STUDY ON THE GENDERED IMPACTS OF EBOLA IN LIBERIA

Study commissioned by Finn Church Aid

Leena Kotilainen, February 2015

Contents

1 Introduction 1

2 Executive summary 2

3 Methodology and constraints of the assessment 3

4 Detailed findings 4

- Overlapping vulnerabilities 4
  - Gender 4
  - Sex 6
  - Social class 7
  - Region 8
  - Age 9
  - Societal stigma and traumas 10
  - Decreased social cohesion 11

5 Analysis of the findings 12

- Mitigating risks 12
- Supporting local structures and initiatives 13

6 Conclusions 14

7 Recommendations 15

Annexes 17

- Annex 1: List of interviewed people 17
- Annex 2: List of reference documents 18

1 Introduction

This independent assessment was conducted in January and February 2015 for Finn Church Aid[1]. The study consists of a two-week desk study and one week participatory field study in the cities of Monrovia and Buchanan in Liberia. The first aim of the assessment was to formulate a comprehensive picture on the gendered impacts of the Ebola virus disease (EVD) in urban and peri-urban Liberia especially from the viewpoint of women and girls. Related to the first goal, the effects of EVD epidemic on gender equality in the country were also scrutinised.

The West African Ebola outbreak was first reported in March 2014 and has been the largest in history. EVD hit several countries but has been especially fatal in Guinea, Sierra Leone and Liberia. EVD is a severe, often fatal illness that belongs to a group of diseases called viral haemorrhagic fevers. Case fatality in human infections varies from 25 % to 90 %, depending on the species of virus and the quality of supportive care. Ebola virus is transmitted to human populations from the body fluids or tissue of infected wild animals, such as bats and non-human primates. Human to human transmission occurs through infected body fluids (e.g. blood, faeces, urine, vomit, saliva, genital secretions, breast milk) when infected fluids come into contact with or mucosa or breaks in the skin. The incubation period varies from 2 to 21 days and humans are not infectious until they develop symptoms. At first the symptoms include high fever, muscle pain, fatigue, headache, and sore throat. Later other symptoms such as vomiting, diarrhoea, rash, and sometimes internal and external bleeding can follow. Especially healthcare workers, caretakers of infected individuals, and mourners who have had a direct contact with the bodies of EVD-victims are most at risk for infection during an outbreak. The Ebola virus is not airborne.[1]

Official data up to 8 February 2015 show that the current epidemic has claimed altogether 9,177 lives, of which 9,162 in the three worst-affected countries and 3,826 in Liberia.[2] It has recently been claimed that the majority of victims in the ongoing epidemic have been women. There are, nevertheless, no reliable data to support this argument. According to WHO's most recent numbers, of the 5,547 confirmed and probable cases of EVD in Liberia, 49,5 % were women and 50,5 % men.[3] These *sex-disaggregated* percentages do not however signify that the current epidemic does not carry *gendered* impacts that are of interest to this study.

In the following gender analysis a special emphasis is placed on *overlapping vulnerabilities* prevalent in today's Liberia. It is thus maintained that factors such as gender, social class, region, and individual's age play a vital role in determining her/his potential to navigate in the country. It is argued that the current EVD epidemic is an additional vulnerability that intersects with and can reinforce already existing discrimination categories.

[1] Finn Church Aid / West and Central Africa Regional Office, Liberia. More info on www.finnchurchaid.fi/en. The views expressed in this study are those of the author alone and do not necessarily represent those of Finn Church Aid. The author can be contacted via email: leena.kotilainen(a)utu.fi.

2 Executive summary

This study examines the gendered impacts of the Ebola virus disease (EVD) in Liberia in the largest outbreak of EVD ever recorded. The findings are based on an extensive two-week desk study and one-week participatory field study conducted in January 2015 in the cities of Monrovia and Buchanan in Liberia.

Gender and sex are addressed in the report in relation to other possible discrimination categories such as social class, geographical region and age. It is emphasised that different forms of discrimination have a tendency to reinforce one another hence causing systematic inequalities and overlapping vulnerabilities. For instance, a young, illiterate and poor woman residing in a shanty town in Liberia was in many ways discriminated even before EVD entered the country (e.g. due to her age, sex, gender, social class, and region), and has therefore been very vulnerable to the short- and long-term impacts of EVD. These include, among other things, reduced health-care possibilities; increased maternal mortality; economic downturn that has hit especially harshly urban petty traders; prolonged closure of the education sector; societal stigmas from EVD and decreased social cohesion in families and communities. It is argued in the study that EVD is an additional vulnerability that has reinforced already existing societal inequalities in Liberia.

The recommendations on how to respond to these multifaceted challenges are separated into three categories. Firstly, general recommendations for addressing overlapping vulnerabilities in fragile contexts are detailed. In this task it is of high importance to include a gender element to all stages of the programme cycle. Among other things, this will allow specifying the interaction between gender-based discrimination and other possible vulnerabilities in the relevant project surrounding. It is also argued that when planning and implementing gender-sensitive programmes, a close relationship with community leaders should be established. These well-respected individuals can in many ways enhance not only the work in the communities themselves but also the sustainability of the project at hand.

The second category of recommendations argues that for addressing possible future EVD epidemics in Liberia and beyond, lessons from the current epidemic should be drafted and made readily available in each involved organisation. It is unfortunate that the current crisis has shown, once again, how short organisational memories can be. The information on how to plan gender-sensitive responses to infectious diseases is for example widely available, yet even WHO failed to follow its own recommendations on the matter at the beginning of the epidemic. A very crucial component of the lessons learnt from the current crisis is that communities need to be deeply involved in all the stages of the programme cycle. Previous examples show that traditional strategies can be found and utilised e.g. for halting infectious diseases in certain communities.

The final set of recommendations concentrates on the aftermath of EVD epidemic in Liberia and argues that the already established community relations should be maintained and utilised in all kind of project work in the future. Since societal stigma of EVD victims and their families is deep and social cohesion in the country was in many ways damaged in the crisis, programmes that aim to enhance mental wellbeing and community cohesion are crucial for successful recovery. In addition, highly-affected groups such as urban petty traders, prostitutes and bushmeat hunters should be supported by providing education on alternative income-generating activities. Finally, and maybe most importantly, restarting and reinforcing the education and healthcare sectors of Liberia are crucial elements of successful post-EVD recovery.

KEY TERMS

EVD — The Ebola virus disease.

GOL — The government of Liberia.

Sex — Biologically determined physiological characteristics of women and men. Universal.

Gender — Socially constructed characteristics of women and men. Culture-specific and learned understandings that typically change over time. Refers often to behaviour models that are considered appropriate to women and men in a given society.

Overlapping vulnerabilities / Intersectional discrimination / Intersectionality

Concepts that are used to describe a situation where multiple discrimination categories overlap and reinforce one another. Different forms of discrimination vary according to the social context and might, among others, include gender, class, age, disability, or ethnic origin.

3 Methodology and constraints of the assessment

The first part of the assessment was undertaken as a desk study in order to map out the already existing information on the issues at hand. In this endeavour, it soon became apparent that although there are some studies, countless newspaper articles, and other media coverage on the gendered impacts of the current EVD epidemic in West Africa, the majority of these outputs do not rely on first-hand sources. As a consequence rumours and estimations, such as the claim that the majority of victims in this outbreak have been females, have started to circulate and have often been taken as facts. For these reasons the principles and ethical guidelines for data collection and data handling in this assessment were formulated as follows:

- Rely on first-hand sources and studies as far as possible.
- Always protect your interviewees from harm. Prioritise their security and confidentiality.
- Follow, in all the stages of the study, Code of Conduct of FCA and the general principles of good research practice.

The participatory field research period was planned and undertaken in close collaboration with FCA's West Africa Regional Office (WARO) in Monrovia. Three focus groups were identified and in all more than 60 individuals were interviewed in Monrovia and Buchanan. In each interview setting the purpose and goals of the assessment were clarified.

As the timeframe for carrying out the research was rather short, both the two-week desk research period as well as the one-week participatory field study were not as profound as they could have been in the ideal case. For example, the field study was limited geographically only to Montserrado and Grand Bassa Counties, and therefore does not cover possible regional differences or variations between urban and rural areas. Nevertheless, the consultant tried to tackle some of these shortcomings in the desk research period. In addition, due to her PhD research[4], the consultant had already developed a deep understanding of gender relations in Liberia. This allowed her to choose and apply the relevant research material as well as estimate critically the already-existing rapid assessment reports and other material on the current EVD outbreak.

4 Detailed findings

The impacts of EVD epidemic in Liberia are scrutinised in this section. A special emphasis is placed on the interplay of EVD and the overlapping vulnerabilities existing in today's Liberia. The discrimination categories of gender, sex, social class, and region are detailed in the analysis but it must be understood that this is not a comprehensive list, however, since relevant vulnerabilities vary according to the specific environment. The effects of societal stigma are addressed at the final part of the section.

Overlapping vulnerabilities

I'm afraid that the already existing social inequalities got perpetuated in the Ebola crisis.
Dr Janice Cooper, National Ebola Taskforce, Monrovia

We the poor people are suffering now. This Ebola virus suppressed us even more.
Volunteer Ebola case finder, Red Light District, Monrovia

It is now widely acknowledged that different types of discrimination categories intersect and reinforce one another hence causing systematic *intersectional discrimination* in a given social context. Intersectional gender analysis holds that it is not enough to place groups of people under single categories (e.g. biological sex) for understanding their statuses in a society. Rather, other contributing factors need also to be considered, such as class, age, religion, or ethnic group.[5] To give an example, a highly-educated elderly female business woman in Liberia is *relationally* in a very much better position to protect her family from EVD infection than an uneducated teenage boy residing in a Monrovian shanty town. In this section, some of these *overlapping vulnerabilities* prevalent in today's Liberia are identified and analysed in the context of the current EVD epidemic.

Gender

Liberia is often discussed as a primary example of female emancipation and increasing gender equality in today's Africa. As *Table 1* demonstrates, the government of Liberia (GOL) has indeed made significant efforts to enhance gender equality in the country. Ministry for Gender and Development, today known as Ministry of Gender, Children and Social Protection, was created already in 2001 and Liberia was the first country to develop a National Action Plan for the Implementation of UN Resolution 1325[6] (see also Table 1). However, as Veronika Fuest argues, in practice a few "business women, some peace activists, leaders of women's organizations tapping into the flow of foreign aid, and female politicians appear to have gained."[7] Besides these privileged individuals and groups, discrimination on the basis of gender is in reality rampant. A telling example is that the 2013 Gender Inequality Index ranked Liberia at 143rd out of 149 countries.[8]

One contributing factor to the ongoing discriminatory practices is that Liberia has no single legal structure and it operates on a complicated dual legal system consisting of statutory and customary law. In practice, marriage is considered civil if officially registered and customary if certain customary rites have been undertaken.[9] Some examples of the contradictory nature of these separate legal systems include:

- The civil law sets the legal age to marriage at 18 years for women and 21 years for men. However, early marriages still take place in rural areas.
- Polygamy is prohibited in the civil law but permitted under customary law. Of women between 15 and 49 years more than one third live in polygamous marriages.
- Married women are considered legal minors under customary law, whereas the civil law treats all individuals equally.
- Married women can inherit property and land in civil law. Customary law does not grant these right to married women.[10]

Table 1: Major milestones in Liberia's gender policy[11]

Agreement / Legal document	Signed	Ratified
The Constitution of Liberia, article 11 (e.g. prohibits sex-based discrimination)		1986
The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)		1984
Optional Protocol to CEDAW	2004	-
National Plan of Action for the Prevention and management of Gender Based Violence in Liberia		2006
Law on rape (includes spousal rape within the definition of rape)		2006
National Girls' Education Policy launched		2006
The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (= Maputo Protocol)		2008
Gender and Sexually Based Violence Act		2008

The on-going customary law practices might pose problems to rural women who have lost their family members in EVD outbreak. A widow of an Ebola-victim might potentially be left without land or other inheritance, and, due to stigma caused by caretaking, even be expelled by the extended family. Since children have been out of school for a prolonged period of time, there will most likely be a rise in teenage pregnancies.[12] In addition, it is likely that some children will not return to schools at all.

Other than heterosexual relationships are illegal in Liberia and can lead to up to one year of imprisonment. A deep societal stigma towards lesbian, gay, bisexual, and transgender (LGBT) people cuts across the Liberian society[13] and was further enhanced by statements of various religious leaders in July 2014 condemning the Ebola outbreak as a punishment sent by God over immoral acts such as homosexuality.[14] This can be seen as an apparent example on how different vulnerabilities intersect and can cause further stigma to already marginalised groups and individuals.

Prostitution is widespread in Liberia. Social class overlaps interestingly with this profession since prostitutes can be separated at least to three different categories: to those "quality women" who have chosen the job willingly for financial gains (the profession can provide a rather good income in comparison to many other alternatives); to females who are forced to perform sexual acts for economic reasons but can still have a decent profit and/or have other small sources of income; and to those poorest females, whose profit is extremely low and who see no other alternatives for prostitution.[15] When the "upper-class prostitutes"

were in many cases able to stop working during the Ebola epidemic, the poorest had to provide sexual services even during the peak of the crisis. **Princess** and **Angeline**, for example, explained that they are the ones responsible for bringing food to the table in their households. Both have two children and live with boyfriends who approve of their profession for economic reasons. Angeline explained her situation:

> Of course I can be afraid now. We are always taking precautions and using condoms. Still, I'm worried about the sweat so I'm only having sex under fans or sometimes in air-conditioned rooms. I'm having my long-sleeve shirt on and stockings that come all the way up to…Well, you know. I'm also using gloves so I could be better protected. But still I and my boyfriend are afraid. He tells me that I can bring the virus to the family.

For a profession that is normally performed after the sunset, the curfew due to EVD posed an additional problem. When many night clubs and bars changed their schedules to keep the businesses running, some prostitutes were able to meet their customers during the daytime. Princess also detailed that because of the outbreak she has given her phone number to numerous customers so they can call her and arrange an appointment. Due to the overall economic impact and the loss of revenues among the customers of Angeline and Princess, the prices have more than halved. Unlike e.g. taxi drivers, who have raised their prices since a smaller quantity of customers is allowed to enter their cars, at least the poorest prostitutes have not had a possibility to increase their prices.

Even though there are numerous programmes and laws for decreasing violence against women and domestic violence in Liberia (see Table 1), both practices remain unfortunately rife in the country. Dr **Janice Cooper**, Chairperson of the National Psychosocial Committee in the National Ebola Taskforce remarks that even during the peak of the crisis the amount of sexual crimes has not decreased and there are even some individuals who have utilised the vulnerability of EVD survivors.

Nonetheless, bearing all the given background in mind, it must also be understood that "local culture" cannot only be blamed for the high rate of GBV in the country. The two long civil wars (1989 –1996 & 1999–2003) did not only abolish formal control mechanisms brought about by legal norms, but they likewise destroyed traditional community-level institutions that controlled the behaviour of women and men, of girls and boys. As scholars Sharon Abramowitz and Mary H. Moran (2012) argue, among all the indigenous communities of the pre-war Liberia there were mechanisms and norms that regulated the behaviour of community members: for example, sexual crimes did not go unnoticed or unpunished among any indigenous group. Although these traditional control mechanisms definitely did not strive to achieve equality between the sexes, they still entail potentials that should not be left unnoticed when planning gender-sensitive programmes in today's Liberia.[16] This remark is discussed further in the section 5 and 6 of the study.

Sex

According to previous research and empirical findings from the current outbreak, EVD also entails some sex-based differences. It seems that nearly 100 % of infected pregnant women pass away if infected; likely due to decreased immunity caused by pregnancy. In addition, spontaneous abortion is frequent in pregnant carriers.[17] On the other hand if a lactating woman is infected and survives, the virus might stay in the breast milk and possibly infect the child of survivor.[18] In addition, it has been estimated that cured men can carry the Ebola virus a prolonged time in their semen[19], although many become impotent[20]. Because of these risks, it is currently advised that survivors and their spouses should abstain from sex for up to three months and be extremely vigilant if sexual acts are taking place.

The dominant narrative on the percentages of victims of EVD epidemic in Liberia (75 % women / 25 % men[21]) relies heavily on the traditional caretaking duties in the country. If and when Liberian women bare

the primary responsibility of caretaking duties inside families, how can the actual numbers of victims be around 50 % / 50 %? Possible explanations include: Women as caretakers have been able to protect themselves, hence education campaigns have been successful; men have been dying for some other reason in huge numbers (e.g. differing hygienic practices between the sexes); infected women have survived in larger numbers than men; other, unknown reasons. It must also be remembered that there might even be flaws in the provided statistics. Many previous studies on tropical diseases have shown that female morbidity may be underestimated in the official data provided by hospitals and health centres since many women do not go to these places for their illnesses.[22] Unfortunately sex-disaggregated data were not available until in the latter part of 2014, although even WHO itself has previously acknowledged the urgent need for this type of information. As is argued in WHO's report entitled *Addressing sex and gender in epidemic-prone infectious diseases* (2007): "The reported data are rarely disaggregated by sex. Furthermore, information relating to the pregnancy status of women and other reproductive factors is seldom systematically collected or included in the reports. This limits the possibilities for understanding the gender dynamics of disease, identifying vulnerable groups, and developing appropriate responses."[23]

Social class

Income inequality in Liberia is among the highest in Africa[24] and the World Bank estimate that some 83,8 % of Liberians live on less than US$ 2 a day[25]. According to the African Development Bank Group only 4,8 % of the population can be considered middle class[26]. Social class is thus probably the most important factor in determining individual's abilities to navigate in (post-) EVD Liberia. Of course being a member of the Liberian elite does not in itself protect anyone from EVD infection, but has nevertheless provided financial opportunities to strategize with possible alternatives. Many have, for example, opted for leaving the country for shorter or longer periods of time and sending their children to countries where schools remain open.

Access to healthcare has been one of the biggest problems in EVD-ridden Liberia. Even prior the Ebola crisis the health sector of the country was in many ways overburdened, even though many improvements were already implemented. For example, the number of nurses had more than doubled from 2006 to 2010. The challenges of the country's health sector date back to the two long civil wars that devastated the healthcare system: when prior the war in 1988 there were 3,526 employees in the public health sector, in 1998 the number had gone down to 1,396.[27] GOL and many international donors have invested heavily on rebuilding health services but access to health facilities and medication still pose enormous challenges especially to the poorest of the poor, whereas the richer segments of the society typically care for their health abroad. According to the most recent data provided by the World Factbook (2011), Liberia used the largest portion of its GDP, almost 20 %, of all the included countries to health expenditures.[28]

Since the symptoms of EVD are similar to "ordinary" diseases such as malaria and typhoid fever, some healthcare facilities have denied access from patients with high fever, running stomach, or other EVD symptoms. There are no data of victims of such misconducts, but the number can be estimated to be rather high. In addition, my interviewees told about many instances where pregnant women were denied access to clinics and had to give birth in the streets, cars, or at their homes. Hence, maternal mortality is again on the rise due to EVD crisis. As Dr Cooper notified: "We were slowly but steadily approaching the Millennium Development Goal but now things have worsened dramatically". Almost all my interviewees explained that they had stocked different kinds of medicine at home and self-treated themselves during the heat of the crisis. These kinds of precautions were of need since many clinics and even bigger hospitals were closed in the worst months of the epidemic. Some of the poorest of my interviewees, however, had not taken precautions with regards to medicine because all their income was utilised on food items.

Economically, EVD epidemic has had devastating effects to the already poverty-ridden West African nations. In 2014 alone, the total fiscal impact of the epidemic has been estimated to be in the three worst-affected countries more than half a billion dollars. For example, Liberia's 2015 GDP growth estimation has

been dropped to 3 % from the pre-EVD estimate of 6.8 %.[29] Although these figures are important for estimating macroeconomic trends in the region, they can also be investigated as projections of the future status of the poorest classes in Liberia. It is clear that those who will carry relationally the biggest financial burden of financial downturns are the poorest of the poor.

Region

According to a recent study carried out by the World Bank, economically the hardest hit by the current epidemic have been those engaged in non-agricultural self-employment activities, of whom the majority are women. At the first round of interviews on which the WB report is based (October 2014), 57 % engaged with self-employment activities were not operating their businesses anymore, whereas in the second round (November 2014) the percentage had risen to 64.[30] When coupled with the increased cost of basic food items (from +42% up to +150% depending on the region[31]), food security has worsened throughout Liberia.[32] In the countryside where extended families typically practice some farming activities, agricultural products have provided backup amidst the epidemic. World Bank underscores that most EVD infections have happened in the poorest and most densely populated areas of the capital Monrovia. Since the majority of the urban poor do not have any possibilities for growing their own crops, the impact of losing one's small business can be felt immediately.[33]

Ms. **Maria Mah** is the coordinator of Forum of African Women Educationalists' (FAWE) Mothers' Clubs project in Liberia. The basic idea of these clubs is to provide a loan of US$ 100 coupled with business education to individual women who use the loan to establish small-scale businesses. According to Ms. Mah, the impacts of EVD epidemic can be clearly seen in the businesses of these women in three specific areas. Firstly, the cost of goods such as fish, palm oil, charcoal, and rice have risen because of the epidemic. In addition, due to closing of borders and the curfew that were put in place in August 2014, many women were not able to go and purchase the goods to be sold – an activity that would normally take place as early as 3 to 4 a.m. Thirdly, the increased transportation fees are causing problems to many petty traders in urban and rural Liberia. Due to EVD epidemic, only three persons are taken in the backseats of public taxis instead of the normal amount of four. In addition, it is customary in the longer journeys to place two persons in the front seat instead of one. Also this practice is currently forbidden for preventing the spread of EVD in the country. All these limitations have resulted in many forced shut downs of small-scale businesses. In a Mothers' Club in Bong County, for example, of altogether 25 active members, seven have given up their businesses due to EVD restrictions. A journey from Bong County to the Red Lights district in Monrovia (one of the most common places to purchase "one's market") had nearly doubled from 500 Liberian dollars (LD) to 900 LD in the time of the writing.

For the purpose of the study, 11 urban petty traders (7 women, 5 men) in various parts of Monrovia were interviewed. The selling items of women included fruits, vegetables, peanuts, cookies, and other food items, whereas the men were typically selling credit to SIM cards or changing US dollars to the local currency. All women reported that EVD epidemic had remarkably decreased their income since "people were afraid of buying food items from the street". During the first weeks of 2015, their businesses had started to grow slightly but remained still very quiet in comparison to the pre-EVD level. The men, on the other hand, reported that their businesses were affected but not as seriously as those of food sellers. As one interviewee explained: "Even in the times of crisis people need to use their phones and change currencies. Of course the money doesn't flow like before because people don't move around that much but I'm still not out of business". Another kind of example was detailed by a business-man from Sinkor who imports household appliances from abroad and resells them to his customers in Monrovia. He reported that his business had not been affected at all.

Loss of income and fear of infection decreased dramatically the income of sewers, barbers and hair-dressers in the worst months of the crisis. The interviewed professionals maintained that little by little

customers had started to return but their businesses were still very unprofitable in comparison to the pre-EVD levels.

All the worst-hit petty traders had to resort to extraordinary measures in the worst times of the crisis. Some received help from their friends and relatives in Liberia and abroad, others contacted "uncles" or "godfathers" (lovers) or ate their "susu". Susu is a very popular way to collect modest funds for small-scale needs. There are numerous variations within susu, but typically a group of individuals donate a small amount of money to a common lot on a regular basis and each month a different individual receives the whole amount.

Hunting of wild animals is the task of men in Liberia. Since EVD crisis has decreased the trade of bushmeat, these men have suffered from significant losses of income. To get a perspective, in a period of 10 months in 2003–4, the value of bushmeat trade in Monrovia alone was estimated to be around US$ 8 million. A lot of this trade relies on endangered species.[34] Typically, it is the job of women to prepare different types of products from bushmeat to be sold in the marketplaces and street corners. Hence, numerous individuals and their families – and the endangered species – would profit if alternative sources of income were possible at least alongside these professions.

On a little bit larger scale, four restaurant/bar owners were also interviewed in Monrovia and Buchanan. The owners of these businesses were all Liberians and their restaurants seated around 40 to 100 customers. All owners of the three food-serving restaurants reported huge losses in their revenues and were forced to close their businesses for up to three months during the heat of the epidemic. "For now, I am not able to pay my taxes to the government since there are still very few customers around", one reported. On the other hand the bar serving mainly drinks was already doing better in January, but the owner reported that also his restaurant had suffered from a significant loss of revenues in the worst months of the epidemic.

On the good side, hotels and expensive restaurants might have had some financial benefits from EVD crisis. These businesses are mainly owned by non-Liberians and have been occupied by the large number of humanitarian aid workers present in the country. The majority of the employees of these businesses are Liberians. One hotel employee, nevertheless, wanted to emphasize that he and his colleagues have been extremely afraid when serving their customers. "Can you imagine, we are serving people who are working in Ebola Treatment Units? We are afraid. So many healthcare workers have died and these people now can bring the sickness with them to the hotel rooms and restaurants. But what to do? We all need our jobs for bringing the daily bread to our families."

Age

> Before Ebola, we used to go to school. We the students are now worried when they say they're going to open the schools again. There are too many students in the classrooms. In rooms of 25 people, more than 50 people! You cannot avoid touching one another! And there is no hygienic education going on for students and teachers. We are worried. No, really, it is only when Liberia is Ebola-free when we can return.
>
> *High school student, male, Monrovia*

Related to poverty, age is another potential vulnerability in (post-) EVD Liberia. Schools have remained closed in the country since July 2014 and it has been estimated that nearly five million children in Liberia, Guinea and Sierra Leone are out of school.[35] Some poverty-ridden families have needed to make careful consideration on how to respond to rise in food prices as well as income losses from closed businesses. As a result, it is likely that some children do not return to schools for economic reasons.[36] Since it has been well-proven that the education level and the overall health of an individual and her/his dependents are deeply interwoven[37], restarting primary and other education institutions in Liberia must be a priority. Originally, the schools were due to be reopened at the beginning of February but because of unpreparedness the teaching is now scheduled to start at 16 February. Since almost all interviewed adults expressed worry over

the safety of the school environment, the decision of GOL to invest more time on careful preparation is a welcomed one for decreasing fears inside families.

Discussions with youth all over Monrovia revealed deep disempowerment and uneasiness brought about by EVD epidemic. Youngsters (13 males, 3 females) from Pagos Island community in Monrovia underlined that idleness has been among the most difficult issues to tackle with in current Liberia. Some had lost their businesses due to the epidemic and felt shame on the fact that they were not able to bring income to the household. For others, various kinds of social events had previously provided a way to forget daily struggles. A male musician from the community explained: "Because Ebola entered Liberia, we are just sitting inside, doing nothing. We cannot even go out and socialise with our friends, meet up in video clubs or entertainment centres, go to play football. This is a setback to the youth. It stole everything already achieved, we can be afraid of one another today."

UNICEF estimates that at least 3,700 children have lost one or two parents in the current EVD epidemic in the worst-affected countries.[38] Ms. **Paté K. Chon** is an executive director for Shalom Inc., a Liberian NGO that has been working extensively with Ebola-affected families throughout the crisis. Ms. Chon explained that the majority of Ebola orphans will be taken care of by their immediate family members – after the 21 days incubation period has passed – but these children are an additional financial burden to many poverty-ridden families. However, there are many children who have been abandoned by their remaining family members and their communities.[39]

Societal stigma and traumas

> I would have gone mad if this one woman from ETU hadn't counselled me. She told me that it is not my fault; that you don't choose to be infected by the virus. Not too long ago, I also gave a testimony at my local church. I was afraid of doing it but people accepted me and can also counsel me.
> *Mariama, Ebola survivor, Monrovia*

In September 2014, **Mariama**'s daughter came down with high fever and rash. Mariama took her child to a well-known clinic and was told that her daughter has both serious malaria and measles. She was given recipes for medication and sent home to treat her child. When the daughter did not feel better even after treatment, Mariama returned to the clinic and was told to leave the child to the premises for professional treatment. Later that day, however, she was called and explained that the child has passed away but the body should remain in the clinic. After demanding explanations for an extensive amount of time, Mariama was told that the child had died of EVD.

Mariama developed a high fever two days later and tried to call to the Ebola emergency number several times with no success. She put on a long-sleeve shirt, long trousers, wrapped her head inside a scarf, and managed to find a motorbike to carry her to one of Monrovia's Ebola Treatment Unit (ETU). Once in the premises, Mariama threw up and was tested positive for EVD. She struggled for her life for several weeks and finally started to gain back her strength. Ebola virus stole altogether 24 members of Mariama's family, including her daughter, fiancée and mother. After the last victim of the household was taken to be buried in a safe manner while Mariama received treatment at the ETU, her family home and her mother's small shop were robbed. "They thought no-one survived, so they took everything. Everything. So when I came back nobody wanted to talk to me. They yelled 'Ebola-woman, Ebola-woman' and were afraid of me. So finally a friend took me in because there were no other places for me to go. But she never told her boyfriend or the other community members that I was a survivor. Otherwise they wouldn't have allowed me to come in".

After a few months, Mariama was offered a position in an ETU as a survivor who provides psychosocial support to Ebola patients. At the beginning of her assignment her traumas came back when witnessing the struggles of patients. Nonetheless, after receiving counselling from her colleagues, she slowly started to manage her trauma. Mariama was later hired as an assisting nurse at the same ETU and was working there

at the time of the interview in January 2014. She remarks that even though she still suffers from physical pain caused by the virus, including joint pain, tension in her muscles and swelling on her feet, the worst part is still mental wellbeing. Mariama cannot sleep well at night, she tries to keep herself busy in order "not to think too much" and gets frequent flashbacks from her horrific experiences. She manages her mental health through discussions with her colleagues and church members, who just recently welcomed her as a member of the church even though she announced publicly to be an Ebola survivor.

Mariama's experiences are a telling example of the utterly complex social realities survivors need to manage in today's Liberia. Even though, on the one hand, the majority of my interviewees convinced that they would accept a survivor to live in their communities after the quarantine period of 21 days was over, on the other hand Mariama's and other survivors' stories reveal deep societal stigmas related to EVD.[40] Ms. Chon also expressed worry over self-stigmatization she has observed among the huge number of survivors she has been working with. According to her, stigmas in the communities are far easier to tackle with through fact-based awareness-rising than deep mental stigmas that many survivors carry in themselves. Ms. Chon explained: "Even families stigmatize themselves and their children. When they see themselves like that, other people start to see them in a similar manner. Children believe they are unclean, they suffer from a very low self-esteem. They blame themselves for surviving when others have died. They believe they might have killed their own parents. Can you imagine that?"

In addition to directly-affected communities, families and individuals, also "normal" Liberians are suffering from traumas. Many of the interviewees of this study, for example, explained that they had troubles to sleep and just hoped "to forget about everything", as one woman illuminated. A focus group discussion in Buchanan with six women and eight men, all of whom were participating a training for trainers in EVD sensitisation, unravelled their views on trauma. They agreed that fact-based awareness-rising in the communities was the key for lessening stigma related to EVD; without correct information received from the trusted community members, traumas and stigmas would prevail. One man explained that convincing people that "we need to look at Ebola orphans as human-beings as ourselves" was the key for their successful reintegration. Many argued for the need to hire counsellors to schools to settle the forthcoming controversies and misunderstandings but were at the same time painfully aware that there were no funds for this purpose. A further challenge for the recovery is that all these new traumas are building up to the numerous and for the most part unprocessed traumas caused by the civil wars.

Decreased social cohesion

> One of the worst impacts of the Ebola crisis is that people are afraid of one another today. They are afraid of going around, even among their own family members. After the crisis we find it difficult to reunite families. It brings a lot of hard feelings into this country.
>
> *Rebecca, Business woman, Capitol Bye Pass, Monrovia*

The most common theme that almost all my interviewees wanted to highlight was fear. Regardless of gender, social class, religious background, or other social factors, mistrust to fellow citizens and even family members was emphasised. Since EVD was considered as a "hidden enemy", and especially when at the first months of the crisis properly planned and executed sensitisation campaigns did not take place, rumours and fears started to spread. But even when detailed information was available, EVD created tensions to families for various reasons. Firstly, everybody was considered a possible carrier: a mother going about to her daily purchases; a father whose extended social network entailed many possible carriers; a daughter having her hair done in a saloon; a son who most likely had various girlfriends. Secondly, if EVD entered the extended family, many decided to protect themselves by breaking contacts to the carrier and to his immediate family altogether. As one young man explained: "My grandmother fell ill. I decided not to even call her, not to answer her calls. If I had answered, she would have asked me to come around, to counsel her and pray with her. But I knew better; I knew that if I answered, I wouldn't be able to say no." Thirdly,

when it was commonly understood that funerals posed a potential risk, many refused to go to any burials at all even though the deceased would have died to a “common” sickness not related to EVD at all. This, I was explained, created many tensions and misunderstandings in a culture where paying respects to the departed is considered almost as a duty.

Due to increased information, successful sensitisation campaigns, and the fact that the EVD case rate had decreased in the country, the worst worries were nevertheless slowly diminishing in the time of the field research period. Yet, numerous interviewees remarked that there would be fear inside them as long as EVD persisted in the country. **Rebecca**, a business woman from Monrovia underlined that even when the country would be Ebola-free, there should still be sensitisation campaigns to bring back social cohesion in the country: “an awareness should be created that it was not in people’s own heart if they lost contact to their loved ones. That they were only afraid.”

5 Analysis of the findings

Although some findings of the study were already examined in the previous parts of the assessment, this section deepens the analysis and paves way to recommendations that are detailed in the concluding chapter. The section begins with an evaluation on how to mitigate possible risks when planning and undertaking gender-sensitive programmes in many ways fragile environments. In the following part, it is argued that one of the most promising ways to both mitigate gender-related risks and to achieve sustainable results is to make use of local initiatives and already-existing community structures throughout the programme cycle.

Mitigating risks

One of the most apparent gender-related risks in projects that are implemented in many ways fragile environments is to unintentionally increase one form of discrimination while trying to alleviate another. Examples of these types of shortcomings might include:

- Girls and women are trained with skills and to professions that have no job market in the specific social environment. Typically women are educated to “feminine fields” such as hairdressers, sewers and bakers even though they would like to learn any skills that could provide their families income in the future. Well-intentioned skills training might in this way unintentionally reinforce already existing gender roles in the region. A proper needs-analysis should therefore be conducted before embarking to any skills training programmes at all[41].
- Boys and men are excluded from workshops and programmes handling gender-based violence. Firstly, creating contacts to (possible) perpetrators is extremely important for sustainable results in lessening GBV enhancing gender equality. Secondly, there is some evidence that GBV against males in conflicts is much more widespread than is normally assumed or publicly admitted.[42] If sexual and other violence against males is not recognised as GBV, gender stereotypes are reinforced rather than dismantled.
- Different kinds of programmes are planned and implemented without consultations and negotiations with local leaders and residents of the area. In the current EVD outbreak, for instance, much-needed safe burial practices of EVD victims caused much alarm and even violent outbreaks in some communities when rumours started to spread due to lack of properly planned and executed sensitisation campaigns. This led to further stigmatisation of Ebola victims and their families. In addition, badly planned and hastily implemented programmes most likely increased the spreading

of the virus in hard-hit communities, when families wanted to hide the infected family members from authorities.

- Organisations that are doing wonderful job with one vulnerable group but are at the same time (openly) discriminatory or even hostile towards other fragile groups are financed and otherwise supported. An example might be a religious group that discriminates against LGBT people.[43]

Previous research[44] and the provided examples hopefully demonstrate that it is of utmost importance to *include gender component* to *all stages of programme cycle* from project planning to its implementation and evaluation. In the ideal case, a mid-term evaluation that entails a gender-perspective should be undertaken and corrections made on the basis of suggested recommendations. As a minimum requirement, a gender-sensitive risk analysis should be a systematic part of all projects implemented in fragile environments.

Supporting local structures and initiatives

In the beginning of the new Millennium, EVD struck Gulu District in Uganda resulting to 224 deaths. In the last month of the outbreak in 2001, a systematic sociocultural study on the outbreak was carried out in the region. The study aimed, among other things, to map and understand local explanatory models towards EVD and detail practices that were either harmful or enhanced the control of EVD. Since the epidemic had had a great toll especially to one ethnic group called Acholi, the two-week research was targeted especially to their living surroundings. The research results revealed that after common diseases such as malaria were ruled out, Acholi people had classified the disease as *two gemo* (two = illness, gemo = epidemic). In Acholi people's culture this classification meant that special arrangements should take place; practices that had been undertaken even before the first Europeans entered Uganda in the late 1800s. Hence, in the case of *two gemo,* families of infected individuals in Acholi culture should, among other things:

- Isolate the patient in a house that is at least 100 m distance from all other houses. No visitors would be allowed to the isolated house.
- A survivor of *two gemo* should bare the caretaking responsibility of the sick individual. If there are no survivors available, caretaking should be done by an elderly woman or man.
- Houses and villages where ill patients resided should be marked with elephant grass.
- Everyone should limit their normal movements and stay at home as much as possible. Food from outsider should not be consumed.
- Pregnant women and children should be extremely vigilant.
- A special emphasis should be given to harmony within households. No harsh words or conflicts would be allowed.
- Sexual relations should be avoided as well as social gatherings, such as dancing.
- Eating rotten or smoked meat would not be allowed. Only fresh meat should be consumed.
- Once the patients is cured and shows no symptoms, he should still be isolated during one full lunar cycle before moving freely in the village.
- If a victim of *two gemo* dies, a person who has survived the disease should do the burying. The funeral should happen at the edge of the village.[45]

As the researchers Hewlett and Amola maintain: "From a biomedical perspective, this protocol constitutes a broad-spectrum approach to epidemic control."[46] Already in 1997, the WHO published a document entitled *WHO recommended guidelines for epidemic preparedness and response: Ebola haemorrhagic fever (EHF)*, where it was stated that special "attention must be given to the actual perception of the outbreak by the community. In particular, specific cultural elements and local beliefs must be taken into account to ensure proper messages, confidence, and close co-operation of the community."[47] It is therefore clear that knowledge and understanding of the positive effects of community-engagement and participatory approaches exist – the challenge is rather to constantly keep these data available.

Traditional, pre-war practices to regulate the relationships between sexes should also be investigated at the local level and considered in programmes trying to enhance gender equality in the country (see chapter 5 / Gender).[48] Although in and of themselves these practices are not sufficient – they do not intend to achieve gender equality – they might provide possible alternatives to take small steps towards increased equality. What backs up this argument is the fact that although Liberia has a wonderful gender policy on paper, it is still among the least gender-equal countries in the world. Hence, some novel approaches should be considered.

Of the few positive things EVD crisis has brought to Liberia, one of the most important ones has been the increased understanding of the crucial roles that community leaders can play in efficient programme management. When it was finally understood that local leadership – village chiefs in rural areas and community leaders in urban surroundings – must be included in all stages of the programme cycle, only then did the sensitisation campaigns start to function as intended. These leaders are elected by the community members and can create contacts to the other key-members of the community, such as to religious and traditional leaders. As a well-educated young man from Monrovia maintained: "Of course I can believe my community chief. We grew up together, so what she tells me to do, I believe her. The whole community has chosen her to lead us, we voted for her. She can also be suspended if she doesn't perform her duties well. It is different with her than with those big belly politicians in the government. Of course it is different if my countryman or -woman tells me to do something than with you foreigners. She is directly responsible to us, to the community members."

6 Conclusions

At the beginning of 2015 it seemed that EVD epidemic in the worst-affected countries (Liberia, Sierra Leone & Guinea) was, for the most part, under control. The latest situation report published on 11 February[49], however, underscores that the weekly case incidence rate increased for the second consecutive week thus continuing the developments reported in the previous situation report. In addition, challenges were faced in the form of community resistance and increasing geographical spread in Sierra Leone and Guinea. A further challenge is the approaching rainy season in the region that poses significant difficulties especially in the transportation sector. Since the borders of the region are in many ways flexible, and because EVD has already proven its capability to travel from one country to another, all these developments in the region should be taken seriously. The epidemic is not yet overcome at the time of the writing.

What is clear, nevertheless, is that intersectional discrimination will be prevalent in (post-EVD) Liberia in the upcoming years, and most likely in a larger scale than has been seen for a while. This is due to many intersecting factors, such as the long-term effects of the decreased financial growth; loss of income and small-scale businesses in individual households; many kinds of traumas from EVD epidemic; the prolonged closure of the education sector; setbacks in the health sector; societal stigmas related to EVD, and the decrease of social cohesion in families and communities. Income and other inequality has widened due to the epidemic since both the short- and long-term effects have hit hardest the most unprivileged groups of the society and especially the vast number of urban poor residing in the Monrovian shanty towns[50]. The

gap between gender legislation and its implementation persists. Hence, all in all, GOL and international community have significant challenges ahead in the upcoming years.

When trying to alleviate the suffering of the least-privileged, it should be understood that different types of discrimination categories have a tendency to reinforce one another. Quite simply, the more categories an individual can be placed into, the likelier it is that (s)he is severely disenfranchised. For example a poor girl child who resides in a Monrovian shanty town carries at least the intersectional vulnerabilities of being a young (age) girl (sex/gender) from a poor family (social class), who is living in a slum (region). These discrimination categories do not, however, mean that this girl could not uplift her status in the Liberian society but the challenges are enormous.

Although the recommendations provided in the next pages are targeted to NGOs such as FCA, they can also be applied to any organisation interested in alleviating the suffering of the least powerful. As a general rule, the recommendations should be understood as flexible and adjustable, bearing in mind that different types of discrimination categories vary according to the specific social surrounding.

7 Recommendations

General recommendations for addressing overlapping discrimination

- Include a gender element to all stages of the programme cycle. In the planning phase, detail the most prevalent discrimination categories in the area of the intended project. Include to the project plan a risk-analysis that entails a gender-component. If possible, undertake a mid-term evaluation in the implementation phase that allows for possible revisions in the on-going project. In the final evaluation phase investigate critically the achieved results from the viewpoint of overlapping vulnerabilities.
- Since it is impossible to do everything in one project, it would be advisable to identify one or two most pressing vulnerabilities. The overall, long-term goal of the project would then be to lessen these discriminatory practices within the project region.
- Be extremely careful not to enhance one form of vulnerability while alleviating another.
- Do not, under any circumstances, give promises that you cannot keep. False promises are not only harmful for the reputation of the organisation but also create false hopes and can hence gravely harm future projects in the target communities.
- Utilise the already-existing community structures and coping strategies in all your work. If possible, work in close collaboration with community leaders, who are elected to their positions by the community members themselves and hence enjoy utmost trust in their communities. When a trusting and respectful relationship is formed, community leaders can also act as links to other key members in the community, such as religious and traditional leaders. When planning and executing projects in close collaboration with the key members of the projects communities, sustainable results can be achieved.

For efficient EVD responses

- For preventing and addressing possible future epidemics of EVD, already-existing strategies, recommendations and lessons learnt should be readily at hand in each organisation. It is surprising that at the beginning of the West African epidemic for example WHO did not follow its own recommendations (e.g. on collecting sex-disaggregated data of victims and involving communities to programme design).
- The knowledge and understandings of the targeted communities themselves should be mapped out and utilised in all the stages of the project cycle. There is a broad consensus that mere biomedical programmes or approaches that have been developed in different societal contexts are not often efficient enough. Knowledge on the positive effects of community-engagement and participatory approaches exist, yet the challenge is to constantly keep these data available.

For the aftermath of EVD epidemic in Liberia

- After a rather clumsy start, different actors in Liberia have shown a great example on how to identify those key members of communities through whom sensitisation campaigns have started to function as intended. These already established links should be upheld and utilised in the future programmes.
- Programmes that aim to further enhance social cohesion and mental wellbeing of highly-affected communities and individuals were requested by the majority of interviewees, regardless of respondent's gender or social class. Facts on the nature of EVD, including biomedical information but also its various social implications were detailed as key topics to handle when aiming to enhance community cohesion.
- Worst-hit petty traders, for instance women selling food items, should be supported if they hope to restart their businesses. Small-scale loans that are planned and implemented in line with local initiatives (such as the *susu*-system) might be of help.
- Alternative income-generating activities and targeted awareness raising should be planned and implemented also with other highly-affected groups such as prostitutes, bushmeat hunters, and sellers of products made of bushmeat. Even though EVD epidemic will hopefully eventually retreat, other benefits could follow. Increased fact-based risk-awareness campaigns among prostitutes would benefit not only the prostitutes themselves but also their spouses and children. Although it is likely that the bushmeat trade will return close to pre-EVD level once the country is declared "Ebola-free", targeted education on alternative income-generating activities might lessen the trade in small regional areas hence enhancing protection of some endangered species.
- Restarting and -building the educational and healthcare sectors must be priorities for addressing the needs of the most vulnerable. There are, however, misconceptions such as that ETUs will later be turned as regular healthcare centres. These kinds of false expectations must be corrected at once.

Annexes

Annex 1: List of interviewed people

1) Focus group interviews

- Trainers on Ebola awareness. 6 women, 8 men. Buchanan.
- Household visit. 2 women. Buchanan.
- Youth group. 13 young men, 3 young women. Monrovia, Pagos Island.

2) Key interviews

Loss of livelihoods

- Petty traders. 7 women, 5 men. Various surroundings in Monrovia.
- Business man. Congo Town, Monrovia.
- Female sewer. Capitol Bye Pass, Monrovia.
- Restaurant owners / employees. 4 men in Monrovia, 1 man in Buchanan.
- Prostitutes. 2 young women. City centre, Monrovia.
- Male barber. Capitol Bye Pass, Monrovia.

Monrovia's neighbourhoods (various interviews with residents of)

- Clara Town
- Pagos Island
- Capitol Bye Pass
- West Point
- Red Light
- Congo Town
- Sinkor

Expert interviews

- Ms. Paté K. Chon. Shalom Inc: Executive director and counsellor of EVD victims and survivors.
- Ms. Maria Mah. African Women Educationalists (FAWE): Coordinator of the Mothers' Clubs project.
- Dr Janice L. Cooper. National Ebola Taskforce: Chairperson of the National Psychosocial Committee. / The Carter Center: Project Lead on Mental Health Program Liberia.
- Ms. Sieane Abdul-Baki. The Deputy Minister for Gender, Liberia. (Phone interview).
- "Mariama". EVD survivor and assistant nurse in a Monrovian ETU.

Annex 2: List of reference documents

[1] Beeching, Nicholas, Manuel Fenech & Catherine F. Houlihan (2014): “Ebola virus disease”. *Clinical Review,* 10 December 2014.

WHO (2015): *Ebola virus disease: Key facts*. Availabe at: <http://www.who.int/mediacentre/factsheets/fs103/en/>.

[2] WHO (2015): *Ebola Situation Report - 11 February 2015*. Data up to 8 February 2015. Available at: <http://apps.who.int/ebola/en/ebola-situation-report/situation-reports/ebola-situation-report-11-february-2015>. It must be, however, kept in mind that there are many cases that have not been reported and are not therefore part of these data.

[3] Ibid.

[4] The consultant is writing up a PhD thesis on former young female soldiers’ post-war realities in Liberia and has spent around 5 months in Monrovia, Kakata, Gbarnga and Ganta. She has been working with her thesis on a full-time basis since June 2011.

[5] E.g. Crenshaw, Kimberlé W. (1991): “Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color”. *Stanford Law Review*, 43(6), pp. 1241–1299.

Shields, Stephanie A. (2008): “Gender: An Intersectionality Perspective”. *Sex Roles*, 59, pp. 301–311.

McCall, Leslie (2005): “The Complexity of Intersectionality”. *Signs*, 30(3), pp. 1771–1800.

[6] The Government of Liberia (2009): *The Liberia National Action Plan for the Implementation of United Nations Resolution 1325*. Available at: <http://www.peacewomen.org/assets/file/NationalActionPlans/liberia_nationalactionplanmarch2009.pdf>.

[7] Fuest, Veronika (2008): “’This is the Time to get in Front’: Changing Roles and Opportunities for Women in Liberia”. *African Affairs*, 107/427, pp. 201–224. On page 223.

[8] UNDP (2014): *Explanatory note on the 2014 Human Development Report composite indices*. Available at: <http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/LBR.pdf>.

[9] USAID (2012): *Liberia Land Policy and Institutional Support (LPIS).* Women’s Land Rights Study.
Scalise, Elisa & Leslie Hannay (2013): *Land Policy Reform for Women in Liberia*. Brief: Focus on land in Africa. Available at: <http://www.focusonland.com/fola/en/countries/brief-womens-land-rights-in-liberia/>.

[10] OECD (2014): *Social Institutions & Gender Index (SIGI): Liberia*. Available at: <http://genderindex.org/sites/default/files/datasheets/LR.pdf>.

[11] The Government of Liberia (2015): *The Constitution of the Republic of Liberia*, 1986. Available at: <http://www.wipo.int/wipolex/en/details.jsp?id=8556>.

UN Women (2014): *Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)*. Available at: <http://www.un.org/womenwatch/daw/cedaw/cedaw.htm>.

UN Women (2014): *Optional Protocol to CEDAW*. Available at: http://www.un.org/womenwatch/daw/cedaw/protocol/.

African Union (2003): *The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa*. Available at: <http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf>.

The Government of Liberia (2006): *National Plan of Action for the Prevention and management of Gender Based Violence in Liberia (GBV-POA).* Available at: <http://www.svri.org/Liberiapolicy.pdf>.

[12] Interview with Dr Janice Cooper.

[13] E.g. the president of Liberia, Ellen Johnson Sirleaf, has defended the law that criminalised homosexual acts in Liberia. See for example The Guardian (2012): *Nobel peace prize winner defends law criminalising homosexuality in Liberia.* Published on 19 March 2012. Available at: <http://www.theguardian.com/world/2012/mar/19/nobel-peace-prize-law-homosexuality>.

[14] See e.g. Hussain, Misha and Maria Caspani (2014): *Gay community under attack in Liberia over Ebola outbreak*. Reuters. Published on 23 October 2014. Available at: <http://uk.reuters.com/article/2014/10/23/us-foundation-ebola-liberia-gay-idUKKCN0IC1GV20141023>.

[15] Focus group discussions with Monrovian prostitutes (+ 50 women) in 2012, 2013 and 2014 conducted by the author. See also Kotilainen, Leena (forthcoming). *Hope is Not Gone Altogether: The Roles and Reintegration of Former Young Female Soldiers in Liberia*. PhD dissertation.

[16] Abramowitz, Sharon and Mary H. Moran (2012): “International Human Rights, Gender-Based Violence, and Local Discourses of Abuse in Postconflict Liberia: A Problem of “Culture”?” *African Studies Review,* 55(2), pp.119–46. On pages 21– 23.

[17] E.g. Mupap Kibadi et al. (1999): “Ebola Haemorrhagic Fever and Pregnancy”. *The Journal of Infectious Diseases,* 179(Suppl. 1), S11–2.

[18] Bausch et al. (2007): “Assessment of the risk of Ebola virus transmission from bodily fluids and fomites”. *Journal of Infectious Diseases*, 196, S142–7.

[19] Ibid.

[20] Communication with Dr Janice Cooper.

[21] See e.g. The Washington Post (2014): *Ebola striking women more frequently than men*. Published at 16 August 2014. Available at: < http://www.washingtonpost.com/national/health-science/2014/08/14/3e08d0c8-2312-11e4-8593-da634b334390_story.html>.

[22] Vlassoff Carol & Claudia Garcia Moreno (2002): “Placing gender at the centre of health programming: challenges and limitations”. *Social Science & Medicine,* 54, 1713–1723.

Vlassoff Carol & Elssy Bonilla (1994): “Gender-related differences in the impact of tropical diseases in women: What do we know?” *Journal of Biosocial Sciences,* 26, 37–53.

[23] WHO (2007): *Addressing sex and gender in epidemic-prone infectious diseases*. Available at: < http://www.who.int/csr/resources/publications/SexGenderInfectDis.pdf >. On page 3.

[24] Boley, Tecee (2013): *Liberia: Very Rich, or Very Poor*. Chutes and Ladders, an article series published by the World Policy Institute.Available at: <http://www.worldpolicy.org/journal/summer2011/chutes-and-ladders-liberia>.

[25] The World Bank (2014): *Poverty and Equity: Country Dashboard, Liberia*. Available at: <http://povertydata.worldbank.org/poverty/country/LBR>.

[26] Boley, Tecee (2013), on the note 23.

[27] Varpilah, S. Tornorlah (2011): "Rebuilding human resources for health: a case study from Liberia". *Human Resources for Health*, 9(11).

[28] CIA The World Factbook (2014): *Africa: Liberia*. Available at: <https://www.cia.gov/library/publications/the-world-factbook/geos/li.html>.

[29] Thomas, Mark R. et al. (2015): *The economic impact of Ebola on sub-Saharan Africa: updated estimates for 2015*. The World Bank working paper no. 9372. Available at: <http://documents.worldbank.org/curated/en/2015/01/23831803/economic-impact-ebola-sub-saharan-africa-updated-estimates-2015>.

[30] The World Bank Group (2014): *The Socio-Economic Impact s of Ebola in Liberia*. Results from a High Frequency Cell Phone Survey, November 19, 2014. Available at: < http://www.worldbank.org/content/dam/Worldbank/document/Poverty%20documents/Socio-Economic%20Impact%20of%20Ebola%20on%20Households%20in%20Liberia%20Nov%2019%20%28final,%20revised%29.pdf>.

[31] PLAN (2014): *Young lives on lockdown: The impact of Ebola on children and communities in Liberia*. Interim report, 12 December 2014. On page 6.

[32] FAO/WFP (2014): *Crop and Food Security Assessment - Liberia*. 17 December 2014. Available at: <http://www.fao.org/3/a-I4278E.pdf>.

[33] See The World Bank Group (2014), on the note 29.

[34] Baron, Ethan (2013): *Bushmeat Trade Thrives on Endangered Species, but Creates Livelihoods*. JHR: Journalists for Human Rights. Available at: <http://www.jhr.ca/blog/2013/04/bushmeat-trade-thrives-on-endangered-species-but-creates-livelihoods/>.

[35] Global Business Coalition for Education (2014): *Ebola Emergency: Restoring Education, Creating Safe Schools and Preventing a Long-term Crisis*, November 2014. Available at: <http://gbc-education.org/wp-content/uploads/2014/12/EbolaandEducationReport122014.pdf>.

[36] Ibid.

[37] E.g. UNESCO (2014): *EFA Global Monitoring Report - Teaching and learning: Achieving quality for all*. Available at: < http://unesco.nl/sites/default/files/dossier/gmr_2013-4.pdf?download=1 >. On the page 15.

[38] UNICEF (2014): *Impact of Ebola*. Available at: <http://www.unicef.org/emergencies/ebola/75941_76129.html>.

[39] See e.g. BBC News (2015): *Meet the children orphaned by Ebola.* Published on 16 January 2015. Available at: <http://www.bbc.com/news/health-30834538>.

[40] See e.g. Ebola Response Anthropology Platform (2014): *Stigma and Ebola: an anthropological approach to understanding and addressing stigma operationally in the Ebola response*. Policy briefing Note, published on 11 December 2014. Available at: <http://www.ebola-anthropology.net/wp-content/uploads/2014/12/Stigma-and-Ebola-policy-brief-Ebola-Anthropology-Response-Platform.pdf>.

Ebola Community Action Platform (2015): *'Survivors and Ebola Workers Suffering Wide Discrimination and Stigma', says Mercy Corps*. Press release, published on 12 February 2015.
Available at: <http://ecapliberia.org/index.php/single-article/585-survivors-and-ebola-workers-suffering-wide-discrimination-and-stigma-says-mercy-corps.html>.

[41] A bad example of a hastily planned and poorly executed skills-training can be found from Utas, Mats (2005): "Building a future? The reintegration and re-marginalisation of youth in Liberia". In *No Peace, no war an anthropology of contemporary armed conflicts*. Paul Richards (ed.). Oxford and Athens: James Currey and Ohio University Press. On page 145.

[42] See e.g. Carpenter, Charli R. (2006): "Recognizing Gender-Based Violence Against Civilian Men and Boys in Conflict Situations". *Security Dialogue*, 37(1), 83–103.

Dolan, Chris (2014): *Into the Mainstream: Addressing Sexual Violence Against Men and Boys in Conflict*. A briefing paper prepared for the workshop held at the Overseas Development Institute, London, 14 May 2014. Available at:
< http://www.warchild.org.uk/sites/default/files/Into-the-Mainstream.pdf>.

[43] The U.S., for example, has taken gay rights as part of its foreign policy. See e.g. U.S. Department of State (2011): *The Department of State's Accomplishments Promoting the Human Rights of Lesbian, Gay, Bisexual and Transgender People.* Available at: <http://www.state.gov/r/pa/prs/ps/2011/12/178341.htm>.

[44] See e.g. WHO (2007), on the note 22.

[45] Hewlett, Barry S. & Richard P. Amola (2003): "Cultural Contexts of Ebola in Northern Uganda". *Emerging Infectious Diseases,* 9(10), pp. 1242–1248. See especially the page 1244.

[46] Ibid. p. 1244.

[47] WHO (1997): *WHO recommended guidelines for epidemic preparedness and response: Ebola haemorrhagic fever (EHF)*. Available at: <http://libdoc.who.int/hq/1997/WHO_EMC_DIS_97.7.pdf>.

[48] Abramowitz, Sharon and Mary H. Moran (2012), on the note 15.

[49] WHO (2015), on the note 2.

[50] The World Bank Group (2014), on the note 29.