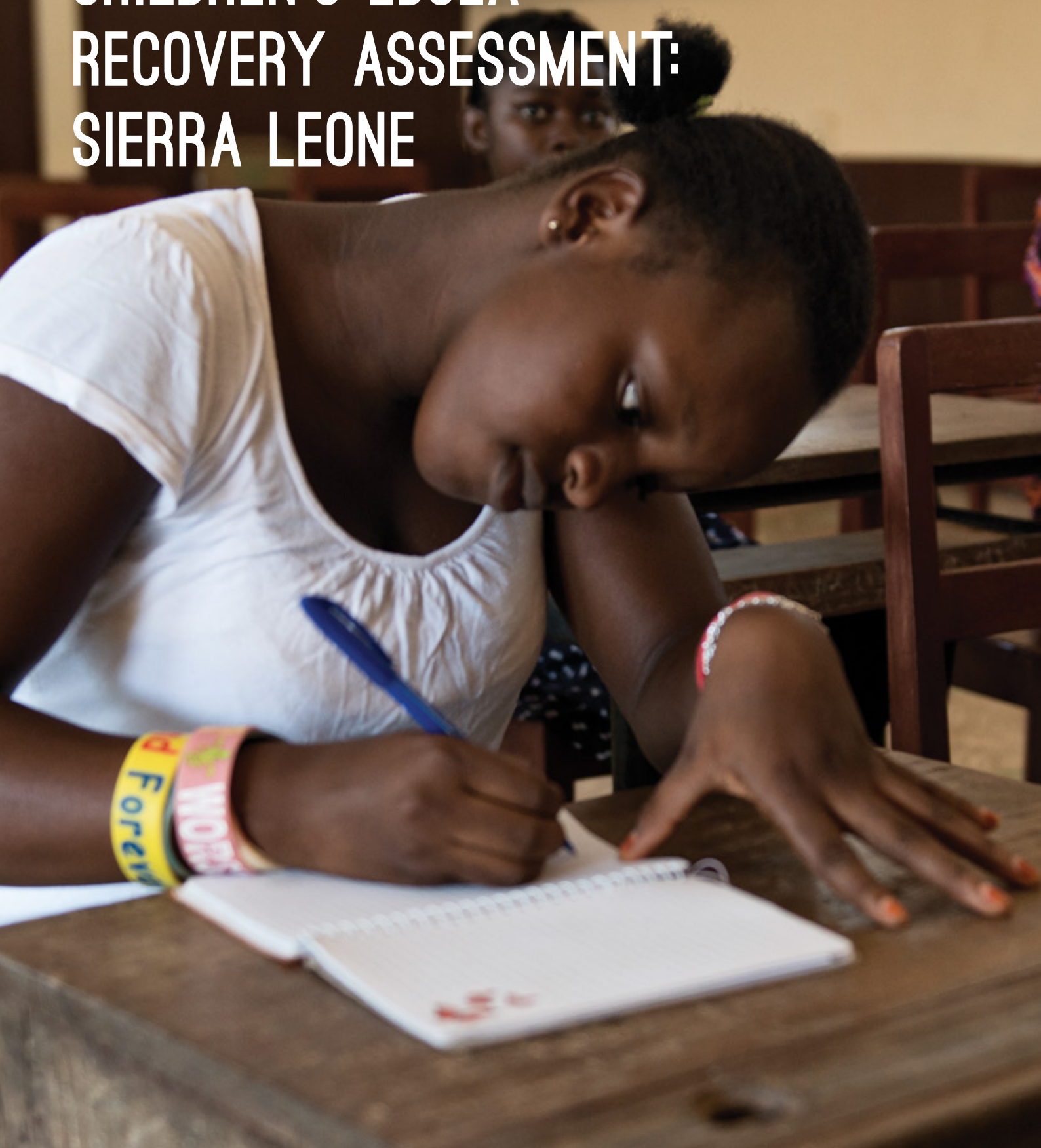


CHILDREN'S EBOLA RECOVERY ASSESSMENT: SIERRA LEONE



Save the Children



Plan

World Vision



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Cover Photo Credit: Neil Brandvold/Plan

ACRONYMS

CERA	Children's Ebola Recovery Assessment		and Children's Affairs
CWC	Child Welfare Committees	MDG	Millennium Development Goals
ERA	Ebola Recovery Assessment	NGO	Non-Governmental Organisation
EVD	Ebola Virus Disease	PHC	Primary Healthcare
ETU	Ebola Treatment Unit	PHU	Peripheral Health Unit
FGD	Focus Group Discussion	PPE	Personal Protective Equipment
FSU	Family Support Units	SCI	Save the Children International
GoSL	Government of Sierra Leone	SME	Small and Medium Enterprise
IPC	Infection Prevention Control	UNMEER	United Nations Mission for Ebola Emergency Response
MEST	Ministry of Education, Science and Technology	WASH	Water, Sanitation and Hygiene
MoHS	Ministry of Health and Sanitation	WVI	World Vision International
MSWGCA	Ministry of Social Welfare, Gender		

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EXECUTIVE SUMMARY

Nearly half the population of Sierra Leone is under the age of 18 yearsⁱ and the impact of the Ebola crisis on their lives now and on their future opportunities has been far-reaching: no school; loss of family members and friends to the virus; and changing roles and responsibilities in the home and the community.

While the priority now remains meeting the goal of zero cases, the Government of Sierra Leone (GoSL) is also developing a comprehensive strategy aimed at supporting communities to recover from this crisis, to put the country back on track to meet development targets. The Ebola Recovery Strategy – currently being finalised by the GoSL – represents a potentially transformative framework to support the immediate recovery of children from the crisis and to ensure their place in the future development of Sierra Leone.

To date, there has not been a formal process for children to outline their own priorities for recovery to decision-makers. In mid-March 2015, child-centred agencies conducted a Children's Ebola Recovery Assessment (CERA) in nine districts across Sierra Leone to create a mechanism for more than 1,100 boys and girls, to discuss issues of concern; assess the impact of the crisis on their roles, responsibilities and future opportunities; and to formulate their recommendations for recovery.

The findings of the CERA powerfully demonstrate the diverse and inter-connected impact of the outbreak for children living through the Ebola crisis in Sierra Leone. Children identified four issues of concern:

1. The impact of school closure on their learning, social interaction and protection and their desire to return to education;
2. The many and varied direct impacts Ebola has had on their lives, including grief, fear and anxiety;
3. Limited access to healthcare for common health problems; and
4. The wider economic impact of the crisis on their families and communities, including access to food and family livelihoods.

Overwhelmingly, children viewed the closure of schools as the issue of primary concern for them and were unanimous about the potential impacts this could have on their futures opportunities. Across all nine districts, children reported a direct correlation between school closure and increases of child labour and exploitation, exposure to violence in the home and community, and teenage pregnancy. Children also described taking on new roles and responsibilities to supplement household income.

As Sierra Leone emerges from one of the most challenging crises in its history, boys and girls have clear views on what they need, want and expect from decision-makers in the community and government. Education, access to healthcare and a safe environment in which to grow up rank top of the list for children's recovery from the legacy of Ebola in Sierra Leone.

STRUCTURE OF THE REPORT

There are five sections to this report. The introduction outlines the rationale for the CERA, and section one describes the methodological approach by partner agencies. Section two focuses on the issues of concern for children – now and as a consequence of Ebola – and zones in on the impact of school closure on children across nearly every aspect of their lives. In the third section, children outline how their roles and responsibilities in the home and the community have changed during the Ebola crisis; it discusses factors – largely related to the closure of schools – that create additional vulnerabilities for children, and it concludes with their views about the challenges that lie ahead when returning to education. The fourth section outlines children’s recommendations for recovery: offering decision-makers a clear set of recommendations on how to support them to get back to school and out of work; stopping violence against children, and reducing the risk of teenage pregnancy to create an enabling environment for children to thrive in Sierra Leone.

INTRODUCTION

Ebola is taking a devastating toll on the lives of Sierra Leoneans affected by the worst outbreak of the epidemic on record. More than 8,500 people – including 1,450 children – have been infected and 3,499 people have died since the declaration of the outbreak in May 2014ⁱⁱ.

There are now positive signs that the tide is turning against the Ebola virus in Sierra Leone; confirmed cases are at their lowest rate since the outbreak began. Communities are taking a frontline role in keeping their families and neighbours safe from infection by maintaining vigilance to ‘Avoid Body Contact’ policies and respecting the new safe burial practices. On 14 April, schools were officially reopened across the country after more than nine months of closure.

People across the country are eager to return to normal life after almost a year of dealing with the impacts Ebola has had on their daily lives. Since early 2015, the GoSL has been developing a comprehensive strategy aimed at supporting the recovery of the country and its citizens from the Ebola outbreak. This process is partly informed by the findings of the Ebola Recovery Assessment (ERA), undertaken by international partners including the United Nations, the World Bank, European Union, and African Development Bank.ⁱⁱⁱ While the ERA represents a major contribution to the ongoing recovery planning process, the formal process did not – due to time constraints – include significant consultation with affected communities or civil society organisations.

From previous experience in other crises and post-crisis settings, partner agencies recognise that children have specific vulnerabilities and distinct experiences of crisis. Consequently, children typically rank priorities for immediate response and recovery in a different order to needs/priorities expressed by adults. Critically, the ERA did not include consultation with children – who represent nearly half the population.^{iv}

Building on similar initiatives following the 2010 earthquake in Haiti^v and Typhoon Haiyan^{vi} in the Philippines, Save the Children, Plan International and World Vision International – with the support of UNICEF – undertook a ‘Children’s Ebola Recovery Assessment’ (CERA). This initiative is designed as a contribution to the ongoing recovery planning process led by the GoSL.

SECTION 1: METHODOLOGY^{vii}

The CERA was undertaken by partner agencies in mid-March 2015, through participatory focus group discussions (FGDs) with 1,193 children from 50 villages in nine districts in Sierra Leone.

In recognition of the different needs and perspectives of children, groups were divided by sex (boys/girls) and age groups (7-10; 11-14; 15-18). A total of 118 FGDs were undertaken by programme staff and youth volunteers from the respective agencies^{viii}, meaning that some of the FGDs were child-led as well as child-focused. Assessment teams received a common training, toolkit and reporting forms^{ix}, and all FGDs explored the following questions:

Districts covered:	9
Villages covered:	50
Focus group discussions conducted:	118
Children involved:	1,193
Assessment days:	6
Assessment staff:	59 (39 male, 20 female)

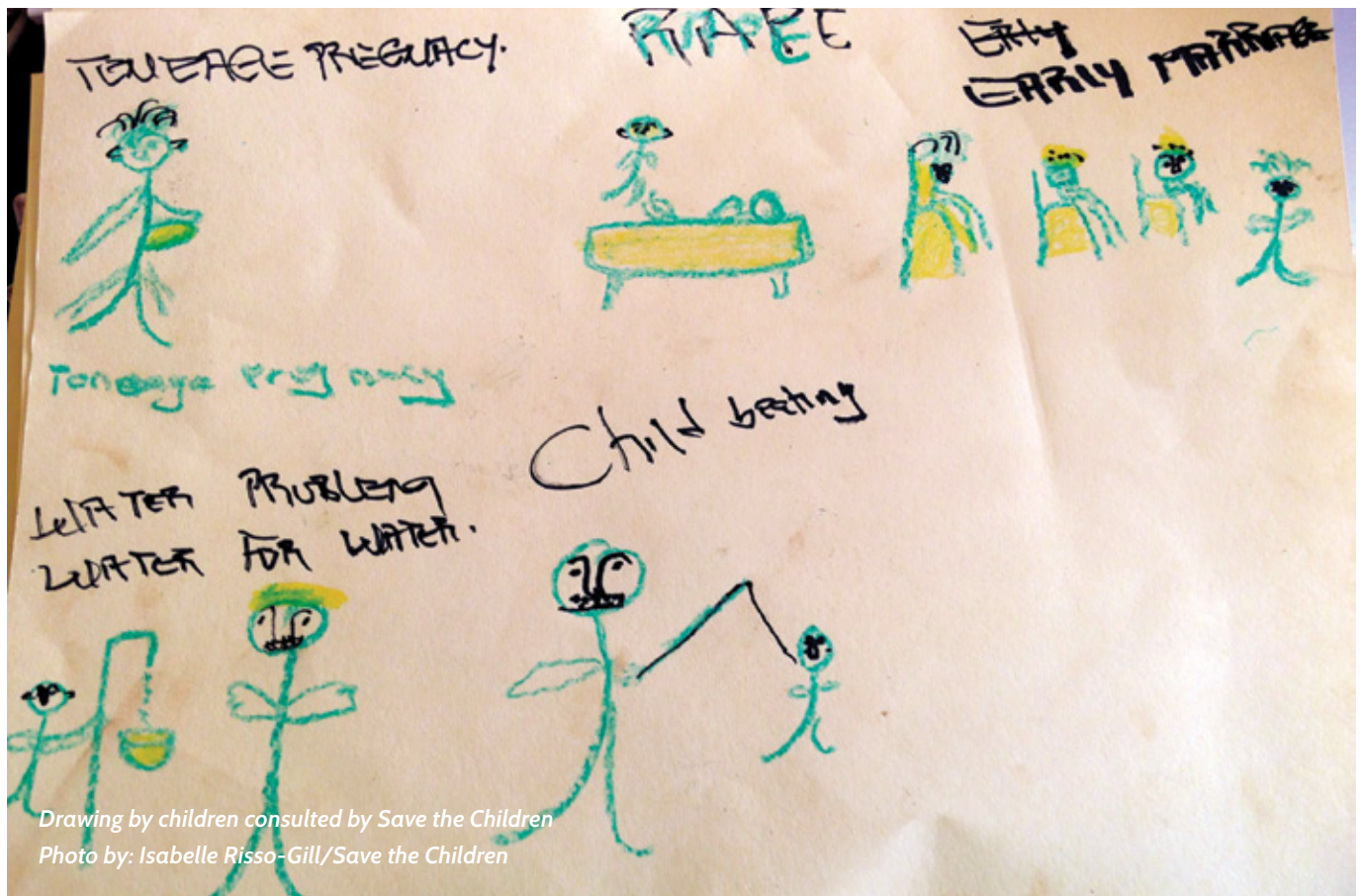
Question 1: What are the biggest issues or problems that the children currently have in their lives, in the context of the Ebola crisis?

Question 2: How do these affect them and their families?

Question 3: Who else is affected by these issues or problems, and how?

Question 4: What do they think are the possible solutions to these problems?

Question 5: Who do they think could help resolve these problems? Who do they think is responsible?



IDENTIFYING GEOGRAPHIC SITES COVERED BY THE CERA

Due to the qualitative nature of the assessment, the target districts and communities were selected purposively and selection of field sites was determined by the operational presence of participating agencies.

The assessment was conducted in four communities in each district. The communities were also selected purposively with the aim of achieving as much generalisability and diversity as possible within a purposive approach.

Further details of the sampling of communities and children can be found in the Annexes.



Figure 1 Selected field sites for the CERA by each participating agency

IDENTIFYING CHILDREN TO PARTICIPATE

Children were selected using systematic random sampling to ensure the participation of a wide range of children.

Age group	Girls	Boys	Total
7-10 year olds	195	189	384
11-14 year olds	206	216	422
15-18 year olds	216	171	387
Total	617	576	1,193

Of the children that participated, many had been directly affected by Ebola. Participating in the assessment, the teams counted:

- 21 survivors
- 100 children who had lost at least one parent to Ebola
- 347 children who had been under household quarantine

Furthermore, the assessment teams counted:

- 130 orphans not Ebola related
- 6 children with disabilities
- 1 pregnant teenage girl



Boys discussing issues of concern during the Ebola crisis.

Photo by: Isabelle Risso-Gill/Save the Children

PARTICIPATORY TOOLS

While all FGDs sought to address the five questions listed overleaf, three different tools were used to identify which of the three main issues affecting the children in the context of the Ebola crisis (answering question 1), detailed in Box. As the three main issues were identified and emerged from the groups, these were discussed in more detail (answering questions 2-5 listed overleaf).

The assessment teams selected the tool they would use before starting the FGD, depending on age group, resources available and the mobilisers' observations of the children's mood or energy. All tools were used with all age and sex groups. However, it was found that Dot Voting worked best with younger children (7-10), whilst the Yes-No-Maybe exercise was not well understood by this age group. Expressive drawing was popular with children over the age of 11, but was not appropriate for children who had not attended school. The Yes-No-Maybe exercise generated good discussion with older children (11-18).

The tools were discussed for cultural appropriateness during the community mobiliser training, and key phrases and resources were language-tested for translation and appropriateness.

1. **Expressive drawing:** children are asked to draw one issue affecting them. Facilitator asks the children what they have drawn and the group then discusses the three most common issues drawn.
2. **Yes-No-Maybe:** prepared "well-being statements" (see Annexe for examples) are read out to the group. Children choose to stand beside either a Yes, No or Maybe sign depending if they agree, disagree or are unsure about the statement. The facilitator asks the children to explain why they were standing where they were. The three issues that created the strongest reactions or discussion are identified as the greatest issues for more detailed discussion by the group.
3. **Dot Voting:** appropriate symbols representing key issues (see Annexe) are presented to the children, who are asked to "dot" – using a finger ink print, sticker or marker – the three issues that most affect them. The three issues with the most dots are identified and discussed in more detail by the group.

For all tools, children are asked to validate the three main issues before the beginning of the group discussion. After agreement is reached on the three main issues, the facilitator follows questions 2-5 to explore each issue in more detail.

DATA COLLECTION AND ANALYSIS

Notes were taken by the assessment staff during each FGD and written up each day on the reporting forms. They were then submitted to the CERA Project Manager for analysis. Reporting forms were submitted in English, and translated from the local language by the assessment teams where required. Data analysis undertook a thematic content analysis approach, inductively drawing out the themes from the data collected. Emerging themes were identified based on the frequency in which they featured in the FGDs, and the severity of the issue; these themes were then mapped to see how the issues linked together. Direct quotes were used to support the themes where available. Furthermore, data from the Yes-No-Maybe exercise was tallied and analysed to provide further supportive evidence for the key themes already identified from the inductive content analysis.

More details of the analysis and a summary of strengths and limitations of the CERA can be found in the Annexe.

Photo by: Isabelle Risso-Gill/Save the Children



SECTION 2: ISSUES OF CONCERN FOR CHILDREN LIVING THROUGH THE EBOLA CRISIS

I. SCHOOL CLOSURE

WE ARE NOT IN SCHOOL

“I can no longer remember what I have previously learnt in school”
– girl aged 7-10, Bo

Issue	# FGDs featured in discussion as an issue
Education	93 (79%), and top-three priority in 89 FGDs (75%)
Children miss learning	53 (45%)
Children lack learning materials	28 (24%)
Children miss playing with friends	28 (24%)
More children dropping out due to closure of school	22 (19%)

Education emerged as the number one priority for children in 59 of the 118 FGDs (45%) and featured among the top three priorities of 89 FGDs (75%). Missing out on months of formal learning in a school setting was generating concern and anxiety among children of all ages (featuring in 45% of FGDs).

As a prevention measure, schools were shut for more than nine months. During the period of school closure, remote learning via radio and television broadcasts was available so that children could continue their learning. On 14 April, the Ministry of Education, Science and Technology (MEST) officially re-opened schools.

Children aged 11-18 in the Western Urban and Rural Areas described having access to the government radio and television education programmes to maintain their education during school closure, electricity permitting. However, children in some rural locations spoke about not having easy or reliable access to radio, television or electricity and, therefore, not being able to benefit from remote learning provided during the school closure.

Lack of electricity at night was a frustration for older children (15-18 years) from the Western Urban and Rural areas, saying this prevented them from following educational programmes available via radio or television broadcast in the evening. Furthermore, children in rural areas reported not having access to radio or television, or electricity, and were therefore unable to benefit from this service either.

The main themes arising from school closure were children’s worries about becoming “backward”, forgetting what they had learned and losing their abilities to concentrate on studying (45% of FGDs); not having any learning materials to maintain study during school closure (24% of FGDs); and missing seeing and playing with friends (24% of FGDs).



*Sierra Leone's schools were closed in June in a bid to halt the spread of Ebola. The Government of Sierra Leone officially re-opened schools on the 14th March 2015.
Photo by: Louis Leeson/Save the Children*

Some children reported feeling worried that they would be scolded or beaten for forgetting previous learning when they returned to school.

“Most of the things we have learnt we have forgotten them. Some of us had poor reading and writing skills. I do not having access to radio so [cannot listen to] the radio teaching programme”

- boy aged 11-14, Bo

“I was very clever at school but because of the delay in the reopening of schools I am afraid I will not be able to cope again”

- boy aged 7-10, Kailahun

Many children reported not having learning materials – textbooks, paper, pens – to continue their studies (featuring in FGDs). Some children (mainly aged 11-18) reported that the textbooks had been destroyed in the house or their school materials had been used for other purposes, meaning that they can no longer study. Children also spoke of being bored and missing the structure of education:

“We have stayed at home for a long time without learning new ideas”

- boy aged 15-18, Bo

The lack of social interaction and ability to play with school friends was another problem commonly identified by children (featuring in 28/118 FGDs) of all ages. Sixty-six per cent of children in the Yes-No-Maybe exercise said that they were not able to play with their friends at that time due to Ebola. The lack of social interaction that typically takes place in school settings led some to report negative feelings of sadness, loneliness and depression.

“I am not sure whether school will reopen again and I have nobody to pay for me to go”

- boy aged 11-14, Kailahun

WE CANNOT AFFORD TO GO BACK TO SCHOOL

Many children voiced concern over not being able to return to school because they could not afford to pay their school fees due to the economic impacts Ebola has had on their parents' livelihoods and household income. Of those raising this concern, some were orphans who had lost the family breadwinner. A few children reported not knowing if it was possible to return to school as they were now working to provide income for their families, and felt their parents may prioritise work over education.

WE ARE SCARED EBOLA WILL COME BACK

About half the children asked said that they were afraid to return to school (during the Yes-No-Maybe exercise, involving 234 children); more girls than boys were afraid to return to school.

In areas that no longer had confirmed reports of Ebola cases, children were concerned that the return of school friends from Freetown and other Ebola-affected areas may increase the risk of carrying Ebola back into the community.

Some children said that although they knew they should avoid physical contact, they will want to play with their friends. At the same time, children worried about the risk of catching Ebola from their friends, and consequently exposing their families and themselves to infection.

“I am scared to return to school because I do not know the status of my friends, and I worry that I will catch Ebola and make my family sick”
– 7-10 year-old boy, Kailahun

“Government has opened the roads and some friends travelled to their biological parents and they might return back from places with Ebola and bring it with them”
– girl aged 11-14, Kailahun

A common theme that arose around returning to school was the concern about poor hygiene facilities. Children did not feel schools had sufficient hand washing points or clean water to enable them to maintain good hygiene practices. In particular, adolescent girls reported concerns about the lack of sanitation facilities at schools. Some girls reported that in the past they had missed school if they were menstruating; there were inadequate facilities for them at the school.

WE ARE NOW TOO OLD TO GO BACK TO SCHOOL

Some older children in the 15-18 age group reported concerns about returning to school as they would be over 18 by the time they finished. They indicated they would feel embarrassed to still be in school at that age: “I feel am getting old and I will be ashamed to be in class with small kids” (boy aged 15-18, Kailahun). Other older children have lost interest in finishing their education:

“Many girls think that schools will no longer re-open and Ebola will never end so that’s is why they have started building their own families”
– girls aged 15-18, Bo

OUR SCHOOLS ARE IN A STATE OF DISREPAIR

In rural areas some children reported that since the schools had closed, the buildings had fallen into disrepair, with crumbling walls and overgrown grounds:

“It is difficult to see our school structure because it has been covered with bush”
– boy aged 7-10, Bo.

In a number of communities, the children reported that school furniture had been stolen or sold, with children asking, “where will we sit when the schools reopen?”. These concerns were confirmed by the assessment teams. There were also reports of teachers asking children and their families for money to buy school materials.

II. DIRECT IMPACT OF EBOLA ON CHILDREN

The main issues identified by the children relating to the direct impact of Ebola included:

- death of parents, relatives, community members, and consequent increase of orphans (featuring in 32% of FGDs)
- fear of getting ill (featuring in 47% FGDs) and creating tensions in the community

“I lost my parents during this Ebola; I don’t know what my future will be like”
– girl aged 15-18, Moyamba

WE HAVE LOST OUR FAMILY AND FRIENDS

Ebola – representing a range of issues including the death of a relative, friend or community member; increase in the number of orphans and fear of the disease – was a ‘top three’ concern for children in 25% of FGDs (30 out of 118), featuring most commonly in Moyamba, Kailahun and the Western Urban and Rural Areas.

“Ebola has killed our friends and families”
– girl aged 11-14, Moyamba

A number of the communities had been, and others continue to be, greatly affected by Ebola, suffering deaths. Some children spoke in detail about their grief, and the impacts of the loss of a family member on their roles and responsibilities in the home:

“I am almost always sad because I lost my grandparents to Ebola”
– girl from group aged 7-10, Bo

“It makes me sad to see when my mother sits down and thinks about my lost brother”
– boy aged 7-10, Moyamba

Following the death of a family member or quarantining of some communities, children reported having to move to live with other family members or being separated from their families, creating a sense of insecurity among the children:

“Most of my family members have died; I lost my aunt in Kenema so I’m not safe. Now I am separated from my family”
– boy aged 11-14, Kailahun

“Living with relatives is never the same like living with parents... they will never treat you like their child... Now I have no one to call mother”
– boy who lost both parents to Ebola, aged 11-14, Port Loko

These concerns were not only described by children directly affected by Ebola, but also other children in the community.

WE ARE SCARED OF EBOLA

“I am scared of the Ebola signs and symptoms poster; I am very afraid of bleeding from my eyes, nose and ears”
– girl aged 11-14, Pujehun

Many children expressed a deep fear of the disease. Some children described specific fear of Ebola Treatment Units (ETUs), temporary holding centres and houses where they knew people had died; others reported fear of the burial teams. In one exercise, which featured a picture of people wearing Personal Protective Equipment (PPE) suits, children said that they were scared of the people in the suits:

“I do not like seeing the men in the [PPE suits]. Each time I see them I know they are here to bury bodies and someone has died. I never want to see them again”
- 10 year-old boy, Kailahun

Other children explained how the presence of Ebola is creating distrust and tension in communities:

“Ebola has created enemies among community members who are now suspicious of each other”
- girl aged 11-14, Port Loko

Although children spoke openly about their fears of Ebola, they also demonstrated a clear understanding of how to protect themselves from the virus. Sixty-six per cent of the children asked during the Yes-No-Maybe exercise said that they knew how to protect themselves from Ebola. Children in the FGDs across the country observed the no-touching rule and displayed good knowledge of how Ebola is transmitted.

“Yes, I can protect myself from Ebola by observing all the rules for interacting with people”
- boy aged 11-14, Bo

III. LIMITED ACCESS TO HEALTHCARE

The main issues around health that children identified were:

- health resources being redirected to Ebola programmes
- lack of sufficiently trained health staff at community level (featuring in 23% of FGDs)

“The arrival of Ebola has worsened the health situation and now we are afraid of going to hospital for fear that we will have Ebola and never be able to return to our families”
- boy aged 11-14, Port Loko

Access to essential services for children’s survival and well-being has been severely disrupted throughout the outbreak. Vital services for children under five – including routine immunisation against diseases and malaria treatment – were all but suspended as national healthcare workers sought to contain, isolate and care for people infected by the virus. Pregnant women and new mothers lost out on access to the pre- and post-natal care that is required to reduce maternal mortality rates. Furthermore, many hospitals and health facilities were used as ETUs during the period of intense transmission.

Health issues – including access to services and concern about going to hospital because of a fear of catching Ebola – ranked among the top three issues for 33 of the focus group discussions. Children demonstrated knowledge that the health service pre-Ebola was already under-resourced, but had deteriorated since the Ebola outbreak.

“The government has forgotten about other sicknesses and concentrated all its attention on Ebola”
- boy aged 15-18, Moyamba

Some children perceived that all health resources were focused on Ebola, neglecting other conditions and resources. Specifically, children spoke about the lack of general healthcare, treatment for malaria, family planning services and maternal and new-born care. Children also reported the withdrawal of services provided by non-governmental organisations (NGOs) and the need to travel long distances to access healthcare.

“Before Ebola, there was free malarial treatment for children in the hospital, but that has stopped due to Ebola”

– girl aged 11-14, Pujehun

Many children spoke about their fears of going to hospitals and catching Ebola:

“We fear visiting hospitals due to Ebola”

– boy aged 11-14, Bombali

Children in 27 of the FGDs spoke of there being inadequate and poorly trained staff in the health centres. This was mainly of concern to girls aged 11-18 and boys aged 7-10, particularly in Bombali and Pujehun. Children referenced widespread reports that some health workers ran away when Ebola started spreading, leaving communities with limited or no healthcare support:

“The only nurse in this village abandoned us during the Ebola outbreak and she comes to the village once or twice a month. We the children have suffered the most. We don’t have a place to go when we are sick”

– boy aged 7-10, Port Loko

Many children reported that the nearest health centres were far away, and with travel restrictions, poor roads and inflated transport costs, this made getting healthcare increasingly difficult (featured in 19% of FGDs, mainly in Pujehun and Bombali):

“The hospital is far away and we cannot access it when we are sick. My parents were sick of Ebola and we called line 117 for support. By the time help came it was too late – they had passed”

– boy aged 11-14, Port Loko

Some children reported the withdrawal of services provided by NGOs, especially for family planning, malaria and other illnesses.



Mohammed*, 11, has lost his father and grandfather to Ebola.
*name changed to protect identity.

Photo by: Dan Stewart/ Save the Children

IV. IMPACT ON FOOD AVAILABILITY AND FAMILY LIVELIHOODS

The main issues affecting the children with regards to food and livelihoods were:

- Lack of food, featuring as a top three issue in 25% of FGDs and a general issue raised in 41% of FGDs
- Lack of money or source of income, featuring as a top three issue in 21% of FGDs
- Impacts of quarantine

“Before the Ebola we were farmers, but at the moment we are not engaged in such activity and that all the food we had has been exhausted, especially the staple food rice”

– boy aged 15-18, Bo

The introduction of a range of measures aimed at halting the outbreak – including restrictions on movement and quarantine in areas with active transmission of the virus – had immediate impacts on the economy; this was felt acutely by parents who rely on trade and agriculture to meet the needs of their families.

The economic impact of the outbreak on the household was raised across all groups of children, with many reporting there not being enough money or enough food at home. Lack of food featured as a top three issue in 25% of FGDs and as a general issue raised in 41% of FGDs. Concern about lack of money or source of income was a top three issue in 21% of FGDs. Quarantine – introduced as part of a wider Ebola containment strategy – also emerged as a challenging issue for children with direct experience of these measures.

In the Yes-No-Maybe exercise, 76% of children said that they did not have enough food to eat. This was reported to be more common with older children (11-18) than younger children (7-10 year-olds). Many reported going to bed hungry and others reported having to work, scavenge or steal to eat.

“It is difficult to have two or three meals a day – the one is not enough”

– girl aged 11-14, Kailahun

“Due to the outbreak with the blockade on movement it is difficult to get food”

– girl aged 15-18, Kailahun

Children recognised that the lack of available food was due to restrictions of movement – including the closure of markets – and the consequent loss of income due to limited trade. Children in rural areas spoke about the spoiling and failure of crops because farmers were frequently unable to tend to agricultural land because of restrictions on movement:

“Roads have being blocked and traders are no longer coming to our village to buy our local goods. My father could not farm because he had no money to buy farm tools, trade fairs are no longer allowed, road blocks prevent us to take our goods to the big cities for sale”

– girl aged 7-10, Bo

Many explained that their parents were no longer able to work as they had before Ebola, which resulted in less money and less food in the house. In the Yes-No-Maybe exercise, approximately half of the children reported that their parents or caregivers did not have work. These were the children more likely to report not having enough food in the house and to express concern about whether their parents would have enough money to pay for school fees.

"I don't have enough to eat because before Ebola our parent used to sell but since the Ebola disease come they are on longer doing the things that make them earn money and so we don't have enough to eat"
– girl aged 15-18, Western Urban Area

"Ebola has caused our parents to be jobless"
– boy aged 7-10, Moyamba

"My parents business capital is finish and she is now bankrupt"
– girl aged 7-10, Bo

Children in rural areas (especially Bombali, Bo and Pujehun) saw the failure of crops – due to quarantines and the suspension of trade and markets – impact their families' incomes. With restrictions on movement and closure of markets, children also reported inaccessibility to normal non-food items, such as clothes, washing items and learning materials.

Girls aged 7-14 from Bo District explain some of the challenges experienced during periods of quarantine in their communities:

"Our houses were burnt because there were confirmed cases there"

"We were asked to move out of our houses to disinfect them"

"I lost my family members and was told not sleep inside my house again"

"When people died of Ebola, their houses were demolished by local authorities because the houses were seen as Ebola contact points"

Other children reported that some people had abandoned their houses during quarantine, resulting in the houses becoming derelict:

"Because of the Ebola some houses were quarantined and people left their homes and fled in fear of being quarantined, homes were deserted for a long time, the houses were worn out, most houses now need rehabilitation"

boys aged 11-14, Bo

Children also reported overcrowding in their houses as a consequence of travel restrictions. This has occurred because people who would typically travel back and forth for work (eg, to mining areas) were instead staying in their home communities for extended periods of time.

SECTION 3: THE IMPACT OF EBOLA ON CHILDREN'S ROLES, PROTECTION AND FUTURE OPPORTUNITIES

Whilst lack of education emerged as a key concern for children, the knock-on effects for roles, child protection and future opportunities were also highlighted during the group discussion. Across all regions where the CERA was conducted, children observed increases in child labour, violence – including sexual violence – teenage pregnancy and early marriage. Children directly attributed these increases to not being engaged in learning activities during school hours.

The main themes related to these issues were:

- increased child labour (reported in 19% of FGDs)
- increased domestic chores (featured in 8% of FGDs)
- increased violence against children
- increased risks, particularly affecting girls
- psychosocial issues (featuring in 14% of FGDs)
- changes in culture and customs (featuring in 3% FGDs).

I. CHILD LABOUR

“Before the Ebola I never sold anything because I was going to school – now I am a trader”

– boy aged 11-14, Moyamba

In the Yes-No-Maybe exercise, 43% of 216 children reported having to work to support their families. According to children, the combination of additional pressure on household income and school closure has resulted in increases in child labour, which was reported in 19% of FGDs, and as a top-three priority in 14% of FGDs. This issue was most prevalent in the Western Urban and Rural Areas and Kono.

Children who lost family members during the outbreak are now playing a role – and in some instances taking on the role of a primary breadwinner – in supplementing household income. They spoke about the pressure of having to provide for their families:

“I lost my mother to Ebola and I am now the breadwinner...I struggle to feed my family”

– girl aged 15-18, Bo

“Older children have to fend for younger siblings through child labour”

– girl aged 11-14, Port Loko

Girls reported being involved in petty trading or collecting firewood for sale to supplement family income. Boys reported being involved in mining and driving motorbikes between towns and, in urban areas, were also involved in petty trading.

Another concern expressed by children was about undertaking work that frightened them or made them feel insecure (12% of FGDs). This concern was most prevalent among girls who reported having to walk long distances

to reach villages in which to trade, often in unfamiliar areas; and among girls feeling vulnerable and scared of abuse and sexual exploitation when travelling unaccompanied. Children also reported the physical pain they experience when doing labour, which was a concern documented in 10 FGDs:

“Parents and caregivers give children heavy loads over and above their body weight and this causes stunted growth. Body and joint pains”

- boy aged 11-14, Bo

There were reports of more transactional sex to cover basic needs among vulnerable girls (reported in 10% FGDs), especially those affected by the loss of relatives to Ebola. Children viewed this as one of several factors contributing to increases in teenage pregnancy. There were also reports of more boys working, especially driving motorbikes, and some children suggested that this meant boys had more money than before, which brought them more attention from girls or enabled them to engage in transactional sex:

“Some of our friends follow boys of their own age group and men for money. Some have lost their parents and they do not have the maximum protection they had before Ebola”

- girl aged 11-14, Western Rural Area

In addition to income-generation activities to support the household income, boys and girls across all age groups reported having to carry out more domestic chores than before. Children viewed this as a consequence of schools being closed. These chores commonly involved collecting water or firewood. In some cases the collection of water or firewood was done for other households and in exchange for money. While girls traditionally undertake more domestic chores than boys, both sexes reported having to do more chores than they had pre-Ebola; although the workload for girls was still reported to be greater than for boys.

II. VIOLENCE

The incidence of abuse was perceived to have increased from pre-Ebola levels: in the Yes-No-Maybe exercise, 55% of children responded ‘yes’ when asked if there was more abuse in the community now than before Ebola came, and this opinion was primarily expressed by older children (11-18 year-olds).

In nearly all communities, children suggested that beatings and the frequency of violence against children had increased since the Ebola outbreak. Of the children asked about increases in incidences of abuse since before Ebola, 55% of children responded affirmatively (77 out of 141 children in the Yes-No-Maybe exercise). Primarily, older children thought abuse had increased (15-18 year-olds). Of those who reported that it had not increased, many said there was already a lot of abuse and violence prior to Ebola.

This was reported more explicitly in the Western Urban area, where four of the FGD groups ranked violence among their top three problems. One child from the Western Urban area said that: “it is a habit practised by most parents in this community” (girl aged 7-10). However, a few girls aged 11-14 in Kailahun reported that “there is no abuse as of now because our parents are afraid to beat us as they are avoiding body contact”. This latter statement was, however, an exception from the norm.

Children highlighted two reasons for increased beatings and violence against children. Firstly, beatings – already common pre-Ebola – were now worse as a result of children being around the house more (due to the closure of schools). Secondly, immense pressure on parents due to economic factors and the wide-

ranging impact of Ebola (including bereavement and general fear of the virus) increased tension at home. At times, this manifested in an increase in violence in the home. Children reported many negative consequences of being beaten, beyond the physical pain; such as psychological problems, fear, stress, hatred towards the abusers, physical deformity or disability, and sometimes death.

III. RISKS FOR GIRLS

“Some of our friends are raped when they go far to get water, some are drowned in the streams”

– boy aged 7-10, Kailahun

Sexual violence against girls was observed to have increased across all districts; and this was stated by both girls and boys. In nearly all of the FGDs where this issue was raised, children could relay a case of rape against a girl in their community, including attacks on girls in quarantine households. Data revealed that risk of rape was highest when girls went to collect water, travelled long distances to trade in other villages, or when using the bush to go to the toilet.

Reports about fear of rape were mainly voiced by girls aged 15-18, but younger girls also shared their concerns. Boys were aware of this happening to their sisters and friends. Many children also spoke about links between increased abuse and higher teenage pregnancies: “yes, there is more abuse in the community now which has resulted in the increase of teenage pregnancy” – girl aged 15-18, Kailahun.

“No we do not feel safe at this very moment because our friends are abused every day, some even sexually, so there are possibilities for the perpetrators to abuse us too”

– girl aged 15-18, Kailahun

Children were concerned about the impacts of rape on their peers, including pregnancy, transmission of sexually transmitted infections, physical harm or death, psychological harm, discrimination and stigma against the survivors.

Of the 161 children asked in the Yes-No-Maybe exercise, 65% knew where to seek help if they were being abused, saying that they would go to their parents, village elders or chiefs. This is still a large number of children not knowing where to seek support.

“Before Ebola I concentrated on my schoolwork but now men are sexually harassing me because I am always at home”

– girl aged 15-18, Bo

An increase in teenage pregnancy was reported in 47% of FGDs, and featured as a top-three concern in 14% of FGDs. This was a priority issue among girls aged 15-18. The issue was also more prevalent in the Western Urban Area, Kailahun and Bo. In the Yes-No-Maybe exercise, 91% of the 151 children participating answered that they felt that there were more girls their age pregnant than before Ebola.

There was also concern that many younger girls – under 15 years-old – were becoming pregnant. This was suggested to be due to exploitation of the younger girls who did not understand about sex (featuring in 15% of FGDs). As discussed above, children felt that the increased incidences of rape and sexual violence were a contributing factor to the increases in teenage pregnancies.

Most girls reported that the higher occurrences of teenage pregnancy were a direct result of being outside the protective environment provided by schools; making them more likely to become involved with men and to fall pregnant:

“As a result of the Ebola, school has been closed and many girls have become pregnant”

– girl aged 15-18, Western Urban Area

“Schools are not functioning, we are idle, that is why men that are older than us keep chasing us”

– girls aged 15-18, Bo

Other girls reported that the increase in teenage pregnancy is due to girls having lost interest in school because they are not sure that their schools will reopen at all. Some girls are preparing to have a family rather than returning to school:

“We have lost concentration and focus on school work, that’s why most of our friends have become pregnant, many girls think that schools will no longer re-open and Ebola will never end so that is why they have started building their own families”

– girl aged 15-18, Bo

Many girls expressed concern that if schools continued to remain closed, they would become pregnant and – following policy guidance issued by the MEST that pregnant girls will not be permitted to sit their exams or return to school until after their babies are born – not be able to return to education. Some children spoke about knowing friends who had become pregnant and were not able to return to school. They also spoke about the stigma they would face as a consequence of teenage pregnancy (mentioned by both boys and girls in 8% of FGDs):

“I will not be happy to return back to school because I am pregnant and I will be provoked by my friends”

– girl aged 11-14, Kailahun

“Teenage pregnancy is now on the increase and some of my friends have become fathers so they will be ashamed to return back to school when school reopens”

– boy aged 15-18, Bo

Children were also uneasy about the risks of maternal mortality; specifically that many teenage girls are not ready to be mothers and therefore put the child at higher risk of illness or death; and risks of becoming poor due to lack of education. Some adolescent girls were concerned about not having access to family planning services as a consequence of NGOs withdrawing services since the Ebola crisis.

The issue of early marriage featured in seven (6%) of the FGDs, all with groups of girls. Of those asked, 80% agreed that they had seen more girls of a young age getting married. This is often a means to generate income through dowry for the family or as a result of an unplanned pregnancy:

“Yes, girls in the village community and the larger towns are getting married very early as their parents can no longer afford to feed them and they give themselves to men for early marriage”

– girl aged 15-18, Kailahun

“Some of our friends have gotten married because of lack of food in their homes”

– girl aged 11-14, Pujehun

Early marriage was even mentioned among the youngest girls, aged 7-10:

“If schools continue to close some of us will be seen as mature girls and we will be asked to get married”

- girl aged 7-10, Port Loko

IV. PSYCHOSOCIAL ISSUES

“Sometimes I cry silently because my father has no money to care for me and my family... I am troubled because my dad has lost his job because of Ebola”

- girl aged 7-10, Bo

With the closure of school, suspension of markets, reduced social interaction, and restrictions on movements, children reported missing their friends and recreational activities, without which they felt sad and alone. Some children described that since the closure of schools, they “have too much time to think and often feel sad”. Older children (15-18 year olds) felt that their futures were more uncertain.

The increase in psychosocial issues was mentioned in 14% of FGDs, featuring most commonly among boys aged 7-10 years-old. As well as those experiencing grief following the death of relatives or friends, many others described feeling “not fine”, sad, depressed or lost. Children also reported increased stress and pressure from having to work to support their families:

“My uncle who was the breadwinner died of Ebola and now I have to work extra hard to put food on the table”

- girl group aged 15-18, Bo

V. CHANGES IN CULTURE AND BEHAVIOUR

Children spoke about how measures introduced to minimise the risk of contagion – for example, restrictions on touching and large gatherings of people – had led to changes in culture and behaviour.

The strongest concern expressed about changes in cultural practices was around safe burial practice, which is a central pillar of containment of the virus. Some children who have lost family members to Ebola voiced sadness around the way that their loved ones were buried. These new safe burial approaches are contrary to traditional practices:

“I am not happy with how my uncle was buried. He was wrapped in plastic and we could not touch him”

- girl aged 11-14, Pujehun

Equally, other children expressed their worries about people in their communities who they believed were still practising unsafe burials (featured in five FGDs), because they understood this was a common way of spreading Ebola. There were also concerns that people were still seeking healthcare from traditional healers – again, because children knew that this is how some cases of Ebola have been spread.

More broadly, children referenced the national protocol prohibiting handshaking and body contact. Children reflected that this was changing the way people interact. They expressed sadness about not being able to worship at churches and mosques when religious services were suspended.

“The community Ebola by-laws have put a stop to all traditional and cultural practices for fear of gathering together and not to contact infected person with the tendency of spreading EVD”

- boy aged 15-18, Bo

In the Yes-No-Maybe exercise, adolescent children were asked if they had seen practices such as “Bondo” initiation^x; continue to be practiced; 90% of participating children said that all traditional activities had been suspended since the Ebola crisis began. The remaining 10% were not sure: “They might be doing it in secret - but we don’t see it happening here” - girls aged 15-18, Kailahun. Some teenage girls said that although such initiations were suspended for now, they were committed to undergo the process when it was reintroduced.



Photo by: Isabelle Risso-Gill/Save the Children

SECTION 4: CHILDREN'S PRIORITIES FOR RECOVERY

I. GETTING TO ZERO

“Everybody must come together in the fight against Ebola”
– boy aged 7-10, Western Rural Area

Children unanimously wished for Ebola to end, and saw that as the first step towards moving forward in any recovery process. There was a strong sense from the children that all people – government officials, chiefs, community members and children themselves – are responsible for bringing Ebola to an end.

As referenced in Section 2, children demonstrated a clear understanding of how to protect themselves from Ebola. They also understood that any new activities implemented in the Ebola recovery programmes needed to include safety – for example, decontamination of schools previously used as treatment centres – and vigilance against the virus as the priority.

Specific solutions mentioned by the children were:

- Everyone should follow standard Ebola prevention protocol including hand-washing, avoiding contact with sick people, avoiding contact with dead bodies
- The Ministry of Health and Sanitation (MoHS) should train more health workers to treat people and sensitise communities about Ebola
- Train teachers to educate children about precautionary measures against Ebola in school and at home
- Government, local authorities and NGOs should provide better support during periods of lockdown, especially for poor and vulnerable families
- Doctors and scientists should develop a vaccine against Ebola
- Government, local authorities and NGOs to better support affected families with livelihoods and food assistance
- Children also suggested more sensitisation to overcome the stigma against survivors and affected families.

Children were keen for social and cultural practices – such as attendance at churches and mosques – to be reinstated so that people can continue to live as they did before and have access to support from their social networks.

II. GETTING BACK TO SCHOOL

"I want to be a doctor, therefore I want school to reopen now"

- girl aged 7-10, Western Rural Area

Nearly all children were eager for the schools to reopen, with one child stating: "The government should re-open the schools and the paramount chief should implement by-laws so that parents take children to school", highlighting the importance of sensitising parents to return their children to school (girl from group aged 11-14, Bombali). In the Yes-No-Maybe activity, 91% of children asked indicated that they wanted to return to school when schools reopened. Many children communicated excitement at getting back to learning as well as being able to see and play with their friends again:

"I want to be educated in future. I want to learn and be responsible for my younger ones"

- boy aged 15-18, Bo

"Even though I have lost my parents, I want to return back to school"

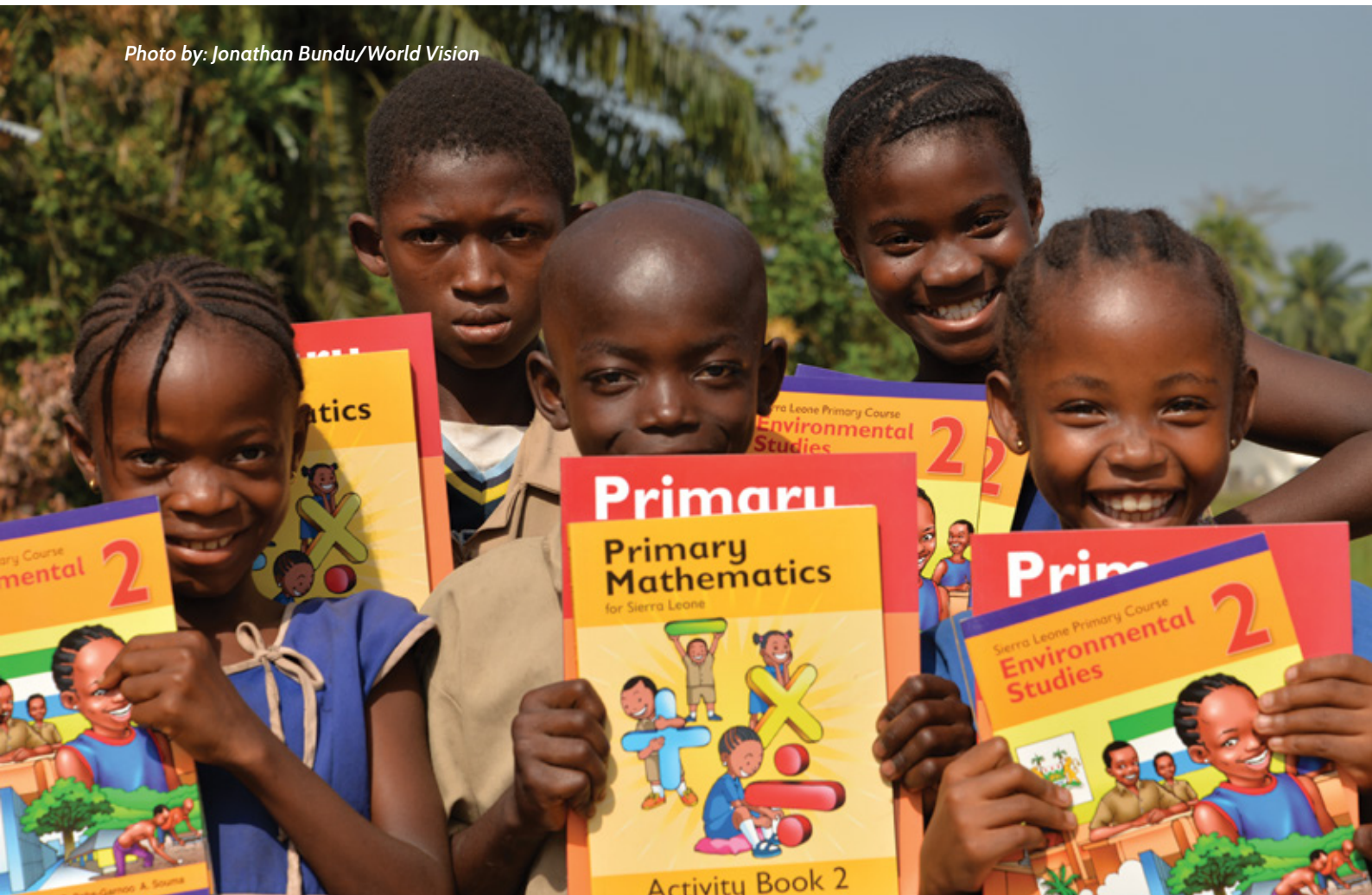
- 7-10 year- old girls, Western Rural Area

"Going back to school will make me happy as I will see friends that I have not seen for so long"

- 11-14 year old girls, Kailahun

However, children were very concerned that, before children returned, all schools be provided with sufficient hygiene and sanitation facilities and Ebola prevention measures – including hand-washing points; clean water; temperature checks and access to healthcare. Furthermore, children requested that any school buildings used as either ETUs or holding centres be disinfected prior to school re-opening.

Photo by: Jonathan Bundu/World Vision



Specific measures identified by children to support their safe return to school included:

- Sensitise parents to encourage them to allow their children to return to school instead of working
- Introduce evening and/or remedial classes for children of all ages to catch up
- Improve radio teaching for children unable to attend schools
- Provide counsellors for children returning to school, so that they do not feel ashamed, especially for older children who may feel that they are too old to be in school
- Allow young girls who have become pregnant or young mothers to return to school, and provide support for them to do so
- Provide school feeding programmes to overcome challenges of food insecurity.

In the longer-term, children outlined the following recommendations to improve access to and quality of education:

- Subsidise school fees and provide scholarships for children who have lost relatives to Ebola, especially orphans
- Free education for all so that the less privileged children have access to education
- Train more teachers, and give extra training to existing teachers
- Build more schools and make more materials available (eg, desks, chairs, textbooks)
- Provide a community library
- Ban teachers from requesting money from students, for materials or for grades
- Have more time for children to play games and sports
- Improve children's recreational areas.

III. REBUILDING HEALTH SERVICES

Children felt strongly that the government, local authorities and NGOs should “make the health system strong”, and they recognised the need for health system strengthening in Sierra Leone. Specifically, children identified the following solutions:

- Build more hospitals and health centres
- Train more nurses, doctors and community health workers
- Equip health facilities with sufficient staff and equipment, including drugs and ambulances
- Make health facilities more accessible by building more facilities in rural areas and improving the road networks
- Provide better primary healthcare at community level
- Improve birthing assistance in health centres to reduce maternal mortality
- Provide PPE to nurses so that they are more confident in their safety and can return to provide non-Ebola related care for communities.

IV. FOOD, MONEY AND LIVELIHOODS

Many children recognised that Ebola needed to come to an end first to allow livelihoods, trade and economic activities to recover. However, children were able to identify a range of solutions to address the challenges affecting the livelihoods of their own families and communities.



Photos by:

Aubrey Wade/Save the Children
(top/middle)

Jonathan Bundu/World Vision
(bottom)

For example, in relation to livelihoods and jobs, children recommended the following measures:

- Reopen trade fairs and markets
- Stop movement restrictions to improve trade
- Introduce microfinance and loan facilities at community level, especially for families directly affected by Ebola
- Provide agricultural support specifically to parents, caregivers or foster parents of orphans; including offering seedlings, tools and farming equipment, and providing labour support for the replanting of fields
- Encourage investors to increase employment opportunities
- Build more roads to increase transport and provide construction jobs.

As highlighted in Section 2 of this report, children were concerned about the lack of food in the communities, and identified short-term solutions as follows:

- Government-led school feeding programmes, which could also act as an incentive to encourage children to return to school
- Targeted food distribution to children who have lost parents or caregivers
- Provide storage facilities for farm products to prevent food spoilage due to the restrictions on travel and trade.

Regarding concerns about transport, children suggested the following solutions:

- Allow free vehicle movement
- Control or subsidise the cost of fuel and transport to make transport and trade more accessible
- Chiefs, counsellors and government should embark on the rehabilitation of roads between communities and big towns
- Demolish checkpoints to allow free vehicle movement
- Provide school buses when schools open

V. CREATING AN ENVIRONMENT FOR CHILDREN TO REACH THEIR POTENTIAL

Children felt that the reopening of schools would reduce the level of child labour, vulnerability to abuse and specific risks for girls – including teenage pregnancy and child marriage – as children would be safer in the school environment.

ENDING CHILD LABOUR

Children identified that another key intervention for overcoming child labour was targeting parents. Specifically, they felt it was important to sensitise parents to the negative impacts of child labour – physically, developmentally, emotionally – and the risks of exploitation and abuse that working children are subjected to. Parents should also be encouraged to undertake the heavy and difficult work themselves, and allow children to focus on learning and education instead.

Children said the government, Family Support Units (FSUs), Children Welfare Committees (CWCs), local councils, community members and NGOs were responsible for advocating against child labour on their behalf.

STOPPING ABUSE

Children identified that the following measures should be taken to stop violence against children, including in the home:

- Encourage more people to stand up to violence against children
- Educate parents and sensitise the community about the effects of child beating
- Provide support and case management care for children who are beaten or abused
- Create by-laws against child beating.

When it came to sexual abuse, including rape, children outlined the following solutions:

- Sensitise men about the impacts of child abuse
- Imprison perpetrators of child abuse and rape
- Parents should stop sending children to fetch water at night
- Provide safe homes for street children or those at particular risk of abuse
- Provide livelihoods support to parents and caregivers so children are not forced to engage in income-generating activities that can expose children to additional risks.

GIRLS NOT MOTHERS

Children unanimously felt that school reopening would lead to a decrease in teenage pregnancy. In addition to getting children back to education, they suggested various other solutions to reduce high rates of teenage pregnancy:

- Promote accessible, free family planning services
- Sensitise teenagers about the risks of teenage pregnancy and how to avoid it
- Parents should be sensitised on the risks of teenage pregnancy and guided on how to talk openly with their children about their sexual choices
- Parents should be discouraged from sending their children out to “find money” and other labour activities
- Livelihoods or food support should be provided to poor families to protect girls from transactional sex
- Legislative measures, including the introduction of by-laws around teenage pregnancy, such as imprisonment or criminal charges against men who impregnate children
- Pregnant girls and young mothers should be able to return to school, and be provided with support to continue their education.

CONCLUSION

For the 1,193 boys and girls involved in the CERA, this consultation offered an opportunity to share their experiences with peers; to get support from understanding that other children share their experiences; to voice concerns and hopes for the recovery. Children expressed unanimously that they wanted to be informed, involved and consulted about the decisions being taken now by national and international actors that will have a major role in shaping their future opportunities. This assessment also proves that children are very capable of contributing meaningfully to these discussions when given the opportunity.

Overall, the findings of the CERA demonstrate the far-reaching impacts of the Ebola crisis on children's lives in Sierra Leone and convey the urgency of ensuring that the next phase of the response is tailored to the specific needs of children; namely, ensuring the safe re-opening of schools and health facilities and putting more emphasis on responding to the psychosocial impacts of the crisis on children.

Children outline a clear vision for what they want and expect from the post-Ebola phase of their lives: education; strong healthcare systems; greater economic prosperity and opportunities for their families and communities; and an end to violence, labour and teenage pregnancy that limit boys and girls from reaching their potential. It is now the responsibility of national decision-makers to ensure that these recommendations – from children themselves – are taken into account.

Photo by: Jonathan Bundu/World Vision



ANNEXE

1. Sampling methodology for the CERA

The following criterion guided the selection of communities:

- How affected they have been by Ebola, including:
 - more affected: many cases/deaths, quarantined houses
 - less affected: no/few cases, no quarantine houses
- Size of community, including larger towns and smaller villages
- Location, such as those near to and far from transport links and health facilities

The aim was to have diversity across the field sites and to limit bias of results towards the worst case scenarios/most affected communities.

Child participants were identified by community mobilisers who randomly selected households using an agreed-upon systematic approach. They explained the purpose and process of the CERA to the caregiver and children, and asked if one child from the household would be available to participate in the focus group discussion. Caregivers and children over 16 years of age were provided with an informed consent form for signature prior to participation. Sampling was completed in advance of the FGD, which was scheduled at a time and location convenient for the children. The assessment teams aimed to conduct two to three focus group discussions in each community of different age and sex disaggregation.

Given the scale of the assessment and nature of the participatory tools, this sampling approach for identifying child participants provides additional rigour to the quantifiable data (although the purposive selection of the communities negated the quantifiable data as statistically representative)^{xi}.

Data was collected in the form of notes taken by staff throughout the FGDs, documenting key points of discussion, quotes from the children and observations on children's behaviours. After each consultation, the assessment teams regrouped to discuss key findings and any challenges encountered during the FGDs. The team would then write-up their findings on the CERA reporting forms – highlighting priority issues and solutions identified by the children, supporting these with related quotes. Forms were submitted to the CERA Project Manager (from SCI) for analysis. Reporting forms were submitted in English and, where necessary, translated from the local language by the assessment teams.

Data was analysed using content analysis methods, involving an inductive approach to draw out key themes from the data. First, the top three issues from each FGD reporting form were tallied to draw out the main issues identified by the children. Then, any issue or challenge featuring on the reporting forms from the general discussion or quotes from children were tallied to see how frequently secondary issues were raised across the FGDs. These were supported with documented quotes from the children. Emerging themes were analysed based on the frequency and importance in which they were raised, and mapped according to how different issues linked together (eg. closure of school can lead to increased child labour and risk of exploitation).

Furthermore, data from the Yes-No-Maybe exercise was tallied and analysed to provide supporting details of the key themes

already identified from the inductive context analysis. Since the -well-being statements from the Yes-No-Maybe activity were prepared in advance of the assessment, this was analysed deductively.

Whilst the approach is primarily qualitative, it is possible to review some data quantitatively to provide a clearer understanding of how many children held certain perspectives. Due to the time frame of this research, transcription and coding was not possible for the analysis.

2. Examples of well-being statements used in the Yes-No-Maybe activity

The following are examples of the well-being statements read out in the Yes-No-Maybe exercise; the children would be asked to stand by either a poster if they agreed, a poster if they disagreed, or an unsure smiley face poster if they were undecided. A total of 24 well-being statements were prepared, from which FGD facilitators selected 10 on average per group:

1. I am happy to return to school
2. Since Ebola came I can play with my friends
3. Since Ebola came I have enough to eat
4. I know how to keep myself safe from Ebola
5. There is more abuse in the community now than before Ebola came
6. Since Ebola came I see more girls my age being pregnant than before Ebola came

- I will go back to school when they are open again
- I am happy to return to school
- I am afraid to return to school

Since Ebola came...

- ...I feel safe where I am living at the moment
- ...I feel safe in my house when I am alone
- ...I feel safe in my house when I am with my family
- ...I can play with my friends
- ...I need to work to get money to support my family
- ...My parent(s)/caregiver is/are working

Since Ebola came...

- I have enough to eat
- I have enough clean water
- I have access to a latrine/toilet
- I feel safe using the latrine/toilet. There is a separate toilet for boys and girls
- I am able to wash and keep clean (for younger children, ask if they are washed every day by their caregiver)
- I can get help if I feel sick
- I know how to keep myself safe from Ebola
- When I have a problem there is someone I can talk to

Since Ebola came...

- I participate in decision making in the community
- People in my community listen to me when I talk about issues affecting me
- There is more abuse in the community now than before Ebola came
- If someone is abusing me I know where to go for help

Only for teenagers

Since Ebola came...

- I see more girls my age being pregnant than before Ebola came
- More girls my age are being married than before Ebola came
- The plans I had for my future have changed
- I have access to family planning services/condoms (for boys)
- There is the continuation of cultural practices, such as Bondo society

3. Caveat in interpreting the quantitative data presented

Whilst this assessment undertook a primarily qualitative approach, some data was quantifiable. Firstly, the top three issues highlighted in each FGD were ranked and quantified. However, in many cases, the single issue highlighted as a priority was often the starting point for myriad other issues that children described. For instance, when children said “education” was a priority issue, they also talked about how the closure of schools led to increased child labour, teenage pregnancy and that they miss playing with their friends. However, the priority ranking would only allow for the idea of “education/school” to be identified. Therefore, the frequency with which these secondary issues were raised was tallied, but is not statistically analysed.

Another challenge about the quantifiable data is that these are taken only from what was documented on the reporting forms. It might be that these issues were mentioned in more FGDs than was documented. Therefore, all quantified data should be interpreted with caution.

Data from the Yes-No-Maybe activity has also been quantified and was used to support primary findings of the assessment. It should be noted, however, that the Yes-No-Maybe activity was not used in all FGDs, as it was found to be difficult to facilitate with the younger age group – 7-10 year-olds. Furthermore, the facilitators would use different “well-being statements” in different FGDs, resulting in some statements being asked widely and others only occasionally. For example, whether the children had enough food to eat was asked in 26 FGDs, whilst whether there is more early marriage was asked in only seven FGDs, targeting older children (11-18 year-olds). These numbers, however, are shared to help support the presented data, but the limitations of this data should be recognised.

4. Strengths and limitations of the assessment

Strengths:

1. The children’s ERA was able to reach a large number of children of different ages across a wide range of communities affected by Ebola.
2. The ability for the participating agencies to mobilise such a large assessment at short notice demonstrates children’s enthusiasm for this initiative.
3. Support from the local communities, paramount chiefs, and teachers, and national and district level representatives from the MSWGCA also facilitated the smooth implementation of this wide-reaching assessment.
4. All agencies worked with existing staff or trained volunteers, all of whom had experience working with children and conducting participatory FGDs.
5. The use of a common training and toolkit helped ensure consistency in data collection approaches across the agencies and field sites.
6. Tools for the activity were deemed appropriate for the context, particularly for young children and children with limited literacy. The choice of three tools also gave facilitators flexibility to successfully engage children in different ways.
7. The presence of at least two note-takers in each FGD allowed for more accurate data collection. The simple reporting formats allowed for clear and accurate documentation of data, which enabled fast analysis.

Limitations:

1. The children’s ERA process was undertaken very rapidly; more time would have allowed for better training, sampling, quality data collection and analyses.
2. Many children described being affected by more than three issues and therefore found it difficult to agree on or rank their primary three issues.
3. Many issues described by the children were inherently linked in complex ways (eg, health and access to food, which linked also with livelihoods and trade restrictions). This made it difficult for some children to articulate the specifics of their concerns; and for the note-takers to capture.
4. Some issues are too sensitive to discuss in open fora, and therefore will not have been as well represented as they might have been using another methodology (eg, key informant interviews).
5. Whilst efforts were made to randomly select the children, there were reports of families refusing that their children participate, leading to a selection bias. Furthermore, due to the systematic random sampling method, children from hard-to-reach areas were less likely to have been selected for participation.
6. With the diversity of languages in Sierra Leone and the data collection being in one language – translated without any formal process or back-translation – and then analyses being organised in English, it is inevitable that certain nuances will have been lost in translation.
7. Each of the three tools had its strengths and limitations. And they extracted data and information from the children in different ways. This resulted in some inconsistencies in how the data was collected and what issues were or were not addressed and discussed in the groups. For example, the Yes-No-Maybe and Dot Voting exercises prescribed the topics for discussion, leaving little room for open inputs from the children.
8. Due to the scale and rapidity of the assessment, the reporting tool was designed to be simple. However, this could lead to minimal depth in the data, and risks of misinterpretation due to lack of context in which the data is presented.
9. Human error in note-taking and evidence that some FGDs were unable to thoroughly record key and supportive statements made by children.

ENDNOTES

ⁱBased on latest data available from 2012, approximately 48% of the population of Sierra Leone is under 18 years of age. Further information available at http://www.unicef.org/infobycountry/sierraleone_statistics.html

ⁱⁱEbola Virus Disease – Situation Report 16th April 2015 issued by the Government of Sierra Leone. Available at: http://reliefweb.int/sites/reliefweb.int/files/resources/Sierra-Leone-EVD-National-SitRep_Vol-323.pdf

ⁱⁱⁱ‘Recovering from the Ebola Crisis’ available at http://reliefweb.int/sites/reliefweb.int/files/resources/Recovering%20from%20the%20Ebola%20Crisis-Full-Report-Final_Eng-web-version.pdf

^{iv}Approximately 48% of the population of Sierra Leone is under 18 years of age.

^vPlan International (March 2010) ‘Anticipating the Future: Children and Young People’s Voices in Haiti’s Post Disaster Needs Assessment’ available at: <https://plan-international.org/where-we-work/americas/publications/children-and-young-peoples-voices-in-haitis-post-disaster-needs-assessment-pdna/>

^{vi}Save the Children, Plan International and World Vision International (December 2013) ‘After Yolanda: What Children Think, Need and Recommend’ available at: <http://resourcecentre.savethechildren.se/library/after-yolanda-what-children-think-need-and-recommend>

^{vii}See Annexe for full explanation of the methodology

^{viii}Each FGD had at least one facilitator and two note-takers. Teams aimed to have female facilitators for all FGDs with girls; however, this was not always possible due to the limited number of available female staff. All FGDs were conducted in the local language. A staff member trained in psychological first aid skills was on site during all assessment activities and proved essential, as some children – especially those who had lost loved ones – required this. All staff members were sensitised in the principles of Child Safeguarding and signed the Child Safeguarding policy of their respective agency. Any children identified as vulnerable or at-risk were referred for follow-up care with the agencies’ respective Child Protection teams.

^{ix}The toolkit was adapted from the “Listening to What Children Think, Need and Recommend in Emergencies: Practical Toolkit” developed by Save the Children UK and World Vision International.

^xBondo initiation is the traditional name for the ceremony where female genital mutilation is practiced.

^{xi}However, the purposive selection of the communities would negate its standing as statistically representative.

PLAN INTERNATIONAL

Plan International has been working in Sierra Leone since 1976. In response to the Ebola outbreak Plan International is operating an ongoing programme to provide care packages to quarantined communities in the four worst affected districts in Sierra Leone. We have also been running five Community Care Centres in Port Loko, to provide complementary care to address the Ebola epidemic by separating suspected cases and decreasing intra-household transmission. Plan has conducted international campaigning and advocacy to increase donor funding for the emergency response. In addition Plan has:

- Conducted 600 Public health promotion and awareness-raising to stop the spread of the virus.
- Supported 2,287 children who have been impacted and orphaned by the disease, many of whom have been stigmatised and discriminated against in their communities.
- 2,807 Ebola houses decontaminated and provided with replacement packages.

SAVE THE CHILDREN

Save the Children has been working in Sierra Leone since the 1990's and began responding to the Ebola outbreak in March 2014, providing healthcare, protecting children and helping families rebuild their lives.

We're providing psychosocial support and interim care to children who have been affected by the virus and conducting family tracing to reunify children with their families; should they have lost their parents or caregivers to Ebola. Save the Children has managed an Ebola Treatment Centre in Kerry Town, providing excellent levels of care to suspect and confirmed Ebola patients since November 2014. In addition, we've been communicating with and educating communities, as we believe that communication is the key to tackling this epidemic once and for all. Finally, as schools across Sierra Leone begin to reopen we have been providing support to allow them to do so safely in Pujehun, Kailahun, Western Rural and Western Urban districts by:

- Providing schools across the four districts with adequate quantities of hand washing stations
- Training over 600 teachers on Safe School reopening Guidance Note and protocols, Ebola prevention and social mobilisation.

WORLD VISION

World Vision is a Christian relief, development and advocacy organisation dedicated to working with children, families and their communities worldwide to reach their full potential by tackling the causes of poverty and injustice. For almost 20 years, World Vision Sierra Leone has partnered with communities to improve health, education, food security and protection for children. World Vision works through 25 area development programmes benefiting more than 58,000 children and their families.

World Vision has focused on community engagement in the fight against Ebola. The agency has conducted more than 6,000 safe and dignified burials in six districts. It has equipped more than 1,000 teachers and 300 mothers' groups in psychosocial first aid and child protection skills. Over 2,500 health workers, paramount chiefs, and faith leaders (ministers and imams) have been trained in Ebola-prevention social mobilization.
