goods had increased greatly, mainly because checkpoints within the country added substantially to travel times, and hence costs. Public transport was also more expensive, because of checkpoints and because people were less willing to crowd into cars, buses and lorries.

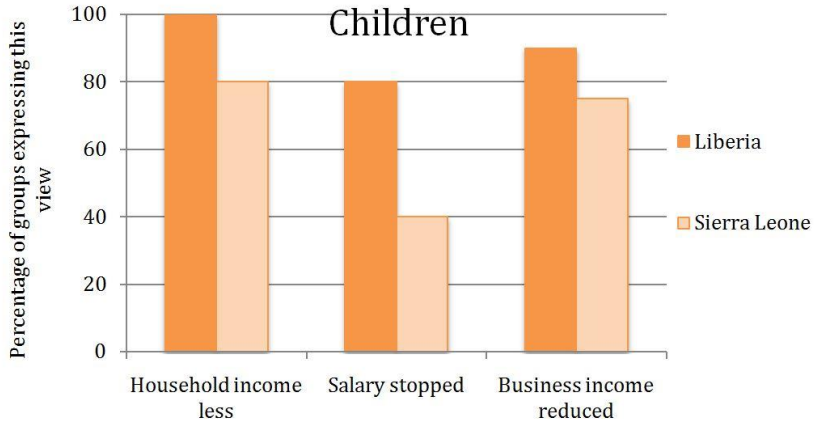
Markets were said to be open by more than half of the adult groups (Figure 6.1), although they qualified this by explaining that the large wholesale markets where traders buy their stock (the *Loma* in Sierra Leone) were mostly closed. It was the smaller local markets where people buy and sell food for the day that remained open (as they must in order for people to eat). In those, the amount of selling and buying was significantly reduced. Women, who do most of the informal market trading, described a lack of affordable goods and a lack of buyers. They continued to engage in business but the scale to which they did had diminished. Like farming, trading had become "hand-to-mouth" rather than profit-making.

Where markets were closed, the research respondents reported that they were more likely to be closed in rural areas than in urban areas in Sierra Leone - 50% of rural

research sites as opposed to 20% of urban research sites - but in Liberia the closure of markets was similar in both the rural and urban research sites. It was found that the market closures affected both high and low outbreak sites; and the factors behind such closures appear to be site specific. The severe reduction in small-scale trading found in this research is in line with the conclusions from other studies. A household survey conducted in Liberia, for example, found that the self-employed people (mostly women) who make up the informal economy were hardest hit by the side-effects of Ebola (LISGIS, 2014).

In examining the differences in responses from Sierra Leone and Liberia, the data indicates a slightly more positive outlook in Sierra Leone in relation to livelihoods. For example a man in Yambama said that he now received "*a little sum of money*" from farm work. A teacher from Moriba said that she was receiving her salary as before. This is in contrast to Liberia, where the responses were more absolute, including teachers complaining that they were not being paid. Children also expressed views on household income and employment and the results concur with the findings from adults' groups that Sierra Leone is slightly less affected. Children mainly spoke about the loss of their mother's trading activities, perhaps because it was more visible to them in the household (Figure 6.2).

Figure 6.2 Impact of Ebola on household income – views of children



Source: Children's focus groups (N=20 Liberia; n=40 Sierra Leone)

The impact on household incomes and the consequences for food security are perfectly illustrated by the example of a man from Kissy ByePass in Sierra Leone. He described how he used to give his wife Le15,000 (3.4 $USD) daily for feeding the family, but since he was no longer getting money from his business he reduced this to Le10,000 daily (2.2 $USD). The discussion group he was part of had earlier described how food prices were typically 50% higher or more than before the outbreak. The situation in this household reflects those in most others: income is down and prices are up, substantially.

> *We used to buy a bag of rice Le120, 000, but now we are buying it Le145, 000. The consequence is we have reduced our daily foods to two meals a day instead of three.*

The cost of one cup of rice now is Le 1,200 before Ebola it was Le 800, even though it depends on the brand of the rice … The price of a cassava bundle (6 pieces) before was Le 1, 000, but now it is Le 2, 000 and sometime it goes up to Le3, 000. (Mens focus group, Kissy ByePass, Sierra Leone, 14 December)

As with food shortages, restrictions on business and a drop in household incomes was a universal effect of the Ebola outbreak, spread across all sites in both countries.

6.2 Credit and savings schemes

Farmers and business people interviewed in both countries described how they had consumed their capital and could not therefore invest in new crops or stock.

We have eaten all of our business money and don't know where to start again (Mother, 72nd Community, Monrovia, Liberia)

In Sierra Leone we asked specifically about savings schemes, an issue which was not explicitly explored in Liberia. Of the 40 adult groups which participated, 23 groups (58%) said they had some form of saving scheme before the Ebola outbreak that was now closed. They gave several reasons for this:

- Business activity was significantly reduced.
- Households were having to use their savings to buy food.
- People withdrew from their savings or credit schemes because they wanted any savings to be held within their family in case they died from Ebola.
- Loan schemes had closed because many people were defaulting on their loans.

Private sector or community-based loan schemes were affected as well as those supported by NGOs. The quote below from a farmer illustrates the importance of these and the way in which their collapse affects communities.

As a master farmer, I used to give out money to other farmers, to help them at the start of every farming season. They pay rice in return. Now all these farms do not do well because there is no way to weed, as no public gatherings are allowed. I neither get the yearly profits I used to get at the end of the season nor will I get my money (loans) back from these farmers because they have not even enough harvest to feed themselves. (Male farmer, Mateboi, Sierra Leone, 8 December)

Smaller incomes and the greater cost of items such food, medicines, water and chlorine, suggest that the capital for re-starting businesses will be in very short supply. There was no mention of private banks in any of the interviews, although media coverage of the impact of Ebola included a report that Liberian banks had restricted lending to certain sectors (including agriculture) in an attempt to protect their own reserves (Daily Observer, 2014).

Based on these findings, the economic shock from the Ebola outbreak appears to have overwhelmed savings and loan schemes. It follows that they were unable to add much to

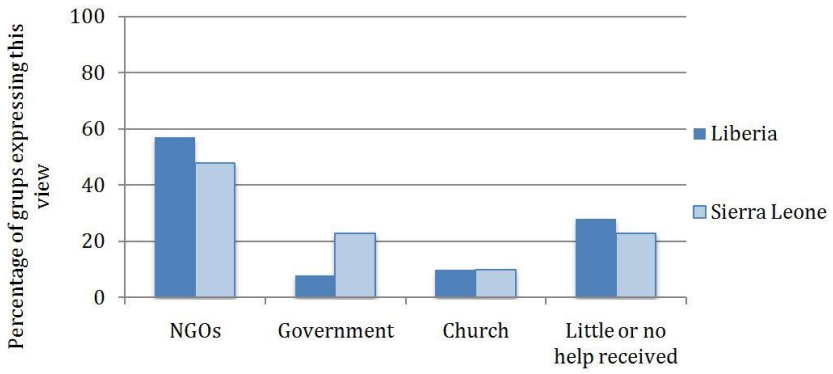
the resilience of families to food shortages and loss of income. It should be stressed however that this topic was touched on only very briefly in this study and so deserves further research.

6.3 Aid assistance

It is clear from the data that parents were attempting to work harder, taking risks with their health by hustling in the community and cutting down on their own food intake in order to provide for their children. It is equally clear from the extent of lost incomes and food shortages that families were very limited in what they could provide for children.

The need for emergency relief for the wider impacts of Ebola was recognised by government and the international community (e.g. the World Food Programme aid) but the research found that the Governments of Liberia and Sierra Leone, with support from international aid, were limited in their ability to step into the gap. The communities who participated in the research said that NGOs provided the most aid to them (Figure 6.3). The help they received was mainly in the form of preventative materials (buckets, chlorine and soap) and food, particularly through the World Food Programme. Churches were also reported as a significant source of help, especially in urban areas. Beyond these three main sources, private individuals (usually local politicians) and private companies (especially large international companies) were also identified as givers of aid.

Figure 6.3 Sources of assistance to families



Source: Adult focus groups (n=60 Liberia; n=40 Sierra Leone)

What is perhaps most striking is the low-key response to the topic of aid; it was not a subject that people raised or responded to in detail and external aid appears not to have played a major role in relieving the harm done by Ebola to the non-health aspects of people's lives. Despite the considerable needs described by communities, for food especially, they did not on the whole appear to have received support or even expect it. For many children, NGOs were less present than they were before Ebola (for example

over 60% of the children's groups in Sierra Leone said that they see less of NGOs). Those that they do see now are concerned only with Ebola.

> *Now we only see the people that come here to do awareness and also the car that comes to pick up dead and sick people (Child, Johnsonville, Liberia, 14 November)*

Some research respondents did express concern that assistance was only given to those directly affected by Ebola, whereas they felt that most or all were suffering equally from problems such as hunger. Dissatisfaction with the aid response feeds into a broader view amongst some communities in both countries that the government (and sometimes NGOs) had not been honest or fair with them in dealing with Ebola, an issue discussed later in the section on community cohesion. However, again this issue was not frequently raised by respondents. Only a quarter of the adult groups in Liberia spoke on the issue of aid, as did just over a third of the Sierra Leone groups.

6.4 Key points on livelihoods

The consequences of the loss of livelihoods go beyond lost incomes and hunger. The impoverishment of families affects many aspects of children's lives, including their education and safety, as we shall see in the following chapters.

<table>
<tr><th colspan="2">Livelihoods</th></tr>
<tr><th>Immediate impacts</th><th>Possible long term consequences</th></tr>
<tr><td>• A substantial reduction in trading results in lost income to most households.
• Salaried employees are largely made redundant as businesses close, including private schools.
• Households have less money to pay for food and other basic needs.
• Families lose savings</td><td>• Family-based businesses lose capital and are unable to re-stock.
• Less money is available for children's education, health, recreation etc.
• Children may be required to make a greater contribution to the household economy by working and are therefore placed at greater risk of dropping out of school or exploitation.</td></tr>
<tr><td colspan="2">Priorities for action
• Provision of credit for re-starting businesses, including support to community savings and loan schemes that have accumulated excessive debt.
• Future emergency and outbreak responses must avoid a silo-approach that concentrates only on health responses and Ebola victims, and consider adopting a systems approach that takes the wider impact of the outbreak and trade control measures into account.</td></tr>
</table>

7 Child protection and well-being

The discussions held with children and adults in Liberia and Sierra Leone confirm that the Ebola outbreak had a wider impact on the protection and well-being of children. Much of this stems from the fact that the ability of extended families and communities to care for children has been undermined. It also stems from the lack of food and money in households, which compels children to look for their own means of survival.

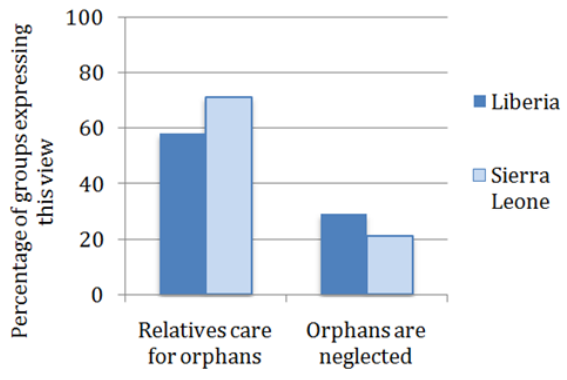
7.1 Children without parental care

UNICEF estimated that over 16,000 children in Liberia, Sierra Leone and Guinea have lost one or both parents to Ebola since the start of outbreak (UNICEF, 2015). This research did not attempt to count orphans in the communities visited or seek them out especially for interview, but it did ask about the alternative care they received. Orphans and adults taking care of orphans were represented in the interviews and focus groups. The main finding with respect to orphans is that relatives and community members are taking care of orphaned children, despite the fear and stigmatisation that surrounds Ebola suspects. However, the level of care that children receive may not always be adequate to meet their welfare and development needs.

7.1.1 Care of orphans

Most of the adult groups we interviewed, in both countries, said that it was relatives that were taking care of Ebola orphans (Figure 7.1). There were no specific examples given of children being cared for in government/NGO run interim care structures. The extent to which people were willing to care for orphans appears to contradict the high level of fear, stigmatisation and indeed abandonment of Ebola suspects that was noted in the previous section on health. The willingness to care amongst individuals and communities obviously depends primarily on individual circumstances, but what the research appears to show is a solid tendency to care for orphans. So whilst adults expressed fears and concerns, when it came down to it, they were prepared to care for children in the greatest of need.

Figure 7.1 Care of Ebola orphans



Source: Adult focus groups in high outbreak sites (n=24 Liberia, n=14 Sierra Leone)

It was noticeable that when discussing orphans in the abstract, adults expressed strong reservations about taking in orphans. Men especially, tended to place caveats on the

extent of care offered to Ebola orphans, insisting that the child must prove to be Ebola free for 21 days before they would take them in. Both men and women pointed out the difficulties they would face in having to feed an extra child, when they didn't have enough food to feed their own children. Parents who did not actually have to face the choice of accepting a child into their households were more likely to say that government or NGOs should take responsibility for orphans. But when real examples were discussed, the result was almost invariably that orphans were cared for by relatives or other members of the community, without delay.

> *I have an additional three children whose parents died during this period and I'm alone taking care of them, plus my children. How do you expect them to have enough to eat? (Single mother, Bahn, Liberia, 23 November).*

Further research would be required in order to understand fully the limitations to such community care and the bonds amongst family, extended family and community that underpin it. What we can say with confidence, based on this research, is that the capacity to care for orphans within communities was very large and survived the extreme stresses imposed by the Ebola outbreak.

Communities, therefore, did not expect government or NGOs to replace them as the carers of Ebola orphans, but there was the hope that governments and NGOs would help families in this role. For example, community leaders in Mount Barclay, a high outbreak site in Liberia, said that there were around 80 children orphaned by Ebola and that they were looking to government and NGOs to help them with food and the costs of schooling.

> *We need help from Government and international NGOs to help take proper care of children whom were made orphaned by Ebola (Community leaders, Mount Barclay, Liberia, November 15)*

7.1.2 The quality of community care

The discussion groups in Mount Barclay also illustrated a wider finding that the quality of care for the orphans without assistance from external organisations would often be poor. They said that although orphans were taken in by new carers, the quality of that care was sometimes low. This view was echoed by 29% and 21% of adult groups in Liberia and Sierra Leone respectively. The low quality care or 'neglect' described by adults and children included being underfed, under-supervised and in some cases an almost complete lack of care, resulting in children becoming beggars and spending a lot of time in the street.

> *Most of the children that were made orphans by this EVD are not really taken care of, even though community based organization and other community dwellers are helping, their help is insufficient to sustain them (Male carer, Mount Barclay, Liberia, 13 November)*
>
> *Children are neglected especially the orphans from Ebola. Even when they look healthy, people can still be afraid to take them. Most times they can't even have food*

to eat, they have to beg. It is really pathetic. (Mother, Kissy Bye Pass, Sierra Leone, 8 December)

The research findings suggest that child welfare and protection is a serious concern for orphans, especially in high-outbreak areas. The earlier chapter on livelihoods suggests that the problem is not just confined to orphans; they may be particularly vulnerable but a much larger number of children are living in households where the parents are very limited in their ability to provide basic needs, such as food.

7.1.3 Care amongst extended family

One of the ways in which some parents tried to protect children was to send them away to stay with relatives in areas of the country not affected by the outbreak. However, this occurred in relatively few of the research communities and it involved relatively few children. Only 5 of the adult groups interviewed in Liberia said that some parents had sent children away to avoid Ebola. Similarly in Sierra Leone, only 4 groups said parents had removed children. Communities who spoke of this practice explained that this happened more at the start of the outbreak, whereas later, as the virus spread, it was understood that nowhere was safe. Amongst the majority of caregivers who did not send their children away, the reasons given were:

- They did not trust anyone else to take care of their children like they did.
- Children who were sent from infected areas were rejected by the intended hosts.
- Travel restrictions prevented children from leaving or returning.

For example, mothers in Zwedu, Liberia, described how parents from high outbreak areas in Monrovia and Ganta sent their children to rural villages only to find that they became trapped when travel restrictions were imposed. In one instance a father tragically reported the severe consequences of sending his daughter away:

I send my children to my uncle in another community that was not affected by the Ebola virus, but I feel bad today because somebody raped my daughter while in that community. (Father. Ganta, Liberia, 20 November)

The previous chapter noted the importance of visits by children to relatives in terms of food security. Children who participated in the research were also concerned that the Ebola travel restrictions would result in the loss of these relationships and the material support that they provided, including help with the cost of schooling. Parents also relied on this wider network as the quote from a mother in Songo village, Sierra Leone illustrates.

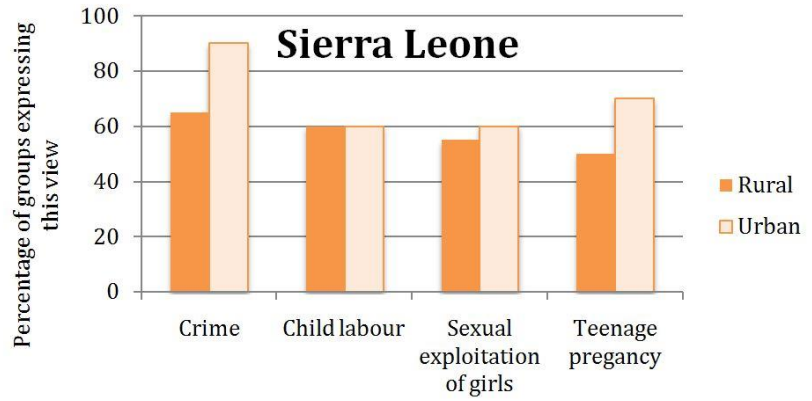
We used to send our children to our relatives during holiday, so upon their return, they will help us by buying some schools materials. Now if schools are open all the burdens will be on us. (Mother. Songo village, 9 December)

7.2 Increased protection risks for children

The following findings related to protection risks for children emerged from the focus group discussions virtually unprompted. While the risks mentioned by children and communities are naturally hard to quantify, it must be borne in mind that it is difficult to clarify which risks are real and which are inferred.

Most of the children's groups interviewed in Sierra Leone were of the view that the risks to children had increased because of Ebola (Figure 7.2). The type of protection concerns that are said to have increased were involvement in crime, child labour and the sexual exploitation of girls. Children also described a greater risk of teenage pregnancy as a result of Ebola. Orphans and children in families who could no longer provide for them were said to be most likely to become victims of abuse and exploitation because they had to fend for themselves.

Figure 7.2 Increased risk to children – Views of children

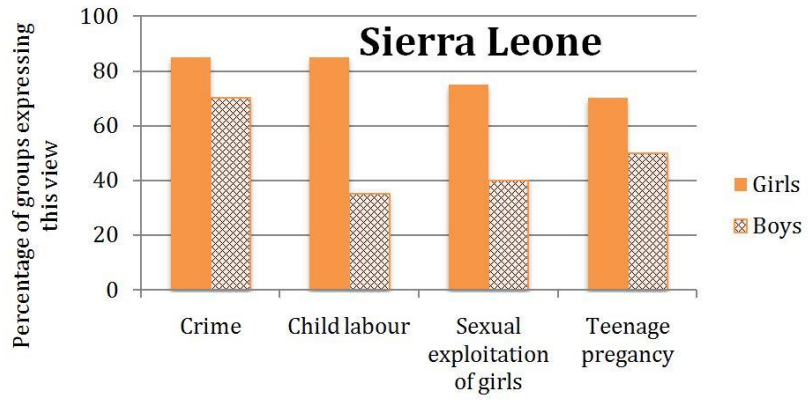


Source: Children's focus groups Sierra Leone (n=20 rural; n= 20 urban)

Figure 7.2 shows the proportion of children's groups in Sierra Leone that see an increase in these particular hazards. It shows that children in urban areas are more likely to be concerned about crime generally, and about teenage pregnancy in particular. When discussing the risk of crime, children (and adults) invariably referred to the greater risk of children, especially boys, becoming involved in stealing for money or food. There was no indication that they were at greater risk of being victims of crime.

The evidence from children in Sierra Leone indicates that girls are much more likely than boys to perceive an increased risk of child labour and sexual exploitation as a result of the Ebola outbreak (Figure 7.3).

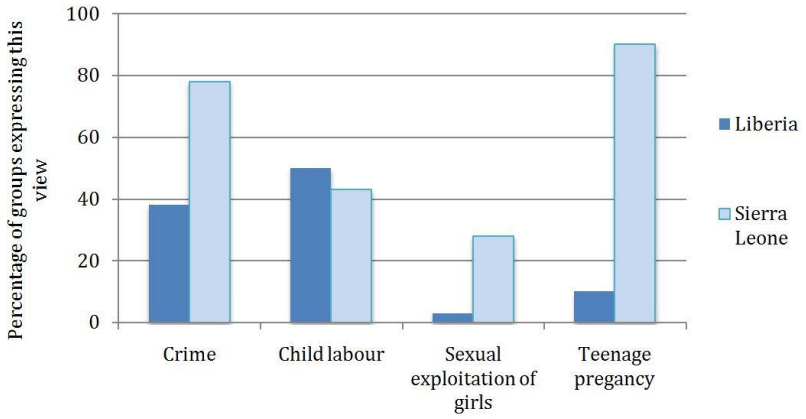
Figure 7.3 Increased risks – views of girls and boys



Source: Children's focus groups Sierra Leone (n= 20 girls; n=20 boys)

The adults groups from Sierra Leone express similar views to the children although they put a greater emphasis on teenage pregnancy (Figure 7.4). However, the results from adults in Liberia are for the most part different to those from Sierra Leone. Whilst participants stated that children from Ebola-affected families faced a double-risk, having lost carers and being subjected to stigmatisation, they showed a much lower concern about this having consequences in terms of crime, sexual exploitation and teenage pregnancy.

Figure 7.4 Increased risks to children – Views of adults



Source: Adult focus groups (n=60 Liberia; n=40 Sierra Leone)

The country difference is also seen in the results from children. Like the adults, Liberian children see less risk of crime, sexual exploitation and teenage pregnancy.

The research does not provide a full explanation for the apparently large difference between the two countries in terms of child protection issues and this is amongst the areas recommended for further research. However, the information provided by adults and children does hint at a possible explanation. Those from Liberia tended to explain that children were as safe (or were safer) than before Ebola because they were largely confined to the house. 70% of the children's groups in Liberia said that they were unable to visit family and friends, whereas the equivalent figure in Sierra Leone was 38%.

Children in Sierra Leone appeared to be more able to circulate within their community (although less free than those in Liberia to travel between communities because of the stricter travel restrictions, mentioned earlier.)

7.3 Increased involvement of children in work

The findings on the increased involvement of children in work are more consistent between children and adults and between the two countries. Children especially describe how involvement in work has increased for all children. Typically, the younger ones are said to help in the house with cleaning and cooking and the older ones help with business work outside. Outside the home, they are often helping the family with farm work or with selling, but they are also heavily involved in paid work outside the family, especially in Sierra Leone. The reasons for this are evident from the preceding sections: the reduction of household incomes, together with the loss of breadwinners, means that children must work more to contribute to the family's income or to provide for themselves.

The amount and type of work varies household to household, as a girl (age 13) from the Mile 47 community in Sierra Leone indicates:

> *Some children do more chores at home, some go and sell for their parents, while others are idle. For me during the day, I sell for my mother". (Girl, Mile 47, Sierra Leone, 16 December)*

Figure 7.5 Examples of work described by boys and girls in Sierra Leone

Boys, Makeni Town, Bombali, 12 December:	**Girls, Mile 47, Port Loko, 16 December :**
• *I go from junction to junction carrying loads for people and get paid (age 18)* • *I make bricks for people instead of idling at home (age 14)* • *I am a carpenter and make racks and chairs (age 18)* • *I go round the town search for jobs where I can get paid (15)*	• *I buy and sell scrap metals and slippers (age 17)* • *I sell boil ground nut for my mother (age 14)* • *I sell a cake we call here" kill driver" (age 17)* • *I gather stones to sell (age14)* • *I sell oranges for my mother (age 14)* • *We help with farming (age 17)*

Source: Focus group discussions with boys and girls.

As the examples in figure 7.5 illustrate, many of the children carrying out paid work are above the minimum working age (16 years) so this does not constitute child labour, although some are younger. All are school children or students in higher education, so the work does represent a change from their normal activity.

> *We're not doing school lessons but we are learning some trade. Some of us are learning tailoring, electrician, others are learning beautician, blacksmith. (Child, Karnplay, Liberia, 25 November)*

In Liberia, the adult groups were more likely to say that the majority of children were idle. They were more concerned about their children being bored and tempted into bad behaviour than they were about overwork (only 50% of adults' groups say that children

are working more, as compared to 85% of children's groups who say they are working more now. The equivalent figures in Sierra Leone are 63% and 93% respectively).

> *Almost all the children remain in their yards whole day, doing nothing except the regular home clean ups and cooking for those who have the food to cook. Some of them, very few, venture into the bush trying to kill birds. (Community leader, Karnplay, Liberia, 25 November)*

It is when children go to work outside of the home and family farm that they are seen by both adults and children as at greater risk of being engaged in child labour (including the worst forms of child labour); the boys from 'hard labour', gambling and illicit work, and the girls potentially from sexual exploitation (hard labour refers to arduous physical work, such as carrying heavy loads). Whilst there are numerous examples of children working from both countries, young people in Sierra Leone appear to be moving around considerably more in search of work and food. Children and adults link this very clearly to an increased risk of exploitation. In addition, the children and adults who participated in the research also identified a greater risk of contracting Ebola amongst those required to go out to earn money.

> *Our children are out selling in the community, helping their family to get food. Some of the younger girls will soon start prostitution, because we can't control the children if we can't provide for them (Mother, Johnsonville, Liberia, 14 November)*
>
> *Most of our school friends are now engaged in stealing and gambling because that is the only alternative for them. (Boy, Masongbo, Sierra Leone, 7 December).*
>
> *I think children are more at risk from abuse and crime, because during this Ebola some children lost their parents and they have no one to take care of them, so they go and do hard labour for their survival (Girl, Masongbo, Sierra Leone 8 December)*

7.3.1 Age and gender differences in children's work and associated risks

The children taking part in the discussion groups were aged 12 to 18, so adolescents rather than young children. From their views and also those from adults a clear split is apparent between youth (aged 15 years and older) and younger children in terms of their involvement in work and associated risks. The younger children are very much confined to the house and help with small domestic chores or do nothing. The older ones mostly have a considerable burden of work in the house or farm and many of these also go out to find paid work. The watershed between these two age groups, as seen by parents, is the child's ability to understand and comply with instructions about avoiding contact with others.

The findings from children's groups in Sierra Leone suggests that girls perceive that work has increased because of Ebola much more than boys do (Figure 7.3). This may be because petty trading, usually of food, is a sector in which women are more prevalent, and this activity has continued to a greater extent during the economic lockdown than

the businesses that generate paid casual work for men and adolescent boys. The greater involvement of girls relative to boys in paid labour is hinted at rather than confirmed by the results of the groups. Much more certain is that girls have a heavier burden of domestic responsibilities as a result of Ebola, including caring for younger siblings and indeed older family members.

> *I am used to being cared for as a child, but I am caring for my young siblings and even for my father, since I lost my mother to Ebola. (Girl, Ganta, Liberia, 20 November)*

7.4 Sexual exploitation

"Protection mechanisms (which often keep girls safe) can be eroded due to factors such as the lack of parental care, the breakdown of community structures, and because (communities) may no longer be administered in such a way as to keep women and girls safe" (SOTWG Report, 2013, p.65). There was a very widespread view amongst children and adults in Sierra Leone that sexual exploitation has increased greatly because of Ebola. Respondents identified a number of reasons for this, which link the increase in pregnancies very firmly to the economic crisis cause by the Ebola outbreak:

- Girls went out selling and so had more contact with men.
- Girls turned to prostitution to get food or money.
- Girls left their families to start a family with men who could provide for them, sometimes in early marriages but more often as just girlfriends.

The research findings demonstrate that communities are concerned about the fact that girls are not in school, connecting this to the need to go out and find work, and increased pregnancy and sexual exploitation of girls. The research does not, however, provide conclusive evidence of the extent to which exploitation is driving up teenage pregnancies. The references made during discussions to prostitution and to transactional sex with older men indicate the potential risk of sexual exploitation. The very consistent view amongst children and adults in Sierra Leone that it is economic factors that are causing the change in girls' behaviour suggest that exploitation is a very large factor. Girls are forced to look for food and money by the economic crisis arising from Ebola and men are providing this in exchange for sex.

> *Girls go and sell themselves to men for food and money. Living with a man who does not pay your bride price is another issue that girls face in this community. (Girl, Masongbo, Sierra Leone 8 December)*

> *There will be a change in the number of teenage pregnancies, but not early marriages. Children are no longer going to school, they are idle and most parents give their children trade to walk on the street. Children can be raped or they themselves can agree with their free will to sleep with men. (Mother, Kissy bye pass, Sierra Leone, 8 December)*

Referring back to charts 7.2 and 7.3, girls identify a greater risk of sexual exploitation as well as a greater risk of teenage pregnancy. The two are not explicitly connected, but girls are clearly saying that both risks are concurrent. Adults express it differently; they recognise the risk of teenage pregnancy but not of sexual exploitation (Figure 7.2). The difference in opinion demonstrates the need for further research around attitudes and norms regarding sexual exploitation, in order to understand how the risks facing girls can be mitigated.

7.5 Teenage pregnancy

There is a very widespread view amongst children and adults in Sierra Leone that teenage pregnancy has increased greatly because of Ebola. This, at least in the opinion of children, is closely linked with an increase in the risk to girls of sexual exploitation (see Figures 7.2-4 above). The quotes below from a group of adult men in Makeni, Sierra Leone is a good example of the explanations provided in relation to this issue:

> *The petty trading that they are doing from place to place has caused these girls to become pregnant as they come across so many men who are trying to convince them to have sex every day … We blame these girls but really, it is not their fault, it is because they are no more going to school, and we no more provide for them their needs. … Because of poverty and hardship at home, people give their daughters in marriage in order to get money. (Men, Makeni Town, Sierra Leone, 12 December)*

Less typical are the statements by the men that it is not the girls' fault. Adults (male and female) and boys were more likely to explain teenage pregnancy as a result of the individual behaviour of girls, rather than as a consequence of their environment. Children, especially girls, explained the increased risk of pregnancy more in terms of deliberate relationships with men, rather than chance encounters that arose because girls were out selling goods. The quotes below from girls in Mile 47 illustrate this:

> *We are encountering lots of teenage pregnancy. Girls get pregnant because they are not going to school and some because they want money … Prostitution is rampant, girls don't eat unless they go and sleep with older men for money … Now, we girls do have sex with our father's age group, because we need money and men don't give money for nothing. (Selection of quotes from a girls group, Mile 47, Sierra Leone, 16 December)*

There is a major difference between Liberia and Sierra Leone in the extent to which teenage pregnancy is said to have increased. Very few adult or children's groups in Liberia said that girls were at greater risk of teenage pregnancy, or sexual exploitation and early marriage because of Ebola. On the few occasions it was mentioned (in 6 of the 60 adult groups interviewed and in 2 of the 20 children's groups), it was more a *prediction* rather than a description of actual change. The quote below from the mother in Bushrod Island is a good example of this.

> *My children are not in school. I am greatly worried about the girls. Some will soon involve themselves in teenage pregnancy. (Mother, Bushrod Island, Liberia, 20 November)*

Children and adults in Sierra Leone, by contrast, are much more likely to describe actual pregnancies that they say are a consequence of Ebola.

> *As for me I have four daughters. The two elder are now pregnant because I can no longer support them like I used to. I am now thinking about how to protect the younger ones not to follow suit. (Father, Mateboi, Sierra Leone, 8 December)*

The closure of schools is important in the explanations provided for teenage pregnancy given by children and adults in both countries. Adults (Like the mother from Bushrod Island) make a direct connection between girls being out of school and a greater risk that they will be engaging in sex and becoming pregnant. More detailed discussion revealed that schools play an important role in occupying adolescent girls during the day and keeping then in a relatively safe environment. Schools and teachers were also an important source of contraception and sexual health education and supervision. Specifically, in Sierra Leone girls described how they were no longer receiving contraceptive pills through the school-based program run by the international NGO Marie Stopes International.

> *Marie Stopes use to go to schools to distribute preventives to girls, but now, there is no school, no Marie Stopes, so we experience more pregnancies and less marriages. (Girl, Mile 47, Sierra Leone, 16 December)*

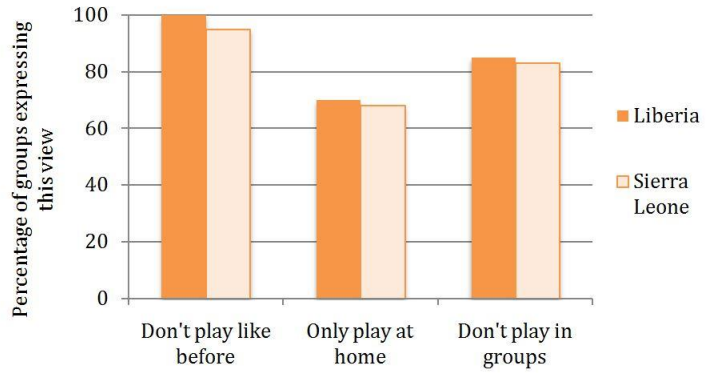
> *When we were going to school, some NGO workers used to come and supply books and pens for us and preventive pills for our sisters. Because they are not coming now most of our sisters are pregnant and this is all because of this Ebola crisis in our country and I feel too bad about that. (Boy, Konta, Sierra Leone, 7 December)*

The considerable difference between Liberia and Sierra Leone indicated by this study requires further comparative research specifically on this topic. During this research, there was a methodological difference which may have affected the results, in that the children's groups in Sierra Leone were conducted as separate male and female groups and there were extra discussion-prompts on gender differences. The children's groups in Liberia were mixed gender. It is possible that the Sierra Leone approach encouraged a more open discussion of sexual practices and increased the frequency with which groups gave these answers. This does not adequately explain the difference, however; the adult groups were split by gender in both countries and followed the same checklist, yet produced different results. On other topics the children's groups in Sierra Leone and Liberia produced broadly compatible findings. Furthermore, the discussions started with an open question on change in general, without prompts on specific issues such as teenage pregnancy. Children and adults in Sierra Leone frequently mentioned an increase in teenage pregnancies amongst the changes they identified. The groups in Liberia did not.

7.6 Play and social opportunities

Children and adults from both countries described a complete change in the play of children. In response to a broad question on whether children played liked before, the answer was almost universally "no" (Figure 7.5). Children went on to explain that play was confined to the home or family compound, and that they no longer played in groups like they did before.

Figure 7.5 Changes in play – views of children



Source: Children's focus groups (n=20 Liberia; n=40 Sierra Leone)

The closure of schools removed children from their daily contact with friends and they were very limited in their ability to play outside of school. The ban on gatherings meant that football, volleyball, kickball and other sports could no longer be played. The places where older children socialised; the video clubs and places to buy food and drink, for example, were closed. Even without the bans and closures, the socialising would have been greatly limited because children said they were afraid of contact with others.

> *Before Ebola we used to play with our friends in school and in our community but they told us not to play and our friends no longer go on the field to play football. (Boy, Ganta, Liberia 20 November)*

> *We used to play under moon-shine, games like hide and seek and who is your best friend. All these have stopped because of Ebola and now I am lonesome … We no longer enjoy our childhood. (Boy's group, Masongbo, Sierra Leone, 7 December)*

From the descriptions of younger children, it can be seen that the quality of play has changed markedly. For most young children in the communities visited, play is described as being isolated or with siblings. For survivors and the much larger number of children stigmatised by Ebola in their family, the social isolation may be complete as the quote from a child in Ganta, Liberia, illustrates.

> *I am no longer accepted amongst my friends since I got sick. They no longer visit me at my house and when I go to their house their parents will make me return home because they said I was sick of Ebola. (Child, Ganta, Liberia 20 November)*

A link between play, food and health is made in a few of the interviews. For example a mother in Aberdeen, Sierra Leone, said that children did not play like before because they don't eat enough food (note the link to the hunger described in chapter 5). The much

bigger impact is likely to be on children's happiness and social development. Children or adults do not say this explicitly, but it is clear from the way in which they talk about missing friends and play that it has a strong psychological effect.

Parents complain about the difficulty of preventing young children from mixing with others to play. As the outbreak wears on, the parents in Sierra Leone especially say that children are increasingly unwilling to put up with the restrictions and obey the "ABC" and "APC" rules (Avoid Body Contact and Avoid People's Compound). Children in Liberia and Sierra Leone gave examples of harsh and violent measures used to enforce the rules preventing play.

> *We don't play now because of Ebola. The last time we gathered to play, we were reported and the chief flogged us. (Girl, Mile 47, Sierra Leone 16 December)*

7.7 Psychosocial impacts on children

The research does not provide direct evidence of emotional harm to children resulting from the Ebola outbreak, but the statements provided by children and adults, coupled with the evidence of the extent to which the wider impacts of Ebola were felt, give strong grounds for concluding that children's psychological well-being has been seriously harmed. Children in their own words talk about being unhappy, about feeling lonely, about being heartbroken at the loss of loved ones, about fear and about crying for what they have lost.

The interviews clearly demonstrate that Ebola has challenged the psychological needs of children for loving relationships, for hope and for self-belief, just as severely as it threatened their physical needs.

> *We no longer hug our parents and other relatives and friends as we used to do before Ebola (Child, Saclepea, Liberia, 21 November)*

Children experience bereavement of parents and family members, and witness it in their community. This is evident in high outbreak areas such as 72nd community in Monrovia, but also in rural Bahn, Liberia, where the community reported only two cases of Ebola.

> *In this community, almost everyone knows somebody who got sick, die or lost a family member from Ebola. (Child, 72nd Community, Liberia, 15 November)*

> *Some children watch their parents die before their eyes and cannot do nothing to help. This is getting our children traumatised. (Mother, Ganta, Liberia 20 November)*

Survivors, or those who were seen as suspected cases, suffered from stigmatisation and even felt it as a form of punishment, as if they were responsible for the disease.

> *I used to go to choir practice every Saturday but since I lost my mother to Ebola, they no longer allow me in their midst. People stigmatize me as if I am responsible for what happen to my mother (Child, Ganta, Nimba, 20 November).*

Survivors and suspected cases in both countries were likely to have the added problem of losing all their possessions. Typically, a person's bed, clothes, personal effects and even

their house was burnt in an attempt to eradicate the virus. Amongst people who typically only own essentials, this is a hard economic blow but it is also psychologically damaging - an obliteration of the past and of future possibilities.

> *Most of our properties were burnt down in suspected and quarantined compounds. (Mother, Bonbohun, Sierra Leone, 8 December)*

The strict isolation measures imposed by households and communities and children's own attempts to protect themselves by avoiding contact with others reflect a high level of fear. Parents said that children were afraid. Children's ability to cope with the fear and distress was not helped by what was, for some children and parents, a more stressful and conflictual home environment. Children describe a claustrophobic tension at home, in circumstances where families were confined together with the children not in school and the parents unable to work. The shortage of food adds more pressure on both adults and children.

7.8 Key points on child protection

The UNCRC affirms the right of children to grow up in a family environment. In some cases, Ebola directly challenges this, either by leaving orphans or when parents send children away and potentially into greater risk. More commonly, older children were force by the economic hardship created by Ebola into premature departure from the family home. In so doing they weaken ties with one source of support, the family, at the same time as other sources of protection are lost: schools and the safety nets provided by relatives and friends. Children therefore lose their sources of protection – family, friends, schools, even NGOs – at the same time as they face greater risks.

The extent to which children felt more vulnerable to various forms of exploitation, particularly child labour and sexual exploitation and especially in Sierra Leone, is a strong finding. Despite the efforts of parents to provide for their children, and even to take care of orphans, children are being pushed into high-risk situations such as begging, stealing or prostitution. The extent to which teenage pregnancy is said to have increased in Sierra Leone, and the sexual exploitation that lies behind that, is also a strong and concerning finding. The research indicates that there are various factors behind this, and that they differ considerably between the two countries where fieldwork was carried out, but important questions are raised and the sexual and reproductive consequences of Ebola should be a priority for further research.

Overall, this section reveals again the interconnectedness of the consequences of the Ebola outbreak on the rights and development issues affecting children; linking food insecurity, loss of livelihoods, loss of parental care and child exploitation.

Child protection	
Immediate impacts	***Possible long term consequences***
• Orphans and those who have lost carers due to abandonment or stigmatisation are at greater risk of neglect, violence, abuse and exploitation. • The closure of schools has weakened the protective environment offered to children. • Older children who have lost parents or who face poverty are likely to be more involved in work. • Girls are at greater risk of sexual exploitation due to the loss of education, family's livelihoods and loss of carers. • Children and youth have reduced opportunities for play and socialising.	• Teenage pregnancy rates increase. • Higher involvement in delinquency. • Potential worsening in sexual and reproductive health. • Increased involvement of children in child labour (including the worst forms of child labour) • Increased domestic violence. • Higher rates of behavioural problems and mental disorders.
Priorities for action	
• Provision of community safe spaces for children and youth to resume socialising. • Reinforce case management systems, including the identification of vulnerable children and referral to essential services. • Improve care for separated and unaccompanied children and ensure appropriate family-based placements for children affected by Ebola. • Implement cash-transfer programming to develop the economic capacity and livelihoods of individuals and households. • Implement and/or recommence sexual and reproductive health programmes. • Counteract the stigmatisation of individuals and communities through reconciliation programmes and awareness-raising. • Psychosocial support for children in families and communities affected by Ebola. • Safeguard girls through economic empowerment programmes and sexual health services provision, as well as awareness-raising to counteract marginalisation.	

8 Education

All schools, colleges, and other places of learning closed in Liberia, Sierra Leone and Guinea in July 2014, and only began to re-open in February 2015, after the field research had been completed. Therefore the findings discussed below come from a time when children were not in school.

An estimated 5 million children were out of school in the three most affected countries; Liberia, Sierra Leone and Guinea (Global Business Coalition for Education, 2014). The closure of all schools, colleges and universities means that a cohort of children will have lost almost a year of education. The findings in this chapter show how being involuntarily removed from school has affected children's well-being over and above the obvious effect on their education.

8.1 School closures and home study

In line with the government directive for the closure of schools, all participants in both Sierra Leone and Liberia confirmed that schools in their communities had closed. When asked about the consequences of school closure, younger children talked mainly about the loss of contact with friends and their confinement at home. Older children were mostly concerned about missing examinations that would determine their progression to higher education or into employment.

> *Since this Ebola outbreak in our country, my school has closed. I do not have the freedom anymore to be with my friends as I did in the past due to the fear of this sickness. This sickness has brought a total change in my life that makes me to feel sad daily. (Girl, Guie Town, Liberia, 20 November.)*

Parents and teachers also commented on the impact that school closures had on children's education and they complained that being out of school had encouraged indiscipline and bad behaviour in children.

> *It has brought our kids backward, it has made them wayward. Children are not reading any books, they are all day playing (Community Leader, 72nd community, Liberia, 15 November)*

8.1.1 Home study

With schools closed, only a minority of the children's focus groups said that studying was taking place at home; 40% in Liberia and just under 30% in Sierra Leone. The level of study reported was typically light; mostly the occasional reading of old notes.

Given the often-reported inequality between girls and boys in accessing education, it is significant that in Sierra Leone only 15% of the girls focus groups mentioned participating in home study, as opposed to 40% of the boys groups. The reasons for this are not

explained by the research results, however there are indications in the other sections of the study which point to girls being used for domestic chores, caring for siblings and being required to earn money to support the household.

In Liberia and Sierra Leone, lessons were broadcast through community radio from mid-September 2014 (UNICEF, 2014$_b$; EDC, 2014). None of the children or adults who took part in the research in Liberia mentioned these broadcasts, although they did describe other ways in which home learning was supported.

In Sierra Leone the radio classes were reported to be helpful by just over half of the children's groups. They said that the classes gave encouragement and structure to their own attempts at home-learning. It is suggested by the interviews that the radio lessons were more likely to be used and valued by the children when siblings or adults gave encouragement and helped children to make this a regular part of their day.

> *During the day, when I'm not at school, I listen to the radio and my sister helps me with things I don't understand (Boy, Kissy Bye Pass 12 December)*

But almost half the children's groups in Sierra Leone said that the radio programmes were not useful. They gave several reasons for this;

- Their parents did not have a radio, or could not afford batteries.
- They could not gather to listen at another household because of the restrictions on contact.
- The radio-teacher went too fast, the sound was unclear, and children were not able to follow as they could not see the teacher or ask questions.

Adults were more negative about the radio broadcasts and prioritised keeping their children safe from Ebola and providing food. The reasons they gave for the lack of home study were; a high proportion of parents are uneducated and so cannot tutor their children[1], children are too hungry to concentrate on studying and children are too busy working.

> *I have a radio but I don't have the mind to buy batteries when my children are crying with hunger. I'd rather buy food for my children with the little money I have. (Father, Mateboi, Sierra Leone, 8 December)*

> *Most parents cannot read or write so they cannot help their children at home and at the same time they don't let other people come to their houses to conduct lessons, or let their children out for even 30 minutes. (Community leader, Saclapea, Liberia)*

It is also notable that adults in both Liberia and Sierra Leone were less likely than the children to say that home study was taking place – in Sierra Leone less than 20% of the focus groups spoke about home study taking place and in Liberia only 12%.

[1] Approximately 40 percent of adults are illiterate in both countries (World Bank, 2014, UNICEF, 2014c).

Children and adults in both countries gave examples of more systematic attempts to provide alternative education, including:

- Older children teaching young siblings at home.
- Private tutors providing lessons at home.
- Teachers continuing to teach their own offspring at home.
- Establishment of regular study classes (discussed only by parents in Bushrod Island, Liberia).

In both countries, it was said that the availability of private classes and community-lessons was very limited because of the restrictions on gatherings, and people wishing to avoid contact with others. The loss of household income also meant that many families could not afford private lessons.

8.2 Barriers to a return to education

Substantial barriers to children returning to school were identified by children and adults in both countries:

- Parents of school children and youth in higher education would no longer be able to afford tuition fees.
- Girls who have become pregnant would drop-out of school
- Girls and boys who have started earning money to support their households would be less likely to return to education.

The downturn in incomes and employment as a result of Ebola means that, even when schools re-open, fewer families will be able to afford to send their offspring to school. Children in interviews and case studies expressed their concern that their parents (and often other family sponsors) would not be able to pay school costs. The large and widespread reduction in household income described earlier suggests that this would be likely to affect many children.

> *Most children, at both elementary school and universities, will be school dropout due to lack of support. (Community leader, Saclapea, Liberia, 22 November)*

From the focus groups it is clear that payment of fees is very common and there are many private teachers. So although education from six to sixteen years is in principle free and compulsory, in practice poverty is a big barrier to attendance. There are many private schools (often church-based) because of dissatisfaction with the quality of government-run schools. Even in ‘free’ state schools, poverty may prevent the return of some students because parents are unable to meet the cost of uniforms, school materials, transport or other charges.

8.3 Key points on education

Schools don't just provide classes for children; they are important places for socialising, contact with peers, and for services such as sexual health, school feeding programmes, etc. When schools close, children are no longer spending the day with peers and teachers in an environment that can provide a level of child protection. Schools can be an integral part of the child protection system, bolstering children's knowledge and understanding of their rights. Finally, from the discussion with adults it can be seen that the knowledge and skills learned in school by children are valued. It is important that school is associated with the empowerment of children and their ability to have a voice in family and community matters.

<table>
<tr><th colspan="2">Education</th></tr>
<tr><th>Immediate impacts</th><th>Possible long term consequences</th></tr>
<tr><td>• All children, in all communities, are out of school and will miss at least a year of education.
• Shortages of money, time and motivation mean home-study is very limited.
• School time is replaced by domestic or paid work.</td><td>• Loss of household income means that many families will not be able to afford fees.
• Children lose confidence and self-esteem as a result of their lost education.
• Longer term impact of the economy because of a potential gap in human resources</td></tr>
<tr><td colspan="2">Priorities for action
• Provision of safe spaces and means of communication so that children can organise and support one another.
• Ensure provision of education in emergencies through innovative and distance approaches including radio, television, mobile and Internet technology for when education institutions are closed. Encourage/increase the participation of private business (IT companies, Media and Communication etc) to improve access to education.
• Improve the resilience of education establishments so that total closure is avoided.
• Invest in health programming and teachers' training; Mainstream psychosocial support in education programmes and ensure access to psychosocial care for children and teachers; support school feeding programmes and improve WASH facilities; support school community for disaster risk reduction action plans.
• Financial support for children, youth and families who cannot afford a return to education.
• Additional support for young mothers and victims of sexual exploitation to return to education.</td></tr>
</table>

9 Community cohesion

The protection and well-being of children greatly depends upon the family and the wider community environment. The research has found that communities have been key in responding to and managing the outbreak. In both countries the prevention measures and messages introduced by governments were generally adopted by communities. This was despite some mistrust about the messaging and resistance to the imposed measures in the earlier stages of the outbreak. Communities were also found to have enforced and enhanced the infection control measures.

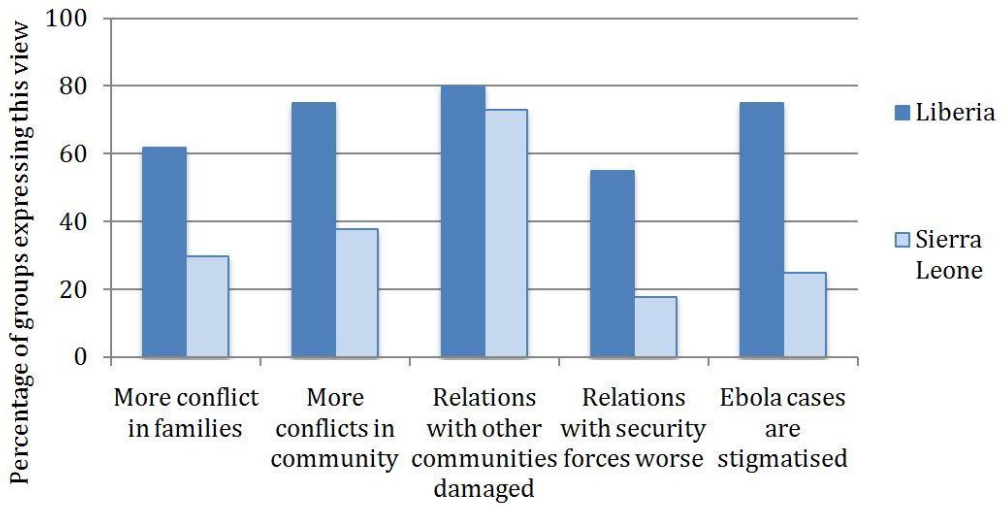
One of the most striking findings from the research in both countries is how little reference is made, by both adults and children who were interviewed, to the actions of government and other external bodies. In other words, very little mention was made of governments and external actors when the research participants described the day-to-day implementation of control measures. The situation that they recounted is one in which the government set the overall rules – the closure of schools, markets and county boundaries for example – but communities were the ones who largely determined what happened on the ground, including the isolation and care of suspected Ebola cases.

However the strict measures adopted by communities to protect the health of children and adults came at a high price. Considerable distrust and tension was created within families and communities, which threatened their ability to deal with the wider impacts and to provide a caring environment for children.

9.1 Evidence of disputes and fragmentation

The research provides some evidence of disputes within families, within communities, between communities and between communities and external agencies (Figure 9.1). The tension and fractured relations that were described by almost all research participants has seemingly led to fractured communities in need of reconciliation and reunification. Recovery efforts in each of the Ebola affected countries need to take cognisance of these definitive findings from the research and address them as part of an integrated approach to all the issues explored within this study.

Figure 9.1 Impact of Ebola on community relations



Source: Adult focus groups (n=60 Liberia; n=40 Sierra Leone)

9.1.1 Disputes and tension within families

The research revealed differing views between Liberia and Sierra Leone on the extent of family disputes as a result of the outbreak.

Most of the adult groups in Liberia stated that disputes within families had increased as a result of Ebola. They attributed this mainly to the tensions that arise over shortages of food and money in the household, and to resentment between family members, including extended family, when they fail to take care of sick family members. Accounts of such disagreements were common and very hard-felt amongst research respondents. In addition, these were sometimes said to spill over into community-wide disputes, as the quote below illustrate:

> *There will be conflict in family and community because they were not there for each other when Ebola attacked (Father, Mount Barclay, Liberia, 13 November)*

From the children's perspective, just under half of the children's focus groups in Liberia said that disputes within the family had increased, for example one girl commented:

> *My own blood sister and best friends despise me, abandoned me and pretended never to know me when I lost my mother to Ebola. They will never again be my family and friends. (Girl, Ganta, Liberia 20 November)*

More commonly, children noted that there was less fighting and shouting in the household on account of all the household members being very concerned about Ebola and the availability of food.

> *There are less conflicts in this community now because everyone is thinking about where or how to get food for his/her household. (Boys, Makeni Town, Sierra Leone, 12 December)*.

In Sierra Leone, only a third of the adult groups expressed the view that tensions within the family had increased. They explained that disputes mainly arose as a result of food shortages. As opposed to Liberia, they did not describe major family rifts occurring. Conversely they also noted that hunger and the necessity to find work made them put the usual quarrels to one side. Children in Sierra Leone were least likely of all the research participants to say that disputes in the family had increased. Indeed, a large majority of the children's groups said that there were less disagreements as a consequence of Ebola.

9.1.2 Tension and disputes within communities

Communities have been considerably damaged by divisions and disputes. Most adult focus groups in Liberia said that there was more conflict within communities as a result of Ebola. Research participants related how community members were abandoned, or saw their loved ones being abandoned by others, and how they felt let down or betrayed by the community that they belonged to. Suspicion about families hiding suspected cases and perceived added to the distrust and divisions. Such feelings were particularly evident in urban, high-outbreak sites (the term "conflict" refers to these tensions and damaged relations and does not relate to physical violence).

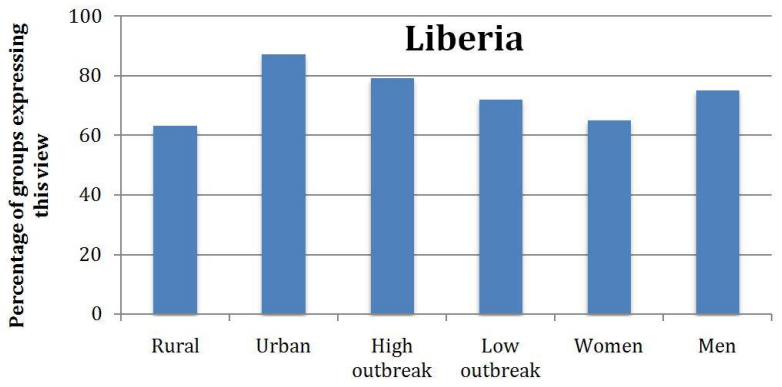
Mis-use of the Ebola hotlines for reporting suspected Ebola cases (4455 number in Liberia, 117 in Sierra Leone) was an often-cited cause of tension and resentment amongst communities, as shown by the quotes below:

> *Many people called the Ebola Team on their neighbour without being sure that what they really saw was signs of Ebola, and some of those people died from such action. (Mother, 72nd community, Liberia, 15 November)*

> *There are two major conflicts; firstly people don't want 117 to be called even if they have sick people at home. Secondly, the food available at home which is now low does not go down well with the women. They tend to confront their husbands (Father, Mateboi, Sierra Leone, 8 December)*

Research respondents described the anger that resulted when one community member reported another as suspected of having contracted Ebola. In Liberia, the view that there were more tensions and disputes in communities as a result of Ebola was widely shared across the different research sites, although it was more frequently expressed in the groups in urban and high outbreak sites. Figure 9.2 gives a breakdown of views on increased conflict within communities by different of groups.

Figure 9.2 Increased conflict within communities – breakdown



Source: Adult focus groups in Liberia (n=30 rural; n= 30 urban; n= 32 High Outbreak, n= 48 low outbreak; n=20 women; n= 20 men.)

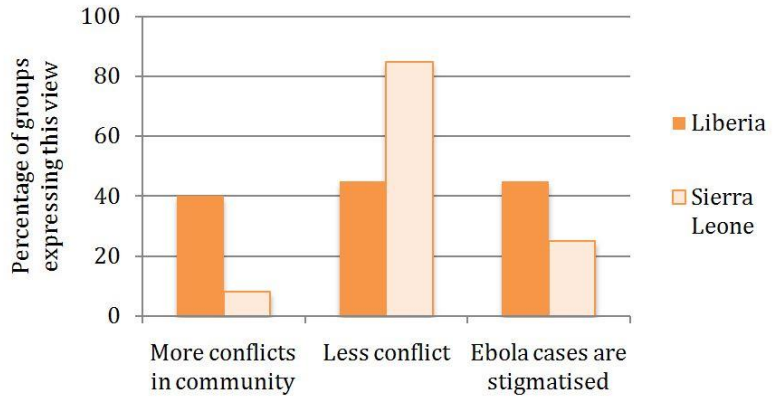
The level of tension and dispute within communities was noticeably less in Sierra Leone. The explanation for this appears, from the findings, to be that communities there were better versed in the prevention messages, more organised in their application of these and better supported by external agencies (for example a higher proportion of health centres were open). Because the peak of the outbreak occurred later in Sierra Leone, and after an initial spike in cases outside of the capital Freetown, communities and authorities had more time to prepare. Communities in Liberia, in contrast, were less able to rely upon their own organisation or external support and consequently turned in on themselves as a result of the greater pressure. They resorted more to stigmatisation as a way to create a separation from Ebola suspects. This discrimination added further fuel to the tensions.

The finding by the research that communities in Sierra Leone were better prepared has some support from statements from published sources. For example, a WHO situation report on Ebola from January 2015 notes that awareness raising has gone successfully through a network of community leaders in Sierra Leone, but such a network has yet to be established in Liberia (WHO, 2015)

Children, especially those from Sierra Leone, were more positive about community relations. Figure 9.3 shows that more children said that there was less conflict within communities as a result of Ebola. Children in both countries, and adults in Sierra Leone more often described a “peace dividend” in that Ebola has reduced the everyday conflicts in families and communities, as people united to prevent infection and hunger.

> *There is less conflict in this community now because everyone is thinking about where or how to get food. (Boy, Makeni Town, Sierra Leone)*

Figure 9.3: Community relations – views of children



Source: Children's focus groups (n=20 Liberia; n=40 Sierra Leone)

9.1.3 Discrimination against Ebola suspects

Stigmatisation is used to create a physical and emotional gap between those who are free of the virus and those suspected as carrying it. As the earlier health section showed, this segregation is often done crudely and sweeps in a large number of people who show signs of any form of illness or have any sort of association with individuals, families or even communities with Ebola.

There were rare examples from Liberia of communities helping Ebola families but in the main they were highly segregated and discriminated against – very much "outcasts" - which was the term often used. In line with the findings in relation to tension and disputes in communities, the stigmatisation of suspected Ebola cases and anyone associated with Ebola is much more frequently described by the adult and child participants in Liberia. 75% of the adult groups in Liberia said that those with Ebola were stigmatised, as did 45% of the children's groups. The quote below illustrates the complete division that was create in some settlements, and the expectation that the rift would continue long into the future:

> *Ebola divided our community into two zones. We now have zone one, free from Ebola and zone two, which has some households infected. Zone two was quarantined for over 21 days during this period. [Interviewer: "After Ebola, what do you think will happen"?] The community that has been divided will remain as it is. (Child. Ganta, Liberia 20 November)*

In contrast, far fewer adult and children's groups in Sierra Leone said that suspected Ebola cases were stigmatised (25% of both adult and children's focus groups). Most groups affirmed that Ebola suspects were not stigmatised. They often said this in the form of "we are not allowed to stigmatise…" or "it is wrong to stigmatise…" and some groups explained that they had received these messages from health workers (the 'Ebola Sensitisation Team'). However, to some extent, it appears that the Sierra Leone groups were speaking from the basis of what they thought they should say, rather than what

actually happened – there is a gap between their rhetoric and their actions, as evidenced by the quotes below.

> *Even some of us children call them 'Ebola Pikin' which mean Ebola affected child. (Girl, Kissi Town, Waterloo Rural Area, Sierra Leone, December 8)*
>
> *My aunty was sick with Ebola and is now a survivor and I feel too bad about it because the stigma will always be on her. (Boy, Makeni Town, Sierra Leone, 12 December)*

As noted elsewhere, one of the recurring themes emerging from the research is the effect of the messaging received by communities. In this case, the awareness raising that people in Sierra Leone received with regards to stigmatisation appears to have been effective. It forms part of the explanation of why they were better able than the Liberian communities to manage Ebola without creating huge divisions and tensions within the community.

9.1.4 Tension between communities

It was found that the divisions between communities were stronger than those within communities. The strict implementation of infection controls by communities themselves meant that extended families were unable to travel to help one another. In addition, many were refusing to help others out of fear of confinement or infection.

> *Nobody is allowed to go to another village or town. If anybody comes to you from another community, they will stay indoors without getting in contact with anyone for 21 days (Child, Karplay, Liberia, 25 November)*

Communities in both countries have elaborate systems of laws, self-imposed rules, and incentives to prevent mixing between communities. In Liberia, the main incentive is the fear of being placed in quarantine for 21 days, as indicated by the quote above. In Sierra Leone, there is the added incentive of fines imposed by the community authorities. Thus, 83% of the adult focus groups in Sierra Leone said that visitors were banned or quarantined and with 62% of groups in Liberia. A similarly high proportion of focus groups in both countries describe ways in which their relations with other communities have been damaged (Figure 9.1).

In both countries, adults and children gave examples of rumours about wells being poisoned by neighbouring communities (for example in Masongbo Town, Bombali, Sierra Leone). Whether true or not, such stories make the wider point that levels of fear and mistrust between communities are high. Several other "them and us" narratives run through the accounts given by adults and children for example between medical workers and patients or between profiteering businesses and those struggling to afford the essentials. However, the stigmatisation of Ebola suspects is by far the largest cause of tensions and fragmentation within and between communities.

9.2 Evidence of cohesion and resilience

There is a strong counter-story to the tensions and disputes described above, which is that, despite the huge pressures created by Ebola, communities managed to continue to work together to protect themselves from the virus.

9.2.1 Decision-making in Communities

In both countries almost all of the adult groups who took part in the research reported that community governance meetings had been much less frequent, because of the ban on gatherings and people's own fear of meeting others. Despite these difficulties, communities had organised themselves against Ebola. Although the virus eclipsed community governance of all other matters, for this critical issue they continued to function as decision-makers. Community decision making structures and coping strategies were not, therefore, abandoned or overwhelmed and communities were (after the initial stages of the outbreak) highly effective in dealing with transmission by isolating suspected cases.

Importantly the research suggests that there has not been a widespread loss of community leadership. Some communities say that their community has been weakened by the death of community leaders, for example an adult group in Daru Town, Kailahun, Sierra Leone explained that most of their religious leaders like imams, had died due to the Ebola outbreak.

> *This sickness has brought backwardness in our lives like in the area of education for our children. It also made most of our health workers to die and in the area of religion most of our religious leaders, like imams, have died due to the Ebola outbreak (Male care, Daru Town, Kailahun, 8 December)*

In the most affected sites, such as Small Ganta in Liberia, the high death rates and high levels of fear and distrust described by the adults focus groups appear to bring the community close to a tipping point at which is will no longer be able to function. But even in these worst sites, complete disintegration was avoided. And in the large majority of communities, in both countries, community leaders were described as playing the key role in protecting people from infection.

9.3 Attitudes towards government and NGOs

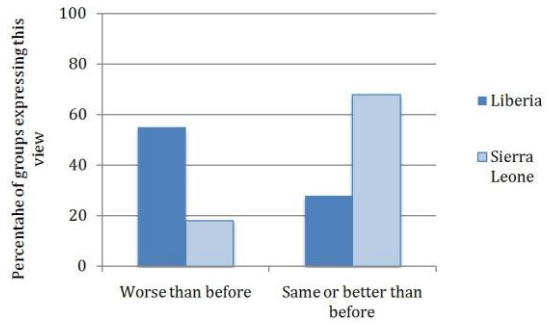
At the local level, in the sites where the research was conducted, some communities describe disputes and complaints with the state authorities. They described mistreatment and corruption by police and army, and they expressed anger at the government and at NGOs for failing to do enough to protect them from Ebola or help them cope with side-effects, such as hunger.

> *There hasn't been any fair play by government of Liberia and NGOs in the fight against Ebola. Sick people were being neglected, left to die all by themselves.*

Materials meant for the community to fight Ebola were not distributed fairly. (Parent, Ganta, Liberia 20 November)

In Liberia, just over half of the adult groups said that their relationship with the police and army was worse, as a result of how they had acted during the Ebola outbreak (Figure 9.4). Whereas about a third of the groups said that it was like before. This changed attitude is perhaps a consequence of the way in which emergency security and Ebola prevention measures were put in place and crudely enforced whilst the outbreak was rapidly rising and before the communities were able to organise themselves. In particular, communities complained about the heavy-handed ways in which curfews, market closures and bans on gatherings were enforced by police and troops in the months after the state of emergency had been declared. Several communities in Liberia complained that Ebola had been handled by the government as a security issue rather than a health crisis. As evidence of this they referred to the Ministry of Internal Affairs rather than the Ministry of Health being in charge of operations. They reported seeing more troops controlling people than health workers treating them.

Figure 9.4 How are community relations with the security forces as a result of Ebola?



Source: Adult focus groups (n=60 Liberia; n=40 Sierra Leone)

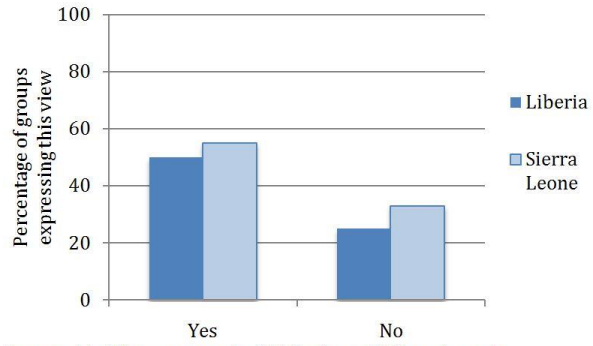
Attitudes amongst the adult groups in Sierra Leone were the reverse of that found in Liberia. Only the minority of focus groups said that relations were worse and most groups said they remained as before.

Even though some of us were angry with the government we now realize that they were helping to save us (Community leader, Toe Town, Liberia, 29 November)

9.3.1 Perceptions about the honesty and fairness of government and NGOs

In response to a more general question about whether governments and NGOs had been honest and fair in the way they dealt with people about Ebola, over half of the adult groups said that they had been honest and fair. Only a minority said not (Figure 9.5). Overall, the attitude towards external agencies is slightly positive and has survived the worst of Ebola. There is therefore some basis to build on between communities, government, and NGOs for the post-Ebola recovery.

Figure 9.5 Were government and NGOs honest and fair about Ebola?



Source: Adult focus groups (n=60 Liberia; n=40 Sierra Leone)

9.4 Views on recovery and permanent change in communities

Most of the children's groups in both countries who expressed a view on the longer-term recovery of their community were of the opinion that it would return to how it was before Ebola. Children tended to see a quicker recovery, speaking about when schools would re-open and it would be possible to mix with friends.

> *For me, what I know is that people will be close again, schools will open and we will play with friends again. (Child, 72nd Community, Liberia, 15 November)*

The adult focus groups also mostly believed that recovery would happen, although it would take longer – from five to ten years in most cases in Liberia. Adult groups in Sierra Leone were generally more optimistic, predicting a return to normal in less than five years in most cases. The types of reasons given by those predicting a longer recovery are illustrated well by the quotes from a women's group in Petifu, Sierra Leone (a low outbreak, rural site).

> *It will take us five or more years, because we will be creeping for survival as we have used all our resources during this crisis, but it all depends on the help from the government and NGOs … It will take us a long time, like five to eight years because most of us have lost our helpers in outside communities and most of us will not have money after Ebola to take care of our homes and also to pay school fees for our children … It will take us like seven to ten years because if whole year pass by without farming it will be like you have lost everything … Things will not be the same after Ebola because we have lost all of resources and most of our girls are now pregnant and most of the boys will be drop outs (Women, Petifu, Sierra Leone, 13 December)*

In both countries, some adults expected Ebola to be a permanent threat. Thus they spoke about maintaining prevention practices: not shaking hands, avoiding contact with corpses and sick people, being careful about meeting others, especially strangers and avoiding multiple sexual partners.

> *We all believe that things will never be the same again. We will never eat together as before. We will never wash our dead bodies as before. We don't believe we will ever shake hands again. We may not welcome visitors as before. We will find it difficult to rally around sick persons like before. (Community leader, Karnplay, Liberia, 25 November)*

However, others referred to the previous civil conflict in Sierra Leone and Liberia and the resilience that communities showed in recovering from these. They said that the communities are quick to forget and so they will put Ebola behind them and go back to their old ways.

> *If the ten years of rebel war came and went yet communities stayed the same, after Ebola communities will also be the same again, as Sierra Leonean are quick to forget (Father, Mateboi, Sierra Leone, 8 December)*

This also implies that some of the practices developed during Ebola that the groups see as positive, such as washing hands, will also be forgotten quickly. One of the traditional practices that appears to have been halted during Ebola is Bondo secret society rituals in Sierra Leone, at which female genital mutilation is carried out.

9.5 Key points on community cohesion

<table>
<tr><th colspan="2">Community cohesion</th></tr>
<tr><th>Immediate impacts</th><th>Possible long term consequences</th></tr>
<tr><td>• Community practices such as meetings, celebrations and burials have largely ceased and some customs may change permanently.</td><td>• Community decision-making capacity has (largely) remained intact, so there are good foundations for community-led initiatives in the recovery phase.
• Communities have been totally focused on Ebola prevention and so other development initiatives and community cohesion practices have generally been neglected and may even have regressed.</td></tr>
<tr><td colspan="2">Priorities for action
• Reconciliation amongst families and communities, as well as between communities and the state.
• Restoring the central role played by families and communities in how their sick and dead are cared for in outbreak scenarios (whilst ensuring safety and infection control) in order to ensure community acceptance of infection control measures.
• Using community and leadership structures as a basis for different recovery interventions e.g. citizenship and governance initiatives, economic security, rebuilding and strengthening health services.</td></tr>
</table>

Part III: Conclusions and recommendations

10 Conclusions and recommendations

This study was exploratory and therefore wide in scope. It sought to examine the indirect consequences of the Ebola outbreak for children and families in relation to defined rights based issues: education; food; livelihoods; child protection; and health. Furthermore, it sought to examine these issues in the light of cross cutting themes such as youth, gender, rural/urban differences and community cohesion. The findings, on the one hand, provide a community and child-based perspective on the intricate and complex ways in which children's lives were affected. They confirm and at times contradict some of the prevailing studies and thinking, but always through a grassroots lens. On the other hand the findings, despite being based on very localised views, have illuminated certain bigger, more fundamental issues that need to be addressed within the response and recovery phase of the Ebola emergency.

Some key conclusions emerge from the study. Upon these, recommendations are made for addressing immediate needs and longer term consequences. Each key conclusion and its attendant recommendations is discussed in turn below.

Finally, while perhaps stating the obvious, despite this being a medical emergency with direct health implications for those infected, the entire population of each country was dramatically affected by the wider consequences of the outbreak. It follows that the recommendations are relevant to the continuing response and recovery for the Ebola outbreak, but also future health emergencies and other types of disasters.

10.1 An integrated, interconnected recovery approach is needed

The research findings clearly demonstrate the complex and interconnected ways in which Ebola affected children and their families. Given the breadth of the impact of the Ebola outbreak, a single issue or single-sector approach, with separate initiatives for mothers or orphans, or for education, health, and child protection, is unlikely to be the most effective. Therefore, a key recommendation that arises from the research is that interventions should be comprehensive and integrated.

In this regard it is recommended that:

- **Measures to protect children's rights and restore services should be taken at scale, in recognition of the way in which all children are seriously affected by the indirect effects of Ebola.** This means working through the existing nation-wide infrastructure (like the education system or health system).
- **Emergency committees and planning processes should involve all relevant stakeholders (e.g. health, education, child services, justice, employment and gender) in the design, planning, budgeting and implementation of the Ebola**

response and recovery. This is to ensure that inter-dependencies, risks and the full range of impacts of an emergency are considered: not just the health implications, but also the social implications.

- **Community representatives and those with local knowledge should be included in top-level decision making**
- **Targeted assistance should be provided within a comprehensive approach because acute needs are created by the wider impacts of Ebola (such as hunger) and some groups are particularly vulnerable (such as children).** These should be implemented in a coordinated fashion For example, coordinating cash programming with providing food aid and the opening of schools.

10.2 Strengthening systems

The research is based very firmly on the experiences and views of children and adults at community-level. It did not include an analysis of the national government systems that contribute to the care environment for children, but the findings point to some conclusions and recommendations in this respect.

An obvious but nonetheless significant point is that least developed and aid-dependent countries such as Liberia, Sierra Leone and Guinea have major weaknesses in their national child-services and child-protection systems. They also lack any state-sponsored social protection system to assist those in poverty. This emphasises the relevance of mainstream development efforts and the importance of community-based support in the absence of state provision.

Schools are shown by the research to have an importance for children that goes beyond the provision of education. They provide the time and space for socialising and peer support. They give children access to information and with this an enhanced status in family and community decision making. They are important centres for sexual health, child protection and other programmes.

Thinking ahead to future emergencies, the most pertinent recommendations that follow are:

- **The closure of schools should be a measure of last resort, only taken with full recognition of the impacts that it will have on the wider well-being of children, as well as on their longer term prospects.**
- **Measures that increase the resilience of schools against complete closure should be prioritised within disaster risk reduction.** For example, infection control measures, coupled with accurate and child-friendly information, could enable schools to stay open in low-outbreak areas.

- **Alternative means of delivering classes to children in homes or other safe environments should be planned and piloted so that future contingency arrangements are in place.**
- **In the absence of national social protection systems, the revival of economic and social activities must be prioritised.** For example, this could be supported by cash programming, waiving of school fee's, government grants, or support to village savings and loans groups.

10.3 Communities are central to response and recovery

The findings demonstrate that communities have played a central role in responding to and ultimately controlling the Ebola outbreak. Far from being passive victims of the virus or beneficiaries of the international emergency response, they managed Ebola prevention and containment when state systems were strained and international relief was slow to respond. Communities enforced their own isolation methods; for example by preventing gatherings and contact with outside communities and by quarantining suspected Ebola cases. Often their actions were crude, but they represented a level of leadership at a time when communities were in crisis. Coping strategies were not entirely abandoned and decision making continued to function. The findings provide confirmation that externally imposed control measures such as isolation, contact tracing or safe-burial do not work unless supported and implemented by communities.

However, it is equally apparent that communities paid a heavy price for their strict control measures. The isolation of suspected cases led to family members, households and even whole communities being shut off and, to a large extent, abandoned. This caused fear and resentment, made worse by the stigmatisation that was used to separate suspected cases and those free from Ebola. The tensions within and between communities damaged important safety nets such as the care normally available to children from extended family, or the practice of sharing food amongst families and friends. The capacity for self-care has been damaged, the research finds, but not lost. To capitalise on the strength and centrality of communities, reconciliation is a critical feature of recovery efforts. The role of communities and the leadership that they displayed is a critical strength that must be supported and built upon in the recovery phase.

In this regard there are some clear recommendations that arise from the findings:

- **Stigmatisation should be addressed by supporting communities with accurate information about risks and how to provide safe care.** This is because the stigmatisation of children and carers associated with Ebola greatly increased their vulnerability. There were instances of individuals being denied food and water, prevented from buying food and losing their job because of their association with Ebola suspected cases.

- **Community-reconciliation initiatives should be used to help families and communities resolve disputes and divisions.** This is so that they can provide the collective care and 'safety nets' that children rely on and prepare them for emergencies of a similar nature.
- **Local civil society organisations that can help fill the gap left by absence of state-led services should be an important component of response and recovery, and should be supported by governments, UN agencies and INGOs at critical stages of emergencies and in resilience planning.** There was an almost complete absence of any other intermediary body to help fill the gap left by the shut-down of state-led provision. This added to the great strain that was placed on communities and families. The research found that organisations such as churches and private companies played a useful role in a few localities, so there is the potential to build this up into a stronger support system for communities and families.
- **Governments, UN agencies, donors and INGOs should work with and through communities in order to make infection control measures effective. This is also true for managing the wider impacts of Ebola.** Decisions about whether measures will do more harm than good are more likely to be correct for local circumstances if they are made with communities, or by communities.

10.4 Community resilience

The resilience of community decision-making and the importance of communities as a bedrock for recovery has already been highlighted. Further conclusions on resilience can be drawn about how the strengths of communities can be built on.

Although an Ebola outbreak of this nature is new to West Africa, sickness, hunger and poverty are not. Parents and communities therefore have coping strategies that the research shows were applied in response to the wider impacts of Ebola. Families resort to home-diagnosis and treatment when medical services are unavailable or unaffordable. They also reduce the number of meals and the quality of food eaten in response to food shortages. In rural areas especially, families have access to land on which they can grow subsistence crops and gather wild food.

A second form of resilience is the elaborate system of familial and community-based support that is available to children and families. For example during the research children described how they often depended upon who they described as 'sponsors' in their extended family to pay for school fees and materials, and how they relied on visits to relatives and friends to get fresh food. Adults described how orphans were almost always cared for in the community by relatives but also by friends and neighbours. Although severely strained by fear of contact, control measures and wider impacts such

as loss of household income, this community-level care remains as a vital component of the recovery and future resilience.

The recommendations that follow from this are that:

- **The strategy for relief and recovery should be built around an understanding of existing coping mechanisms and have the central aim of supporting, not replacing, the care services that communities provide.** For example, supporting community care of orphans rather than removing children into state alternative care.
- **The adverse consequences of short-term coping strategies need to be recognised and mitigated.** For example, changes in food intake are likely to exacerbate undernourishment and stunting in infants.
- **The limitations of community-based care should be recognised, in particular the vulnerability of children being informally placed in alternative care.** Support for community care should therefore be complemented by enhanced protection safeguards.

10.5 Social mobilisation and awareness raising

This was an emergency that rocked the core of each of the three nation states most severely affected by the outbreak of Ebola. The messaging employed by the governments and UN agencies to prevent the spread of the disease are shown by the research to have been problematic in the way they were received and enacted in communities:

- The crude prevention messages that were used to try and contain and stop further transmission had unintended consequences – for example, the messages “Ebola kills,” “There is no cure for Ebola” and “Don’t touch” were reasons given by adults who participated in this research for avoiding health services and refusing to care for others.
- The ban on bushmeat addressed a minor risk of infection yet had a very far-reaching effect on food security, spilling over into a general fear of eating meat in some cases and denying a large proportion of the population their main source of protein.
- Ebola Task Forces or Sensitisation Units were often perceived as playing more of a security than a health-care role, sometimes brutal in their enforcement of laws such as the ban on bushmeat or gathering in groups. When this happened it caused resentment rather than cooperation in communities.

This is a difficult balancing act because the priority must be to get the essential safety messages across, and in this respect the research found that messaging clearly worked. People in both countries were very clear about the basic “don’ts.” However, some other

messages about what could be done safely would have helped to reduce the wider impacts and supported communities in the actions they were attempting to take.

In this regard, some recommendations on messaging can be made as follows:

- **Messaging should include information to counteract rumours**. For example this research found that vaccinations were widely believed by parents to be a possible cause of Ebola.
- **Messages should be accompanied by measures which enable communities to do what is being asked.** For example suspected cases could not present to the authorities for isolation and treatment when no such facilities were in place. Communities could not leave bodies for burial teams when these were unable to collect bodies in a reasonable time.
- **Lessons need to be learnt on how to ensure more effective messaging is delivered at community level**. For example, it was found that community leaders played a crucial role in determining whether messages were acted upon by the wider community. Therefore, governance structures should be involved at the outset on both the content and mode of delivery.

10.6 Vulnerability of children

The vulnerability of children was exacerbated by the Ebola outbreak, because family and community safety nets were less able to care for and protect them.

A vital factor in vulnerability is care. Essentially, the most vulnerable are those who require most care. So children who lose their parents or carers, unborn or newly born babies and children with illnesses or disabilities are acutely vulnerable. But perversely, Ebola also threatens care-givers. Health care workers died in large numbers are those who remained were afraid to treat patients, as the research demonstrates. Parents are carers at home faced the same risks and fear of infection and stigmatisation.

The vulnerability of children to the wider consequences of Ebola can be seen in terms of the extent to which they have been disempowered. They have been shut out of awareness-raising and risk reduction by the closure of the institutions that usually rely upon for information and support - education establishments and development programs. They have no safe space to meet with peers and so help each other or their community. Those who are forced from education into work or early marriage have their future taken out of their hands.

Another principal factor governing vulnerability to the wider impacts of Ebola is poverty. Ebola impoverishes families, as the evidence from communities shows, and this has consequences for children such as shortages of food and other essentials. Although Ebola kills the wealthy as well as those who live in poverty, the poor are affected

disproportionately because they have fewer reserves to cope with the impact on standards of living by Ebola. They lack adequate nutrition and access to clean water and sanitation, they live in overcrowded, inadequate accommodation and they are less able to pay for medical care. They cannot afford to move away or stay away from work. Everyone in the household must work to secure food or money, including the children. In numerous ways, they have fewer options. Children in poorer households are therefore more vulnerable to infection by Ebola and to the side-effects of attempts to control it. They face a 'double-hit'.

The recommendations that follow from this are:

- **Relief and recovery planning should be informed by vulnerability assessments, specifically including children.** Conventional assessments, which typically concentrate on care-dependent people, should be expanded to include care-givers, including parents and carers at community level.
- **The wider impacts of outbreak control measures and their likely effects on the population at large, and on vulnerable groups in particular, should be built into crisis assessments and planning from the outset of any emergency**. This is in order to mitigate, if not avoid, harmful side effects.
- **There is a pressing need for safe spaces and safe means of communication so that children can exchange information and support one another.** This is so that they can organise themselves in order to play a full role in decision making and crisis response even when schools are closed and movement is restricted.
- **Vaccination services need to be restored. Children who have not been vaccinated need to be identified and vaccinated and future disaster risk reduction efforts must safeguard vaccination programmes.** A clear finding from the research was that children were no longer being vaccinated.

10.7 The need to listen and learn

This research demonstrates the value of listening to the voices of children and communities. The observations, experiences and lived realities of those at the sharp end of the outbreak provide important insights into how wider impacts occur and hence how they might be addressed. One example can be found in the section on education where children and adults spoke about the availability of radio broadcasts as an alternative to closed schools. It was clear from the focus group discussions that there were a number of challenges encountered including both the quality of the broadcasts and access to radios or even batteries for radios. Shared experiences, such as these, should be utilised in order to inform improved responses, relief and recovery efforts in future emergencies. Humanitarian action often involves rapid assessments and situation analysis, but the

value of structured dialogue to give voice to those affected at grassroots level cannot be underscored enough.

- **It is therefore recommended that in emergency situations, a multi-faceted approach to information gathering and learning needs to be implemented including in depth qualitative research with children.** However, listening is not enough, where needed the information gathered through the various studies needs to be fed through to communities and other decision makers to drive continuous improvement in humanitarian responses.

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1 Appendix 1

EBOLA: beyond the health emergency

Case Studies

Introduction

Two case studies were researched and written for each site; forty from Liberia and forty from Sierra Leone. There are 43 girls and 37 boys in total. These have an individual child as their focus and involved in-depth discussion with that child and their parents or carers. They often required speaking with more than one adult as well as the child.

The case studies were prepared from short discussions (typically 10-20 minutes), depending on how much information the child and cares had to give. The guidance used for conducting case studies is included in appendix 2. This included advice on handling confidentiality and child protection/ethical issues in the following way:

- The participants for the case studies will come from the discussions with children and parents and they will therefore be selected by the participants and with their consent.
- The child's name will not be included in the final, published version of the case study, although it will be recorded during the research.
- The parent/carer of the child will be invited to give her/his verbal consent to the case study on the understanding that it will only be reported anonymously.

The intention with the case studies is that they complement the other sources of information; the focus groups and the 1-1 interviews with community leaders; by telling a real-life story which illustrates the consequences of Ebola for a child, relating this to how the family and community have been affected.

The length and quality of the case studies varies considerably, because of differences in the way they were carried out as well as differences in the individual stories and the circumstances in which the interviews were conducted. Some illustrate a single aspect of the impact of Ebola whereas others reveal various, inter-connected issues. Read, together, they provide a first-hand account of the many ways in which children are affected by the indirect, as well as direct, impacts of the Ebola outbreak. Those from Ebola orphans and survivors are particularly dramatic, but the accounts from children less directly affected give an equally important description of the comprehensive harm cause by the Ebola outbreak. The wording of the field-notes is reproduced, with only minor editing to improve readability. As a consequence, the grammar is often incorrect although the meaning is clear.

In this case study book, the Liberian case studies are presented first, followed by those from Sierra Leone. For both countries, cases from high outbreak areas are given first, followed by those from low-outbreak areas. Within each sub-section, urban and rural areas are presented in that order and under the urban/rural heading, girls are followed by boys.

NB: The names and locations in the case studies have been removed to protect the child's identity.

2 Appendix 2A

TRAINING and FACILITATION GUIDE

EBOLA HUMANITARIAN CONSEQUENCES RESEARCH

Contents

1. Research objectives and approach

The research objectives create some big challenges for how we carry out the fieldwork.

Firstly, this research is not about the direct impacts of Ebola (sickness and death). It is about the way in which children and adults have had to change the way they live as a result of Ebola, and the consequences that this has, or will have, on education, child protection, food security, livelihoods and community cohesion.

So we are not testing people on what they know about Ebola or how to protect themselves. We are going to be asking them about the changes they have had to make in their lives and how these affect their children and family. The basic questions that we want to explore with people are:

- What changes in your day-to-day life have happened because of Ebola?
- How are these changes affecting the well-being and development of children and the strength of the family and community?

Secondly, it is not easy to ask this kind of question:

- The changes and consequences can be many, so a discussion can be complicated and long.
- People might want to tell you about Ebola sickness and how it directly affects people, because this is what they think you want to hear and it is what they are immediately concerned about.
- People naturally focus on immediate problems and on those that they think NGOs/donors might help them with. For example, people may talk more about money or food, because they are necessities and they hope to get financial assistance or food aid. They may talk less about children being afraid or being out of school and less able to play with friends, because the long-term consequences of this are less obvious, as are the immediate solutions that NGOs can bring.

Thirdly, the research aims to get an in-depth understanding of the consequences and how they happen, at the same time as getting a general understanding across communities in Sierra Leone that can also be applied to Guinea and Liberia. It is difficult to balance these two levels of analysis. For in-depth, we want to spend a lot of time talking in detail. For general, we want to cover a wider set of questions, consistently, with a large number of people.

Fourthly, the purpose is to enable Plan International and others to improve their response to this and future outbreaks of deadly viruses. We therefore need to relate our findings to what individuals and communities can do to help themselves, and how Plan and others can support people, communities, civil society organisations or their governments. So we want to understand how the wider consequences of Ebola happen, in order to identify what interventions will help most.

What this means for how we do fieldwork

With these challenges, it is very important that the research teams understand why we are doing the research. We don't have a questionnaire that researchers just work through, asking every question. If we had this it would be too long, and it would mean that we have already set the agenda – communities would not be free to tell us their priorities, in their own way.

Instead, we have a checklist that gives themes and prompts for the researchers to use. The facilitator therefore needs to use their skill and judgement to decide what questions to ask or not. They need to find the right balance between:

- allowing participants to describe the changes and consequences as they see them;
- making sure we cover the themes and ask a consistent set of core questions at each site.

To do this, facilitators need to:

- Organise the group so that different types of people and perspectives are included.
- Facilitate the discussion so that each person has an opportunity to speak
- Begin the discussion by asking the participants to list the most important changes in the lives of children and families that they see.
- Use follow up questions to get an in-depth understanding of (only) the most important changes/consequences.
- Use the checklist to make sure that all the themes and core indicators are covered.
- Use the change chart to measure the scale of change in core indicators and to feed the results of the discussion back to participants.

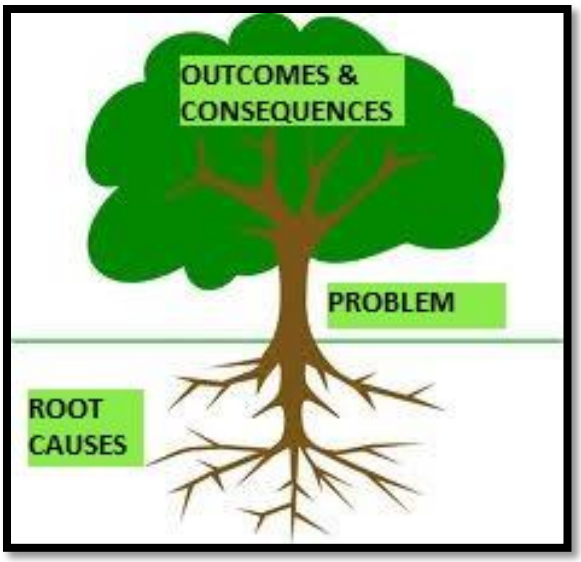
Training Purpose	Resources
To understand the objectives of the research so that the research tools can be applied most effectively.	• Research Terms of Reference • Research Proposal • Research Tools and facilitation guide (included in this document)
Training Tasks • Read research terms of reference and proposal. • As a group, carry out a '*problem tree analysis'* for an example (fictional) pregnant woman, based on what you already know about changes and consequences of Ebola. The reason for doing this is that it shows the kind of 'cause and effect' discussion we want to have with children and adults and the importance of follow-up questions to reveal consequences. It also shows the sort of 'story' that we want to be able to tell in the reporting/write-up of the consultations and case studies.	

Step-by-Step: Problem tree analysis

Step 1: Explain to the participants that you are going to read a scenario that deals with the consequences of the Ebola outbreak in Sierra Leone

Step 2: Explain the following short scenario to the group:
A 15 year old girl living in a village outside of Port Loko fell pregnant in November. This girl did not use a contraceptive during intercourse as she was afraid to go to her local clinic due to the threat of Ebola. Her friends who have been to the clinic say there is nothing there anyway. Now her village is quarantined, and she is worried about accessing a PHU for the duration of her pregnancy.

Step 3: On flipchart paper, draw a tree with the roots showing underground and branches leading up to the sky. Label the tree as highlighted below:



Step 4: Introduce this as a simple tool which can be used effectively to identify and explore the root causes and impact of any identified problem.

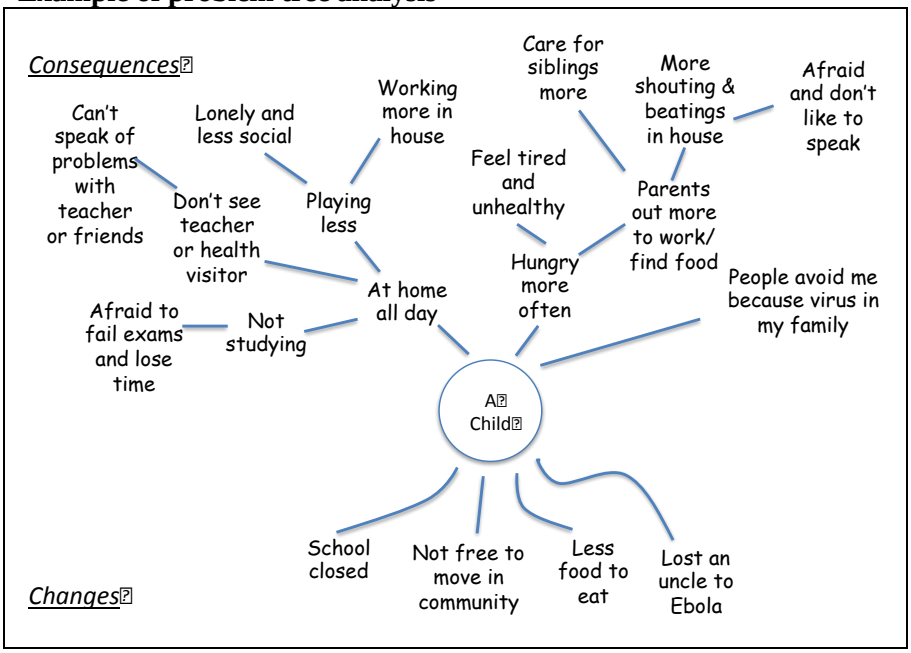
Step 5: Use the problem tree to explore the wider consequences of the Ebola outbreak.

NOTE: that the 'causes' we are interested in are not the causes of Ebola, but rather the causes of the wider impacts. This is important because we want the children, adults and communities we speak to to focus on the changes that trigger wider consequences, such as closed schools, or quarantines

Step 6: Facilitate a discussion on the problem tree analysis, emphasizing the following:

- First ask questions about the problem itself, then follow up with questions about the solutions.
- What are the most serious outcomes/consequences?
- Which causes and consequences can this this sudy help address? How can local leaders help? How can the government help? Where can international agencies help? What can communities and people do? Etc.

Example of problem tree analysis



2. Safety protocol

Training Purpose	Resources
To provide the research teams with a set of rules to follow during fieldwork, so they can protect themselves from infection and also protect participants.	• Safety protocol • Established practices of NestBuilders and Plan Sierra Leone.
Training tasks • Each team to nominate a lead person on safety. This person will be responsible for ensuring that safety guidelines are followed during fieldwork. At training, the nominated person should lead the team through the following tasks: • Taking the safety protocol as the starting point, each team to compile a list of measures that they will follow to: a) protect themselves and each other; b) protect participants. • Agreed safety protocol to be written up, give to all researchers and sent to project coordinator.	

SAFETY PROTOCOL (to be checked, revised if necessary and adopted by all teams)

- All researchers will be given a written version of this safety protocol and will rehearse this in training.
- Before meeting any communities, contact by telephone will have been made with at least two members of that community to discuss the arrangements for the research, safety precautions and to seek approval for the meetings.
- Researchers will work in pairs.
- One team member will have overall responsibility for safety.
- Research teams will be equipped with water, disinfectant etc. to enable washing.
- The research team will wash hands on entering a community, before meeting people.
- Researchers will carry their own disinfected water for hand washing.
- Researchers will not enter buildings or confined areas where there are suspected cases of Ebola or meet with people who appear to display associated symptoms.
- Meetings will take place outside or in an open space, with people seated separately and with distance maintained between everyone.
- There will be no physical contact (hand shake, back slapping etc.) and no exchange of materials such as pens, paper, food, drinks.
- Travel to different places and communities for research purposes will be minimised.
- If a researcher believes they may have come into contact with the virus they will be removed from the research team and will follow the contact-minimisation and health-monitoring steps advised by the Sierra Leonen authorities.

3. Child Protection

Training Purpose	Resources
To ensure the fieldwork is conducted in a way that avoids any harm or distress to children and young people.	Plan Child Protection Policy Child protection skills and knowledge of NestBuilders

Training tasks

- All researchers to read Plan Child protection policy.
- Research team to draw up a list of practical steps they will follow to put the child protection policy into practice during the fieldwork.
- Agreed child protection steps to be written up, given to all researchers and sent to project coordinator.

Notes

The organisation conducting the survey work have members who are experienced at working with children and young people on sensitive topics such as health.

The practical steps for child protection that we set out in our proposal are that:

- All meetings with children should take place outside or in an open space and will be done alongside meetings with other sections of the community.
- Parents, teachers and others should be fully aware of the presence of the research team and all will be within close proximity.
- Researchers will work in pairs.
- There will be a range of ages in each group, from 12 to 18, so younger children will be accompanied by older peers.
- Girl's and boy's FGDs will be conducted separately. To avoid participant discomfort, FGDs with girls will be conducted by female researchers, whilst FGDs with boys will be conducted by male field staff.

Researchers will be aware that the discussion of Ebola and its consequences may be distressing and fearful for children in particular. They should therefore treat these discussions with great sensitivity and take the lead from participants and about what topics can be explored without causing too much distress. If a child or adult is distressed, researchers should ensure that the person's concern is recognised (e.g. by allowing them time to talk, making eye contact, empathising whilst maintaining professional boundaries) and that they have the comfort of family, friends or others, before leaving.

If researchers become aware of children who are at risk, in terms of Plan's child protection authority, they should report it to the team leader who will in turn report it to Plan and/or other appropriate authorities (including local leaders) if it requires immediate intervention.

4. Selection of participants

Training Purpose	Resources
To guide the research teams in the selection of participants by explaining the purpose and approach.	• Safety protocol • Table describing groups and participants • Contacts in communities

Training tasks

- Read and understand the guidance here on selecting participants and organising the groups.
- Check the guidance against your own experience/knowledge of the communities we will be working in and add to or improve it.
- Agree how to approach local contacts and explain what we want in terms of groups.

Purpose and method for inviting participants

The aim of the research is to produce findings that are relevant throughout Sierra Leone, Guinea and Liberia. So the sites we have chosen represent the different kinds of settings in which people are living with Ebola. For the same reason, we need to invite participants that represent the different types of people living with the consequences; young, old, parents, leaders, women, men, disabled etc.

We will not use a strict method for selecting individuals (sampling framework) of the kind that is used sometimes for statistical studies; e.g. when households or individuals are randomly selected. This is because:

- It requires a large number of participants to become representative. In our small groups we need to deliberately select the type of individual we want to represent the diversity in the community (Called 'Selective', or 'Purposive' sampling).
- Randomised sampling involves the selection of individuals, whereas we want to select the type of person and leave some choice about who actually participates. This is to avoid people feeling they have to participate.
- Randomised sampling takes a lot of time and organisation to implement and involves researchers going amongst households;

Instead, we want to give to communities clear guidance on the type and numbers of people we want to meet and ask them to help invite suitable individuals. The types of people we want are:

Groups and participants table

FGD/Interview	Group	Participants
1	Children (Girls)	8-12 **female** school age children (12-18)
2	Children (Boys)	8-12 **male** school age children (12-18)
2	Carers (Female)	8-12 **female** parents and teachers
3	Carers (Males)	8-12 **male** parents and teachers

INTERVIEWS	X4: With key leaders (e.g. chief/headman/local government/NGOs)
CASE STUDY	X2: 1) Boy + 2) Girl. Focus on the individual child. Also speak to carers and teachers of this child

Organising the groups in advance

You should try and organise the groups before arriving at the site, by speaking with contacts in the community. In explaining what you want, you will want to describe the groups above, but also to emphasise that:

- We want to hear the different perspectives/voices within the community, so want to meet with people who come from different family circumstances and different experiences.
- This is about the wider consequences of Ebola, so we don't just want people who have suffered directly from the virus.
- We will speak in a group and we will ask people to talk about their lives and what is happening in the community. So the people must be willing to speak in a small group, although they don't need to be a spokesperson.

Managing the size of the groups

It is not always possible to control the numbers and composition of the group. Men are more likely to come than women to the mixed groups. People may join the group during the discussion. It is sometimes impossible to control this strictly (It is not a military exercise!).

The overriding necessity is to stick to safety rules – i.e. to limit group meetings to maximum of 12 participants. If more than 12 come, stop the meeting, explain that we want to keep the group small for everybody's safety and ask for their cooperation.

If the community, or you, think that even a small group is unsafe, then ask to meet with individual households.

If there are chairs, it may help to set out the right number of chairs and no more.

The team supervisor can also assist in ensuring that the size of the group is managed. Once the participants have been selected and the FGD begins, if curious outsiders attempt to join discussions, the supervisor (who is not responsible for facilitating discussions or note-taking) of the facilitator can ask the group to explain to others that the maximum number cannot be exceeded, and that extra people cannot join.

5. Informed Consent Form

Training Purpose	Resources
To familiarise the research teams with the need to obtain consent from participants, and with the form to use.	• Informed consent form

Training tasks

- Check that team understand the purpose and use of the form, and the need for joint signatures from facilitator and note-taker.
- Check the words used to introduce yourselves and the study, and make improvement where you can, so that it will be well understood by participants.

The consent form below will it to be used to check that participants are informed of the research and have expressed their willingness to participate. We do not need signed consent forms from each participants. This is often good practice but it is not desirable in this case because it would involve the exchange of pens, paper etc. and hence risk.

INFORMED CONSENT FORM

Date:
Site:
County:
Number of participants: **Female _ _ _ _ _ Male _ _ _ _ _**

Information to be communicated to participants by Researcher/Facilitator (tick when conveyed)	
My name is [*Give names of facilitator and note takers.*] from the organisation [ORGANISATION] You are being invited to speak with us for a research study. Would you please give me a short time to explain the study, after which I will ask if you are willing to participate. Please ask me if there is anything that is not clear or if you would like more information. Plan International and a team of consultants are working together to learn more about the impact of Ebola on children, their families and their communities. We know it makes people sick, but we also want to learn from you if it gives you other problems, for example if schools close, or if the health clinics close, or if it is harder to get food. We are speaking with small groups of people from this Community to hear the views of children, parents, teachers, community leaders and others. The findings will be used to help Plan International and other organisations to plan and improve the help that they give. We cannot help directly and Immediately with problems that you raise. The purpose of this study is to record your views and report to Plan. This study is funded by Plan International.	☐ ☐
If you agree to discuss this topic, the discussion will take about 1 hour, but no more than 2 hours. Notes will be taken during the discussion. If we wish to use a recording machine to record the discussion we will ask your permission.	☐ ☐
Any information you give us will be confidential within the laws of Sierra Leone and the UK. We will not say your name in reports, or identify you with anything you say in this discussion. We will keep all information safely stored in a computer and cupboard.	☐
Your participation is completely voluntary. If you don't want to participate please say. You can stop and leave at any time and we respect that. At any stage you can also ask us to delete statements you have made from our notes or choose not to answer certain questions. You will not receive any direct benefits by agreeing to talk to me.	☐ ☐
Do you have any further questions? Are you willing to participate in the discussion?	YES/NO YES/NO

I have communicated the above information to the participant and they have agreed to participate.

Signature of researcher: _ _ _ _ __ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ _ _ _ _ _ _ _ _ _ _

Signature of second researcher: _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ _ __ _ _ _ __ __

6. Organisation of research teams

Training Purpose	**Resources**
To select and organise the teams of researchers who will carry out the fieldwork in the sites.	• Table of groups and researchers (below)

Training tasks

- Compile a team list with names, relevant training and skills.
- Assign team members to particular survey tasks.
- Write a checklist listing the materials and copies of checklists that you need to take to sites.

Guidance on team selection

Essential

- Minimum of five researchers in team.
- Minimum of 2 females or 2 males.
- The team leader and the facilitators are the same for all sites, so that they build up experience, so that the method is consistent and so that they can compare the results in each site.
- The number should allow for researchers to work in pairs for all groups/interviews.
- Experienced in working in Ebola affected communities.

Desirable

- Mix of younger and older researchers.
- At least one member of the team is known personally in the community being visited.
- Facilitators speak dialect of community.
- Trained in child protection

Table of Groups and Researchers

FGD/Interview	Group	Participants	Research Team
1	Children (Girls)	8-12 **female** school age children (12-18)	One facilitator and one note-taker
2	Children (Boys)	8-12 **male** school age children (12-18)	One facilitator and one note-taker
2	Carers (Female)	8-12 **female** parents and teachers	One facilitator and one note-taker
3	Carers (Males)	8-12 **male** parents and teachers	One facilitator and one note-taker
INTERVIEWS	X4: With key leaders (e.g. chief/headman/local government/NGOs)		One facilitator and one note-taker
CASE STUDY	X2: 1) Boy + 2) Girl. Focus on the individual child. Also speak to carers and teachers of this child		One facilitator and one note-taker

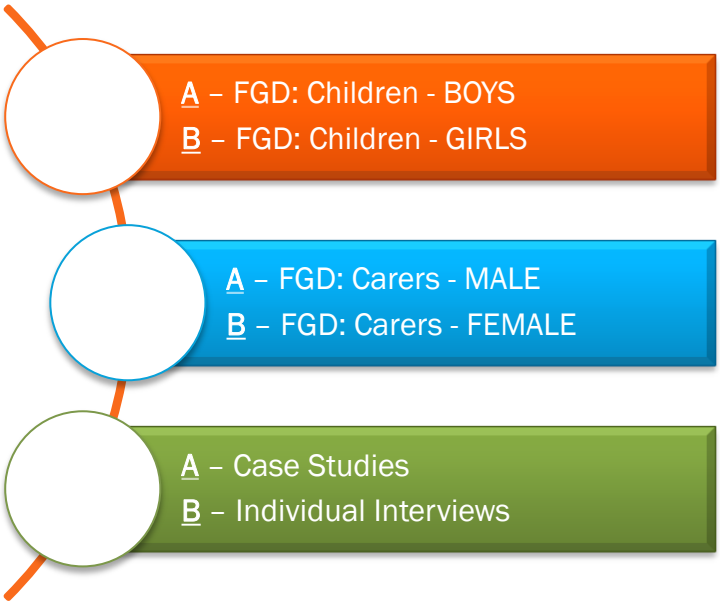
The workplan and budget is based on three teams with at least 5 members each. This number allows the surveys to be completed relatively quickly, as two groups/interviews can be going at the same time.

However, it is for the organisations carrying out the fieldwork to decide if more than 5 are required. For example, you may want to include extra researchers if they are known in the community or if they speak local dialect.

Timing, the order of groups and other aspects of organisation are to be decided by the research team, in consultation with local contacts and leaders. The example given below is just a suggestion. It will probably be desirable, in most cases, to have the same pair of researchers meeting with children, female carers and doing case studies, because the case studies will be identified through the discussions with children and carers (Facilitator A and Note-taken A in the example below.)

Example of survey schedule

Activity [Team members involved]
Introductions and courtesy meeting with community leaders [***All***]
Organisations of timing and group with leaders and local contacts [***All***]



Activity [Team members involved]
Debriefing: Improvements to survey implementation and read-through, checking and labelling of notes [***All***]

7. Survey checklist

Training Purpose	**Resources**
To familiarise research teams with the checklist and to give guidance on its use.	• Checklist, with version adapted for children. • Facilitation guide (in this document)
Training tasks • Read through the checklists as a team to clarify the meaning and purpose of the prompts and to check that the wording will be understood by participants. For difficult question agree a form of wording that will help participants to understand.	

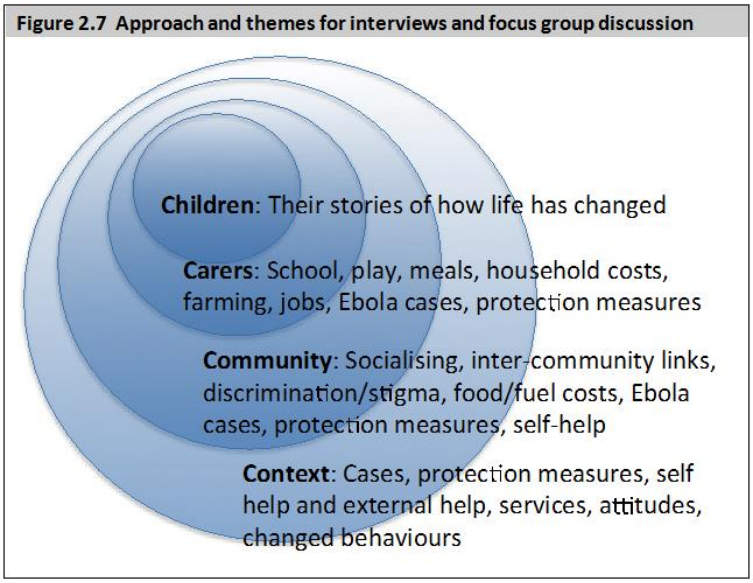
- Pilot the checklist (and informed consent form), change chart and case study template with one group of children, one group of carers and one case study in a community.
- Review your use of the form, the checklist and the recording sheets. Send a copy or transcript of the recording sheets to project manger. Make minor improvements (e.g. changes to wording/translation) in your team. Major improvements/changes to the tools should be discussed with the other organisations and the research coordinator and manager, so that we maintain consistency.

Facilitation notes

The checklist is to guide the semi-structured discussions in small groups or in 1-1- interviews. It uses themes and prompts that allows space for the community to state its own views on the most important consequences, and space for the facilitator to use follow up questions to dig deeper into priority issues. The purpose of the key indicators is to have a small number of factors that are asked in each discussion, to improve consistency and to enable comparison from site-to-site.

A shortened version of the checklist, with age-appropriate language, is used with children. The facilitator will place different emphasis on different themes within the checklist. With children it will be their immediate experience of school, play, day-to-day living and care. With parents and carers the emphasis will be on families and households. With community leaders it will be on the community impacts and responses to Ebola and the context for this created by external agencies such as Government and NGOs.

Figure 2.7 Approach and themes for interviews and focus group discussion



The main steps in facilitating the meetings are:

- Introduction and consent request [Informed Consent form].
- Introduction of participants
- General question on changes ("*What are the main changes in your lives and in your community because of Ebola*?)

  In this part of the discussion you want to get a list of the different types of changes and an indication of which the participants see as most important. It may be helpful ask each person in turn, to get different perspectives and to encourage all to speak.

Children especially will tend to give the same answer as older children of the one who was asked before them, so you will have to encourage them to speak their own mind, e.g. by saying that we are interested in different answers, everyone's opinion is valuable and that there is no right or wrong answers.

- Go through the rest of the checklist, concentrating on the themes that are most important to the participants and using follow-up questions to understand how consequences happen, how children are effected and what sort of solutions can work.

  It is difficult to do this quickly and better to let people speak in a relaxed way. An hour is the minimum it will take. The note-taker can help by watching the time and helping you to stick roughly to the agenda.

  If people give general or superficial answers you will need to use follow-up questions to test the accuracy of what they are saying and to gain details. Asking for examples or "why do you say that?" ... or … "what evidence do you have for that?" may be helpful follow-up questions.

  Deal with themes as people raise them. You do not need to follow the order of the checklist, just make sure that all topics are covered by the end of the session.

- Use the Change Chart (adult groups only) to get a rough measure from the participants of the proportion of children who are effected, using the key indicators.

  You'll need to use an example, such as the proportion of children in school, to show participants how the chart works.

  Try to avoid using numbers and percentages. Numbers exclude less numerate people from the conversation and favours others (e.g. teachers). It is better to talk in terms of "majority & minority", "more than half & less than half" or "small & plenty". When placing the indicator on the scale, check the different opinions. If the change is particularly significant ask people's reasons for saying it is high or low.

  It is important that people can see the change chart and engage in deciding where on the scale the indicators should be. It is usually done on a big sheet of paper (flipchart), on the floor in the middle of the group, using post-its so that the indicators can be moved around easily.

- Use the change chart to summarise to participants what they have told you, adding in some key points from the earlier discussion.

- Explain what you will do with the results and give thanks.

Recording Sheets (Groups and Interviews)

Group/Individual _____ Site _____Date _____

Number of participants: Female _____ Male _____

Theme:

Question:

Answers:

***The following discussion guides will be reviewed:**
1A: Discussion Guide: Boys (Children)

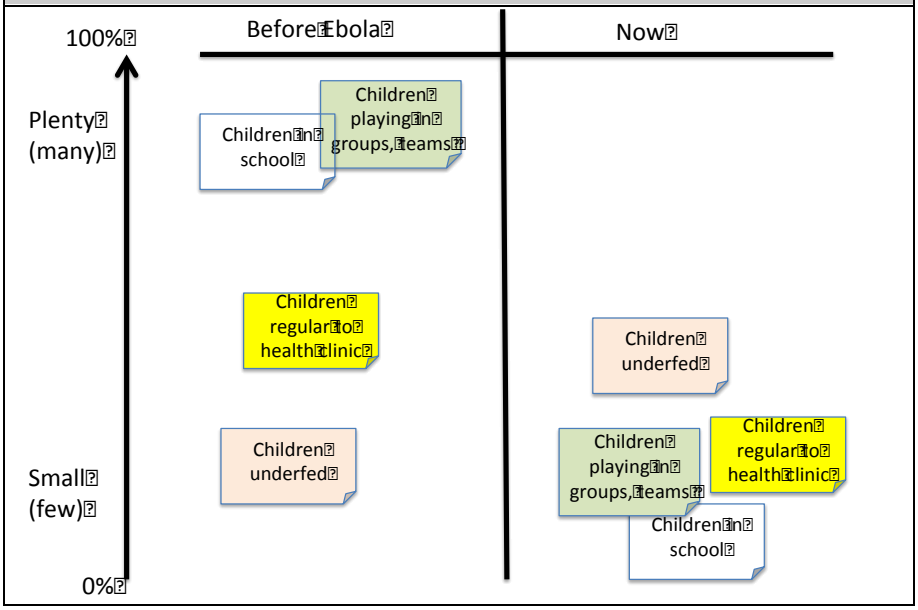
1B: Discussion Guide: Girls (Children)
1C: Discussion Guide: Female Carers
1D: Discussion Guide: Male Carers
1E: Interview Guide for Key Leaders/Informants

8. Change Chart

The Change Chart is to be used at the end of the adult group discussions to summarise views on the change that they have seen in a number of the key indicators. It does not involve any additional activities or individuals and it will be completed by the facilitator, on behalf of the group, to avoid the exchange of pens, papers etc.

For the participants, is provides some confirmation that their views have been recorded in a way that they can see. It is a way to 'play back' to the group some key points from the discussion.

Change Chart (illustration)



Materials required

- Flip chart paper (usually better without stand)
- Post-it notes (large) with headings for key indicators written in advance (to save time and to ensure none are forgotten)
- Pens
- **Camera to take a photo of the completed change chart**

9. Case Studies

Two case studies per site will be researched and written-up. These will have an individual child as their focus and so will involve in-depth discussion with that child and their parents/carers. They may require speaking with more than one adult as well as the child. These discussions may be short (e.g. 10-15 minutes) depending on how much information they have to give, but allow one hour in total researching each case study. The confidentiality and child protection/ethical issues that arise from this are handled in the following way:

- The participants for the case studies will come from the discussions with children and parents and they will therefore be selected by the participants and with their consent.
- The child's name will not be included in the final, published version of the case study, although it will be recorded during the research
- The parent/carer of the child will be invited to give her/his verbal consent to the case study on the understanding that it will only be reported anonymously.

When finalised and written-up, the case studies should be no more than two pages in length although you may need to take more notes. They should tell a real-life story which illustrates the consequences for a child of Ebola, relating this to how the family and community have been affected. Include actions that have been taken by the child, family, community, NGOs or other organisation to help the child and family.

They must relate to one or more of the research priorities: **education, child protection, food security, livelihoods, psychosocial consequences and community cohesion**.

Take notes during the interviews for the case study under the headings given in the template below, and use the template to write the case study from your notes.

Case Study Template
Childs Name (First name and first letter of surname only) Sex Age Location (Site)
***Child**: What has changed in this child's life and in what way has Ebola been the cause?* [*expand as required]*
Family: How have changes in the life of the child affected the family and how have changes in the family (jobs, food, travel etc.) affected the child? [*expand as required]*

Community: In what ways was the child's and family's situation affected by events or actions in the wider community? [*expand as required]*
The parent/carer of this child gives their consent to the case study being reported anonymously and they have been told/read the key points that will be written: Signed (researcher) _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ _ _ _ _ _

10. Debrief, recording and write-up of data

Debrief

A debrief after the work in each site is important to:

- Collect and clearly label each recording sheet and change chart (sites, date, name of group etc.).
- Take photos of all the charts and recording sheets so we have a digital record.
- Review the safety of the site activities, identifying any breaches of the safety protocol, any inadequacies in the protocol and agreeing improvements to practices if there have been (and sharing these with the other organisations and project manager).
- Review the research tools and how you used them, identify any problems and agree solutions.
- Review the results of the discussions and made additional notes if necessary, so that you are clear about the key points that participants made (in pairs of facilitator/note-taker)

Recording

The note-taker will take hand-written notes of key points from the discussion and from the interviews and case studies. We do not need a record of every word said, but it is important to capture the main points in detail. Ensure that all notes are labelled so that you can tell subsequently which discussion/group it was from.

Write-up

Notes should be typed up by the note taker and/or facilitator in microsoft word. It is strongly recommended that you do this the same day as the survey, when your memory of the discussion is fresh and before it gets confused by discussions from other sites. These are to be sent to the team leader and project manager.

Team leaders are asked to produce a site report, which includes the main points, analysis and findings from each site, organised the themes in the checklist. These are to be sent to the project manager.

11. Confidentiality and data protection

Confidentiality

The research tools described above provide templates for recording the information gathered. They will be completed by note takers/facilitators during the consultations and copied as digital images. Transcripts will therefore be held in both original (paper) and digital form.

The survey produces a substantial number of records; at least 80 discussion/interview transcripts and change charts and 40 or more case studies. Each area team will produce site reports; word documents which compile the information from the different interviews under the theme headings.

Names of participants will be recorded in the fieldwork notes and transcripts. E.g. The names of the group will be written down during introductions. Please use **first name and first letter of surname**. This is important for authentication and also to acknowledge the attendance and contribution of the participants.

No names or information that would make a person identifiable will be included in the reported/published documents arising from the research.

Children's names will be disclosed if researchers deem this necessary to protect a child from substantial risk, in terms of the Plan child protection policy (e.g. a child who reports being abused). In which case the researcher will advise the team leader who will report the incident to Plan in the first instance.

Informants will receive a summary of key points that the researchers have noted (particularly through use of the change chart). A contact telephone and email address will be left and participants will be informed that they can request a copy of the report or contact researchers to provide further information.

Data protection

Fieldwork transcripts, reports and electronic data relating to this processed data will be stored by Plan IH for a two year period after completion of the research project. All hard copies of raw data – data recording sheets, informed consent forms, will be transferred to Plan IH upon completion for the project and stored by them for five years, after which is will be destroyed in accordance with the legal, ethical, confidentiality requirements relevant to Plan IH.

Prepared by David Rothe, Project Manager and Contractor.
28 October 2014-10-28

Contact: David Rothe +44 1223 366 680, +44 7889 522 373, rothedavid@gmail.com

3 Appendix 2B Focus Group Discussion Checklist: Boys

Discussion with 8 -12 school age **boys** and a range of **ages from 12 to 18**

A. Interview Identification	
A1. SITE NAME: _____	**A2. AREA:** _____
A3. RURAL (01)/URBAN (02)	3.1.1 A4. DATE OF INTERVIEW: 3.1.2 (dd/mm/yy): ___/____/___
A5. NUMBER OF MALE PARTICIPANTS	**A6. NUMBER OF FEMALE PARTICIPANTS** **0 0**
A7. FACILITATOR (ENUMERATOR ID #)	**A8. NOTE-TAKER (ENUMERATOR ID #)**

Instructions:
1. Read the 'Informed Consent Form' to all participants
2. Prior to beginning the discussion, ask each participant to introduce themselves. Ask for the respondents name and age (remember to reiterate that names will not be reported). Fill in the details in the table below
3. As each participant introduces themselves, distribute a sticker name tag with their corresponding ID# recorded on it and ask them to affix it to their shirt for the duration of the discussion (this is meant for recording purposes so that we are able to trace responses back to the respondent. As you record participant responses, record the speakers ID# next to their response)

ID#	NAME	AGE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

THEME	KEY QUESTIONS
INTRODUCTIONS	Icebreaker activity: Favourite song (group singing). Have you learnt any Ebola prevention songs?
CHANGES DUE TO EBOLA	Since the Ebola outbreak, is there any difference in your life for you, and for your friends? → If yes, how?
EDUCATION	Before Ebola, did you all go to school? → If you are not going to school now because of Ebola, how do you feel about this?
	During this Ebola outbreak, are you taking lessons out of school? → If yes: Who is providing your lessons out of school? → If no: Why are you not taking lessons out of school?
	Does any member of your family own a radio? → If yes: Do you listen to the radio for lessons or teaching? Is the radio programme or teaching useful to you? Why or why not?
	If you are not going to school, what are you and other children doing in the day? → PROBE: do you have more chores at home? ETC.
CHILD PROTECTION AND WELLBEING	Do you and your friends play like you did before Ebola? → If no, why? What has changed?
	Tell me about a normal day for you during the Ebola outbreak? → PROBE: If you are not in school or playing, what are you doing in the day and who are you with?
	Has your life with your family at home changed since the Ebola outbreak? What is different?
	Do you see people from the government (e.g. education and health workers) or from NGOs more or less often now, compared to before Ebola? How does this make you feel?
	Do you think that you and other children are more at risk from abuse, crime or neglect since the Ebola outbreak? If so why?
FOOD SECURITY	Compared to December last year, do you have more or less food to eat now? → Why do you think this is?
	Has the kind of food or the quality of food that you eat changed since a year ago?
	Do you help with farming, getting food or preparing food like you did before Ebola?
LIVELIHOODS	Does your family get money from trade or salary (employment/work) like they did before the Ebola outbreak? → What has changed?

	→ How has this affected your life? (Give specific examples)
	Do boys and girls do the same household work as they did before the Ebola outbreak? → PROBE: what has changed?
	Do you work outside home to earn money or to get food? → If yes: What do you do? Do you think your involvement with such activities has increased since Ebola?
COMMUNITY COHESION	Are you free to visit friends and receive visitors from <u>within</u> your community? → Why or why not? → If no, how does this make you feel?
	Can you visit friends or family or receive visitors from <u>outside</u> your community? → Why or why not? → If no, how does this make you feel?
	Do you see more or less conflict (fights, confusion, shouting) in your community, compared to before Ebola? → Why do you think this is so?
	Do you know of any households or people in your community that have had contact with the Ebola virus? How are children or adults in households with Ebola treated by others in the community?
PROTECTION, CONTROL, RECOVERY	Do you know someone who has been sick with Ebola? → If yes, how did this make you feel?
	What do you do to prevent yourself from getting Ebola?
	Do you have everything you need to protect yourself from Ebola? → If no, what are you missing?
	Does your community get help to prevent Ebola from government or NGO organisations? → If yes: What do they do? Do you think this has helped protect you community from Ebola?
	After Ebola, do you think your life will be different? → PROBE: If yes, how? If no, why?

GENDER SPECIFIC QUESTIONS	Thinking about your life since the start of the Ebola outbreak: do you think that the girls in your community have been treated differently than the boys? → PROBE: do you girls or boys have more responsibilities? Freedom?
	Thinking about your life since the start of the Ebola outbreak: are there any issues that boys in your community face that girls do not? → If yes, what are the top three issues? → If no, why not?
	Do you think that there will be a change in the number of teenage pregnancies or early marriages because of Ebola? → If yes, why do you think this is so? → If no, why do you think this is so?

4 Appendix 2C Focus Group Discussion Checklist: Girls

Discussion with 8 -12 school age **girls** and a range of **ages from 12 to 18**

B. Interview Identification	
A1. SITE NAME: _____	**A2. AREA:** _____
A3. RURAL (01)/URBAN (02)	4.1.1 A4. DATE OF INTERVIEW: 4.1.2 (dd/mm/yy): ___/____/___
A5. NUMBER OF MALE PARTICIPANTS **0 0**	**A6. NUMBER OF FEMALE PARTICIPANTS**
A7. FACILITATOR (ENUMERATOR ID #)	**A8. NOTE-TAKER (ENUMERATOR ID #)**

Instructions:
1. Read the 'Informed Consent Form' to all participants
2. Prior to beginning the discussion, ask each participant to introduce themselves. Ask for the respondents name and age (remember to reiterate that names will not be reported). Fill in the details in the table below
3. As each participant introduces themselves, distribute a sticker name tag with their corresponding ID# recorded on it and ask them to affix it to their shirt for the duration of the discussion (this is meant for recording purposes so that we are able to trace responses back to the respondent. As you record participant responses, record the speakers ID# next to their response)

ID#	NAME	AGE
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		

THEME	KEY QUESTIONS
INTRODUCTIONS	Icebreaker activity: Favourite song (group singing). Have you learnt any Ebola prevention songs?
CHANGES DUE TO EBOLA	Since the Ebola outbreak, is there any difference in your life for you, and for your friends? → If yes, how?
EDUCATION	Before Ebola, did you all go to school? → If you are not going to school now because of Ebola, how do you feel about this?
	During this Ebola outbreak, are you taking lessons out of school? → If yes: Who is providing you lessons out of school? → If no: Why are you not taking lessons out of school?
	Does any member of your family own a radio? → If yes: Do you listen to the radio for lessons or teaching? Is the radio programme or teaching useful to you? Why or why not?
	If you are not going to school, what are you and other children doing in the day? → PROBE: do you have more chores at home? ETC.
CHILD PROTECTION AND WELLBEING	Do you and your friends play like you did before Ebola? → If no, why? What has changed?
	Tell me about a normal day for you during the Ebola outbreak? → PROBE: If you are not in school or playing, what are you doing in the day and who are you with?
	Has your life with your family at home changed since the Ebola outbreak? What is different?
	Do you see people from the government (e.g. education and health workers) or from NGOs more or less often now, compared to before Ebola? How does this make you feel?
	Do you think that you and other children are more at risk from abuse, crime or neglect since the Ebola outbreak? If so why?
FOOD SECURITY	Compared to December last year, do you have more or less food to eat now? → Why do you think this is?
	Has the kind of food or the quality of food that you eat changed since a year ago?
	Do you help with farming, getting food or preparing food like you did before Ebola?

LIVELIHOODS	Does your family get money from trade or salary (employment/work) like they did before the Ebola outbreak? → What has changed? → How has this affected your life? (Give specific examples)
	Do boys and girls do the same household work as they did before the Ebola outbreak? → PROBE: what has changed?
	Do you work outside home to earn money or to get food? → If yes: What do you do? Do you think your involvement with such activities has increased since Ebola?
COMMUNITY COHESION	Are you free to visit friends and receive visitors from <u>within</u> your community? → Why or why not? → If no, how does this make you feel?
	Can you visit friends or family or receive visitors from <u>outside</u> your community? → Why or why not? → If no, how does this make you feel?
	Do you see more or less conflict (fights, confusion, shouting) in your community, compared to before Ebola? → Why do you think this is so?
	Do you know of any households or people in your community that have had contact with the Ebola virus? How are children or adults in households with Ebola treated by others in the community?
PROTECTION, CONTROL, RECOVERY	Do you know someone who has been sick with Ebola? → If yes, how did this make you feel?
	What do you do to prevent yourself from getting Ebola?
	Do you have everything you need to protect yourself from Ebola? → If no, what are you missing?
	Does your community get help to prevent Ebola from government or NGO organisations? → If yes: What do they do?

	Do you think this has helped protect you community from Ebola?
	After Ebola, do you think your life will be different? → PROBE: If yes, how? If no, why?
GENDER SPECIFIC QUESTIONS	Thinking about your life since the start of the Ebola outbreak: do you think that the girls in your community have been treated differently than the boys? → PROBE: do you girls or boys have more responsibilities? Freedom?
	Thinking about your life since the start of the Ebola outbreak: are there any issues that girls in your community face that boys do not? → If yes, what are the top three issues? → If no, why not?
	Do you think that there will be a change in the number of teenage pregnancies or early marriages because of Ebola? → If yes, why do you think this is so? → If no, why do you think this is so?

5 Appendix 2D Discussion Checklist Female Carers

Discussion with 8-12 **female parents and teachers**	
C. Interview Identification	
A1. SITE NAME: _____	**A2. AREA:** _____
A3. RURAL (01)/URBAN (02)	5.1.1 A4. DATE OF INTERVIEW: 5.1.2 (dd/mm/yy): ___/____/___
A5. NUMBER OF MALE PARTICIPANTS **0 0**	**A6. NUMBER OF FEMALE PARTICIPANTS**
A7. FACILITATOR (ENUMERATOR ID #)	**A8. NOTE-TAKER (ENUMERATOR ID #)**

Instructions:
1. Read the 'Informed Consent Form' to all participants
2. Prior to beginning the discussion, ask each participant to introduce themselves. Ask for the respondents name and role (remember to reiterate that names will not be reported). Fill in the details in the table below
3. As each participant introduces themselves, distribute a sticker name tag with their corresponding ID# recorded on it and ask them to affix it to their shirt for the duration of the discussion (this is meant for recording purposes so that we are able to trace responses back to the respondent. As you record participant responses, record the speakers ID# next to their response)

#	NAME	ROLE (E.G. MOTHER, TEACHER, ETC.)
25.		
26.		
27.		
28.		
29.		
30.		
31.		
32.		
33.		
34.		
35.		

THEME	KEY QUESTIONS
INTRODUCTION	Lead the group in prayer.
CHANGES DUE TO EBOLA (UNPROMPTED)	What are the main changes in your lives and in your community because of Ebola?
EDUCATION CHILDREN RECEIVING EDUCATION	Are your children going to school?
	Since the closure of schools, are your children getting classes outside school? (i.e. radio programme, private classes) → If yes: Which one are they using? And why do you prefer it? Do you think they are useful?
	During the day when children are not in school, where are they and what do they do?
CHILD PROTECTION AND WELLBEING CHILDREN PLAYING IN GROUPS/TEAMS	Have you noticed a change in children's behaviour since the start of the Ebola outbreak? → If yes, what are the major changes you see?
	Do children play like they did before Ebola?
	Is your nearest health clinic open? → If open: Do people visit the clinic like before Ebola? → Why?
	Do you / the community use traditional medicines and healers like before the Ebola outbreak? → Why/why not?
	Has Ebola affected where or how mothers give birth and their breast-feeding? → Why?
	Are malaria and other diseases being treated like before? → Ask for respondents to provide examples
VACCINATIONS	Do children in the community usually receive vaccinations? Has this changed because of Ebola? → How has it changed?
	Are parents sending children away to stay with other relatives, to avoid Ebola? → Why have they done this? → What has been the consequences of this?

CONFLICT WITHIN FAMILIES	
	Do you see more, or less, conflict within families due to Ebola? (e.g. fights, confusion, shouting) → Why?
	If a person in your community died of Ebola, would you take care of his or her son or daughter?
	Do you think that children are more at risk from crime or neglect since the Ebola outbreak? → If so, why?
	Do you think that there will be a change in the number of teenage pregnancies or early marriages because of Ebola? → If yes, why do you think this is so? → If no, why do you think this is so?
FOOD SECURITY	Have you noticed a change in the price of rice in your community? Please provide details on this: How much more for rice (and/or Cassava) * record the price before Ebola and the current price of rice and cassava
	Is bush meat being eaten as before? → Why? Why not?
	Have you noticed or heard of changes in farming because of Ebola? → If yes: Elaborate
	Do you think the harvest be like last year? Do you think it will be affected by Ebola? → If yes, how will this impact your life?
UNDERFED CHILDREN	Since the Ebola outbreak started: are there more children in the community with not enough to eat now? → If yes, do you think this is because of Ebola? WHY?
	Are households in your community having to eat more of lower quality food (e.g. dry rice or cassava with no soup) since the Ebola outbreak? → PROBE: WHY? WHY NOT?
LIVELIHOODS HOUSEHOLD INCOME	Are you getting money from trade or salary (employment/work) like before?
	Have local businesses closed since the Ebola outbreak? → PROBE: Provide examples – was this directly linked to Ebola outbreak?
	Is the nearest market open like before? → If yes: Is the market as busy (like before Ebola)?
	Are there shortages of any goods because of Ebola? (Which goods?) How does this impact your normal life?

	Do people still collect water and wash themselves as before? → If change: What has changed? Why?
	Are there travel restrictions in your community? → If yes: What do these prevent you from doing? How do the travel restrictions affect your life? Livelihood? Well-being?
	Do your children work outside home to earn money or to get food? → If yes: What do they do? Do you think their involvement with such activities has increased since Ebola?
COMMUNITY COHESION FREQUENCY OF COMMUNITY MEETINGS	Does the community meet to discuss matters and make decisions like before? → If no: What is the impact of this? How does it make you feel?
	How is sensitization done in your community? Who in the community is most important in telling people about Ebola and what to do? Are people listening to him/her?
	Has Ebola created tension or conflict <u>within</u> the community? → If yes, why?
	Has Ebola affected relations with <u>other</u> communities and visitors? → If yes, why?
	How has Ebola affected the relationship between people and the police, army or other state organisations?
	Do you know of any houses/people in your community that have had Ebola? → If yes: How are children or adults in households with Ebola treated by others in the community?
	Thinking about your community since the start of the Ebola outbreak: Who in the community is most affected? (not just by the disease but by other consequences related to nutrition, employment, livelihood, general health, education, etc.) **Arrange from most to least and give rationale as to why:** - Children - Elderly - Women - Single mothers - Disabled and long-term sick? Why do you think this is?
PROTECTION, CONTROL,	How many people in this community have been sick with Ebola?
	Do the same number of women and men get sick with Ebola? If different, why is this?

RECOVERY KNOW SOMEONE WITH EBOLA	What actions have you taken personally and for your family, to prevent Ebola?
	What has been done by outside organisations in your community, since Ebola? - By NGOs (who and what?) - By Government (who and what) - By other (e.g. Church, Private)
	Which kind of organisation has given you the most assistance?
	How can organisations improve the help they give to children and communities to tackle Ebola? [Or: What are the two most important things that you and your community would like to do to protect against Ebola?]
	Do you think government organisations and NGOs have been honest and open with you about Ebola?
	When Ebola has been controlled and there are no more new cases, how long do you think will it take before things are normal? → Why?
	After Ebola, do you think the Community will ever be the same as before? What will have changed?

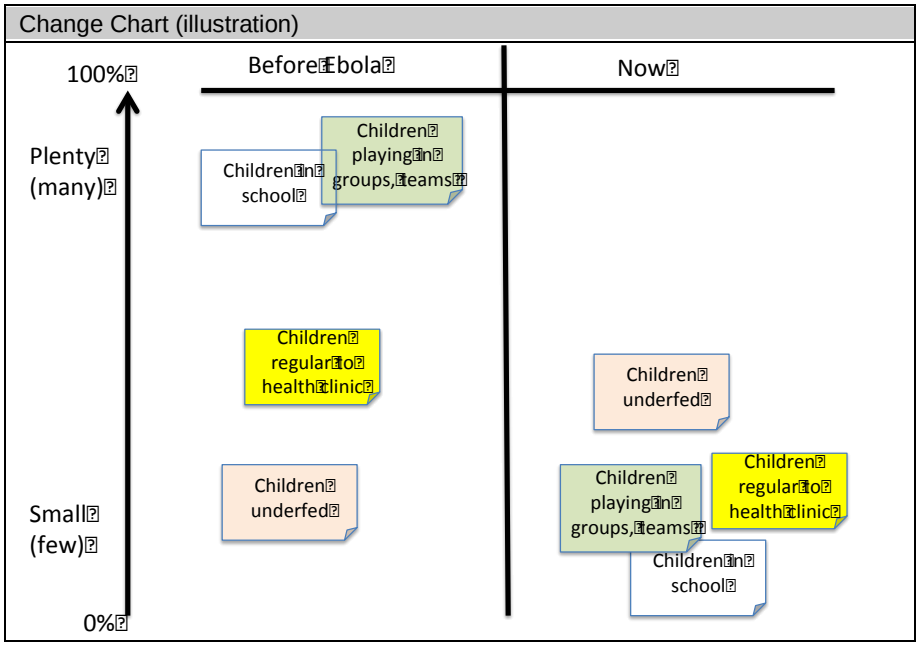
→ Change Chart

1. Next, use the change chart **to measure and summarise views on the change that they have seen in a number of the key indicators.**
2. At the end of the FGD, with your colleagues, take each **key indicator listed below** and summarize the main points the group discussed for this indicator. Direct the conversation to focus on talking about the change experienced by **children.**
3. As you discuss each one, show the group the pre-written post-it note that has the key indicator written on it.

Theme	Main Indicator
Education	Children in school
Child protection & wellbeing	Children playing in groups/teams Children receiving vaccinations Children regular to health clinics Mothers having safe deliveries Conflict within families Children at risk from crime
Food security	Underfed children Families eating rice once a day
Livelihoods	Households receiving money from trade or salary Markets opened Goods easily available Goods are affordable Children doing house chores
Community cohesion	Community meetings happen regularly

Protection, control & recovery	Assistance from organizations

4. Display the flip chart paper with the change chart already drawn on it, and provide an example of how the change chart works :



5. Using the first indicator "Children in school" as a group, to try to ascertain where on the scale this indicator was before Ebola, and then after Ebola came to their community ("NOW"). **Avoid using numbers (this would exclude less numerate people from the conversation). Try to understand from the participants whether the change has been 'small' or 'plenty'.**
6. Facilitate the change chart activity with the remaining key indicators.
7. When placing the indicator on the scale, check the different opinions. If the change is particularly significant, ask people's reasons for saying it is high or low.
8. **When completed →Take a photograph of the change chart.**
9. Explain what you will do with the results, and thank the participants for their input.

Significant on-going discussions and debates →

6 Appendix 2E Focus Group Discussion Checklist: Male Carers

Discussion with 8-12 **male parents and teachers**	
D. Interview Identification	
A1. SITE NAME: _____	**A2. AREA:** _____
A3. RURAL (01)/URBAN (02)	6.1.1 A4. DATE OF INTERVIEW: 6.1.2 (dd/mm/yy): ___/___/___
A5. NUMBER OF MALE PARTICIPANTS	**A6. NUMBER OF FEMALE PARTICIPANTS** **0 0**
A7. FACILITATOR (ENUMERATOR ID #)	**A8. NOTE-TAKER (ENUMERATOR ID #)**

Instructions:
1. Read the 'Informed Consent Form' to all participants
2. Prior to beginning the discussion, ask each participant to introduce themselves. Ask for the respondents name and role (remember to reiterate that names will not be reported). Fill in the details in the table below
3. As each participant introduces themselves, distribute a sticker name tag with their corresponding ID# recorded on it and ask them to affix it to their shirt for the duration of the discussion (this is meant for recording purposes so that we are able to trace responses back to the respondent. As you record participant responses, record the speakers ID# next to their response)

#	NAME	ROLE (E.G. FATHER, TEACHER, ETC.)
36.		
37.		
38.		
39.		
40.		
41.		
42.		
43.		
44.		
45.		
46.		

THEME	KEY QUESTIONS
INTRODUCTION	Lead the group in prayer.
CHANGES DUE TO EBOLA (UNPROMPTED)	What are the main changes in your lives and in your community because of Ebola?
EDUCATION CHILDREN RECEIVING EDUCATION	Are your children going to school?
	Since the closure of schools, are your children getting classes outside school? (i.e. radio programme, private classes) → If yes: Which one are they using? And why do you prefer it? Do you think they are useful?
	During the day when children are not in school, where are they and what do they do?
CHILD PROTECTION AND WELLBEING CHILDREN PLAYING IN GROUPS/TEAMS	Have you noticed a change in children's behaviour since the start of the Ebola outbreak? → If yes, what are the major changes you see?
	Do children play like they did before Ebola?
	Is your nearest health clinic open? → If open: Do people visit the clinic like before Ebola? → Why?
	Do you / the community use traditional medicines and healers like before the Ebola outbreak? → Why/why not?
	Has Ebola affected where or how mothers give birth and their breast-feeding? → Why?
	Are malaria and other diseases being treated like before? → Ask for respondents to provide examples
VACCINATIONS	Do children in the community usually receive vaccinations? Has this changed because of Ebola? → How has it changed?
	Are parents sending children away to stay with other relatives, to avoid Ebola? → Why have they done this? → What has been the consequences of this?

CONFLICT WITHIN FAMILIES	
	Do you see more, or less, conflict within families due to Ebola? (e.g. fights, confusion, shouting) → Why?
	If a person in your community died of Ebola, would you take care of his or her son or daughter?
	Do you think that children are more at risk from crime or neglect since the Ebola outbreak? → If so, why?
	Do you think that there will be a change in the number of teenage pregnancies or early marriages because of Ebola? → If yes, why do you think this is so? → If no, why do you think this is so?
FOOD SECURITY	Have you noticed a change in the price of rice in your community? Please provide details on this: How much more for rice (and/or Cassava) * record the price before Ebola and the current price of rice and cassava
	Is bush meat being eaten as before? → Why? Why not?
	Have you noticed or heard of changes in farming because of Ebola? → If yes: Elaborate
	Do you think the harvest be like last year? Do you think it will be affected by Ebola? → If yes, how will this impact your life?
UNDERFED CHILDREN	Since the Ebola outbreak started: are there more children in the community with not enough to eat now? → If yes, do you think this is because of Ebola? WHY?
	Are households in your community having to eat more of lower quality food (e.g. dry rice or cassava with no soup) since the Ebola outbreak? → PROBE: WHY? WHY NOT?
LIVELIHOODS HOUSEHOLD INCOME	Are you getting money from trade or salary (employment/work) like before?
	Have local businesses closed since the Ebola outbreak? → PROBE: Provide examples – was this directly linked to Ebola outbreak?
	Is the nearest market open like before? → If yes: Is the market as busy (like before Ebola)?
	Are there shortages of any goods because of Ebola? (Which goods?) How does this impact your normal life?

	Do people still collect water and wash themselves as before? → If change: What has changed? Why?
	Are there travel restrictions in your community? → If yes: What do these prevent you from doing? How do the travel restrictions affect your life? Livelihood? Well-being?
	Do your children work outside home to earn money or to get food? → If yes: What do they do? Do you think their involvement with such activities has increased since Ebola?
COMMUNITY COHESION FREQUENCY OF COMMUNITY MEETINGS	Does the community meet to discuss matters and make decisions like before? → If no: What is the impact of this? How does it make you feel?
	How is sensitization done in your community? Who in the community is most important in telling people about Ebola and what to do? Are people listening to him/her?
	Has Ebola created tension or conflict <u>within</u> the community? → If yes, why?
	Has Ebola affected relations with <u>other</u> communities and visitors? → If yes, why?
	How has Ebola affected the relationship between people and the police, army or other state organisations?
	Do you know of any houses/people in your community that have had Ebola? → If yes: How are children or adults in households with Ebola treated by others in the community?
	Thinking about your community since the start of the Ebola outbreak: Who in the community is most affected? (not just by the disease but by other consequences related to nutrition, employment, livelihood, general health, education, etc.) **Arrange from most to least and give rationale as to why:** - Children - Elderly - Women - Single mothers - Disabled and long-term sick? Why do you think this is?
PROTECTION, CONTROL, RECOVERY KNOW SOMEONE WITH EBOLA	How many people in this community have been sick with Ebola?
	Do the same number of women and men get sick with Ebola? If different, why is this?
	What actions have you taken personally and for your family, to prevent Ebola?
	What has been done by outside organisations in your community, since Ebola?

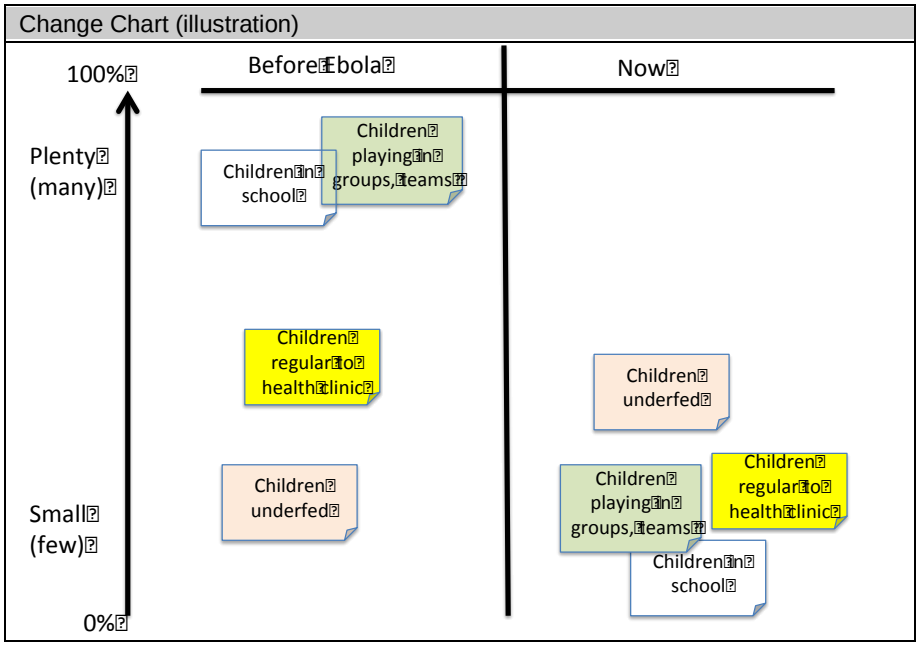
	- By NGOs (who and what?) - By Government (who and what) - By other (e.g. Church, Private)
	Which kind of organisation has given you the most assistance?
	How can organisations improve the help they give to children and communities to tackle Ebola? [Or: What are the two most important things that you and your community would like to do to protect against Ebola?]
	Do you think government organisations and NGOs have been honest and open with you about Ebola?
	When Ebola has been controlled and there are no more new cases, how long do you think will it take before things are normal? → Why?
	After Ebola, do you think the community will ever be the same as before? What will have changed?

→ Change Chart

10. Next, use the change chart **to measure and summarise views on the change that they have seen in a number of the key indicators.**
11. At the end of the FGD, with your colleagues, take each **key indicator listed below** and summarize the main points the group discussed for this indicator. Direct the conversation to focus on talking about the change experienced by **children.**
12. As you discuss each one, show the group the pre-written post-it note that has the key indicator written on it.

Theme	Main Indicator
Education	Children in school
Child protection & wellbeing	Children playing in groups/teams Children receiving vaccinations Children regular to health clinics Mothers having safe deliveries Conflict within families Children at risk from crime
Food security	Underfed children Families eating rice once a day
Livelihoods	Households receiving money from trade or salary Markets opened Goods easily available Goods are affordable Children doing house chores
Community cohesion	Community meetings happen regularly
Protection, control & recovery	Assistance from organizations

13. Display the flip chart paper with the change chart already drawn on it, and provide an example of how the change chart works :



14. Using the first indicator "Children in school" as a group, to try to ascertain where on the scale this indicator was before Ebola, and then after Ebola came to their community ("NOW"). **Avoid using numbers (this would exclude less numerate people from the conversation). Try to understand from the participants whether the change has been 'small' or 'plenty'.**

15. Facilitate the change chart activity with the remaining key indicators.
16. When placing the indicator on the scale, check the different opinions. If the change is particularly significant, ask people's reasons for saying it is high or low.

17. When completed → Take a photograph of the change chart.

18. Explain what you will do with the results, and thank the participants for their input.

19. Sketch the findings of the change chart below, and in the box below record any significant on-going discussions and debates.

Significant on-going discussions and debates →