

# **ASSESSMENT OF THE IMPACT OF EBOLA VIRUS DISEASE (EVD) IN FIVE DISTRICTS IN SIERRA LEONE**

**BRAC – SIERRA LEONE**

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## SUMMARY

The scale of the outbreak of Ebola virus disease (EVD) in West Africa has decreased considerably since its peak in 2014. In Sierra Leone, the number of new cases dropped to a total of eighteen confirmed cases per week at the beginning of May – from almost four hundred in November 2015. As the most-affected West African countries move closer to zero cases of Ebola, their leaders have called for a plan for long-term regional reconstruction; stressing, in particular that the “most important long-term response to Ebola... rests in plans and strategies for economic recovery”<sup>1</sup>.

With an eye on post-EVD recovery, BRAC – Sierra Leone – in partnership with Oxfam UK – implemented an extensive assessment of the effects of EVD on select districts in Sierra Leone. The objective of the *Assessment of The Impact of EVD in Five Districts in Sierra Leone* was to examine the effects of the EVD outbreak for the purposes of designing and implementing recovery-focused interventions in a variety of sectors in Sierra Leone. It used a two-pronged mixed methodology that consisted of household questionnaires and community-based focus group discussions (FGDs). Surveys were used to quantitatively establish the types, characteristics, and magnitude of the effects of EVD, while FGDs were used to identify explanatory variables related to these effects. Eight communities – Koinadugu, Bombali, Port Loko, Western Urban, and Western Rural Districts – were purposefully chosen, stratifying in each for urban and rural classifications and those areas that were considered to be more- and less-affected by EVD. Although quantitative data generated by the assessment cannot strictly speaking be said to be statistically representative, the sample of household 793 surveys does yield important quantitative insights into the impacts of EVD in Sierra Leone. The assessment also captured qualitative data through 219 FGDs, with 1,589 participants from the following groups: health workers, adolescent girls, community leaders, parents, market women and middlemen, petty traders, and farmers.

This assessment found that the effects of the EVD outbreak in Sierra Leone were profound and widespread – both for those individuals, households, and communities directly affected by the virus, as well as for those indirectly affected by school closures, restrictions on movement and gatherings, reduced provision of health services, etc. Of the households surveyed, 11.3 per cent reported an EVD case and 20.4 per cent had been part of a quarantine area. Although EVD had significantly declined since its peak last year, it must be emphasized that the impact of the EVD outbreak is persistent and ongoing; and may continue for years, or even decades to come, if appropriate measures are not taken by the Government of Sierra Leone and its national and international partners.

### Effects of EVD on Food and Income Security

Quantitative and qualitative data both revealed that the top-ranked effects of EVD were less food in the household, decreased farming output, lower household income, and more unemployment. Even among households that had experienced at least one case of EVD, food and income insecurity were still considered the key effects of EVD; though EVD-affected households were much more likely than other households to also point to death or illness from EVD as an important impact of the outbreak.

More than eight-in-ten of all households surveyed reported that they had decreased income compared to before the outbreak. A larger share of those households that had experienced a case of EVD reported less income than those that had no cases. Making matters worse,

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<sup>1</sup> Al Jazeera English, 2015, “West African leaders urge Ebola ‘Marshall Plan,’” <http://america.aljazeera.com/articles/2015/3/3/african-leaders-urge-ebola-marshall-plan.html> (accessed 27 March 2015).

as opportunities to generate income fell, prices of food and other staple goods increased across Sierra Leone. For all households, food and income effects will be felt beyond the crisis. For instance, those households that sold or otherwise used household goods, farming tools, or business supplies will require considerable outlays to replace these items. Others that took loans to cope with income shortfalls will need to pay these off, and many may incur a debt burden as a result of interest payments. The tragic loss of life many households experienced will also lower productive capacities within those households, and increase family care responsibilities in instances where guardians are among those that have died.

According to survey responses, living on less money was the most used financial coping mechanism during the crisis. Other important coping mechanisms included: borrowing from family and friends, moneylenders, and *osusus*,<sup>2</sup> and having adults in the household do more paid work. The two most frequently mentioned forms of additional work undertaken were: backyard gardening and petty trading. Other popularly given forms of financial coping indicated by focus groups included: processing of palm oil, collection and sale of firewood, hard labour, and brickmaking. Surveys also revealed that income from unskilled labour, gifts from family and friends, and cash transfers from governmental and from non-governmental organizations increased as households coped with less income and diversified their income sources.

Food security was also significantly affected by the EVD outbreak. A sizeable majority of survey respondents reported that the frequency of meals eaten in their households decreased compared to before the outbreak. Households that reported a case of EVD were most likely to say that they ate fewer meals than before, as were rural and larger households, as well as those households that primarily relied on farming and unskilled labour. Survey respondents also reported eating smaller meals than before the outbreak. The categories of households that were most likely to report eating smaller meals were: households that experienced EVD cases, households that reported primary incomes from farming and unskilled labour, female-headed households, households in rural communities, and larger households.

### **Effects of EVD on Health**

There was considerable concern among FGD participants about the impact that EVD-related mortality had on the Sierra Leonean health system, especially in decreasing human resources for health. Concerns were also expressed that lowered capacities within the health system could have adverse effects on health-seeking behaviours, and in particular, demand for health services in the medium-to-long-term. Anecdotal evidence from FGDs suggested that demand for formal healthcare might have decreased, with people foregoing clinics and hospitals in favour of traditional medicine or self-medication. Displacement of non-EVD health services, in particular maternal, newborn, and child health (MNCH) services by an overburdened system that was reacting to EVD was cited as a key concern. According to one health worker, symptoms of “anaemia, pneumonia, and malaria have some signs of Ebola so people were afraid of coming to the hospital [and] instead they take traditional medicine. It has affected the wellbeing of under-five as their mothers do not bring them for [treatment].”<sup>3</sup>

However, survey results revealed that the effects of EVD on the health system are complex and it remains unclear from the assessment exactly how demand for health services may be

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<sup>2</sup> An osusu is a form of microfinancial capital accumulation that consists of small groups of members that pool capital on a daily, weekly, or monthly basis, and rotate the use of the accumulated amount regularly amongst group participants.

<sup>3</sup> Health FGD, Maforki Town, 27 February 2015.

affected in the future. For instance, there was a general ambivalence regarding trust in health systems. More respondents were more likely to report a decrease in trust in the health system, but many also reported that their trust in health structures had increased. Further, trust in the health system appears dynamic. It was reported to be dependent not only on effective service provision, but also effective sensitization activities, suggesting that sensitization through community structures – and perhaps, in particular, community health workers – will be an important strategy for driving demand for health services post-Ebola.

Household surveys did not have baseline data against which to estimate changes in health-seeking behaviours. That being said, of all survey respondents that reported an illness other than HIV, 61.3 per cent also reported receiving treatment at a health facility. For those persons that chose a health facility for treatment most did so because they perceived it to be the best or safest treatment option. For those that sought another type of treatment, the primary reasons were affordability and accessibility.

Household surveys also did not capture baseline data on levels of antenatal and postnatal care. Nor was there comparable baseline data to examine changes in rates of facility-based delivery. Nevertheless, surveys did find that since the beginning of the EVD outbreak, more than two-thirds of women that gave birth did so in a health facility. Further, surveys suggested that future demand for healthcare may not have been as negatively affected as qualitative data implies. Of those that could have children in the future, 94.4 per cent of households said they would prefer to deliver in a hospital or clinic. This statement is made with the caveat that intentions do not necessarily translate into action. Health-seeking preferences may change, or impediments related to finances and geography may limit access to health facilities in the future. For those that would go to a health facility for a future delivery, 86.7 per cent stated that trust in health facilities –as the better or safer delivery option – was the main reason.

### **Effects on EVD on Children**

The key effects of the EVD outbreak on children, in general, and orphans and vulnerable children (OVCs), in particular, were believed to be in areas of food and income insecurity and education. In terms of food security, it was reported in many FGDs that OVCs were more income insecure than other populations of children. In regards to education, there was a concern that enrolment and retention would decrease when schools re-opened post-Ebola. OVCs were perceived to be at a higher risk of dropping out due to a need to focus on income-generation to sustain themselves. Younger OVCs were said to rely relatives, and to a lesser extent, communities as the main form of social safety net. Older OVCs, on the other hand, were reported to be combining help from relatives with income-generating activities – especially petty trading.

Survey findings did not seem to support the widely held belief in FGDs that the EVD outbreak would negatively affect enrolment and retention in the educational sector, with 94.6 per cent of parents reporting that they planned to send their child to school next year. But, as with health-seeking behaviours, it must be said that intentions do not necessarily translate into action, especially as pressing practical constraints such as income and food insecurity may increase the burden of work on children inside and outside of the house. Overall, 46.4 per cent of households that did not plan to send a child to school cited an inability to afford school as the main reason. This was, by far, the most popular reason given for not planning to do so.

Regarding the topic of child labour, 85.2 per cent of households reported that, in the week preceding the survey, children did at least one of three types of work: household work, work on the farm or selling in the street, or work for somebody outside the household.

Respondents reported that 91.8 per cent of girls had done some kind of work, compared to 83.4 per cent of boys. Surveys also revealed that almost one-in-five children had done all three of these types of work in the last week. Girls were somewhat more likely to have done all three types of work than boys, as were children from households that reported cases of EVD and children in ever-quarantined households – that is, households that were ever part of a quarantine area.

Sexual exploitation of adolescent girls was reported by FGDs to have increased as a result of the EVD outbreak. Financial and food insecurity were reported to be key contributing factors. As a consequence, qualitative data indicated that teenage pregnancy is an important problem since the EVD outbreak. Increased early marriage was also reported to be a key effect of the EVD outbreak. Further, lack of sexual and reproductive health commodities during the crisis has potentially exacerbated the risk of sexually transmitted infections and other communicable diseases, in particular for those girls that were involved in transactional sex. Problems associated with teenage pregnancy, sexually transmitted infections, and early marriage will persist even after EVD. As a result, adolescent girls affected by these issues will require particular support during post-EVD recovery.

### **Effects of EVD on Community and Institutional Trust**

Regarding community trust, 87 per cent said of survey respondents stated that they have less trust in other people in their communities when compared to before the EVD crisis. Ever-quarantined households and households that reported a case of EVD have the highest levels of distrust of other community members. Lower trust in communities was said to be the result of the potential for infection from others. While the greatest concerns over loss of human resources were for health workers that died from EVD, some FGD also mentioned that other important community groups had been decimated by the outbreak. The loss of these social resources is likely to disrupt community-driven development during the post-EVD recovery process, especially if compounded by persistently low social cohesion.

In terms of institutional trust, there appears to be an overall decrease in trust of the police services. More than one-in-three respondents said they have less trust in police now, while just over one-in-ten said they have more trust. Where there was increased trust of police, it was the result of perceptions that police work was carried out effectively throughout the crisis. Grievances with police typically related to perceptions of ineffectiveness and corruption. People's feelings towards the government as a whole were less clear-cut. About one-in-five respondents stated that they have less trust in government as compared to before the EVD crisis, with a slightly larger proportion indicating that they have more trust in government.

### **Development Concerns**

Across all household types, the inadequate provision of clean water, education, food, and healthcare were reported as the main community development concerns. Since the beginning of the EVD outbreak, food increased significantly as a concern, but especially for those households that reported a case of EVD. Education grew as a concern for all household types, whereas clean water decreased as a concern. The primary difference between quantitative and qualitative analyses of development concerns was the focus on income-generation within FGDs. Key among these concerns was the need to capacitate business people and farmers with credit to revive income- and food-generating activities. Respondents also mentioned the need of farmers for agricultural inputs such as: seeds, tools, and fertilizer. Emphasis on income-generation in FGDs – as compared to in surveys – may be explained by the participants' perception that this is an area that BRAC could provide assistance in, making them more likely to voice such concerns in discussions.

Perhaps not surprisingly, FGDs reported that the programmes or services that are currently being provided to communities are predominately health-oriented; others are focused on supply of household goods, food, or financial assistance – especially for EVD survivors and OVCs. Troublingly, many FGDs reported that their communities were receiving no programmes or services.

### **Conclusions and Key Recommendations**

The analysis presented above shows that the impacts of the EVD outbreak in Sierra Leone were considerable and multi-sectoral. Interventions implemented over the next few years will play a major role in determining the prospects for national, community, and household development. The following are key recommendations for BRAC and its development partners to address the effects of the EVD crisis and facilitate recovery in Sierra Leone:

1. There is still a need to scale up short-term food security operations to answer the immediate food needs of the most vulnerable people.
2. In the agricultural sector, actions are needed in assisting agricultural production operations linked to harvesting and post-harvesting activities, transportation, and storage of output to increase availability and facilitate sales of produce.
3. Measures should be put in place to improve the purchasing power of most vulnerable populations and assist them in accessing markets. Existing productive safety nets and social protection programmes should be scaled up and strengthened, as required.
4. Proactive efforts must be made to stimulate an early economic recovery by helping people restart activities affected by the epidemic. Priority attention could be paid to the poorest households and those with OVCs from the EVD epidemic. Supplies of capital should also be provided, and complemented by training opportunities to ensure their renewed economic activities and future prospects.
5. Economic recovery will also require support such as: start-up packs and grants to revitalize new and existing enterprises, as well as medium-term support for local economic revitalization through small-and-medium-sized enterprise development and vocational and business training.
6. Early childhood development programmes focused on OVCs may also make it possible for children that have lost one, or both parents, to grow and develop to their full potential, thus reducing the need for remedial services to address stunting, developmental lag and social problems later in life<sup>4</sup>.
7. Programmes targeted at adolescent girls should emphasize employment and income generation, as well as reproductive and sexual health and family planning.
8. Accelerated recovery of the health sector should be given priority. Medium-term strategic interventions that should occupy stakeholders' priority attention include strengthening human resources for health and improving basic service delivery.
9. Demand for education and health services must be closely monitored in the short-to-medium term, so as to gauge the lasting effect – if any – of the EVD outbreak on these sectors.

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<sup>4</sup> Republic of South Africa and United Nations Children's Fund (UNICEF), 2006, *Guidelines for Early Childhood Development Services*, Pretoria: Department of Social Development and UNICEF, p. 13.



## 1 INTRODUCTION

On 23 March 2015, it was reported that the United Nations predicted that the current outbreak of Ebola virus disease (EVD) in West Africa would end by August<sup>5</sup>. Whether these predictions prove true remains to be seen. Nevertheless, the scale of the outbreak decreased significantly from its apex. In Sierra Leone, for instance, the number of new EVD cases dropped from 385 new confirmed cases, as reported by the World Health Organization (WHO) in the week to 23 November 2014<sup>6</sup>, to a total of eighteen confirmed cases in the week to 3 May 2015.<sup>7</sup> While West African leaders have stated a need “to guard against complacency” in efforts to get to zero cases, they have also called for a plan for long-term regional reconstruction; stressing, in particular, that the “most important long-term response to Ebola... rests in plans and strategies for economic recovery”<sup>8</sup>.

In line with this call for reconstruction, BRAC Sierra Leone, in partnership with Oxfam UK, implemented a broad assessment of the effects of EVD in five districts in Sierra Leone: Koinadugu, Bombali, Port Loko, Western Urban, and Western Rural. The assessment was conducted between February and April 2015, with the objective of examining the effects of the EVD outbreak in order to produce meaningful quantitative and qualitative data for developing and implementing programmes for intervention in a variety of sectors, including: food security, livelihoods, sexual and reproductive health, maternal and child health, HIV/AIDS, social cohesion, education, and violence against children.

At the time of writing this assessment, a number of sources of research outlined the effects of EVD in Sierra Leone – in specific – and in West Africa – more generally. Most assessments conducted on EVD focused on issues related to food and income security. In some instances a more detailed analysis was provided across other sectors; for instance, those related: to health, education, children’s and gender issues, and governance. However, to date, assessments have not provided a sufficiently multi-dimensional and multi-level description of the effects of EVD in Sierra Leone, so as to effectively inform the design and implementation of broad-based recovery-oriented interventions. The BRAC Sierra Leone *Assessment of The Impact of EVD in Five Districts in Sierra Leone* seeks to fill this knowledge gap.

This document outlines the findings of the assessment. It begins by situating the assessment in the context other research undertaken on the effects of EVD in Sierra Leone. The document then provides an overview of the methodology used, including its research design, methods, and limitations. After detailing the assessment’s main findings, the document concludes by providing key recommendations as a first step towards developing and undertaking recovery-focused programming in post-EVD Sierra Leone.

## 2 EVD, IN CONTEXT

Even before the EVD outbreak, Sierra Leone already ranked near the bottom on the United Nations Human Development Index (HDI). Poverty in the country was widespread, with more than 60 per cent of the population living on less than USD 1.25 a day. Levels of

<sup>5</sup> Mundasad Smitha, 2015, “Ebola Outbreak ‘Over by August’, UN suggests,” *BBC News*, 23 March, <http://www.bbc.com/news/health-32009508> (accessed 27 March 2015).

<sup>6</sup> WHO, 2014, “Ebola Situation Report – 26 November 2014,” <http://apps.who.int/ebola/en/ebola-situation-report/situation-reports/ebola-situation-report-26-november-2014> (accessed 27 March 2015).

<sup>7</sup> WHO, 2015, “Ebola Situation Report – 6 May 2015,” <http://apps.who.int/ebola/en/current-situation/ebola-situation-report-6-may-2015> (accessed 8 May 2015).

<sup>8</sup> Al Jazeera English, 2015, “West African leaders urge Ebola ‘Marshall Plan,’” <http://america.aljazeera.com/articles/2015/3/3/african-leaders-urge-ebola-marshall-plan.html> (accessed 27 March 2015).

unemployment and illiteracy were also high, particularly among the youth<sup>9</sup>. Sierra Leone's HDI value for 2013 was 0.374 – which is in the low human development category – positioning it at 183 out of 187 countries and territories<sup>10</sup>. As will be detailed below, this already precarious socioeconomic status was exacerbated by the outbreak of EVD.

As of 3 May 2015, Sierra Leone had experienced 12,440 cases of EVD – the most of all countries affected by the outbreak – 3,903 of which were fatal<sup>11</sup>. But measures of the impacts of the EVD outbreak extend far beyond just total cases and mortality rates. The outbreak, for instance, has had a serious negative effect on economic development. Official forecasts for growth in Sierra Leone in 2014 were revised downwards by 6.4 percentage points since the onset of the outbreak<sup>12</sup>. Restrictions on travel and public gatherings, implemented as part of the government response to EVD, severely impeded many economic activities<sup>13</sup>. Other control measures instituted to control the emergency – for example the closure of businesses, quarantining of homes and communities, and destruction of property – also had significant economic costs during the last year. Surveys conducted during the last quarter of 2014 found increased unemployment levels, particularly in urban areas and amongst those employed in wage work and non-agricultural self-employment, compared to reference survey data collected earlier in 2014<sup>14</sup>.

Overall, the EVD outbreak also resulted in a serious shock to the agriculture and food sectors in 2014<sup>15</sup>. For instance, restrictions on gathering and movement discouraged many farmers from harvesting their fields<sup>16</sup>. The epidemic started spreading when many crops were being planted and expanded, and when staple crops rice, maize, and cassava were to be harvested. The imposition of quarantines and restrictions on social gatherings hindered the sowing period of the agricultural production cycle. Moreover, the increasing caseload of people sick from EVD, and the need for women – who are traditionally farm labourers – to become caregivers further reduced the labour force available to work in the fields<sup>17</sup>. According to Assessment Capacities Project (ACAPS), food insecurity was an important issue during the crisis, and will likely continue to be so until agricultural production resumes<sup>18</sup>.

Disruption to agriculture and food production as a result of EVD were reported to have had particularly strong adverse effects on food security. The Food and Agricultural Organization of the United Nations (FAO) and World Food Programme (WFP) estimated that about

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<sup>9</sup> United Nations Development Programme (UNDP), "About Sierra Leone,"

<http://www.sl.undp.org/content/sierraleone/en/home/countryinfo.html> (accessed 6 April 2015).

<sup>10</sup> UNDP, 2014, *Human Development Report 2014 Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience*, Explanatory note on the 2014 Human Development Report composite indices for Sierra Leone, p.1.

<sup>11</sup> WHO, "Ebola: Current Situation," <http://apps.who.int/ebola/en/current-situation> (accessed 6 April 2015).

<sup>12</sup> UNDP, 2014, *Assessing the Socio-economic Impacts of Ebola Virus Disease in Guinea, Liberia and Sierra Leone – The Road to Recovery*, December, p. 17.

<sup>13</sup> ACAPS, 2014, *Briefing Note: Potential Impact of Ebola on Food Security*, 10 November.

<sup>14</sup> Government of Sierra Leone, the World Bank, and Innovations for Poverty Action, 2014, *The Socio-Economic Impacts of Ebola in Sierra Leone Results from a High Frequency Cell Phone Survey Round 1*, 12 January, p. 7.

<sup>15</sup> Food and Agricultural Organization of the United Nations (FAO) and World Food Programme (WFP), 2014, *FAO/WFP Crop and Food Security Assessment – Sierra Leone*, Special Report I4279E, 17 December, p. 4.

<sup>16</sup> Assessment Capacities Project (ACAPS), 2014, *Briefing Note: Potential Impact of Ebola on Food Security*, 10 November.

<sup>17</sup> *Action Contre la Faim*, n.d., *Food Security Impact of 2014 Ebola Virus Epidemic Population Exposed to Undernourishment: Forecasts in Guinea, Liberia And Sierra Leone*, p. 2.

<sup>18</sup> Assessment Capacities Project (ACAPS), 2014, *Briefing Note: Potential Impact of Ebola on Food Security*, 10 November.

450,000 people – or 7.5 per cent of the population of Sierra Leone – were severely food insecure as of December 2014<sup>19</sup>. The impact of EVD accounted for more than a quarter of the food insecure. About 76 per cent of the EVD related food insecure individuals were said to live in rural areas.

Inflation also rose during the crisis, as a result of reduced supply of labour and goods<sup>20</sup>. The increased cost of living compounded vulnerability among many Sierra Leoneans. The resultant reduction in household purchasing power caused poor households in much of the country to be unable to cover essential non-food expenditures and face food insecurity<sup>21</sup>. Making matters even worse, social safety nets were also in disrepair. The devotion of increased expenditures to fighting the EVD outbreak, coupled with declining government revenues, expanded fiscal deficits and reduced expenditures on activities not directly related to EVD response.<sup>22</sup>

In particular, the already fragile Sierra Leonean health system was further weakened by cuts in expenditures on non-EVD related health services. A dramatic fall in the use of services – for instance: health agency visits, assisted childbirths, antiretroviral therapy drugs, home visits – was reported, owing to fears of infection. If reports of lower demand are true, and if these are sustained into the future, more people may die from childbirth, malaria and AIDS<sup>23</sup>. One specific concern is that the health system has been unable to adequately address the needs of women to access maternal health services including delivery and antenatal care<sup>24</sup>. With abandoned health facilities and limitations on people's movement, pregnant women were reported to be more likely to give birth unattended and forego ante and post-natal care, including prevention of maternal to child transmission of HIV. Available research, for instance, revealed a decline in the utilization of prenatal services in Freetown during the outbreak, which could also reflect decreased utilization of other non-EVD related health services. In 2013, 78 per cent of urban households with a pregnant women reported attending at least one prenatal visit in the previous two months. However, a survey conducted in November 2014 revealed that this level dropped to just over 40 per cent<sup>25</sup>.

Moreover, with the trauma of the EVD crisis and its aftermath, affected communities and families as well as EVD survivors were exposed to significant psychological stressors such as the loss of loved ones, loss of livelihoods and resources, fear, social isolation and loss of social networks and supports. The loss of family members meant that women and children find themselves taking on the roles and responsibilities as the heads of household, or men have to take on additional childcare responsibilities<sup>26</sup>. These exacerbated sources of stress increase the risk of developing longer-term mental health problems such as depression or

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<sup>19</sup> FAO and WFP, 2014, *FAO/WFP Crop and Food Security Assessment – Sierra Leone*, Special Report I4279E, 17 December, p. 4.

<sup>20</sup> UNDP, 2014, *Assessing the Socio-economic Impacts of Ebola Virus Disease in Guinea, Liberia and Sierra Leone – The Road to Recovery*, December, p. vii.

<sup>21</sup> FEWS NET, 2015, *Guinea, Liberia, and Sierra Leone Special Report*, January, p. 1.

<sup>22</sup> World Bank, 2014, *The Economic Impact of the 2014 Ebola Epidemic: Short and Medium Term Estimates for Guinea, Liberia, and Sierra Leone*, Report No. 90748, 17 September.

<sup>23</sup> UNDP, 2014, *Assessing the Socio-economic Impacts of Ebola Virus Disease in Guinea, Liberia and Sierra Leone – The Road to Recovery*, December, p. vii.

<sup>24</sup> Inter-agency Standing Committee (IASC), 2015, *Humanitarian Crisis in West Africa (Ebola) Gender Alert: February 2015*.

<sup>25</sup> Government of Sierra Leone, the World Bank, and Innovations for Poverty Action, 2014, *The Socio-Economic Impacts of Ebola in Sierra Leone Results from a High Frequency Cell Phone Survey Round 1*, 12 January, p. 19.

<sup>26</sup> Inter-agency Standing Committee (IASC), 2015, *Humanitarian Crisis in West Africa (Ebola) Gender Alert: February 2015*.

anxiety disorders<sup>27</sup>. The epidemic is also reported to have broken down social ties. Longstanding traditions of community support and care giving were disrupted, EVD victims were stigmatized and social gatherings cancelled<sup>28</sup>. Many people have come to fear contact with strangers and sometimes even with their own family.

The closure of schools was an additional care burden – primarily for women – with their children out of school. For children, closure of schools has meant that they also saw their education delayed, which could increase risk of their dropping out in future after resuming studies<sup>29</sup>. School feeding programmes providing much-needed nourishment to children have stopped due to the government closure of all educational institutions. Of the almost 2 million children affected by school closures, almost 1.6 million children were in school feeding programmes<sup>30</sup>.

Compounding this, an increased risk of gender-based violence and exploitation of girls and young women has been reported in countries most affected by Ebola<sup>31</sup>. Reports of teenage pregnancies are on the rise, and are likely associated with the lack of time spent in supervised school environments<sup>32</sup>. Women have also felt reversals in economic empowerment, owing to the shutting of borders affecting cross-border trade – where the majority of traders are women – and in agriculture and mining – which have significant female workforces<sup>33</sup>. As women are pulled out of their daily work to care for sick family members or children orphaned by the disease, they have less time to earn money and grow and sell food, which can lead to increased food insecurity and perpetuation of the poverty cycle<sup>34</sup>.

### 3 METHODOLOGY

It is in the context of issues outlined above that the assessment was conducted. It was initiated in February 2015, with fieldwork taking place 22 February to 6 March 2015. Research was designed so as to identify the effects of EVD and their characteristics, explain their causal mechanisms, and determine the magnitude of these effects – both generally, and for particular groups. To accomplish this, the assessment used a methodology that consisted of household questionnaires and community-based focus group discussions (FGDs). As will be detailed below, surveys were used to quantitatively establish the types, characteristics, and magnitude of the effects of EVD, while FGDs were used to identify explanatory variables related to these effects. See Annexes A-C for a list of research communities and for examples of quantitative and qualitative tools used during research.

#### 3.1 Sampling of Research Communities

Research relied on a two-stage sampling process. At the first level, communities were chosen purposefully, precluding statistically representative data to be generated. The

<sup>27</sup> Inter-agency Standing Committee (IASC), 2015, *Humanitarian Crisis in West Africa (Ebola) Gender Alert: February 2015*.

<sup>28</sup> UNDP, 2014, *Assessing the Socio-economic Impacts of Ebola Virus Disease in Guinea, Liberia and Sierra Leone – The Road to Recovery*, December, p. vii.

<sup>29</sup> UNDP, 2014, *Assessing the Socio-economic Impacts of Ebola Virus Disease in Guinea, Liberia and Sierra Leone – The Road to Recovery*, December, p. vii.

<sup>30</sup> ACAPS, 2014, *Briefing Note: Potential Impact of Ebola on Food Security*, 10 November.

<sup>31</sup> United Nations Economic Commission for Africa (UN ECA), 2014, *Socio-Economic Impacts of The Ebola Virus Disease on Africa*, p. 29.

<sup>32</sup> UNDP, 2014, *Assessing the Socio-economic Impacts of Ebola Virus Disease in Guinea, Liberia and Sierra Leone – The Road to Recovery*, December, p. vii.

<sup>33</sup> United Nations Economic Commission for Africa (UN ECA), 2014, *Socio-Economic Impacts of The Ebola Virus Disease on Africa*, p. 29.

<sup>34</sup> UN ECA, 2014, *Socio-Economic Impacts of The Ebola Virus Disease on Africa*, p. 29.

second stage of sampling for household surveys was randomized, while the second stage of sampling for FGDs was done purposefully. Stage one sampling favoured communities in which BRAC and its partners were already working, as it was deemed that resultant interventions could be more easily situated in these communities – at once leveraging existing relationships and on-the-ground knowledge for subsequent interventions. Eight communities each in – Koinadugu, Bombali, Port Loko, Western Urban, and Western Rural Districts – were chosen, stratifying for urban and rural classifications<sup>35</sup> and those areas that were considered to be more- and less-affected by EVD.

*Table 1: Breakdown of Surveys Conducted by District and Urban/Rural Communities*

	Urban	Rural	Total
<i>Western Urban</i>	159	0	159
<i>Western Rural</i>	0	155	155
<i>Port Loko</i>	100	60	160
<i>Bombali</i>	80	80	160
<i>Koinadugu</i>	99	60	159
<b>Totals</b>	<b>438</b>	<b>355</b>	<b>793</b>

Categorization into more- and less-affected groups was done according to two key criteria: perceived number of cases of EVD relative to surrounding areas and past presence of quarantine. As localized quantitative data was not always available to guide community selection, communities were chosen based on the recommendations of BRAC field staff. These staff possess considerable localized knowledge of the research areas, and were considered to be able to identify the required communities with sufficient accuracy for the purposes of this assessment. Ultimately, disaggregation for experiences with quarantine and EVD were conducted at the household level, and community-to-community comparisons were not made. That is, categorization of communities based on EVD-related affects were only used to guide sampling, and not for data analysis. Of the households surveyed, 11.3 per cent reported an EVD case and 20.4 per cent had been part of a quarantine area.

### **3.2 Household Surveys**

While quantitative data generated by the assessment cannot strictly speaking be said to be statistically representative, it does yield important quantitative insights in the impacts of EVD in Sierra Leone, which can largely be considered to represent the experiences with, and effects of, EVD in the districts researched. The specific methodology used for the household surveys is outlined below. For instance, care was taken to produce a quantitative sample size large enough so as to not exacerbate other design biases. Calculations were made using an unknown prevalence rate, a confidence interval of +/- 5, and a 95 per cent level of confidence. Further adjustments were made to account for the cluster sampling methodology using a design effect of two; as is typical for surveys using a cluster sampling methodology<sup>36</sup>. According to this rationale it was deemed that a sample of 768 was a desirable. This figure was rounded up to 800, to accommodate the possibility of non-response.

<sup>35</sup> In the field it was determined that some communities originally coded as urban or rural, should in fact have had the opposite coding. Where required, necessary changes in coding were made to reflect the actual characteristics of each community. For this reason, there does not exist an equal number of urban and rural communities, as can be seen in Table 1.

<sup>36</sup> See, for example: Liberia's *Malaria Indicator Survey* (2009) and very similar to Sierra Leone's *Demographic and Health Survey* (2013).

As already stated, the surveys used a two-stage sampling design. While this method is less precise than a typical random sample and it cannot be used for calculations of estimates of individual clusters, it is cost-effective while still providing a more-than-acceptable level of accuracy. In the first stage of sampling communities more- and less-affected urban and rural communities were purposefully chosen from the five districts assessed, as described above. In the second stage of sampling, a fixed number of households – twenty in each community – were selected with equal probability within each community. Households were selected by computing a sampling interval based on the number of households in the community, divided by twenty, and then selecting a random start by drawing a random number between one and the sampling interval. In the field, each research assistant was provided with the sampling interval and random start for each community. Since households were selected randomly, there was no special emphasis placed on selecting BRAC beneficiaries as respondents.

Male-female representation was maintained by allocating surveys in each community according to an approximately fifty-fifty split between males and females. Each survey is marked as either ‘male’ or ‘female’ and research assistants were instructed to select a respondent from the household of the indicated sex. Survey respondents were split approximately equally by sex, with females making up 51 per cent of respondents, and males making up the remaining 49 per cent.

Due to ethical and practical challenges involved in surveying children, information about children was collected by interviewing adults. In the lead-up to questions in Section B of the questionnaire, randomization was conducted at the household level to choose one child in households that had multiple children. Each respondent was asked to respond to questions only about the specific child selected – as opposed to all children, or any other children in the household or community. Data was collected for a total of 640 children, of which 57.5 per cent were boys and 42.5 per cent were girls. The following table provides a breakdown of ages for which the data was collected.

*Table 2: Age Breakdown of Children about Whom Data Was Collected*

Age Range	Percentage (n=643)
1-5 years	11.6%
6-10 years	22.5%
11-15 years	41.5%
16-17 years	24.4%

In total, 799 completed surveys were administered during the fieldwork. After a cleaning data for invalid answers and sequencing, incompleteness, skipping, and other sources of error, six surveys were rejected due to high rates of error. To compensate for rejected and missing data, the remaining surveys were weighted so that each community was given an equal weighting of twenty surveys in analysis.

### **3.3 Focus Group Discussions**

Qualitative data was collected through FGDs. These were used to add context to and validate quantitative data, as well as to determine causal factors driving the effects of EVD. FGDs also examined coping mechanisms, responses from government and from non-governmental organizations, and remaining priority needs of the communities sampled – topics that were not covered by quantitative data. FGDs were used instead of key informant interviews – and other types of one-on-one interview formats – because they offer an opportunity to solicit a broader range of perspectives for each discussion than would an interview with just one respondent. FGDs were semi-structured, and allowed for follow-up

questions in order to develop deep descriptions of the effects of EVD and to map the processes of cause, effect, and response.

Six FGD categories were included in research: health workers, adolescent girls, community leaders, parents, market women and middlemen, petty traders, and farmers. Prior to implementation of research, these groups were identified as most important to informing eventual BRAC programming. FGDs with health workers were only held in those communities with a health facility. FGDs with petty traders were only held in urban areas, whereas FGDs with farmers were only done in rural communities.

Selection of FGD participants relied on a combination of two forms of purposeful sampling: convenience sampling and maximum variation sampling. There was very little – if any – overlap between FGD participants and survey respondents, as survey respondents were chosen randomly at community level. Using convenience sampling for FGDs, the evaluation leveraged focus group participants that were available at the time of data collection. However, convenience samples were also stratified by key characteristics to ensure maximum variation within groups; that is, heterogeneity of persons sampled. For instance, sex composition was considered in all FGDs, to ensure, as much as possible, representation of both males and females. A separate FGD was held for adolescent girls. Further, FGDs with health workers, were comprised of representatives from ‘unique’ perspectives – for instance, each health function was only represented once in each FGD, as was each community organization for community leader FGDs. As with household surveys, no special emphasis was placed on selecting BRAC beneficiaries as respondents.

In total there were 219 FGDs conducted, with 1,589 participants. Since notetaking was used rather than transcription, a large sample of FGDs was deemed necessary. Indeed, while a great deal of rich qualitative information was collected, the quality of FGD data was limited by poor notetaking by some research pairings, as will be discussed below. FGDs were made up of 6-8 persons and those included as participants were chosen according to a combination of convenience and maximum variation. Using 6-10 persons per discussion is standard practice when conducting FGDs. The lower end of this spectrum was chosen to allow for a deeper analysis of the project through discussion.

### **3.4 Data Capture, Entry, Analysis, and Reporting**

The research team was made up of the research consultant, three research supervisors from the BRAC Research and Evaluation Unit (REU), twenty research assistants, and six data entry clerks. The methodology was implemented by research assistants and supervised by the research consultant and REU staff.

Assessment data was captured through paper-based household questionnaires and notetaking forms. Survey data was entered using Census and Survey Processing System (CSPro)<sup>37</sup>, and cleaned for logical consistency, skipping, skip patterns, outlying variables, and invalid and missing responses. Questionnaires with high error rates were rejected, as was stated above. Conclusions from all research are drawn from the identification of generalizable patterns and trends through the analysis of quantitative and qualitative data. For quantitative data, analysis was done using the statistical application SPSS Statistics. For qualitative research, analysis was specifically undertaken through content analysis. Coding for content analysis was done *a posteriori*, by identifying key commonalities in

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<sup>37</sup> CSPro is a public domain statistical package that can be used for entering, editing, tabulating, mapping, and disseminating census and survey data. This package is widely used by statistical agencies in developing countries and major international household survey programmes, such as Multiple Indicator Cluster Surveys (MICS) and Demographic and Health Surveys (DHS).

responses between FGDs. Preliminary research results were presented to BRAC for feedback and incorporated into an initial draft report, which then required another round of extensive commentary. All comments and feedback resulting from this process were considered for this final assessment report.

### **3.5 Limitations**

As stated above, the purpose of the assessment did not allow for representative quantitative data to be collected. The methodology was also constrained by logistical and financial limitations. In particular, no organizational vehicles were available for the assessment and rental costs of vehicles were deemed prohibitively expensive. As a result, researchers were unable to access more remote parts of the research districts. Instead, research activities were localized around particular urban areas, focusing on rural settings that were reachable by public transportation from those urban centres. Though transport was limited, efforts were made, whenever possible, to ensure geographical distribution of research activities.

Another limitation was a lack of access to areas of the country that were quarantined during the assessment. Only on one occasion did this particular limitation alter the preferred sampling strategy, which called for research to be conducted in the Aberdeen area of Freetown at a time when households in this area were under quarantine. Instead of working in Aberdeen, research activities were moved to another previously quarantined community in Freetown.

Finally, as stated, poor notetaking in some FGDs limited the effectiveness of qualitative data. Unfortunately, the assessment timeline did not allow for sufficient time to transcribe and analyse FGDs. For those FGDs that were noted poorly, notetakers produced lists, rather than deep narratives of the discussions. The large number of FGDs conducted as part of the research mitigated the effects of inadequate notetaking, and ample qualitative data was still captured to meet the objectives of the assessment.

### **3.6 Ethical Considerations**

Broadly, research activities were directed by principles of voluntariness-of-participation, anonymity, and confidentiality. All participants were given the opportunity to opt out of participating in the questionnaire or specific questions. Confidentiality of respondents was protected by using identification codes rather than names and by safe storage of data after collection. Moreover, research assistants were trained in appropriate research techniques, including how to ask questions about sensitive topics and were provided with relevant security training, in order to keep their respondents and themselves secure at all times. Through this training, research assistants were made aware of the potential types of the physical and emotional harm that respondents could face by participating in the research. Importantly, it was deemed the role of research assistants to promote a secure and comforting environment, but to proactively appraise situations for potential sources of insecurity. Maintaining the security of all persons participating in the research was prioritized ahead of any other research activity. Therefore, if the security of any person was threatened as a result of research, research assistants were instructed to terminate survey activities and report situations of insecurity to supervisors.

Throughout the research activities, and in all aspects of the research, regular contact was maintained between research assistants and their supervisors, and between supervisors and the lead researcher. Whenever possible, contact was also sustained directly between research assistants and the research lead. Regular contact and monitoring activities acted as a safeguard to ensure that the safety and security protocol discussed during training were followed appropriately.



## 4 FINDINGS

This section outlines the key impacts that the EVD outbreak in Sierra Leone, according to the quantitative and qualitative findings of this assessment. The findings focus on indicators related to income and food security, health, education and other children's issues, community and institutional trust, as well as other development concerns. The assessment maps both the past effects of the EVD outbreak, as well as its continuing impacts. Thus, while EVD had significantly declined at the time of the research project – at least as compared to peak EVD levels in 2014 – it must be emphasized that the impact of the EVD outbreak is persistent and ongoing. In fact, it may continue for years – or even decades – to undermine development in Sierra Leone if appropriate measures are not taken by the Government of Sierra Leone and its national and international partners.

### 4.1 Effects of EVD

Household survey respondents were each asked to list and rank up to three of the most important effects of EVD at the household level. The results of these responses are provided in Table 3 below. Overall, the top-ranked effects of EVD were less food and/or less farming and less income and/or more unemployment. Qualitative data supported these findings. The vast majority of FGDs also mentioned food and income security as a key effect of EVD, with respondents often pointing to increased poverty and less food as a result of restrictions on movement and social gatherings.

*“The Ebola crisis affected household food security and income. Since the outbreak, households started to lack many things due to lack of sales and shortages of food in the home.”*

Even among ever-quarantined households – that is, households that were ever part of a quarantine area – as well as among households that had experienced at least one case of EVD, food and income insecurity were still considered the top-ranked effects of EVD; though these two household categories were much more likely than other households to also point to death or illness from EVD as an important impact of the outbreak. Many of those households that experienced EVD cases were doubly affected. In addition to the tragic loss of life that afflicted those households experiencing EVD-related deaths, many persons that died were likely to have participated in household income and food generation; their deaths also lowered overall household income and food security. Respondents were particularly concerned about the effects of EVD on the many children that had lost one, or both, guardians. Mortality rates were likely to have important multiplier effects, as they result in “increased family [care] responsibilities due to the death of family members,”<sup>38</sup> as was identified in one FGD. Such responsibilities will not only be limited to those that have experienced a death in the immediate household, but will also affect those that have taken on dependents from outside of their household.

<sup>38</sup> Petty Traders FGD, Masuba, 26 February 2015

**Table 3: Most Important\* Effects of EVD**

	All Households (n=786)	Ever-quarantined Households (n=159)	Households with EVD Cases (n=86)
<i>Not affected</i>	3%	1.3%	0%
<i>Death/illness</i>	12%	45.9%	57.1%
<i>Less food / farming</i>	73.8%	71%	69.8%
<i>Stigma</i>	10.6%	15.8%	10.4%
<i>Lack access to health</i>	7.6%	6.3%	7%
<i>Less income / employment</i>	68.3%	62.8%	59.2%
<i>Movement restrictions</i>	43.5%	34.1%	33.7%
<i>No education for children</i>	53%	37.7%	37.1%
<i>No community development</i>	6.7%	11.3%	12.8%
<i>Other</i>	1.4%	1.3%	2.3%

\* Respondents were asked to choose up to three main sources of income. Aggregated and totals may add up to more than 100 per cent.

While most FGDs stressed the immediate effects of the crisis, some also linked these to future concerns, such as poor health from malnutrition, foregone capital from spent savings, higher financial burden from loans taken on during the crisis, etc. For all households, food and income effects will be felt beyond the crisis. For instance, those households that have sold or otherwise used household goods, farming tools, or business supplies will require considerable outlays of funds to replace these items. Others that have taken on loans to cope with income shortfalls will need to pay these off, and many may incur a debt burden as a result of interest payments. As stated by one FGD participant, “there is a high rate of poverty, because [people] have eaten all their capital due to less sales in the market”<sup>39</sup>. Another participant stated that “parents cannot save money for future developments in their lives and the lives of little ones, [as] they have used the money and [sold] the things in the house to survive”<sup>40</sup>.

## **4.2 Income Security**

Across all household categories, respondents reported that they had decreased income compared to before the outbreak. More than eight-in-ten of all households reported this. Across all FGDs it was also reported that there has been a decrease in income. Making the situation even worse, as opportunities to generate income fell, prices of food and other staple goods increased across the country.

As can be seen from the table below, a larger share of those households that had experienced a case of EVD reported less income than those that had no cases. Surprisingly, a smaller percentage of ever-quarantined households reported having less income than those households that had never been in a quarantine area. It is unclear from either quantitative or qualitative research why ever-quarantined households would be less income insecure – or less food insecure, as will be shown below – than those that had never been quarantined. This finding also runs counter to other assessments conducted in Sierra Leone<sup>41</sup>. A possible explanation for these findings is that income and food provided by government and non-governmental organizations was targeted at quarantined households.

<sup>39</sup> Middlemen and Market Women FGD, Lansana Street, 26 February 2015.

<sup>40</sup> Farmers FGD, Marforki, 27 February 2015.

<sup>41</sup> For example, see: Oxfam, 2015, *Rapid Food Security and Livelihood Assessment, Northern Province, Sierra Leone*. It should be noted that the Oxfam’s rapid assessment used a different methodology and covered a different research area than did this assessment of the impacts of EVD.

However, in this case, one would also expect households with EVD cases to have been targeted in this way. Consequently, there is uncertainty as to whether relatively higher income and food security levels represent an actionable research finding, or whether this is simply a statistical anomaly. Subsequent research is required to come to a definitive answer.

*Table 4: Perceived Changes in Household Income from Before EVD, by Type of EVD Effect*

	Never-quarantined Households (n=637)	Ever-quarantined Households (n=163)	Households without EVD Case (n=687)	Households with EVD Case (n=87)
<i>Less income</i>	82.7%	78.5%	80.9%	88.5%
<i>Same as before</i>	3.5%	3.1%	3.6%	1.1%
<i>More income</i>	13.8%	18.4%	15.4%	10.3%

The table below suggests that the main sources of income – both at the time of the survey and before EVD – for all respondents were reported to be petty trading. Farming and other trading were other important income-generating activities. Across all categories of respondents, farming, fishing, livestock, petty trading, other trading, and professional employment have all decreased in frequency as sources of income. Income from unskilled labour, remittances and gifts from family and friends, and cash transfers from non-governmental organizations and government have increased as households have had to cope with less income, and diversify their income sources away from those they relied on previously.

*Table 5: Most Important Sources\* of Income Today and Before EVD*

	All Households (n=800)		Ever-quarantined Households (n=163)		Households with EVD Cases (n=87)	
	<i>Today</i>	<i>Before EVD</i>	<i>Today</i>	<i>Before EVD</i>	<i>Today</i>	<i>Before EVD</i>
<i>Farming</i>	36.2%	39.2%	32.1%	40.8%	32.3%	40.4%
<i>Fishing</i>	1.2%	1.9%	2.5%	3.7%	3.4%	4.6%
<i>Livestock</i>	3.3%	5.1%	4.4%	7.4%	4.6%	6.9%
<i>Petty trading</i>	61.8%	65.2%	58.6%	66%	64.4%	73.5%
<i>Other trading</i>	25.5%	42.3%	26.5%	43.1%	25.2%	40.1%
<i>Unskilled Labour</i>	21.5%	20.7%	21.5%	16%	21.8%	21.8%
<i>Professional</i>	18.5%	25.8%	8.1%	16.7%	5.7%	12.6%
<i>Remittances and gifts</i>	29.8%	20.7%	38.9%	21.7%	37.8%	16%
<i>Cash transfers from NGOs/government</i>	2%	1.6%	5.6%	2.5%	5.8%	1.1%
<i>Other</i>	3.9%	2.7%	0.6%	0%	1.1%	4.6%

\* Respondents were asked to choose up to three main sources of income. Aggregated and totals may add up to more than 100 per cent.

Based on the following table, it seems that households that secured their primary source of income from petty trading and professional occupations were less likely to state that they had less income than before EVD, than were those respondents from households primarily gaining income from unskilled labour and farming. Although some households may be particularly income insecure, it must be reiterated that the majority of all respondents reported a loss in household income over the course of the crisis. This should also be noted for all other disaggregations calculated for income changes below.

**Table 6: Perceived Changes in Income from Before EVD, by Main Income Source Today\***

	Farming (n=212)	Petty Trading (n=282)	Unskilled Labour (n=57)	Professional (n=112)
Less income	87.3%	78%	86%	78.6%
Same as before	0%	2.8%	0%	11.6%
More income	12.7%	19.1%	14%	9.8%

\* Fishing, livestock, and other trading and commercial activities reported too few responses to allow for disaggregation.

Further disaggregation of changes in income shows almost no difference between households based on the sex of the household head, whereas respondents in rural communities were somewhat more likely to report having less income than those in urban communities – 84.4 per cent, as compared to 80 per cent, respectively. Finally, Table 7 indicates that the likelihood of reporting less income than before EVD increases with household size, with 89.1 per cent of respondents from households that had more than ten people reporting that they had less money than before the EVD outbreak. This is compared to respondents from households that have 1-5 people and 6-10 people, of whom 70.6 per cent and 81.9 per cent reported less income, respectively. The negative relationship between household size and income may exacerbate the income security of those households that took in orphans and vulnerable children (OVCs) from other EVD-affected households.

**Table 7: Perceived Changes in Income from Before EVD, by Household Size**

	1-5 People (n=143)	6-10 People (n=419)	More than Ten People (n=230)
Less income	70.6%	81.9%	89.1%
Same as before	6.3%	3.3%	0.9%
More income	23.1%	14.8%	10%

Table 8 lists financial coping mechanisms households used when short on money during the EVD outbreak. According to survey responses, coping with less money was the most used mechanism. FGDs supported these findings. According to one such respondent, those households that had savings would “survive on... savings until they were finished”<sup>42</sup>. In light of this, another respondent added that “BRAC should cancel all previous loans... as we have eaten all these money since there no trade going on”<sup>43</sup>. Other important coping mechanisms included: borrowing from family and friends, moneylenders, and *osusus*,<sup>44</sup> and having adults do more paid work. FGDs validated that those households that did access credit would rely on relatives and friends and sometimes business partners to borrow money, to repay with interest, while others would rely on *osusu* groups.

<sup>42</sup> Farmers FGD, Makama, 25 February 2015.

<sup>43</sup> Community Leaders FGD, Magbesenah, 5 March 2015.

<sup>44</sup> An *osusu* is a form of microfinancial capital accumulation that consists of small groups of members that pool capital on a daily, weekly, or monthly basis, and rotate the use of the accumulated amount regularly amongst group participants.

**Table 8: Most Important\* Financial Coping Mechanisms**

	All Households (n=772)	Ever-quarantined Households (n=155)	Households with EVD Cases (n=80)
<i>Not short on money</i>	1.4%	0%	0%
<i>Cope with less money</i>	84%	81.8%	73.8%
<i>Borrow from friends and family</i>	34.5%	43.5%	44.9%
<i>Borrow from money lender</i>	13.6%	16.3%	23.7%
<i>Borrow from osusu</i>	24.7%	18.1%	28.6%
<i>Adults do more paid work</i>	24.1%	18.8%	13.7%
<i>Children do more paid work</i>	1.6%	2.6%	1.3%
<i>Other</i>	1.2%	3.9%	3.7%

\* Respondents were asked to choose up to three main sources of income. Aggregated and totals may add up to more than 100 per cent.

Though surveys indicated that ever-quarantined households and households that had EVD cases were less likely to have adults do more work, FGDs still noted numerous forms of work as key coping mechanisms. For instance, according to one respondent, “sometimes they will cope with less money, or sometimes they will even go into bushes to find bananas and bush yams”<sup>45</sup>. The two most frequently mentioned forms of additional work were that people “managed by involving [themselves] in backyard gardening and do street trading for survival”<sup>46</sup>. Other popularly given forms of work indicated by focus groups included: processing of palm oil, collection and sale of firewood, hard labour, and brickmaking. Such financial coping mechanisms were widely reported as strategies that were used “to provide for families so they don’t sleep on [an] empty stomach”<sup>47</sup>. As will be described below, reported increases in transactional sex, especially amongst adolescent girls, were mentioned as another prevalent financial coping mechanism.

FGDs also indicated that as income-generating opportunities were reduced, households often managed by bartering, in which case they would “exchange what [they] have at hand and others need to someone that have what [they] want”<sup>48</sup>. In dire circumstances, FGDs also reported that households resorted to “selling properties and clothing just to survive”<sup>49</sup>. Some respondents also reported received finances, food, and household goods from government and non-governmental organizations. But as was shown above in Table 8, there were few households that reported relying on transfers from government and/or non-governmental organizations as a main source of income.

#### **4.2.1 Farming**

Across FGDs – both those with farmers and others – there was agreement that the quantity of foodstuffs and income from farming activities was significantly affected as a result of the EVD outbreak. The most significant contributing factors cited were: restrictions on social gatherings and movement, fear of contracting EVD through social interaction, and death to family members involved in farming.

Most FGDs spoke of the general effects on farming, indicating that the effects on agriculture were widespread and felt across different types of crops. In some cases, focus group participants spoke of specific crops being particularly affected. They identified, for instance, a reduction in the production of rice, groundnuts, beans, and yam as a result of movement

<sup>45</sup> Parents FGD, Kumala, 1 March 2015.

<sup>46</sup> Community Leaders FGD, Arabic College, 26 February 2015.

<sup>47</sup> Farmers FGD, Marforki, 27 February 2015.

<sup>48</sup> Parents FGD, Lansana Street, 26 February 2015.

<sup>49</sup> Farmers FGD, Arabic College, 26 February 2015.

restrictions. Some focus groups noted that rice was particularly affected due to a lack of access to swamp land, as the concentration of swamps in remote areas meant that these areas are likely to require longer distances to be accessed.

In some instances farmers reported that they were able to undertake a partial harvest, but generally lost significant crops to decay and/or consumption by pests, as a result of to EVD-related delays. Some FGDs indicated employing various coping mechanisms to reduce the impact of EVD on their agricultural activities; such coping mechanisms included: setting of traps to reduce the effect of pest, paying regular visits to their farms, mobilizing family members to implement an expedited harvest, and keeping seeds or crops from previous harvests in order to have seeds to cultivate within the next season.

Despite these measures – and notwithstanding that there were instances where individual crop types were singled out as being particularly damaged by EVD – FGDs suggest that the effects of EVD on agriculture were extensive and very destructive. The following sections examine the effects of EVD on a simple, linear, and generic agricultural value chain comprised of: inputs, planting and harvesting, storage and processing, wholesaling and retailing, and consumption.

### Inputs

One of the primary impacts of movement restrictions was that these obstructed farmers' ability to access agricultural inputs such as: land, seeds, tools, and fertilizers. As mentioned, farmers were often unable to move sufficiently to access farmland; especially remote farmland, such as the swamps required for farming rice, "as swamps are far from the village."<sup>50</sup> As a result of the delay in harvesting, many seeds were lost to decay, especially where farmers lacked storage facilities for seeds. When planting occurred, seeds held over from previous harvests were reported to often be insufficient for planting. But due to a lack of movement and trading, farmers were unable to access additional seeds. Those seeds that were accessible significantly increased in price.

The same is true of agricultural tools, the prices for which increased during the outbreak. As one FGD participant said, "the movement restriction makes the seeds or tools to be more expensive. So, you went to a shop to buy a tools you will meet high prices."<sup>51</sup> One focus group also mentioned that the death of blacksmiths due to EVD meant the availability of "less agricultural tools in community."<sup>52</sup> This, however, was not confirmed through other FGDs. Finally, the combination of decreases in income and rising prices were exacerbated by an inability by farmers to secure financing to purchase inputs.

### Planting and Harvesting

Planting and harvesting were also greatly impacted by the EVD outbreak. As one farmer said, "we were about to start our harvesting when people start dying so it restricted our movement to our farm causing our crops to destroyed. The ban on public gatherings also had a significant impact on agricultural cultivation. Collective work of farms was prohibited. Prior to the prohibitions, farmers reported having many participants aiding them in collective processes of planting and harvesting. During the EVD outbreak, a combination of government restrictions and fear impeded such

*"No harvest during the Ebola crisis has led to the distribution of food planted and low income among farmers; and there are even little farming activities going on presently."*

<sup>50</sup> Community Leaders FGD, Maforki Town, 27 February 2015.

<sup>51</sup> Farmers FGD, Devil Hole, 24 February 2015.

<sup>52</sup> Farmers FGD, Kagbantama, 24 March 2015.

collective work. As a result, farmers were not able to properly cultivate their produce and many crops were lost to decay and/or were eaten by pests.

### Storage and Processing

Even for many of the foodstuffs that were harvested, impediments to bringing goods to market meant that many agricultural goods were lost, or farmers and their households consumed what they managed to harvest. Farmers reported that the produce that was already “rotten [they] disposed, and the others [they] ate them”<sup>53</sup> or “discarded the rest to the pigs, especially the perishable product like vegetables”<sup>54</sup>.

### Wholesaling and Retailing

As was already stated, FGDs reported that the EVD outbreak affected the ability to bring agricultural goods to market. For example, “restrictions on the entry and exit into the districts have slowed the transportation of cash crops and food crops. Perishable crops have been greatly affected because such crops need to be in market immediately after harvesting”<sup>55</sup>. Specifically, restrictions on movement between districts during the EVD outbreak were reported to have limited the number of commercials available to transport farm produce, with the few that were available demanding high costs to transport products to market. If farm goods were not transported in time, the “result was that produce spoiled and farmers were unable to sell their farm produce”<sup>56</sup>.

### Consumption

Decreases in the supply of agricultural goods increased the prices of these goods considerably. However, with decreased incomes, the purchasing power of consumers was significantly reduced. Slow sales were said to have further increased the rate of attrition of agricultural produce. The result, as described by one FGD participant is that “we’ve used to cook six cups of rice and now we can only afford to cook three cups. Our families are suffering and as a mother I feel the pain seeing my children starving”<sup>57</sup>. As will be shown below, both the frequency and size of meals is said to have gone down among farmers and other groups of respondents.

#### 4.2.2 Petty Trading

*“All farmers forms of trading were affected, and we only survive by the grace of God and by the little sales we had for the day.”*

FGDs also indicated increasing income insecurity among petty traders. In general, petty traders said “the Ebola crisis has affected household food security and income among those working in market”<sup>58</sup> and that “most [traders] have eaten [their] business money”<sup>59</sup>. The key causal factors related to decreased business and increased income insecurity among petty traders were reported to be: restrictions to movement, trading restrictions, increased price of products, decreased sales and income, and a lack of capital. The most-mentioned obstruction to trading was said to be movement restrictions. Though most FGDs emphasized national restrictions on movement, on a few occasions, bans on cross-border movement were also mentioned as impediments to trading.

<sup>53</sup> Farmers FGD, Lumpa, 3 March 2015.

<sup>54</sup> Middlemen and Market Women FGD, Makama, 25 February 2015.

<sup>55</sup> Petty Traders, Fullah Street, 26 February 2015.

<sup>56</sup> Community Leaders FGD, Kendeya, 3 March 2015.

<sup>57</sup> Parents FGD, Rogbakar, 2 March 2015.

<sup>58</sup> Middlemen and Market Women FGD, Masomgbo, 6 March 2015.

<sup>59</sup> Parents FGD, Old Town, 1 March 2015.

Due largely to movement restrictions, there were reports of increases in prices of goods from middlemen. In a time of falling sales and capital, these prices were often prohibitively high to purchasing goods for sale. Both the prices of goods and the cost of transportation were said to have seriously increased. Consequently, “some petty traders have stopped trading because they cannot afford the goods to trade due to price increases”<sup>60</sup>. As prices of wholesale goods increased, those that did bring goods to market often found a dearth of consumers to purchase them. As there is “no money to buy things, business is being affected and the amount of costumers reduced”<sup>61</sup>. As a result of fewer sales “there is no money and the time give to us to close our shop and store is too early and some of us get our sales at night”<sup>62</sup>.

Related to the movement restrictions are restrictions on market activities, another central obstruction to trading. According to one FGD participant, “since the outbreak of Ebola business has been going very slowly due to government policy like the reduction of market hours”<sup>63</sup>. The capping of selling to 6pm, is said to have really limited opportunities for selling. Banning markets or *lumas* has further curtailed profits, and “caused a great fall in the trading sector”<sup>64</sup>. As mentioned above, falling incomes and rising prices created a dual burden that forced many to consume savings, take loans, sell assets, and implement other survival mechanisms that may have a considerable impact on future income, access to capital, and business.

After movement restrictions and market restrictions, a lack of capital was given as a main hurdle to trading. Due to the fall in business activities and income, loans are scarce. “There has been a collapse of business because of low capital”<sup>65</sup>. Lack of capital to maintain business activities “leads to less income in the household”<sup>66</sup>. Many petty traders were reported to have used business capital they did have for survival, and some now report depending on support from family and neighbours. As stated above, others were able to borrow funds from family and friends. “Since there is less sales the only way for us to survive is to cope with less sales or we borrow money from anybody who we later repay with a little interest”<sup>67</sup>. Importantly, FGDs reported that those who used to rely on loans from BRAC and other organizations were forced to cope with less assistance, as BRAC and other organization scaled back activities during the EVD outbreak.

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<sup>60</sup> Petty Traders FGD, Teneba Road, 27 February 2015.

<sup>61</sup> Middlemen and Market Women FGD, Maforki Town, 27 February 2015.

<sup>62</sup> Middlemen and Market Women FGD, Lansana Street, 26 February 2015.

<sup>63</sup> Petty Traders FGD, Lansana Street, 26 February 2015.

<sup>64</sup> Farmers FGD, Kagbantama, 24 March 2015.

<sup>65</sup> Petty Traders FGD, Lansana Street, 26 February 2015.

<sup>66</sup> Middlemen and Market Women FGD, Mabel Brown, 5 March 2015.

<sup>67</sup> Petty Traders FGD, Lansana Street, 26 February 2015.



### 4.3 Food Security

FGDs indicated an overall decline in food security. FGDs often linked food insecurity to lower farm production, saying that “there is reduction in farming activities in the community. Even when people go to the farm they will one have food for their various houses and not for sale. [As a result,] there will be some amount of food shortage,”<sup>68</sup> and “you no longer get the food you use to get”<sup>69</sup>. These qualitative findings were supported by survey data. Most respondents reported that the frequency of meals they eat has decreased compared to before EVD, as seen in the table below. FGD participants reported that their households consumed “less meals”<sup>70</sup> or that they “managed sometimes going to bed without food”<sup>71</sup>. Households that reported a case of EVD were most likely to say that they eat fewer meals than before the EVD outbreak. However, ever-quarantined households were less likely to report having less means than were never-quarantined households. As was already mentioned, at this point it is unclear if this finding is a statistical anomaly, or if ever-quarantined households report less food insecurity. Further investigation of this issue is required.

*“You either reduce the amount of meals per day or size of the meal and sometime you reduce both. Or you reduce your expenditure so that you can have a little to cope with.”*

*Table 9: Perceived Changes in Meal Frequency from Before EVD, by Type of EVD Effect*

	Never-quarantined Households (n=637)	Ever-quarantined Households (n=163)	Households without EVD Case (n=686)	Households with EVD Case (n=87)
<i>Fewer meals</i>	73.6%	68.1%	72%	78.2%
<i>Same as before</i>	5.7%	7.4%	6%	4.6%
<i>More meals</i>	20.7%	24.5%	22%	17.2%

Though all household types were more likely to report eating fewer meals than before the EVD outbreak, it can be seen from Table 10 that those that primarily relied on farming and unskilled labour were more likely to do so than households that primarily relied on petty trading and professional occupations.

*Table 10: Perceived Changes in Meal Frequency from Before EVD, by Main Income Source\**

	Farming (n=212)	Petty Trading (n=282)	Unskilled Labour (n=57)	Professional (n=122)
<i>Fewer meals</i>	81.6%	72.3%	80.7%	61.6%
<i>Same as before</i>	1.4%	4.3%	3.5%	12.5%
<i>More meals</i>	17%	23.4%	15.8%	25.9%

\* Fishing, livestock, and other trading and commercial activities reported too few responses to allow for disaggregation.

There was no reported difference between changes in frequency of meals and the sex of the household head. There were, however, differences between urban and rural households. Of rural households, 75.6 per cent reported having few meals, compared to 69.9 per cent of urban households. Moreover, the following table shows that the frequency of meals decreases as household size increases.

<sup>68</sup> Farmers FGD, Kagbantama, 24 March 2015.

<sup>69</sup> Middlemen and Market Women FGD, Mabel Brown, 5 March 2015.

<sup>70</sup> Parents FGD, Thunder Hill / Kissy By Pass, 27 February 2015.

<sup>71</sup> Farmers FGD, Arabic College, 26 February 2015.

**Table 11: Perceived Changes in Meal Frequency from Before EVD, by Household Size**

	1-5 People (n=144)	6-10 People (n=420)	More than Ten People (n=230)
<i>Fewer meals</i>	60.4%	74%	78.3%
<i>Same as before</i>	9.7%	20.2%	3.9%
<i>More meals</i>	29.9%	3.9%	17.8%

Again, all respondents were more likely to say that they eat smaller meals than before the crisis. The category of respondents that was most likely to say this is households with EVD cases. Similarly to the findings above, ever-quarantined households were less likely to report eating smaller meals than those households that had never been quarantined.

**Table 12: Perceived Changes in Meal Size From Before EVD, by Type of EVD Effect**

	Never-quarantined Households (n=637)	Ever-quarantined Households (n=163)	Households without EVD Case (n=686)	Households with EVD Case (n=87)
<i>Smaller meals</i>	81%	75.5%	79.6%	83.9%
<i>Same as before</i>	10%	9.8%	10.3%	4.6%
<i>Bigger meals</i>	8.9%	14.7%	10.1%	11.5%

As with meal size, those households that reported primary incomes from farming and unskilled labour were more likely to also report eating smaller meals than before EVD. This can be seen in the following table. By comparison, households earning primary income from petty trading or professional occupations were less likely to report a smaller meal size.

**Table 13: Perceived Changes in Meal Size From Before EVD, by Main Income Source\***

	Farming (n=211)	Petty Trading (n=282)	Unskilled Labour (n=57)	Professional (n=122)
<i>Smaller meals</i>	88.6%	80.1%	86%	70.5%
<i>Same as before</i>	1.4%	6%	5.3%	25%
<i>Bigger meals</i>	10%	13.8%	8.8%	4.5%

\* Fishing, livestock, and other trading and commercial activities reported too few responses to allow for disaggregation.

Though the sex of the household head was not reported to affect meal frequency within households, 82.9 per cent of respondents from female-headed households said that meal size had decreased from before EVD; 78.7 per cent of respondents from male-headed households reported a decrease in meal size. Households in rural communities were also more likely to report eating smaller meals when compared to before EVD, than those in urban areas – 83.3 per cent, as compared to 77 per cent respectively.

**Table 14: Perceived Changes in Meal Size from Before EVD, by Household Size**

	1-5 People (n=143)	6-10 People (n=420)	More than Ten People (n=230)
<i>Smaller meals</i>	76.9%	81.2%	79.6%
<i>Same as before</i>	14%	8.6%	10%
<i>Bigger meals</i>	9.1%	10.2%	10.4%

Larger households were again more likely to report eating smaller meals, with approximately eight-of-ten households with at least six persons reported eating smaller meals. This was somewhat more frequently than households with 1-5 people.

## 4.4 Health

*“At first people visited the health centre but now most of the people buy drugs from peddlers or visit traditional healers. There is a lack of confidence and trust in the health facilities and health workers.”*

There was also considerable concern about the impact that EVD-related mortality had on the Sierra Leonean health system, through decreased human resources for health. As stated in one FGD, “medical practitioners have died [and there is] reduced manpower in the field causing problems with the health system”<sup>72</sup>. There exists the potential for perceptions of decreased health system efficacy to affect health-seeking behaviours; in particular, demand for health services in the medium-to-long-term.

Surveys suggest ambivalence towards the health system among many Sierra Leoneans. Compared to before EVD crisis, 30.6 per cent of respondents said they have less trust in health facilities, while 20.2 per cent said they have more trust. Those households that have reported a case of EVD had significantly lower levels of trust in the health system. Interestingly, never-quarantined households were slightly more likely to report that they have less trust in the health system than were ever-quarantined households.

*Table 15: Changes in Trust in Health System, by Type of EVD Effect*

	Never-quarantined Households (n=633)	Ever-quarantined Households (n=159)	Households without EVD Case (n=683)	Households with EVD Case (n=85)
<i>Less trust</i>	32.1%	29.6%	30.6%	40%
<i>Same as before</i>	50.1%	40.9%	49.8%	34.1%
<i>More trust</i>	17.9%	29.6%	19.6%	25.9%

Many respondents who said that their trust was decreased in health facilities reported that this was as a result of the health system’s perceived ineffectiveness – both during and after the peak of the EVD outbreak. However, trust in the health system seems dynamic and was reported to be contingent not only on effective service provision, but also effective sensitization activities. For instance, one participant suggested that “at first, people did not have any trust in the health facilities because they thought the virus was manmade, but later they have regain the trust in health facilities because [community health workers] come their houses and talked to them”<sup>73</sup>. Such experiences were echoed in other communities, which suggested that more sensitization programmes are needed to help restore confidence in Sierra Leone’s health systems. Continued sensitization through community structures – and perhaps, in particular, community health workers – will be an important strategy for driving demand for health services post-Ebola.

Though there was also anecdotal evidence from FGDs that demand for formal healthcare may have decreased, with people foregoing treatment in health facilities in favour of traditional medicine or self-medication, surveys indicated that the majority of people were accessing the formal health system when sick. Of all survey respondents, 32.7 per cent reported an illness other than HIV. The most common illnesses treated were malaria or typhoid (reported by 52 per cent of respondents, followed by a headache or other body pain (reported 15.9 per cent of respondents), and a fever or cold (reported by 10.1 per cent of respondents). For all illnesses, 61.3 per cent of respondents reported receiving treatment at a health facility, as shown by the following table. Unfortunately, no comparable baseline data exists for determining if demand for healthcare is falling or rising.

<sup>72</sup> Farmers FGD, Mabureh, 27 February 2015.

<sup>73</sup> Community Leaders FGD, Mabel Brown, 5 March 2015.

*Table 16: Percentage Reporting Illness in Last Three Months*

	Percentage by Treatment Type (n=800)
<i>No treatment</i>	3.9%
<i>Peddlers</i>	16.7%
<i>Spiritual healer</i>	3.1%
<i>Health facility</i>	61.3%
<i>Pharmacy</i>	13.1%
<i>Other</i>	1.9%

Those persons that chose a health facility for treatment typically did so because they perceived it to be the best or safest treatment option. For those that sought another type of treatment, the primary reasons were affordability and accessibility. Based on this data, trust and safety were secondary decision-making criteria for choosing treatment outside of a health facility, and practical considerations and constraints were paramount.

*Table 17: Reasons for Choosing Treatment Option*

	Health Facility	Other Treatment Type
<i>More affordable</i>	1.3%	32.6%
<i>Do not trust other options</i>	1.3%	14%
<i>Safest/best treatment option</i>	77.3%	11.6%
<i>More accessible</i>	0%	31.4%
<i>Legally required</i>	7.1%	1.2%
<i>Other</i>	13%	9.3%

FGDs also reported a displacement of MNCH services by an overburdened system that was reacting to EVD. According to one health worker, “the Ebola crisis has really affected the way people now visit the health facilities. Because now less people visit the under-five clinic, the general clinic, and the immunization process”<sup>74</sup>. Similarly, another health worker indicated that parents were “afraid to take their children for anti-natal healthcare service, and because of this their children missed their immunization treatment”<sup>75</sup>. Further, symptoms of “anaemia, pneumonia, and malaria have some signs of Ebola so people were afraid of coming to the hospital instead they take traditional medicine. It has affected the wellbeing of under-five as their mothers do not bring them for [treatment]”<sup>76</sup>.

Although surveys did not capture data on levels antenatal and postnatal care, surveys did investigate rates of pregnancy and facility-based delivery among respondents. Since the beginning of the EVD outbreak, 7.8 per cent of respondents said there was an under-eighteen pregnancy in the household. Unfortunately, lack of methodologically comparable baseline data precludes calculations and comparisons of rates of teenage pregnancy. But, again, available data does suggest that most women were giving birth in health facilities. Of those under-eighteen-year-olds that gave birth, all but two gave birth in a health facility. Among 16.4 per cent of households a birth was reported for an over-eighteen-year-old, of which 76.9 per cent of deliveries were in a health facility. It is unclear why discrepancies between quantitative and qualitative findings exist. Without baseline data, it is not possible to measure changes to health-seeking behaviours. It may be that FGD participants were referencing MNCH-seeking behaviours during the peak of the EVD outbreak, and demand

<sup>74</sup> Health FGD, Makama, 25 February 2015.

<sup>75</sup> Health FGD, Makama, 25 February 2015.

<sup>76</sup> Health FGD, Maforki Town, 27 February 2015.

for MNCH services has since increased. Alternatively, women and girls may be going to health facilities to deliver, but foregoing other types of MNCH.

Of those that could have children in the future, 94.4 per cent of households said they would prefer to deliver in a hospital or clinic. Of course, it must also be understood that a stated intention to deliver in hospital or clinic does not guarantee that this will occur. Health seeking preferences may change, or impediments resulting from financial outlays related to delivering in a health facility – for instance, those associated with travel, food, and lodging – may ultimately dissuade some from choosing a health facility as a preferred delivery option.

For respondents that would go to a health facility for a future delivery, 86.7 per cent stated that trust in health facilities as the better/safer delivery option was the main reason. Those that would deliver at home stated the main reasons were that it is more accessible (42.9 per cent said this) and/or they cannot afford the costs associated with transportation, food, and lodging if delivering at a health facility (57.1 per cent said this). For respondents whose preference for future deliveries was with a traditional birth attendant, the main reason was trust in this delivery option as the better/safer mode of delivery; 65.2 per cent said this.

*Table 18: Likelihood of Under-Eighteen Pregnancy, by Household Type*

	<b>Under-18 Pregnancy</b>	<b>No Under-18 Pregnancies</b>
<i>Without EVD Case (n=674)</i>	12%	88%
<i>With EVD Case n=87)</i>	17.5%	82.5%
<i>Urban (n=357)</i>	16.9%	83.1%
<i>Rural (n=430)</i>	9.7%	90.3%
<i>1-5 people (n=142)</i>	14.5%	85.5%
<i>6-10 people (n=411)</i>	11.5%	88.5%
<i>More than 10 people (n=229)</i>	13.1%	86.9%

The table above disaggregates pregnancies among under-eighteen-year-old females. Analysis of household surveys showed no difference in likelihood in this category based on the household's quarantine history, size, sex of the household head, or main source of income; consequently, this analysis is not included below. However, there were differences in the likelihood of an under-eighteen pregnancy for households with EVD cases and urban households.

## 4.5 Child Protection

As described earlier, the assessment also collected data on children's issues, by randomly selecting a child in each household with children and asking guardians specific questions only about that child. The responses of these guardians informed the analysis in this section. Across FGDs there was a general indication that children were particularly vulnerable to the impacts of the EVD outbreak. Issues related to child wellbeing are explored in greater detail below.

### 4.5.1 Orphans and Vulnerable Children

While the assessment did not specifically collect quantitative data on OVCs, qualitative data does yield insights in the vulnerabilities of this group, as discussed below. Across many EVD-affected communities, OVCs were cited as a group particularly vulnerable to the effects of EVD. Many FGD participants stated that a considerable number of children had lost one or both parents. In other FGDs, the impacts on OVCs were considered from the point-of-view of their lower resilience to the shock of the outbreak, especially for younger children. The key effects of the EVD outbreak on children, in general, and OVCs, in specific, were believed to be in areas of: food and income insecurity and education. One FGD participant described the situation of OVCs as follows: "there are children that have lost their parents due to the Ebola crisis, some now [have only a] single parent while others are orphans. These orphans feed on the farms that their parents left, and are also sometimes supported by neighbours and relatives"<sup>77</sup>. In terms of food security, it was reported in many discussions that OVCs are more income insecure than even other populations of children. In regards to education, there is a belief that OVCs are also at a higher risk of dropping out due to a need to focus on income-generation activities to sustain themselves. Younger OVCs were said to rely on relatives, and to a lesser extent, communities as their main form of social safety net. As said in one FGD, "the groups of children most affected are from one-to-ten-years old. Grandparents have more burden in taking care of them because they have no support"<sup>78</sup>. Older children, on the other hand, were reported to be combining "help from some relatives"<sup>79</sup> with income-generating activities – often "taking care of themselves through petty trading"<sup>80</sup>.

*"For instance, children been affected greatly, they are not in school, eat less meals, their growth is affected, and many became orphans with so much emotional trauma."*

To a lesser extent, FGDs also considered the psychosocial impacts of losing a parent, or both parents, at a young age. This may be particularly true for children in the first one thousand days of life<sup>81</sup>, whom are particularly at risk of not achieving their full developmental potential because of inappropriate caregiving and early stimulation practices<sup>82</sup>. Even older children "who lost parents are traumatized, and won't be able to associate no more with their colleagues or any other person"<sup>83</sup>.

<sup>77</sup> Parents FGD, Kagbantama, 24 February 2015.

<sup>78</sup> Parents FGD, Wharf, 26 February 2015.

<sup>79</sup> Parents FGD, Old Town, 1 March 2015.

<sup>80</sup> Parents FGD, Technical, 3 March 2015.

<sup>81</sup> Brooks-Gunn, Jeanne, Pamela Klebanov, and Greg Duncan, "Ethnic Differences in Children's Intelligence Scores: Roles of Economic Deprivation, Home Environment, and Maternal Characteristics," *Child Development*, 67 (1996): pp. 396- 408.

<sup>82</sup> Republic of South Africa and United Nations Children's Fund (UNICEF), 2006, *Guidelines for Early Childhood Development Services*, Pretoria: Department of Social Development and UNICEF, p. 13.

<sup>83</sup> Parents FGD, Old Town, 1 March 2015.

### 4.5.2 Youth Crime

In some urban FGDs, increasing crime was reported to be an impact of financial insecurity caused by the EVD outbreak. While security issues were not foremost amongst any group of respondents, some expressed – highly gendered – concerns that young males would become involved in robbery and theft – “stealing properties and selling them in order for them to survive”<sup>84</sup>. Young women, it was said, were most in danger of transactional sex, becoming pregnant, and/or contracting sexually transmitted infections. Unfortunately, neither survey data nor other secondary data were available to check the veracity of claims of increased crime amongst male youth in urban settings.

### 4.5.3 Child Labour

Regarding the topic of child labour, 85.2 per cent of households reported that, in the last week, children about whom data was collected as part of the survey did at least one of three types of work: household work, work on the farm or selling in the street, or work for somebody outside the household. Respondents reported that 91.8 per cent of girls had done some kind of work, compared to 83.4 per cent of boys. There was little variation in this measure of child labour among children from ever-quarantined households and children from households that reported cases of EVD.

Surveys also reveal that almost one-in-five children had done all three types of work listed above in the last week, as is shown in Table 19 below. Girls were somewhat more likely to have done all three types of work, than were boys; 21.5 per cent of girls did all three types of work in the last week, compared to 17.4 per cent of boys. Troublingly, surveys report a more significant work burden among certain children in ever-quarantined households and children from households that reported cases of EVD.

Table 19: Percentage of Children Doing All Types of Work in The Last Week

	All Types of Work
All households (n=800)	19.5%
Never-quarantined households (n=508)	17.1%
Ever-quarantined households (n=140)	27.9%
Households without EVD Case (n=552)	70.5%
Households with EVD Case (n=74)	77%

Because of school closures, children were reported to do more work at home than before the EVD outbreak. Those children living in poor households may be in particular danger of not continuing their educations once schools are re-opened in Sierra Leone. As described by on FGD, “some of the [children from] less privileged [families] work so hard for their parent in the farm. Some also sell the farm produce for their parents. Some fetch water and firewood for home use”<sup>85</sup>. Inside the home children would help with household chores, while outside of the home, children were reported to collect firewood and fetch water for domestic use, as well as help in backyard gardening or brushing farms. Still others may be engaged in income-generating activities, such as petty trading or *okada*<sup>86</sup> riding. There are also indications that the division of labour amongst children is gendered. Male children were more likely to be mentioned as being engaged in manual jobs, while adolescent girls were

<sup>84</sup> Parents FGD, Lungi Road, 24 February 2015.

<sup>85</sup> Parents FGD, Technical, 3 March 2015.

<sup>86</sup> An *okada* is a local motorbike taxi.

reported to be more engaged in domestic work such as: cleaning, collecting firewood, and fetching water. As will be shown below, adolescent girls were also said to be involved in transactional sex.

In a number of focus groups, the opinion was expressed that housework can be beneficial for children. For example, it “makes them to learn more on the basic housework like cleaning and cooking”<sup>87</sup>. In terms of the detrimental impacts of increased child labour, the vast majority of discussions focused on general effects on education and health. Increased workloads were said to be taking children “away from studying”<sup>88</sup> in the present. As is mentioned below, concerns were also raised that work at home will negatively impact enrolment and retention once schools re-open. However, as is shown in Table 23 below, most parents report an intention to send their children to school. In terms of health, many focus group participants noted that increased use of children for labour could have short-term and long-term effects to children’s health. “Some children are too young to undertake some of these work, and they become sick with pains and other health issues”<sup>89</sup>. Finally, for adolescent girls involved in transactional sex, pregnancy and risk of sexually transmitted infections and other illnesses were reported as serious concerns.

Overall, in the past week, 87.1 per cent of all respondents reported that the children for whom data was collected had done household work such as: shopping, collecting firewood, fetching water, or caring for children. For girls about whom data was collected, 91.8 per cent were reported to have done household work in the last week, compared to 80.1 per cent of boys. Most were reported to have done 1-4 hours of this type of work per week. There were no discernable difference between households that had been quarantined, those that had cases of EVD, and other households.

*Table 20: Hours Spent Doing Household Work*

Hours Worked / Week	Percentage (n=500)
<i>Less than 1 hour</i>	32.1%
<i>1-4 hours</i>	53.8%
<i>5-7 hours</i>	12.2%
<i>8 or more hours</i>	1.9%

In terms of working on the farm or selling goods in the street in the week preceding the survey, 41.7 per cent of respondents stated that the children in question had done this type of work. Again, girls were more likely to be engaged in this type of work, with 46.3 per cent of girls for whom data was collected reported have worked on the farm or sold goods in the street, as compared to 35 per cent of boys. Again, the majority of children were reported to have done 1-4 hours of such work in a week. That being said, a much higher percentage of children engaged in doing farm work and street selling for 5-7 hours per week than for the other two types of work.

<sup>87</sup> Parents FGD, Ropolon, 24 February 2015.

<sup>88</sup> Parents FGD, Patebana Marank, 1 March 2015.

<sup>89</sup> Parents FGD, Gbouwria 2, 24 February 2015.



*Table 21: Hours Spent Working on Farm or Selling in The Street*

Hours Worked / Week	Percentage (n=224)
Less than 1 hour	6.7%
1-4 hours	50.7%
5-7 hours	36.7%
8 or more hours	5.9%

Children in ever-quarantined households were somewhat more likely to have done farm work or selling, than those from never-quarantined households; 45.7 per cent, as compared to 40.6 per cent, respectively. Conversely, there was no difference between likelihood of doing this type of work for children from households that had cases of EVD, relative to those without cases of EVD.

Overall, 38 per cent of respondents reported that children that did work for somebody that is not a member of the household. From the table below it can be seen that most children did 1-4 hours of this type of work in a week. There were no differences between the likelihood that boys and girls did work for somebody outside the household.

*Table 22: Hours Spent Working for Somebody Outside the Household*

Hours Worked / Week	Percentage (n=209)
Less than 1 hour	31.8%
1-4 hours	51%
5-7 hours	11%
8 or more hours	6.2%

Children in ever-quarantined households were also more likely to have done some type of work for somebody that is not a member of the household in the past week, relative to households that had never been quarantined; just over half (50.7 per cent) for households that at one point had been quarantined, versus 34.4 per cent for never-quarantined households. Similarly, for those households that reported cases of EVD, 57.5 per cent stated that children did work for somebody outside of the household, as compared to 36 per cent for those households that had never experienced a case.

#### 4.5.4 Education

Of the children sampled, 86.6 per cent attended school before EVD. As illustrated in Table 3 above, the disruption of education was listed as one of the main impacts of the EVD outbreak by respondents of household surveys; 53 per cent of all respondents mentioned this as an effect. To mitigate the impacts on Sierra Leone's education system, radio programmes that have been continuing school curriculums across the country<sup>90</sup> and some children have been managing by taking lessons at home. Family support is said to be important educational continuity in this context, with focus group participants reporting that children have been "managing through teaching from their parents, elder siblings, or any educated relatives near them"<sup>91</sup>. That being said, many FGDs suggested that the break in studying would cause "most students to forget about the things they have learned"<sup>92</sup>.

<sup>90</sup> Couch, Robbie, 2015, "Radio Stations Broadcast Lessons To Sierra Leone Kids Still Out Of School Due To Ebola," *The Huffington Post*, 20 February [http://www.huffingtonpost.com/2015/02/20/sierra-leone-schools-radio\\_n\\_6714364.html](http://www.huffingtonpost.com/2015/02/20/sierra-leone-schools-radio_n_6714364.html) (31 March 2015).

<sup>91</sup> Adolescent Girls FGD, Old Town, 1 March 2015.

<sup>92</sup> Adolescent Girls FGD, Technical, 3 March 2015.

As stated above, focus group participants worry that there will be a decrease in enrolment and retention once schools re-open. In particular, it is believed that a lack of income and savings will result in decreased future enrolment in schools for school-going children. In a response that was typical of many FGDs, one participant stated that “the set of children that are mostly affected are the children that were going to school. Most of them are now engaged in farming activities and petty trading. The crisis has left us with no money for business and to even pay school fees when school re-open”<sup>93</sup>. Others suggested that dropout rates would increase for adolescent girls as a result of high rates of teenage pregnancy and early marriages. Survey findings do not support these opinions, with 94.6 per cent of parents reporting that they planned to send that child to school next year. Disaggregation by sex reveals that there was little difference in the likelihood that boys and girls would be sent to school. As with planned health-seeking behaviours, it must be understood that intention to send a child to school does not necessarily translate into action, especially in the face of pressing practical constraints such as income and food insecurity that may put pressure on children to stay home and work.

*Table 23: Plans to Send Child to School in Following Year, by Type of EVD Effect*

	Never-quarantined Households (n=474)	Ever-quarantined Households (n=135)	Households without EVD Case (n=513)	Households with EVD Case (n=72)
Yes	95.1%	92.6%	95.7%	93.1%
No	4.9%	7.4%	4.3%	6.9%

The table above suggests slight differences between the likelihood of sending a child to school between categories of households, with ever-quarantined households and those households reporting EVD cases being slightly less likely to send children to school in the coming year. There were insufficient responses to disaggregate between household categories for reasons for not sending a child to school. But overall, 46.4 per cent of households that did not plan to send a child to school cited an inability to afford school as the main reason. This was, by far, the most popular reason given for not planning to do so.

#### **4.5.5 Abuse and Violence against Children**

Other than sexual exploitation of adolescent girls, no FGDs identified abuse or violence against children as an increasing problem due to the EVD outbreak. Nevertheless, quantitative data collected for the assessment on this issue is presented below. The table below illustrates that, overall, the most common forms of abuse that children experienced in the month preceding the survey was being yelled at and being called names. Troublingly, 84.5 per cent of respondents stated that the child being reported on had experienced at least one of the types of abuse or violence listed below.

<sup>93</sup> Parents FGD, Kagbantama, 24 February 2015.

*Table 24: Abuse and Violence Against Children for All Households in The Past Month*

	All Households (n=800)
<i>Called child names</i>	48.8%
<i>Yelled or screamed at child</i>	76.1%
<i>Slapped child on bottom with hand</i>	27.5%
<i>Slapped child on face, arm, or leg with hand</i>	15.9%
<i>Hit child with an object</i>	28.8%
<i>At least one type of violence</i>	84.5%

The following table suggests no discernable patterns in abuse and violence between household categories. Reports of children experiencing at least one type abuse or violence in the month preceding the survey are comparable, with ever-quarantined households and households never having a case of EVD reporting slightly higher levels. Otherwise, differences exist between categories and types of violence, with a clear pattern emerging.

*Table 25: Abuse and Violence against Children for All Households in The Past Month, by Type of EVD Effect*

	Never-quarantined Households (n=507)	Ever-quarantined Households (n=140)	Households without EVD Case (n=551)	Households with EVD Case (n=74)
<i>Called child names</i>	50.3%	43.6%	49.2%	44.6%
<i>Yelled or screamed at child</i>	74.7%	80.9%	75.7%	75.6%
<i>Slapped child on bottom with hand</i>	28.7%	22.7%	28.6%	24.3%
<i>Slapped child on face, arm, or leg with hand</i>	15.3%	17.7%	16.3%	13.5%
<i>Hit child with an object</i>	28.4%	30%	29.3%	31.1%
<i>At least one type of violence</i>	84.1%	85.8%	84.6%	82.4%

Though there were no differences in rates of abuse and violence against children by the type of EVD affected household, there were sex-disaggregated differences. Boys and girls were equally as likely to experience any type of violence, but boys were more likely to experience more severe types of violence listed above. For instance, 31 per cent of boys had been slapped on the bottom in the last month, as compared to 25.3 per cent of girls. Similarly, 20.3 per cent of boys were slapped on the face, arm, or leg, and 32 per cent were hit some sort of object, compared to 12.5 per cent and 26.2 per cent of girls, respectively.

Sexual exploitation of adolescent girls was a major concern reported throughout FGDs. Financial and food insecurity were reported to be key contributing factors. Qualitative data indicates that teenage pregnancy is an important problem since the EVD outbreak. According to one adolescent girl, “our friends and sisters have become pregnant more than before. We see them everyday”<sup>94</sup>. Others suggested that adolescent girls get “involved in prostitution, as that is the only way they feel they can make income and also to provide for

<sup>94</sup> Adolescent Girls FGD, Teneba Road, 27 February 2015.

their family,”<sup>95</sup> as “adult men take advantage on them and wants to influences them with money and other expensive things”<sup>96</sup>.

*Children have been unable to attend school for a whole academic year and this has led to high rate in teenage pregnancy and prostitution and early marriage amongst adolescent girls.”*

As a consequence, qualitative data also indicates that teenage pregnancy is an important problem since the EVD outbreak: “since there is a halt in the formal schooling due to the crisis, this contributed to the increase in teenage pregnancy”<sup>97</sup>. Other FGDs noted that access to contraception was less available during EVD outbreak. As told by one participant, “under normal circumstances, adolescent girls go to school and sometimes visit the Marie Stopes society for contraceptives or preventive measures to avoid being pregnant”<sup>98</sup>. Lack of sexual and reproductive health commodities likely increased the risk of sexually transmitted infections and other communicable diseases, in particular for that are involved in transactional sex. A related issue is early marriage. Increased early marriage was also reported to be a key effect of the EVD outbreak, with “lowered progress in the lives of the teenage girls leaving some with no choice but to engage in early marriage as an avenue to secure an economic future”<sup>99</sup>. Problems associated with teenage pregnancy, sexually transmitted infections, and early marriage will persist even after EVD. As a result, adolescent girls affected by these issues will require particular support during post-EVD recovery.

#### 4.6 Community and Institutional Trust

Regarding community trust, 87 per cent of survey respondents stated that they have less trust in other people in their communities when compared to before the EVD crisis. As can be seen from the table below, ever-quarantined households were most likely to report negative changes in community trust, and households that reported a case of EVD have even larger increases in distrust of other community members.

Table 26: Changes in Trust in Community, by Type of EVD Effect

	Never-quarantined Households (n=633)	Ever-quarantined Households (n=159)	Households without EVD Case (n=687)	Households with EVD Case (n=87)
Less trust	85.9%	91.4%	85.9%	95.4%
Same as before	12.9%	6.2%	12.7%	2.3%
More trust	1.3%	2.5%	1.5%	2.3%

Lower trust in communities is largely due to potential for infection from others. “People were been stigmatize due to the amount of death of colleagues, family members and love ones because of this there was no trust for anybody within the community”<sup>100</sup>. Among many FGD participants there was a stated fear to interact with fellow community members because of the fear of contracting EVD. Further, restriction of movements have stopped social life and reduced social activities, “wherein people here stopped to watch football in the cinemas, people were also stopped to attend night clubs due to the Ebola crisis”<sup>101</sup>.

<sup>95</sup> Adolescent Girls FGD, Maforki Town, 27 February 2015.

<sup>96</sup> Adolescent Girls FGD, Ropolon, 24 February 2015.

<sup>97</sup> Adolescent Girls FGD, Mabureh, 27 February 2015.

<sup>98</sup> Adolescent Girls FGD, Lungi Road, 24 February 2015.

<sup>99</sup> Adolescent Girls FGD, Mabureh, 27 February 2015.

<sup>100</sup> Community Leaders FGD, Lungi Road, 24 February 2015.

<sup>101</sup> Farmers FGD, Kagbantama, 24 March 2015.

While the greatest concerns over loss of human resources were for health workers that died from EVD, some FGD also mentioned that other important community groups had been damaged by the outbreak. “Members of important [community] groups are now dead due to the Ebola crisis outbreak”<sup>102</sup>, while some other “groups have stopped to function because of laws against [social gatherings]”<sup>103</sup>. The loss of these social resources is likely to disrupt community-driven development during the post-EVD recovery process, especially if compounded by persistently low social cohesion.

There appears to be a decrease in trust of the police services. More than 37.7% per cent of all respondents said they have less trust in police now and 11.6 per cent said they have more trust. Again, households reporting a case of EVD have considerably less trust in police than a before the EVD crisis. Ever-quarantined households were also more likely to report less trust for police than never-quarantined households.

*Table 27: Changes in Trust in Police, by Type of EVD Effect*

	Never-quarantined Households (n=629)	Ever-quarantined Households (n=156)	Households without EVD Case (n=678)	Households with EVD Case (n=87)
<i>Less trust</i>	34%	38.5%	33.5%	44.8%
<i>Same as before</i>	53.6%	53.2%	54.1%	47.1%
<i>More trust</i>	12.4%	8.3%	12.4%	8%

Where there was increased trust of police in amongst participants, it was generally as a result of perceptions that police work was being carried out effectively. For instance saying that “during the outbreak the police made sure that all the laws that were put in place in the community towards the fight against Ebola”<sup>104</sup>. FGDs indicate that grievances with the police typically related perceptions of ineffectiveness, as with health facilities, and corruption. In terms of ineffectiveness, in some instances police have been reported to “leave quarantine homes and go about their business leaving people to interact with each other [in this way exacerbating the crisis]”<sup>105</sup>. Regarding corruption, some FGDs reported that police “collected bribe[s] from quarantine houses for them to have free movement”<sup>106</sup>, and “if your business valuable or you are rich you can secure a pass and go buy goods”<sup>107</sup>.

People’s feelings towards the government in general were less clear-cut. Almost an equal number of respondents were likely to have either more or less trust in government. About one-in-five stated that they have less trust in government as compared to before the EVD crisis, and with slightly higher percentage indicating that they have more trust in government. As with survey data, FGDs around trust in government were often mixed. Respondents from households reporting a case of EVD were more likely to say that they have less trust in government. Similarly, respondents from ever-quarantined households were slightly more likely to report less trust.

<sup>102</sup> Adolescent Girls FGD, Kagbantama, 24 February 2015.

<sup>103</sup> Parents FGD, Lansana Street, 26 February 2015.

<sup>104</sup> Community Leaders FGD, Fullah Street, 26 February 2015.

<sup>105</sup> Community Leaders FGD, Timbo Sokuralla, 24 February 2015.

<sup>106</sup> Community Leaders FGD, Devil Hole, 24 February 2015.

<sup>107</sup> Petty Traders FGD, Fisher Street, 3 March 2015.

*Table 28: Changes in Trust in Government, by Type of EVD Effect*

	Never-quarantined Households (n=635)	Ever-quarantined Households (n=159)	Households without EVD Case (n=685)	Households with EVD Case (n=87)
<i>Less trust</i>	20.5%	22%	20%	26.4%
<i>Same as before</i>	58.4%	53.5%	58.8%	46%
<i>More trust</i>	21.1%	24.5%	21.2%	27.6%

Mixed feelings towards government were exemplified in FGD. According to a community leader, “at first, we trust government but now [there is] no trust.” Though some participants were in agreement with this opinion, others disagreed – stating, for instance, that “since the beginning of Ebola government has done a lot”<sup>108</sup>. It must also be said that in at least one community, trust for BRAC was eroded due to its perceived inactivity during the EVD outbreak. In one FGD in this community it was opined that BRAC was “part of the community [before the crisis] but BRAC did not render any help to this community during the time of the crisis,”<sup>109</sup> while another person in the same community asked: “BRAC only stepped in after the crisis; why didn’t they do so during the crisis?”<sup>110</sup>

#### **4.7 Development Concerns**

According to the table below, clean water, education, food, and healthcare were the main concerns today for all households – as listed in order of perceived magnitude of the problem. Similarly, the top-ranked development concerns for ever-quarantined households and households with EVD cases were: education, clean water, food, and healthcare. The largest change between concerns today and concerns from before EVD were that food increased significantly as concern for all groups, but especially for those households that reported a case of EVD. Education also grew as a concern for all groups since before EVD, whereas water has decreased as a concern from before EVD.

*“We are asking the government of Sierra Leone and all others NGOs to please help us especially in education, water, and health services.”*

<sup>108</sup> Community Leaders FGD, Devil Hole, 24 February 2105.

<sup>109</sup> Community Leaders FGD, Gbendembu, 24 February 2015.

<sup>110</sup> Health FGD, Gbendembu, 24 February 2015.

**Table 29: Most Important\* Development Concerns**

	All Households (n=800)		Ever-quarantined Households (n=163)		Households with EVD Cases (n=87)	
	Today	Before EVD	Today	Before EVD	Today	Before EVD
No concerns	0%	0%	0%	0%	0%	0%
Education	54.8%	42.3%	61.1%	49.6%	60.8%	53.5%
Healthcare	41.5%	44.4%	38.4%	38%	41.5%	41.9%
Transportation	4.3%	4.9%	4.9%	5.1%	2.3%	1.2%
Employment	21.2%	22.5%	18.4%	25.5%	24.1%	27.8%
Clean water	55.6%	63.3%	53.3%	61.6%	56.5%	65.2%
Food	42.6%	23.3%	45.6%	18.6%	44.8%	12.8%
Housing	2%	3.4%	1.2%	2.5%	0%	0%
Electricity	19.4%	27%	14.7%	32.8%	10.3%	29%
Sanitation	8.7%	12.1%	13%	16.1%	10.3%	13.9%
Other	0%	0%	37.7%	30.5%	35.7%	33.8%

\* Respondents were asked to choose up to three main sources of income. Aggregated and totals may add up to more than 100 per cent.

Perhaps not surprisingly, FGDs reported that the programmes or services that were currently being provided to communities were predominately health-oriented; others were oriented on supply of household goods, food, or financial assistance – especially for EVD survivors and OVCs. Health-related activities include: provision of chlorine and sanitizer, training of burial teams, supply of protective equipment, provision of ambulances, building of community care centres, training of community health workers, EVD sensitization and contact tracing, and supply of anti-malarial drugs. Supply of household goods, food, or financial assistance included: provision of financial grants or micro credit, supply of staple foods, provision of buckets, soap, blankets, school materials, etc. Troublingly, many FGDs reported that they were receiving no programmes or services.

**Table 30: Most Important Development Concerns Today, by Urban and Rural**

	Urban (n=360)	Rural (n=440)
No concerns	0%	0%
Education	49.9%	60.7%
Healthcare	34.8%	49.8%
Transportation	4.6%	4%
Employment	22.8%	19.2%
Clean water	55.1%	56.1%
Food	43.2%	41.8%
Housing	2.3%	1.7%
Electricity	16.6%	22.9%
Sanitation	11%	5.9%
Other	38.6%	28.4%

As can be seen from the table above, development concerns between urban and rural contexts were similar. The main development concerns in urban communities – as ranked in order of importance – were: clean water, education, food, and healthcare. Rural communities listed the same concerns as being important, but prioritized these differently; the development concerns of rural communities, in order of magnitude, are: education, clean water, healthcare, and food. Moreover, disaggregating development concerns for petty

traders and farmers showed that, petty traders exactly mirrored the ranked list of urban development priorities, while farmers provided an identical list as that disaggregated by rural communities. This is not surprising, given the predominance of trading as a primary source of income in urban communities and farming as primary source of income in rural communities.

*Table 31: Most Important Development Concerns among FGD Participants*

	<b>Top-four Development Concerns for Each FGD Category</b>
<i>Adolescent girls</i>	<ol style="list-style-type: none"> <li>1) Re-open, build and/or rehabilitate schools; provide scholarships and materials</li> <li>2) Supplement food supply of households</li> <li>3) Supply clean drinking water</li> <li>4) Provide support to survivors and OVCs</li> </ol>
<i>Community leaders</i>	<ol style="list-style-type: none"> <li>1) Improve quality of education and provide it for free; especially for OVCs</li> <li>2) Provide credit to business people to increase business activities</li> <li>3) Build, rehabilitate, expand, staff, and supply health facilities</li> <li>4) Capacitate farmers; especially by providing farming inputs</li> </ol>
<i>Parents</i>	<ol style="list-style-type: none"> <li>1) Improve quality of education and provide it for free</li> <li>2) Build, rehabilitate, and expand health facilities</li> <li>3) Supplement food supply of households</li> <li>4) Provide credit to business people to increase business activities</li> </ol>
<i>Farmers</i>	<ol style="list-style-type: none"> <li>1) Capacitate farmers; especially by providing farming inputs</li> <li>2) Improve roads; for the purposes of bringing farm goods to market</li> <li>3) Provide credit to farmers and business people to increase farming and business activities</li> <li>4) Build, rehabilitate, and expand health facilities</li> </ol>
<i>Petty traders, middlemen, and market women</i>	<ol style="list-style-type: none"> <li>1) Provide credit to business people to increase business activities</li> <li>2) Re-open, build and/or rehabilitate markets</li> <li>3) Supply clean drinking water</li> <li>4) Build, rehabilitate, and expand health facilities</li> </ol>
<i>Health workers</i>	<ol style="list-style-type: none"> <li>1) Build, rehabilitate, expand, staff, and supply health facilities</li> <li>2) Provide sensitization to communities to promote demand for health services</li> <li>3) Supplement food supply of households</li> <li>4) Provide or improve sanitation facilities in communities</li> </ol>

The table above provides a collated summary of the top development concerns, as listed by categories of FGD participants. While, quantitative data suggested considerable homogeneity in development concerns across different categories of survey respondents, FGD show that a detailed qualitative analysis produced some important nuances and differences. Adolescent girls, community leaders, and parents were most likely to say that education was the top development concern. In this regard, community leaders and parents spoke of the affordability and quality of education, while adolescent girls indicated that re-opening, building, or rehabilitating schools and providing materials and scholarships were the most pressing needs. Further, clean drinking water was listed as a development priority by adolescent girls and petty traders, middlemen, and market women, while the need to supplement household food supply was a priority among adolescent girls, parents, and health workers.

Healthcare was also listed as key concern across groups. Community leaders, parents, farmers, and petty traders, middlemen, market women, and health workers all indicated that building, rehabilitating, and expanding health facilities was a development priority. Community leaders and health workers also mentioned the need to staff and supply health facilities. Health workers also expressed the need for sensitization to encourage demand for health services in the wake of the EVD outbreak.



The primary difference between quantitative and qualitative analyses of development concerns was the focus on income-generation within FGDs. Key among these concerns was the need to capacitate business people and farmers with credit to revive selling and agricultural activities. Respondents also mentioned the needs of farmers for agricultural inputs such as: seeds, tools, and fertilizer. Emphasis on income-generation in FGDs may be explained by the participants' perception that this is an area that BRAC could provide assistance in, making them more likely to voice concerns related to income-generation.

## 5 CONCLUSIONS

The analysis presented above shows that the effects of the EVD outbreak in Sierra Leone were considerable, and spanned across indicators related to: income and food security, health, child protection, education, community cohesion, and institutional trust. Key effects were less farming and food, less employment and income, and no education for children. Not surprisingly, for those households that had experienced quarantine and/or a case of EVD, EVD-related illness and death were also listed as key effects of the outbreak. The majority of households reported less income than before the EVD outbreak. Those households that had reported an EVD case were particularly affected by income insecurity. Farmers and unskilled labourers were also relatively more income insecure, as were large households. The effects of farming spanned the entirety of the value chain. Inputs such as seeds, tools, and fertilizer were scarce, while movement and gathering restrictions undermined planting, harvesting, and selling activities. Similarly, trading was negatively impacted by these restrictions, significantly decreasing sales and incomes among petty traders, middlemen, and market women. Decreased farming and lower income and also translated into increased food insecurity. The majority of all households reported consuming fewer and smaller meals. While most households simply coped with less money, some also employed other strategies, including: borrowing from friends and family, borrowing from an *osusu*, and doing more paid work.

But the effects of the EVD outbreak were felt well outside of just income and food security. There was a general concern that the supply of health services will be adversely impacted as result of the deaths of health workers. Experiences with the health system during the EVD outbreak also have potential future ramifications for the demand for formal healthcare. There is anecdotal evidence from FGDs that demand for formal healthcare may be on the decrease. Many respondents – and especially those whose households reported a case of EVD – indicated decreases in trust in the health system. Overall, community cohesion is said to have decreased considerably, largely due to fear of contact and contracting EVD. Surveys also revealed ambivalence towards police and government, with trust in these institutions both decreasing and increasing.

There were indications that children were particularly vulnerable to the impacts of the EVD outbreak. While the assessment did not collect quantitative data on OVCs within the households sampled, qualitative data does yield considerable insights in the vulnerabilities of this group. This group was perceived to be more income and food insecure, with lower prospects for education, and larger potential for psychosocial trauma. Across all children, the majority of households reported that children had done some sort of work – inside or outside the household – in the last week. Girls were more likely than boys to do work. Girls were also reported to be at risk of transactional sex as a result of food and income insecurity, putting them in danger of getting pregnant and contracting sexually transmitted infections.

Overall, the primary development concerns were reported to be: clean water, education, food, and healthcare. The largest change between concerns today and concerns from

before EVD were that food has increased significantly as a concern for all groups, but especially for those households that reported a case of EVD. Education has also grown as a concern for all groups since before EVD, whereas water has decreased as a concern from before EVD. Qualitative research reported that the programmes or services that are currently being provided to communities are predominately health-oriented; others are oriented on supply of household goods, food, or financial assistance – especially for EVD survivors and OVCs. Health-related activities include: provision of chlorine and sanitizer, training of burial teams, supply of protective equipment, provision of ambulances, building of community care centres, training of community health workers, EVD sensitization and contact tracing, and supply of anti-malarial drugs. Supply of household goods, food, or financial assistance included: provision of financial grants or micro credit, supply of staple foods, provision of buckets, soap, blankets, school materials, etc. Troublingly, many FGDs reported that they were receiving no programmes or services.

As was mentioned in the previous section, qualitative research also reinforced that clean water, education, food, and healthcare were key development concerns, but also suggested the need to focus on income-generation within FGDs. Key among these concerns was the need to capacitate business people and farmers with credit to revive these activities. Respondents also mentioned the needs of farmers for agricultural inputs such as: seeds, tools, and fertilizer.

## 6 KEY RECOMMENDATIONS

Sierra Leone is at a critical period. Interventions implemented over the coming years will play a major role in determining the prospects for national, community, and household development. Accordingly, this assessment aims to inform the shape and structure of early recovery in Sierra Leone through holistic quantitative and qualitative analysis of the effects of EVD in the country. The following are recommendations for BRAC and its development partners to address the crisis and facilitate post-EVD recovery.

1. There is still a need to scale up short-term food security operations to answer the immediate food needs of the most vulnerable people, and especially to address food supply gaps, particularly among most-affected demographics. To be effective, the food security response should assess, redevelop, and protect local institutional infrastructure – for example, farmers' associations, cooperatives, savings and loan schemes, local government structures, etc. – and strengthen the access of vulnerable populations to existing food supplies. Where appropriate, cash transfers can help assure food access for people whose main livelihood is not agriculture. Given reductions in trader activity, local purchase in surplus areas can help assure that surpluses are being redistributed.
2. In the agricultural sector, actions are needed in assisting agricultural production operations linked to harvesting and post-harvesting activities, transportation, and storage of output to increase availability and facilitate the sale of produce. Examples might include: activities to increase access to credit, the provision of inputs to farmers to compensate for losses during the outbreak, and support for re-establishing local markets that have been closed.
3. Measures should be put in place to improve the purchasing power of most vulnerable populations and assist them in accessing markets. For this purpose, existing productive safety nets and social protection programmes should be scaled up. For example, OVCS will be vulnerable owing to the stigma of the disease. Special grants should be considered for the families and relatives that take them in. For those of adolescent age, measures should be taken to ensure their enrolment in, for instance, vocational training programmes, allowing them to join the labour market.

4. Proactive efforts must be made to stimulate an early economic recovery by helping people restart activities affected by the epidemic. Priority attention could be paid to the poorest households and those with OVCs from the EVD epidemic. In particular, supplies of capital, undercut by the crisis, should be provided. Particular focus could be paid to women's access to credit and financial products. Increasing the supply of microfinance is a pathway to recovery, especially of the micro and small-scale enterprises in the most-affected communities. Those that had previously been given loans by BRAC may also be forgiven their debt obligations. In particular, adolescent girls affected by sexual exploitation and abuse should be supported in the access to livelihood opportunities as part of the recovery efforts.
5. Economic recovery will require support for strategic actions such as: start-up packs and grants to revitalize new and existing enterprises, as well as medium-term support for local economic revitalization through vocational and business training.
6. Early childhood development programmes focused on OVCs may also make it possible for children that have lost one, or both parents, to grow and develop to their full potential, thus reducing the need for remedial services to address stunting, developmental lag and social problems later in life<sup>111</sup>.
7. Programmes targeted at adolescent girls should emphasize employment and income generation, as well as reproductive and sexual health and family planning.
8. Accelerated recovery of the health sector should be given priority. Medium-term strategic interventions should include: strengthening government capacities and training and capacitating human resources for health – with a focus on providing improved basic services delivery. There may also be a need to engage sensitization aimed at driving demand for health services, as this is needed to rebuild confidence in health institutions, and the government in general.
9. Demand for health and education services must be closely monitored in the short-to-medium term, so as to gauge the lasting effect – if any – of the EVD outbreak on these sectors. Health monitoring should focus on MNCH services, while educational monitoring should focus on low-income households and OVCs.

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<sup>111</sup> Republic of South Africa and United Nations Children's Fund (UNICEF), 2006, *Guidelines for Early Childhood Development Services*, Pretoria: Department of Social Development and UNICEF, p. 13.

**ANNEXES****Annex A: Research Community List***Table: List of Research Communities*

<b>Community Name</b>	<b>Surveys</b>	<b>Weights</b>
<i>Arabic College</i>	20	1.00
<i>Campbell Town</i>	20	1.00
<i>Devil Hole</i>	20	1.00
<i>Fareehkoro</i>	20	1.00
<i>Fenbakoro</i>	20	1.00
<i>Fisher St</i>	20	1.00
<i>Fulah Street</i>	20	1.00
<i>Gbendembu</i>	20	1.00
<i>Gbouwria 2</i>	20	1.00
<i>Hennessy St</i>	20	1.00
<i>Kagbantama</i>	20	1.00
<i>Kendeya</i>	20	1.00
<i>Kumala</i>	19	1.05
<i>Lansana St</i>	20	1.00
<i>Lumpa</i>	20	1.00
<i>Lungi Road</i>	20	1.00
<i>Mabel Brown</i>	20	1.00
<i>Mabureh</i>	20	1.00
<i>Maforki Town</i>	20	1.00
<i>Magbaffi</i>	19	1.05
<i>Magbesenah</i>	20	1.00
<i>Makama</i>	20	1.00
<i>Makapri</i>	20	1.00
<i>Masomgbo</i>	20	1.00
<i>Masuba</i>	20	1.00
<i>Mathinka</i>	20	1.00
<i>Monkey Bush</i>	18	1.11
<i>Old Town</i>	20	1.00
<i>Palmoronkoh</i>	20	1.00
<i>Pate Bana Marank</i>	20	1.00
<i>Kingtom</i>	19	1.05
<i>Rogbakar</i>	20	1.00
<i>Rokel</i>	18	1.11
<i>Ropolon</i>	20	1.00
<i>Sand Sand Water</i>	20	1.00
<i>Technical</i>	20	1.00
<i>Teneba Road</i>	20	1.00
<i>Thunder Hill / Kissy By Pass</i>	20	1.00
<i>Timbo Skuralla</i>	20	1.00
<i>Wharf</i>	20	1.00
<b>Total</b>	<b>793</b>	

**Annex B: Survey for BRAC EVD Assessment**

**CONSENT FORM** Hello. My name is \_\_\_\_\_ and I am working with BRAC, an international organization working in Sierra Leone. We are conducting a survey in this district about the effects of the Ebola virus. We would very much appreciate your participation in this survey.

I would like to ask you about some of the effects of Ebola on this household. This information will help BRAC, other organizations, and the government plan to deliver programmes and services to Sierra Leone. The survey usually takes between 20 and 45 minutes to complete. Your answers will be kept strictly confidential and will not be shown to other persons and we will not link your name to any answers.

We cannot provide you with any direct benefits for your household, or promise any specific development for your community. But we are gathering data to better understand the situation in your community and in this district. We will make sure that what you tell us today will be communicated to BRAC and its partners so that they can try to help communities such as this one.

Participation is voluntary and you can choose not to answer any individual question you find very personal or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey? (After answering any questions). May I begin now? (Get verbal consent).

YES → **Q01**  
NO → **END**

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<b>Q01</b>	Enter questionnaire ID	_ _ _ _ _ _ _
<b>Q02</b>	Enter community name	_____
<b>Q03</b>	Enter enumerator ID (2-3 initials)	_ _ _ _ _
<b>Q04</b>	Enter date	_   _  February/March 2015
<b>Q05</b>	Enter interview start time	_ _  :  _ _

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**NOTES:**

When asking questions, do not give the answers immediately, unless promoted by: Only read **▣▣ Read answers out loud. ▣▣**

For all other answers, allow the respondents' to answer and record them. When respondents cannot give answers, say the options available.

**SECTION A: HOUSEHOLD AND COMMUNITY QUESTIONS**

"I would now like to ask you some questions about your household and community."

<b>A01</b>		
Indicate gender of the respondent.  <input type="checkbox"/>	Female 1 Male 2	
<b>A02</b>		
"Including you, how many people live in this household in each age group?"  <input type="checkbox"/>	Specify number in each age group 1  Under 13 _____ 13 to 18 _____ Over 18 _____  Don't know 77 Refuse to answer 88	
<b>A03</b>		
"Is the head of the household male or female?"  <input type="checkbox"/>	Female 1 Male 2  Don't know 77 Refuse to answer 88	
<b>A04</b>		
"What is the age of the head of the household?"  <input type="checkbox"/>	Specify age 1  _____  Don't know 77 Refuse to answer 88	

<b>A05</b>		
<p>“The Ebola crisis can have many affects. Please tell me the MAIN ways this household was affected by the crisis?”</p> <p>☐☐ <i>Select up to three and rank in order of importance.</i> ☐☐</p> <p style="text-align: center;">☐</p> <p style="text-align: center;">☐</p> <p style="text-align: center;">☐</p>	<p style="text-align: right;">Not affected <b>A</b></p> <p style="text-align: right;">Ebola death/illness in the household <b>B</b></p> <p style="text-align: right;">Less food / no farming <b>C</b></p> <p style="text-align: right;">Stigma from Ebola case <b>D</b></p> <p style="text-align: right;">Lack of access to health <b>E</b></p> <p style="text-align: right;">Less income / unemployment <b>F</b></p> <p style="text-align: right;">Movement restrictions <b>G</b></p> <p style="text-align: right;">Less food due to movement restrictions <b>H</b></p> <p style="text-align: right;">No education for children <b>I</b></p> <p style="text-align: right;">No community development <b>J</b></p> <p style="text-align: right;">Other (specify) <b>96</b></p> <hr style="width: 50%; margin-left: auto; margin-right: auto;"/> <p style="text-align: right;">Don't know <b>77</b></p> <p style="text-align: right;">Refuse to answer <b>88</b></p>	
<b>A06</b>		
<p>“<u>Considering all of the different effects the Ebola crisis can have</u>, how affected was this community by the crisis compared to other communities?”</p> <p>☐☐ <i>Read answers out loud.</i> ☐☐</p> <p style="text-align: center;">☐</p>	<p style="text-align: right;">Affected less than other communities <b>1</b></p> <p style="text-align: right;">Affected the same as other communities <b>2</b></p> <p style="text-align: right;">Affected more than other communities <b>3</b></p> <p style="text-align: right;">Don't know <b>77</b></p> <p style="text-align: right;">Refuse to answer <b>88</b></p>	
<b>A07</b>		
<p>“<u>Considering all of the different effects the Ebola crisis can have</u>, how affected was this household by the crisis compared to other households?”</p> <p>☐☐ <i>Read answers out loud.</i> ☐☐</p> <p style="text-align: center;">☐</p>	<p style="text-align: right;">Affected less than other households <b>1</b></p> <p style="text-align: right;">Affected the same as other households <b>2</b></p> <p style="text-align: right;">Affected more than other households <b>3</b></p> <p style="text-align: right;">Don't know <b>77</b></p> <p style="text-align: right;">Refuse to answer <b>88</b></p>	

A08		
<p>“Has this household ever had an Ebola case?”</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p style="text-align: right;">Specify number of cases <b>1</b></p> <p style="text-align: right;">Deaths _____</p> <p style="text-align: right;">Recovered _____</p> <p style="text-align: right;">No case <b>0</b></p> <p style="text-align: right;">Don't know <b>77</b></p> <p style="text-align: right;">Refuse to answer <b>88</b></p>	
A09		
<p>“Has this household ever been part of a quarantine area?”</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p style="text-align: right;">Yes <b>1</b></p> <p style="text-align: right;">No <b>0</b></p> <p style="text-align: right;">Don't know <b>77</b></p> <p style="text-align: right;">Refuse to answer <b>88</b></p>	
A10		
<p>“<u>Today</u>, what are the MAIN sources of income / food for this household?”</p> <p>☐☐ <i>Select up to three and rank in order of importance.</i> ☐☐</p> <p style="text-align: center;"><input type="checkbox"/></p> <p style="text-align: center;"><input type="checkbox"/></p> <p style="text-align: center;"><input type="checkbox"/></p>	<p style="text-align: right;">Farming <b>A</b></p> <p style="text-align: right;">Fishing <b>B</b></p> <p style="text-align: right;">Livestock <b>C</b></p> <p style="text-align: right;">Petty trading <b>D</b></p> <p style="text-align: right;">Other trading and commercial activities <b>E</b></p> <p style="text-align: right;">Unskilled labour <b>F</b></p> <p style="text-align: right;">Professional <b>G</b></p> <p style="text-align: right;">Remittances and gifts from relatives and friends <b>H</b></p> <p style="text-align: right;">Cash transfers from government or NGOs <b>I</b></p> <p style="text-align: right;">Other (specify) <b>96</b></p> <p style="text-align: right;">_____</p> <p style="text-align: right;">Don't know <b>77</b></p> <p style="text-align: right;">Refuse to answer <b>88</b></p>	



A11		
<p>“<u>Before the Ebola crisis</u>, what were the MAIN sources of income / food for this household?”</p> <p>☐☐ <i>Select up to three and rank in order of importance.</i> ☐☐</p> <p style="text-align: center;"> <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/> </p>	<p style="text-align: right;">Farming <b>A</b></p> <p style="text-align: right;">Fishing <b>B</b></p> <p style="text-align: right;">Livestock <b>C</b></p> <p style="text-align: right;">Petty trading <b>D</b></p> <p style="text-align: right;">Other trading and commercial activities <b>E</b></p> <p style="text-align: right;">Unskilled labour <b>F</b></p> <p style="text-align: right;">Professional <b>G</b></p> <p style="text-align: right;">Remittances and gifts from relatives and friends <b>H</b></p> <p style="text-align: right;">Cash / food transfers from government or NGOs <b>I</b></p> <p style="text-align: right;">Other (specify) <b>96</b></p> <hr style="width: 50%; margin-left: auto; margin-right: 0;"/> <p style="text-align: right;">Don't know <b>77</b></p> <p style="text-align: right;">Refuse to answer <b>88</b></p>	
A12		
<p>“<u>Compared to before the Ebola crisis</u>, the amount of money that this household has is...”</p> <p>☐☐ <i>Read answers out loud.</i> ☐☐</p> <p style="text-align: center;"> <input type="checkbox"/> </p>	<p style="text-align: right;">Less money <b>1</b></p> <p style="text-align: right;">The same as before <b>2</b></p> <p style="text-align: right;">More money <b>3</b></p> <p style="text-align: right;">Don't know <b>77</b></p> <p style="text-align: right;">Refuse to answer <b>88</b></p>	

A13		
<p>“<u>Since the beginning of the Ebola crisis</u>, if this household was short on money, what things did you do to survive?”</p> <p>☐☐ <i>Select up to three and rank in order of importance.</i> ☐☐</p> <p style="text-align: center;">☐</p> <p style="text-align: center;">☐</p> <p style="text-align: center;">☐</p>	<p style="text-align: right;">Household was not short on money <b>A</b></p> <p style="text-align: right;">Cope with less money <b>B</b></p> <p style="text-align: right;">Borrow money from family, friends, or neighbours <b>C</b></p> <p style="text-align: right;">Borrow money from money lender <b>D</b></p> <p style="text-align: right;">Borrow money from osusu <b>E</b></p> <p style="text-align: right;">Have adults in household do more paid work <b>F</b></p> <p style="text-align: right;">Have children in household do more paid work <b>G</b></p> <p style="text-align: right;">Other (specify) <b>96</b></p> <hr style="width: 50%; margin-left: auto; margin-right: auto;"/> <p style="text-align: right;">Don't know <b>77</b></p> <p style="text-align: right;">Refuse to answer <b>88</b></p>	
A14		
<p>“<u>Compared to before the Ebola crisis</u>, the number of meals per day that this household eats is...”</p> <p>☐☐ <i>Read answers out loud.</i> ☐☐</p> <p style="text-align: center;">☐</p>	<p style="text-align: right;">Less meals <b>1</b></p> <p style="text-align: right;">The same as before <b>2</b></p> <p style="text-align: right;">More meals <b>3</b></p> <p style="text-align: right;">Don't know <b>77</b></p> <p style="text-align: right;">Refuse to answer <b>88</b></p>	
A15		
<p>“<u>Compared to before the Ebola crisis</u>, the size of each meal that this household eats is...”</p> <p>☐☐ <i>Read answers out loud.</i> ☐☐</p> <p style="text-align: center;">☐</p>	<p style="text-align: right;">Smaller meals <b>1</b></p> <p style="text-align: right;">The same as before <b>2</b></p> <p style="text-align: right;">Bigger meals <b>3</b></p> <p style="text-align: right;">Don't know <b>77</b></p> <p style="text-align: right;">Refuse to answer <b>88</b></p>	

<b>A16</b>		
<p>“<u>Since the beginning of the Ebola crisis</u>, has any person <u>under-18 years old</u> in this household become pregnant?”</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>No under-eighteen females in the house <b>0</b> Specify number of under-18 pregnancies <b>1</b></p> <hr style="width: 80%; margin: 10px auto;"/> <p style="text-align: right;">No pregnancies <b>2</b> Don't know <b>77</b> Refuse to answer <b>88</b></p>	<p>→ Go to <b>A19</b></p> <p style="text-align: right;">} → Go to <b>A19</b></p>
<b>A17</b>		
<p>“<u>Since the beginning of the Ebola crisis</u>, has any person <u>under-18 years old</u> in this household given birth?”</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p style="text-align: right;">Specify number of under-18 births <b>1</b></p> <hr style="width: 80%; margin: 10px auto;"/> <p style="text-align: right;">No <b>0</b> Don't know <b>77</b> Refuse to answer <b>88</b></p>	<p style="text-align: right;">} → Go to <b>A19</b></p>
<b>A18</b>		
<p>“How many births to <u>under-18</u> year olds took place in a clinic or hospital?”</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p style="text-align: right;">None <b>0</b> If only some, please specify number <b>1</b></p> <hr style="width: 80%; margin: 10px auto;"/> <p style="text-align: right;">All <b>2</b> Don't know <b>77</b> Refuse to answer <b>88</b></p>	
<b>A19</b>		
<p>“<u>Since the beginning of the Ebola crisis</u>, has any person <u>over-18 years old</u> in this household given birth?”</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p>No over-eighteen females in the house <b>0</b> Specify number of over-18 births <b>1</b></p> <hr style="width: 80%; margin: 10px auto;"/> <p style="text-align: right;">No births <b>2</b> Don't know <b>77</b> Refuse to answer <b>88</b></p>	<p>→ Go to <b>A21</b></p> <p style="text-align: right;">} → Go to <b>A21</b></p>



<b>B0SCREENING</b>		
“Is there a under-eighteen child living in this household?”  <input type="checkbox"/>	Yes <b>1</b> No <b>0</b>	→ Go to <b>Section C</b>

**SECTION B: QUESTIONS FOR SELECTED UNDER-EIGHTEEN-YEAR-OLD CHILD**

“Now I would like to ask you some questions about one of your under-eighteen-year-old children. If there is more than one under-eighteen-year-old child in this household that you are the parent of, we will have to randomly select the child we will be asking you about.”

*▣▣ Conduct randomization exercise. ▣▣*

“When I ask you the following questions, I will be asking only about (NAME). Please answer them only about (NAME) and not about other children in this household or community.”

<b>B01</b>		
“How old is (NAME)?”  <input type="checkbox"/>	Specify age <b>1</b>  _____  Don't know <b>77</b> Refuse to answer <b>88</b>	
<b>B02</b>		
“Is (NAME) a girl or a boy?”  <input type="checkbox"/>	Girl <b>1</b> Boy <b>2</b>  Refuse to answer <b>88</b>	} → Go to <b>B04</b>
<b>B03</b>		
“ <u>Since the beginning of the Ebola crisis</u> , has (NAME) become pregnant?”  <input type="checkbox"/>	Yes <b>1</b> No <b>0</b>  Don't know <b>77</b> Refuse to answer <b>88</b>	
<b>B04</b>		
“ <u>In the last week</u> , did (NAME) do any kind of work for someone who is not a member of this household?”  <input type="checkbox"/>	Yes <b>1</b> No <b>0</b>  Don't know <b>77</b> Refuse to answer <b>88</b>	} → Go to <b>B07</b>

<b>B05</b>		
<p>“What type of work did (NAME) do?”</p> <p><b>☐☐ Select all that apply. ☐☐</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Agricultural work <b>1</b></p> <p>Small business <b>2</b></p> <p>Street selling <b>3</b></p> <p>Babysitting / caring for children <b>4</b></p> <p>Household work <b>5</b></p> <p>Manual labour <b>6</b></p> <p>Other (specify) <b>96</b></p> <hr/> <p>Don't know <b>77</b></p> <p>Refuse to answer <b>88</b></p>	
<b>B06</b>		
<p>“In the last week, how many hours did (NAME) spend doing work for someone who is not a member of this household?”</p> <p><b>☐☐ Read answers out loud. ☐☐</b></p> <p><input type="checkbox"/></p>	<p>Less than 1 hour <b>A</b></p> <p>1-4 hours <b>B</b></p> <p>5-7 hours <b>C</b></p> <p>8 or more hours <b>D</b></p> <p>Don't know <b>77</b></p> <p>Refuse to answer <b>88</b></p>	
<b>B07</b>		
<p>“In the last week, did (NAME) help with household chores like shopping, collecting firewood, cleaning, fetching water, or caring for children?”</p> <p><input type="checkbox"/></p>	<p>Yes <b>1</b></p> <p>No <b>0</b></p> <p>Don't know <b>77</b></p> <p>Refuse to answer <b>88</b></p>	<p>} → <b>Go to B09</b></p>
<b>B08</b>		
<p>“In the last week, how many hours did (NAME) spend helping with household chores like shopping, collecting firewood, cleaning, fetching water, or caring for children?”</p> <p><b>☐☐ Read answers out loud. ☐☐</b></p> <p><input type="checkbox"/></p>	<p>Less than 1 hour <b>A</b></p> <p>1-4 hours <b>B</b></p> <p>5-7 hours <b>C</b></p> <p>8 or more hours <b>D</b></p> <p>Don't know <b>77</b></p> <p>Refuse to answer <b>88</b></p>	

B09		
<p>“In the last week, did (NAME) do any other family work on the farm or business or selling goods in the street?”</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p style="text-align: right;">Yes 1 No 0 Don't know 77 Refuse to answer 88</p>	<p>→ Go to <b>B11</b></p>
B10		
<p>“In the last week, how many hours did (NAME) spend doing any other family work on the farm or business or selling goods in the street?”</p> <p>▣▣ <i>Read answers out loud.</i> ▣▣</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p style="text-align: right;">Less than 1 hour <b>A</b> 1-4 hours <b>B</b> 5-7 hours <b>C</b> 8 or more hours <b>D</b> Don't know 77 Refuse to answer 88</p>	
B11		
<p>“Last year, did (NAME) attend school?”</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p style="text-align: right;">Yes 1 No 0 Don't know 77 Refuse to answer 88</p>	<p>→ Go to <b>B13</b></p>
B12		
<p>“What is the highest grade (NAME) has ever <u>attended</u>?”</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p style="text-align: right;">Specify grade 1</p> <hr style="width: 60%; margin: 0 auto;"/> <p style="text-align: right;">Don't know 77 Refuse to answer 88</p>	
B13		
<p>“Do you plan to send (NAME) to school in the next school year?”</p> <p style="text-align: center;"><input type="checkbox"/></p>	<p style="text-align: right;">Yes 1 No 0 Don't know 77 Refuse to answer 88</p>	<p>→ Go to <b>B15</b></p>

<b>B14</b>		
<p>“What is the MAIN reason (NAME) will not be attending school next year?”</p> <div style="border: 1px solid black; width: 40px; height: 40px; margin: 20px auto;"></div>	<p style="text-align: right;">Child is too young for school <b>0</b></p> <p style="text-align: right;">School is not important <b>1</b></p> <p style="text-align: right;">Cannot afford to send child to school <b>2</b></p> <p style="text-align: right;">Child helps on farm or in household <b>3</b></p> <p style="text-align: right;">Child is needed to earn money for household <b>4</b></p> <p style="text-align: right;">Child attends religious school instead <b>5</b></p> <p style="text-align: right;">Child is mistreated at school by teachers or classmates <b>6</b></p> <p style="text-align: right;">Child does not have proper clothes or supplies <b>7</b></p> <p style="text-align: right;">School is too far <b>8</b></p> <p style="text-align: right;">School is too difficult <b>9</b></p> <p style="text-align: right;">Other (specify) <b>96</b></p> <hr style="width: 30%; margin: 10px auto;"/> <p style="text-align: right;">Don't know <b>77</b></p> <p style="text-align: right;">Refuse to answer <b>88</b></p>	

**B15 – B19**

“All adults use certain ways to teach children the right behavior or to correct a behavior problem. I will read various methods that are used and I want you to tell me if you or anyone else in your household has used this method with (NAME) in the past month.”

<i>Place a 'X' in response cell for each statement.</i>				
<i>Do not know: 77; refuse to answer: 88.</i>				
	Yes <b>1</b>	No <b>0</b>	Don't know <b>77</b>	Refuse to Answer <b>88</b>
<b>B15</b>	“ <u>In the last month</u> , when (NAME) has done something wrong, you or somebody in this household has <i>called him/her dumb, lazy, or another name like that?</i> ”			
<b>B16</b>	“ <u>In the last month</u> , when (NAME) has done something wrong, you or somebody in this household has <i>shouted, yelled, or screamed at him/her?</i> ”			
<b>B17</b>	“ <u>In the last month</u> , when (NAME) has done something wrong, you or somebody in this household has <i>slapped him/her on the bottom with a bare hand?</i> ”			
<b>B18</b>	“ <u>In the last month</u> , when (NAME) has done something wrong, you or somebody in this household has <i>slapped him/her on the face, head, arm, or leg?</i> ”			
<b>B19</b>	“ <u>In the last month</u> , when (NAME) has done something wrong, you or somebody in this household has <i>hit him/her on the body with something like a belt, a stick, or other hard object?</i> ”			





**SECTION C: QUESTIONS ABOUT HOUSEHOLD AND COMMUNITY HEALTH AND WELLBEING**

“Now I would like to ask you some more questions about life in this household and community.”

<b>C01</b>		
“In many houses there are people living with HIV/AIDS, is there somebody like this living in this household?”  <input type="checkbox"/>	Yes 1 No 0 Don't know 77 Refuse to answer 88	} → Go to <b>C04</b>
<b>C02</b>		
“ <u>In the last three months</u> , has that person received his/her anti-retroviral treatment?”  <input type="checkbox"/>	Yes 1 No 0 Don't know 77 Refuse to answer 88	→ Go to <b>C04</b>
<b>C03</b>		
“Why did this person did not get his/her anti-retroviral treatment?”  <input type="checkbox"/>	No drugs available 1 No money for drugs 2 No access to clinic or hospital 3 Other (specify) 96 _____ Don't know 77 Refuse to answer 88	
<b>C04</b>		
“ <u>In that last three months</u> , has somebody in this household had any illness (other than HIV/AIDS)?”  <input type="checkbox"/>	Yes 1 No 0 Don't know 77 Refuse to answer 88	} → Go to <b>C08</b>
<b>C05</b>		
“What kind of illness was it?”  <input type="checkbox"/>	Specify illness 1 _____ Don't know 77 Refuse to answer 88	

C06					
"What is the MAIN place that person got treatment?"  <input type="checkbox"/>	Person received no treatment <b>0</b> Peddlers <b>1</b> Spiritual healer <b>2</b> Clinic or hospital <b>3</b> Pharmacy <b>4</b> Other (specify) <b>96</b>  _____				
	Don't know <b>77</b> Refuse to answer <b>88</b>				
C07					
"What is the main reason the person chose this treatment option?"  <input type="checkbox"/>	Specify reason <b>1</b>  _____				
	Don't know <b>77</b> Refuse to answer <b>88</b>				
C08 – C12					
"I will now read you a number of statements. Please select the response on this scale that best describes your opinion of each situation."  <p style="text-align: center;">▣▣ Read the scale out loud. ▣▣</p>					
<b>1</b>		<b>2</b>		<b>3</b>	
<b>Less trust</b>		<b>Same as before</b>		<b>More trust</b>	
▣▣ Place a 'X' in response cell for each statement.  Do not know: 77; refuse to answer: 88. ▣▣				<b>1</b>	<b>2</b>
				<b>3</b>	<b>77</b>
				<b>88</b>	
<b>C08</b>	"Compared to before the Ebola crisis, your trust in other people in this community is..."				
<b>C09</b>	"Compared to before the Ebola crisis, your trust in health facilities is..."				
<b>C10</b>	"Compared to before the Ebola crisis, your trust in police is..."				
<b>C11</b>	"Compared to before the Ebola crisis, your trust in courts is..."				
<b>C12</b>	"Compared to before the Ebola crisis, your trust in government is..."				



C13		
<p>“<u>Today</u>, what are the MAIN concerns for this community?”</p> <p>☐☐ Select up to three and rank in order of importance. ☐☐</p> <p style="text-align: center;">☐</p> <p style="text-align: center;">☐</p> <p style="text-align: center;">☐</p>	<p>There are no issues or concerns <b>A</b></p> <p>Education (lack of or inadequate) <b>B</b></p> <p>Healthcare (lack of or inadequate) <b>C</b></p> <p>Transportation (lack of or inadequate) <b>D</b></p> <p>Employment (lack of or inadequate) <b>E</b></p> <p>Clean water (lack of or inadequate) <b>F</b></p> <p>Food (lack of or inadequate) <b>G</b></p> <p>Housing (lack of or inadequate) <b>H</b></p> <p>Electricity (lack of or inadequate) <b>I</b></p> <p>Sanitation (lack of or inadequate) <b>J</b></p> <p style="text-align: right;">Other (specify) <b>96</b></p> <hr style="width: 50%; margin-left: auto; margin-right: auto;"/> <p style="text-align: right;">Don't know <b>77</b></p> <p style="text-align: right;">Refuse to answer <b>88</b></p>	
C14		
<p>“<u>Before the Ebola crisis</u>, what were the MAIN concerns for this community?”</p> <p>☐☐ Select up to three and rank in order of importance. ☐☐</p> <p style="text-align: center;">☐</p> <p style="text-align: center;">☐</p> <p style="text-align: center;">☐</p>	<p>There were no issues or concerns <b>A</b></p> <p>Education (lack of or inadequate) <b>B</b></p> <p>Healthcare (lack of or inadequate) <b>C</b></p> <p>Transportation (lack of or inadequate) <b>D</b></p> <p>Employment (lack of or inadequate) <b>E</b></p> <p>Clean water (lack of or inadequate) <b>F</b></p> <p>Food (lack of or inadequate) <b>G</b></p> <p>Housing (lack of or inadequate) <b>H</b></p> <p>Electricity (lack of or inadequate) <b>I</b></p> <p>Sanitation (lack of or inadequate) <b>J</b></p> <p style="text-align: right;">Other (specify) <b>96</b></p> <hr style="width: 50%; margin-left: auto; margin-right: auto;"/> <p style="text-align: right;">Don't know <b>77</b></p> <p style="text-align: right;">Refuse to answer <b>88</b></p>	

“Thank you for speaking with me today. The interview has now been completed. Do you have any questions regarding the interview

**Q06** Enter Interview End Time | \_\_\_\_ \_\_\_\_ : \_\_\_\_ \_\_\_\_ |

**COMMENTS ABOUT SURVEY (IF NOT COMPLETED, STATE WHY NOT)**

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**COMMENTS SPECIFIC QUESTIONS (PLEASE NOTE QUESTION NUMBER WITH COMMENTS)**

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**OTHER COMMENTS**

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## **Annex C: FGD Guide for BRAC EVD Assessment**

### **INTRODUCTION**

Hello. Thank you for meeting with us today. My name is \_\_\_\_\_ and I am working with BRAC, an international organization working in Sierra Leone. We are conducting an assessment in this district about the effects of the Ebola virus. We would very much appreciate your participation in this discussion. We are having discussions like this with many different people in district, including: health workers, community leaders, farmers, traders, girls, and parents to find out more about the effects of Ebola.

The discussion will last about one hour. Your name will be kept strictly confidential and will not be shown to other persons.

Your answers will be kept strictly confidential and will not be shown to other persons and we will not link your name to any answers. We cannot provide you with any direct benefits for your household, or promise any specific development for your community. We can give you some refreshments for your participation today.

We are gathering data to better understand the situation in your community and in this district. We will make sure that what you tell us today will be communicated to BRAC and its partners so that they can try to help communities such as this one.

We thank you for your participation.

Do you have any questions about any of the things that I just mentioned?

- If **YES**, answer all participants' questions and continue.
- If **NO**, continue to **CONSENT**.

### **CONSENT**

Participation in this focus group is completely voluntary. If I ask any question you do not want to answer, let me know and you will not have to answer. You can end your participation in the focus group at any time.

However, I hope you will participate since your views are very important to understanding how we can improve the lives of young children in this community and others like it.

Did the respondents give consent?

YES → **GROUND RULES**  
NO → **END**

▣ At the end of each FGD, please check the notes with both the notetaker and facilitator, to fill in any missing information. ▣

## **FURTHER INTRODUCTION AND GROUND RULES**

Facilitator should introduce themselves and the notetaker, and explain why they are taking notes and what is being noted.

Participants should introduce themselves.

Conduct an ice breaker.

Have participants set ground rules, for example:

- One person speaks at a time
- Raise hand to be recognized
- Let everybody speak
- Respect others' opinions
- Turn off phones
- No talking to person beside you
- One person speaks at a time

## **EXPLAIN HOW QUESTIONS WILL BE ASKED**

"I am going to ask you several questions. I will ask everyone about their opinions for each question. You will have the option to you chose that answer and discuss how you may agree or disagree with others in the group. Sometimes I will ask follow-up questions."

## **QUESTIONS TO ASK IN ORDER TO HELP DISCUSSION**

★★ *Do not read these follow-up questions. They are for reference only.* ★★

You can ask the following questions to help discussion:

- How is that so?
- Why is that so?
- What are the consequences of this for the future?
- Can you explain what you mean?
- Does everybody agree with this?
- Are there any other things about this topic that we have not mentioned?



**HEALTH**

★★ *In communities where there are no hospitals/clinics, try to interview CHWs and other community actors involved in health development.* ★★

FGD of 6-8 people, which includes some of the following people: OIC, Certified Midwife, Nurse, vaccinators, community health workers, etc.

1. What have been some of the MAIN ways that the people in this community were affected by the Ebola crisis?
  - Which have been the biggest effects?
  - What are the future consequences of the effects mentioned?
2. Has the Ebola crisis affected the availability of health services in this community?
  - The supply of what types of health services have been most affected?
  - How has this affected health of people in the community?
3. Has the Ebola crisis affected how much people go to the clinic/hospital to seek services?
  - What types of health services are people more/less likely to seek from the clinic/hospital?
  - If people are not less likely to go to clinic/hospital, where do they go instead?
4. Has the health of children been particularly affected?
  - In what ways have children been particularly affected?
  - In what ways have teenage girls been particularly affected?
5. Has the Ebola crisis changed the likelihood that people go to clinic/hospital for maternal, newborn, and child health services?
  - Why are people more/less likely to go to clinic/hospital for maternal, newborn, and child health services?
  - Where are people going instead for healthcare?
6. Are there government or NGO groups that are NOW providing health programmes to the people of this community currently?
  - What groups are assisting?
  - What types of health services have these groups been giving?
7. What types of health programmes are STILL most needed to assist the people of this community after the Ebola crisis?
8. Given all the topics we have discussed, is there anything else anybody would like to add?

**RURAL FOOD SECURITY / LIVELIHOODS**

★★ *Only conducted in rural areas.* ★★

FGD of 6-8 people, which includes: farmers.

1. What have been some of the MAIN ways that the people in this community were affected by the Ebola crisis?
  - Which have been the biggest effects?
  - What are the future consequences of the effects mentioned?
2. What are the MAIN ways that farmers and farming activities have been affected?
  - In what ways have farmers managing?
  - What crops have been most affected and why?
3. In what ways has the Ebola crisis affected the production of farm goods?
  - Has it affected the access to land, tools, seeds, or any other thing like that?
  - Have farmers used any coping mechanisms against the effects on the production of farm goods?
4. In what ways has the Ebola crisis affected the harvest of farm goods?
  - What crops have been most affected and why?
  - Ability to work together to harvest crops?
  - Have farmers used any coping mechanisms to mitigate the effects on the harvest of farm goods?
  -
5. In what ways has the Ebola crisis affected people's ability to bring farm goods to market?
  - What crops have been most affected and why?
  - What have farmers been doing with their crops, if they cannot sell them?
6. Are there government or NGO groups that are NOW assisting farmers of this community currently?
  - What groups are assisting?
  - What types of help have these groups been giving?
7. What types of programmes are STILL most needed to assist the farmers of this community after the Ebola crisis?
8. Given all the topics we have discussed, is there anything else anybody would like to add?

## **URBAN FOOD SECURITY / LIVELIHOODS**

★★ *Only conducted in urban areas.* ★★

FGD of 6-8 people, which includes: petty traders.

1. What have been some of the MAIN ways that the people in this community were affected by the Ebola crisis?
  - Which have been the biggest effects?
  - What are the future consequences of the effects mentioned?
2. What are the groups in this community that have been most affected by the Ebola crisis?
  - In what ways have these groups been affected?
  - What are people doing to manage?
3. Are there some forms of trading that have been affected more than others?
  - Which types of trading are most affected and why?
  - For those most affected, how have they managed?
4. In what ways has the Ebola crisis affected the ability to secure financing?
  - For people that are not able to access capital, how are they managing?
5. In what ways has the Ebola crisis affected the ability to bring goods to market?
6. Are there government or NGO groups that are NOW assisting traders and small business people of this community currently?
  - What groups are assisting?
  - What types of help have these groups been giving?
7. What types of programmes are STILL most needed to assist the traders and small business people of this community after the Ebola crisis?
8. Given all the topics we have discussed, is there anything else anybody would like to add?

## **MIDDLEMEN AND MARKET WOMEN**

★★ *Only conducted in those areas where there are middlemen and market women.* ★★

FGD of 6-8 people, which includes some of the following people: middlemen and market women in communities.

1. What have been some of the MAIN ways that the people in this community were affected by the Ebola crisis?
  - Which have been the biggest effects?
  - What are the future consequences of the effects mentioned?
2. What are the groups in this community that have been most affected by the Ebola crisis?
  - In what ways have these groups been affected?
  - In what ways have these groups managed?
3. How has the Ebola crisis affected household food security and/or income among those working in markets?
  - In what ways are people managing?
4. How has the Ebola crisis affected market activities?
  - What types of activities have been most affected and why?
  - In what ways are people managing?
5. Are there government or NGO groups that are NOW assisting middlemen and market women of this community currently?
  - What groups are assisting?
  - What types of help have these groups been giving?
6. What types of programmes are STILL most needed to assist the farmers of this community after the Ebola crisis?
7. Given all the topics we have discussed, is there anything else anybody would like to add?

**PARENTS; INCLUDING FEMALE HEADED HOUSEHOLDS**

FGD of 6-8 people, which includes some of the following people: parents from the communities.

1. What have been some of the MAIN ways that the people in this community were affected by the Ebola crisis?
  - Which have been the biggest effects?
  - What are the future consequences of the effects mentioned?
2. What are the groups in this community that have been most affected by the Ebola crisis?
  - In what ways have these groups been affected?
  - In what ways have these groups managed?
3. Have children been more affected by the Ebola crisis?
  - In what ways have children been affected by the Ebola crisis more than other groups?
4. Are there groups of children that have been most affected?
  - Are there more children that have lost one, or both parents as a result of the Ebola crisis?
  - What are the effects of this on the wellbeing of these children?
5. Work at home:
  - Are children more likely to do work at home as a result of the Ebola crisis?
  - What are the effects of this on children?
6. Work outside the home:
  - Are children more likely to do work outside the home as a result of the Ebola crisis?
  - What are the effects of this on children?
7. What types of programmes are STILL most needed to assist the people of this community after the Ebola crisis?
8. Given all the topics we have discussed, is there anything else anybody would like to add?

**ADOLESCENT GIRLS**

FGD of 6-8 people, which includes some of the following people: girls 16-19-years-old from communities.

1. What have been some of the MAIN ways that adolescent girls in this community were affected by the Ebola crisis?
  - Which have been the biggest effects?
  - What are the future consequences of the effects mentioned?
2. What are the groups in this community that have been most affected by the Ebola crisis?
  - In what ways have these groups been affected?
  - In what ways have these groups managed?
3. Is there more teenage pregnancy than before the Ebola crisis?
  - Why is there more teenage pregnancy than before the Ebola crisis?
  - What are the effects of this on adolescent girls?
4. Work at home:
  - Are adolescent girls more likely to do work inside/outside the home as a result of the Ebola crisis?
  - What are the effects of this on adolescent girls?
5. Are adolescent girls more likely to engage in transactional sex as a result of the Ebola crisis?
  - Why is this happening?
  - What are the effects of this on adolescent girls?
6. What types of programmes are STILL most needed to assist adolescent girls after the Ebola crisis?
7. Given all the topics we have discussed, is there anything else anybody would like to add?

**COMMUNITY LEADERS**

FGD of 6-8 people, which includes some of the following people: chiefs, other traditional leaders, elders, religious leaders, women's groups, youth groups, etc. from communities.

1. What have been some of the MAIN ways that the people in this community were affected by the Ebola crisis?
  - Which have been the biggest effects?
  - What are the future consequences of the effects mentioned?
8. What are the groups in this community that have been most affected by the Ebola crisis?
  - In what ways have these groups been affected?
  - In what ways have these groups managed?
2. How was the crisis affected people's trust in health facilities?
3. How was the crisis affected people's trust in government?
4. How was the crisis affected people's trust in police and courts?
5. Are there government or NGO groups that are NOW assisting the people of this community currently?
  - What groups are assisting?
  - What types of help have these groups been giving (health, WASH, education, livelihoods, food security, others)?
6. What types of programmes are STILL most needed to assist the people of this community after the Ebola crisis?
7. Given all the topics we have discussed, is there anything else anybody would like to add?

## **SUMMARY AND CONCLUSION**

At the end of each focus group, the facilitator should:

- Summarize MAIN points of the focus group discussion
- Reiterate confidentially

“Thank you for your time. Your help in this research is very important. We will do our best to ensure that these results are communicated to BRAC and its partners.”

★★ *At the end of each FGD, please check the notes with both the notetaker and facilitator, to fill in any missing information.* □ ★★