REPORT OF
THE MULTISECTOR IMPACT ASSESSMENT OF GENDER DIMENSIONS OF THE EBOLA VIRUS DISEASE (EVD)
IN
SIERRA LEONE

December, 2014

Ministry of Social Welfare, Gender and Children's Affairs

UN WOMEN
United Nations Entity for Gender Equality and the Empowerment of Women

OXFAM

STATISTICS SIERRA LEONE

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ABBREVIATIONS

ADBG	African Development Bank Group
ABC	Avoid Body Contact
A4P	Agenda for Prosperity
CSPro	Census and Survey Processing computer package
EVD	Ebola Virus Disease
FGM	Female Genital Mutilation
FGDs	Focus Group Discussion
GBV	Gender-Based Violence
GEWE	Gender Equality and Women's Empowerment
GII	Gender Inequality Index
MRU	Mano River Union
NERC	National Ebola Response Centre
SLDHS	Sierra Leone Demographic and Health Survey
SOWIES	Local Traditional Circumcisers in Sierra Leone
UNIPSIL	United Nations Integrated Peace building Mission
UNCT	United Nations Country Team
UNDAF	UN Development Assistance Framework
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women

ACKNOWLEDGEMENTS

This report is a collaborative effort of the Ministry of Social Welfare, Gender and Children's Affairs, UN Women Sierra Leone, OXFAM Sierra Leone and Statistics Sierra Leone who jointly partnered in order to generate national comprehensive data on the multi-sector impact of Ebola from a gender perspective to guide targeted and gender response to the containment of the Ebola Virus Disease in Sierra Leone.

The Partners would like to thank the following institutions and individuals for their invaluable contributions to the conceptualization, design,data collection, analysis and production of the study report. Distinguished gratitude go to:

The Minister of Social Welfare, Gender And Children's Affairs for his visionary Leadership and support in mobilizing exemplary participation from the technical and administrative arms of the Ministry from the central to the district levels in all regions of the country.

The Director of Gender Affairs, MSWGCA for technical input and supervision of the study from start to the end;

The Administrative and Technical teams in the Ministry of Social Welfare, Gender and Children's Affairs; Statistics Sierra Leone, UN Women, Oxfam GB who worked diligently round the clock in conceptualizing the need for the study; designing and testing the study tools; training the enumerators; supervising data collection, analysis and disaggregation by sex and production of the report.

The United Nations Country Team under the Leadership of its Resident Coordinator, Mr David McLachlan-Karr for his unwavering and exemplary leadership, advocacy role and support for Gender Responsiveness in all UN programmes and methodologies and for lending his support to the study conceptualization and design;

Mr Philip Dive in the Office of the Resident Coordinator for his technical role in advocating for the need to ensure gender responsiveness in EVD response in Sierra Leone and for reading and providing input into the draft study report;

Mr Andrew McGregor, in the Office of the Resident Coordinator for ensuring that the study design observed human rights of respondents in regards to confidentiality and the right to chose to participate or not;

Ms Linda-Marie Bladvall in the office of the Resident Coordinator for logistical and technical support in the process of project conceptualization and design;

Ms Letitia Belford, for logistical and management support in ensuring that the study team accessed the Office of the resident Coordinator;

NERC Corporate Administration for facilitating the issuance of travel permits to the Districts for the Study implementers and for the dissemination of the findings to the NERC Situation Room;

UNMEER and NERC for their contribution to the study design and facilitating the processing and conveyance of letters of introduction of the enumerators to the District EVD Coordinators at the height of EVD outbreak in Sierra Leone;

UNMEER Advisory Board for technical inputs, guidance and connecting the study team with women traditional leaders;

Ms Memuna Pratt for in-depth literature review which informed thisstudy design and corroboration of the study findings with other studies on EVD in Sierra Leone, Uganda and DRC;

Development Partners Gender Reference Group for the support and input into the study design as well as during the dissemination of the preliminary findings of the study;

Special recognition and appreciation go to the Policy and Administrative arms of the Ministry of Social Welfare, Gender and Children's Affairs in supporting the study design. The following individuals and teams significantly supported the successful design, implementation and analysis of the data including the preparation of the report:

Hon Alhaji Moijue Kaikai, Minister for Social Welfare, Gender and Children's Affairs; Mr Charles Vandi, the Director of Gender Directorate MSWGCA; Mr Joseph T Kanu, Permanent Secretary (MSWGCA); Mr Mohamed King Koroma, Statistician General, SSL; Dr Mary Okumu, UN Women Representative (SLE); Ms Baindu Massaquoi, Programme Specialist (Gender, Human Rights and Governance)- UN Women; Mr Marbey Sartie, Programme Specialist (Strategic Planning, Policy, Sustainable Development); Ms Naheed M. Ahmed, Programme Specialist (Gender Equality and Women's Empowerment)-UN Women; Mr Simon Opolot, GENCAP Advisor- UNCT/UN Women; Ms Emma Vincent (Communications Officer); Mr Lamin Bangura, Finance Associate, UN Women, Mr Allieu Bangura, Admin and Programmes Associate UN Women: Ms Blerta Aliko, Gender Advisor, Humanitarian Action-UN Women New York.Ms Puk Ovesen, Programme Specialist, Gender and Humanitarian Action,

Tess Dico-Young, Global Gender Adviser Humanitarian- Humanitarian Dept.Oxfam GB, Ms Thynn Thynn Hlaing, Country Director, Oxfam Sierra Leone, for technical and financial support to the Study.

Special thanks go to:

H.E. The First Lady of Sierra Leone Madam Sia Nyama Koroma for championing advocacy on the need to involve traditional leadership mechanisms in the fight against Ebola and for convening and chairing inter- agency consultations on gender and EVD Response and supporting the study design consultation teams;

Mr Peter Bangura, Director of the Demographic and Social statistics Division(SSL) for his role in supervising data analysis and report production;

Ms Finda Koroma, Independent Consultant who facilitated technical consultations with various stakeholders and contributed data on impact of EVD on maternal health in DRC and provided comparative analysis of EVD since the early outbreaks.

Ms Alimatu Vandi, Assistant Statistician -SSL contributed to the developed of the study tools; training of enumerators; field Supervision of data collection and analysis and production of the report;

Mr Francis Tommy, Senior Statistician, SSL for his role in the study design and supervision of data collection and report production;
Mr Sallieu Mansary, Assistant Statistician – SSL for his role in training of enumerators and field Supervision of data collection, analysis and report production;

Mr Abdulai H. Kamara, Assistant Statistician- SSL for his role in training of enumerators and field Supervision of data collection, analysis and report production;

Ms Wairimu Munyinyi Wahome, Country Advocacy& Campaigns Manager, Oxfam Sierra Leone for project, design and supervision of data collection and report production;

Ms Konima Bobor - Kamara, National Advocacy & Campaigns Officer, Oxfam Sierra Leone for her role and contribution to the study design, supervision of data collection and report preparation

Mr Nicholas Jonga- Programme Specialist (Research, Information and Data Management) - UN Women for his pivotal role in data analysis and final report production.

The Enumerators and Data Collection Supervisors who collected the data. We salute you and pay a special tribute and gratitude to you for selflessly serving the country by going out into the field to collect the data at the height of the EVD outbreak in all the districts taking a great risk; Your exemplary commitment is in record for the service to country.

To our Donors who generously funded the Study through UN Women Headquarters and Oxfam GB; a BIG Word of Appreciation.

Ministry of Social Welfare, Gender and Children's Affairs, UN Women,Country Office-Sierra Leone, Statistics Sierra Leone, Oxfam GB/Sierra Leone.

December 31,2014.

FOREWORD

In the face of adversity such as the crisis of the Ebola Virus Disease (EVD) which has dealt a heavy blow to the Republic and the people of Sierra Leone; and the efforts to urgently respond to the epidemic, all systems have been activated to stop the disease in Sierra Leone.

Whereas projections were made based on epidemiological modeling on the possible cumulative number of EVD cases, at the time, it appeared a little remote and no one could have imagined that the disease would killed so many people and the disease stay the duration it has. More than ten thousand cumulative cases of EVD have been recorded with close to three thousand confirmed deaths due to Ebola.

Given the virulence of the Ebola Virus Disease properties, virulence and scope, focus of the national EVD response was to prevent infection, rapidly identify and safely transfer suspected Ebola cases for prompt management which concomitantly addressing the socio-cultural factors propagating its spread through the six Pillars (Case Management/Laboratory Services, Social Mobilization;Surveillance /Contact Tracing, Coordination and Logistical Support, Food Security and Nutrition, Psychosocial Counselling, Gender and Child Protection) of EVD Response. In doing so, the government and development partners as well as civil society actors and the Traditional Leadership structures were all mobilized each bring to bear their respective expertise and resources.

As important as the specific Pillar Targeted responses were Protocols, Methodologies and Processes in the national EVD Response. To this end, the government through the Leadership of the Ministry of Social Welfare, Gender and Children's Affairs in partnership with UN Entity for Gender, (UN WOMEN), OXFAM GB-Sierra Leone and Statistics Sierra Leone designed and executed the Multi-sector Gender Dimensions Impact Assessment of the Ebola Virus Disease on the people of Sierra Leone in order to better understand the gender dimensions and impact of EVD on men, women, boys and girls so that gender responsive and specifically targeted interventions could be designed and implemented. To this end, the government of the republic of Sierra Leone is pleased to avail this Report to the EVD national Response actors and stakeholders as a tool that will inform EVD national response towards Getting to Zero and towards EVD Early Recovery Measures.

The government is grateful to the partners, the enumerators and to the respondents who so selflessly collaborated in generating this comprehensive set of gender/sex disaggregated data.

As the Minister of Social Welfare, Gender and Children's Affairs, I on behalf of the government of the Republic of Sierra Leone am pleased to release and avail this Report to all of you for better programming in achieving gender responsive EVD prevention, control and elimination in Sierra Leone.

For and on behalf of the government of the republic of Sierra Leone

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Hon Moijue Kaikai, Minister for Social Welfare, Gender and Children's Affairs
This Day December 31, 2014, Freetown, Sierra Leone

STATEMENT OF AFFIRMATION AND SOLIDARITY IN ACHIEVING GENDER RESPONSIVENESS IN ALL HUMANITARIAN ACTION AND DEVELOPMENT PROGRAMMING INCLUDING ELIMINATING EVD IN SIERRA LEONE

Since theFourth World Conference on Women held in Beijing in 1995, gender equality became internationally accepted and advanced indivisible human rights principle with the strategy for achieving it commonly referred to as and gender mainstreaming.

Recalling that UN member states and governments committed themselves to creating enabling environments as well as enacting supportive legislations and policies for achieving Gender Equality in their own countries as an affirmation of the centrality of Gender equality to state stability and progress; the commitments have been reiterated in several international agreements, regional and national instruments such as the Monterey Consensus (2002); the OECD High Level Aid Effectiveness Forum at which the Paris Declaration was adopted (2005) and which commits 0.7% of all Overseas development Assistance (ODA) to financing Gender Equality Goals; the Doha Declaration on Financing for development (2008) also reaffirm the centrality of Gender Equality to Equitable and Sustainable Development; the Accra Agenda for Action (AAA) (2008) emphasizes Gender Equality and the need for governments to account for the rights of women; the Africa Union Nairobi Declaration on the African Women's decade (2010-2020) which emphasizes the need to establish National Institutional Mechanisms for mainstreaming gender in all policies and programmes and the protection of women's rights;the *New Deal for Engagement in Fragile States* that was endorsed by partner countries and donors at the Fourth High Level Forum on Aid Effectiveness held in Bussan(2011) and also affirmed Financing for Gender Equality.

In Sierra Leone, in 2007, the enactment of triple Gender Laws (The Domestic Violence Act) outlawing domestic violence; the Devolution of Estates Act (that established the rights of women in relation to inheritance; and the enactment of the Registration of Customary Marriages and Divorce Act) were an important step and attestations in improving the status of women and ensuring greater protection for women and girls against violence in the home and community across Sierra Leone. The passage of these Bills and enactment into law was widely seen as government strong commitment to Gender equality. These Acts are operationalized through the National Strategy for the Empowerment of Women.

As the United Nations Resident Coordinator, through the United Nations Country Support Team (UNCT), we have ensured that all the Ebola Response interventions have incorporated gender responsiveness in all the EVD Response Pillars as defined in the Sierra Leone UNCT Gender Mainstreaming Strategy for Ebola Response.

It gives great pleasure through this Report to note that the UN system in Sierra Leone will continue its unwavering commitment to Gender Equality Goals and highly congratulate the Government of the Republic of Sierra on its leadership role through this Report in generating gender/sex disaggregated data. The empirical data and knowledge generated on the specific gender related concerns in Ebola Virus Disease will inform the EVD Response in this second phase of the response. The United Nations will continue to work closely with the government and Development Partners as well as Civil Society Organizations in an accelerating the efforts of “Kicking Ebola Out of Salone so that Together”, we can get back on track in supporting the country to get back on its feet in meeting the needs of its people.

I join the Minister of Social Welfare, Gender and Children's Affairs and our UN Teams in supporting the release of this Report and urging its urgent application in informing the Getting to Zero and Early Recovery work.

.....
David McLachlan -Karr
UN Resident Coordinator
UN, Sierra Leone

December 31, 2014

WALKING THE TALK: MOVING FROM THEORY TO PRACTICALITY IN ACHIEVING GENDER RESPONSIVE INTERVENTIONS IN EBOLA PREVENTION, INFECTION CONTROL AND TARGETED MANAGEMENT

The United Nations Entity for Gender, Statistics Sierra Leone and Oxfam GB-Sierra Leone each provided their technical expertise in the conceptualization, design and execution of this assessment which converged to generate gender/sex disaggregated data.

Through this partnership, practical tools and processes for generating sex/gender disaggregated data were developed in supporting the implementation of the globally agreed commitments contained in the numerous outcomes of the global international instruments and Declarations on gender Equality. By supporting this vital impact assessment from a gender perspective, the partners have contributed not only to the primary objective of generating sound empirical data and knowledge on the gender dimensions of Ebola virus Disease but have also generated new tools, methodologies and processes which will go to refine the EVD interventions. In this way, the partners have also contributed to the broader goals of strengthening mutual accountability for gender equality commitments and responsibilities.

In undertaking the Joint Assessment through a Partnership Framework, we have enhanced institutional and staff capacity; we have demonstrated that together we are stronger and better; we have demonstrated better resource management through rationalization and joint ownership and mutual accountability to each other and also to the citizens which is the focus of all Development assistance. In the progress of negotiated corporate arrangement and thoroughly coordinated front we were able to put aside our individual organizational identifications and flags for the common good the contribution towards the overall goal of achieving gender responsive interventions in Ebola prevention, control and management. The joint planning and study design, data collection and analysis all the principles of mutual accountability, coherence and results/evidence base were achieved. This means gender programming tools and processes when deliberately and openly applied can be practically achieved. The partners feel privileged to have worked together in generating the first of its kind, rich and accessible data which will speak to addressing gaps in many sectors' planning needs in relation to Gender and EVD Response.

Through this study, we have walked our Talk-- Demonstrating our individual corporate institutional and collective commitment to and expertise in Gender Equality programming.

Like the Minister for Social Welfare, Gender and Children's Affairs and the UN Resident Coordinator, We would like to join hands in conveying the data to all potential users in the rush to get to Zero Ebola cases in Salone as we look forward to joining other stakeholders in the next phase -the ardours journey to Post Ebola recovery.

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Dr Mary Y Okumu
Representative, UN Women, Sierra Leone Country Office

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Thynn Thynn Hlaing, Country Director, Oxfam GB/Sierra Leone

_____

Mr Mohamed King Koroma, Statistician General, SSL

December 31, 2014

EXECUTIVE SUMMARY

The first Ebola outbreak in West Africa was reported in December 2013[i], in Guéckédou, a forest area of Guinea near the border with Liberia and Sierra Leone and by March 2014, Liberia had reported eight suspected cases. On Monday 25th May 2014, the Government of Sierra Leone through the Ministry of Health and Sanitation declared an outbreak of Ebola Virus Disease in Sierra Leone following the laboratory confirmation of a suspected case from Kailahun district.[1]. The EVD crisis continues to have unimaginable and colossal impact on human lives in the affected countries of West Africa including Sierra Leone.

In Sierra Leone, as of December 31st 2014, there were 9605 cumulative cases of Ebola with 7458 confirmed EVD cases; of which 2801 were cumulative deaths with 2435 asconfirmed EVD deaths[2], reflecting the colossal impact on EVD in the country.

The government of Sierra Leone represented by the lead line Ministry on behalf of the National Gender Machinery, the Ministry of Social Welfare, Gender and Children's Affairs in partnership with, UN Women, Statistics Sierra Leone and Oxfam GB, conducted a national comprehensive Multi-Sectoral Study to examine,identify, understand and quantify the gender differential impact of EVD on women, men, boys and girls closely examining the issues around vulnerability and its underlying factors and drivers, the various contexts and circumstances under which the infection transmission occur and the life experiences of women, men, boys and girls since the outbreak of EVD in the country to-date and to understand, document and share data on coping mechanisms of women, men, boys and girls particularly at household level.

Two thousand seven hundred and eighty-eight (2788) post-quarantined households were studied out of the targeted 3000 households, yielding a response rate of 93percent. All post-quarantined households that were successfully interviewed had a total 16,520 persons, of which 52.9% were females.The Assessment covered all the 14 districtsof Sierra Leone.Quantitative and qualitative data collection methodologies including key informant interviews and focus group discussions were used.

Key findings

EVD Infection rate by gender

In Sierra Leone, using gender lens, to follow the chain of EVD transmission and to analyze the transmission,the study established that women have been more infected by EVD than men reflecting a sex differential incidence statusof 56.7%for femalesand 43.3%for malesrespectively. This disproportionate sex differential finding relates to the social risk factors for women attributable to their care giving role within the family and community which increases their vulnerability to EVD infection.This differentiated impact is traced to socially prescribed gender norms and behavior that perpetuate gender inequality; the gendered division of labour between men and women; and

[1] Source: WHO, Report to United nations Country Team (UNCT) Meeting May,
[2] Source: WHO Daily Situation Report Sitrep), Sierra Leone; December 31, 2014.

gender-related differences in access to and control over productive resources including access to information on EVD prevention. In thecontext of EVD outbreak in Sierra Leone,unprecedented challenge is evidenced by this finding in relation to the national goal achieving protection of women and girls in the context of ensuring gender equality and women's empowerment. For example, the pre-existing ***unpaid care work***of women at household and community levels as well as the gendered division of labour have led to women bearing the brunt of the EVD outbreak as supported by empirical data from this study.

Socio-cultural determinants and drivers of EVD transmission from a gender perspective

Traditionally, little attention is given to sex and gender differences in infection prevention and control, (with the general assumption that infectious disease affect both male and female). This view was also reflected by respondents in the study further revealing a gap in understanding the behavioural and social contexts of disease aetiology. In their views, 99% of informants did not associate high infection rate of EVD amongst females to their social and other care giving roles including care for the sick in the family, washing and treating the dead for burial, fending for food, water and fire wood as well as playing a key role in the traditional healer role of women in the household and community.

In relating to their experiences reflectively, the respondents attributed the EVD causal factors to curses/mystical realms which they could not explain and the fact that men and women, boys and girls died (in their minds in equal numbers, the sex/gender differential vulnerabilities and ensuing cumulative impact was not obvious to them. From their perspectives, it would seem sufficient to only focus on public health interventions during an outbreak control, case management and treatment. However, from technical expertise,applying gender ***lens*****,** we understand the need to identify, understand and address gender inequalities pre, during and post EVD outbreaks which this study noted. This is because socio-cultural determinants such as behaviour (anthropological underpinnings) closely interact with and inform aetiology and epidemiology as it has in the case of the EVD.

Impact of Ebola Crisis on Structural and Pre-existing Social and Economic Vulnerabilities

The assessment revealed the disproportionate risk of infection and mortality between women and men from EVD (see Figure 3 below), which according to the assessment indicates that more females were infected. This differentiated impact is traced to gender norms and behaviour that perpetuate gender inequality. Because of this, the EVD outbreak poses an unprecedented challenge in the overall achievement of gender equality and women's empowerment.

Meanwhile, the assessment found the EVD has brought about sharp decline in maternal and child health indicators. With medical facilities overwhelmed and the prevailing mistrust of health services and the fear of contracting EVD, the health seeking behaviour of affected communities generally, and of women in particular, has been negatively impacted.

According to the assessment, 29 percent of post-quarantined households that had pregnant women by the time of the survey were not receiving antenatal check-up mainly for fear of contracting EVD.

Similarly, 24 percent of these post-quarantined households with under-five children were not taking up their normal vaccine doses for the same reason. From the respondents in this study, almost all Ebola female survivors' negative and traumatic experiences shared were related to the processes of their extraction from their families when the rapid response teams arrived in their homes to transfer them to holding or treatment centers and from the security imposed on them by the military and police units guarding their quarantined homes. Respondents narrated bitterly their experiences faced particularly by female Ebola suspected persons at the time. Female and male survivors narrated how inhumanly they had been handled by the rapid response teams. They narrated how ambulance teams did not even explain to them why and where they were being taken to. No explanations were offered to affected families and their family members who witnessed their extraction from their homes-- adult and children alike were confused and afraid.

The respondents described their removal from their homes as being in their own words; "***traumatizing as if they were criminals".*** This experience was for men, women and children alike. Respondents reported that children who were removed and transferred to holding centres were unaccompanied and this separation was especially haunting their parents/guardians and in particular where none of the family members subsequently survived EVD. They reported lingering unanswered questions around whether it was death due to Ebola or other means. The fact that these dead family members did not return to give their own accounts made it harder for remaining family members to understand EVD.

Female respondents mentioned in particular, their negative hospitalization in which women, men., boys and girls patients were all put in the same ward (*without segregation and with no due regard that some were in their menstrual cycle; some were expectant, some were old/young and all required dignity)*. In their own words, women reported "*particularly mishandled, exposed* and *naked"*.This experience was not accompanied with any psychosocial counselling or support to explain to them what was happening and what they could expect. Being bundled in the same small vehicle --10 people in an ambulance in total disregard of their possible EVD status was a traumatizing experience and they reported that this lead to their isolation and a sense of rejection and being treated like criminals. Many said that they went in depression. This is not to mention the gender issues such as the fact that women and girls did not have sanitary pads or water with which to wash themselves on their way to being transferred from their homes to holding and treatment centers and those in their menstrual cycle at the time of extraction from their homes to holding centers were treated as if they were bleeding from EVD and suffered and felt serious indignation.

From the qualitative methodologies, respondents reported that women and girls in quarantined homes had to negotiate with guards who were uniformed military or police stationed to guard their homes to get out of their homes to go fetch water or firewood with which to prepare food which was supplied to quarantined homes. The negotiation included paying the guards with money or in kind by returning favour for letting the women and girls in quarantined homes out of the homes. The in-kind return of favour included sexual favour or giving food or other valuables to the guards. This act would have had direct implication for the spread of EVD and for household safety and well being of in particular female household members.

EVD impact on Maternal and Child Health

The assessment established that EVD has brought about sharp decline in maternal and child health indicators. With medical facilities overwhelmed and the prevailing mistrust on health services and the fear of contracting EVD, the health seeking behavior of affected communities generally, and of women in particular and especially expectant mothers, has been negatively impacted. Expectant mothers opted to seek help from Traditional Birth Attendants (TBAs) some of whom are untrained. A considerable numbereven opted to deliver unattended thus risking their lives and that of the newborns. This practice will have taken maternal health back several years in relation to maternal morbidity and mortality (MMR) rates for Sierra Leone which were already poor according to the Demographic Health survey (2014) which indicates that MMR was 1165/100,000 live births.[3]

The Sierra Leone study findings on maternal and child health corroborate well with previous EVD outbreaks in DRC, Uganda and in South Sudan which showed that pregnant women and children under five years are at a greater risk of contracting the disease due to interaction with health care workers and as a result of the physiological changes in their system during pregnancy status. This is because of their reduced immune system due to their gravidarum status. Children under the age of five years are also similarly affected often because of incomplete immunization and or poor nutritional status which increase their susceptibility.

According to the assessment, 9.5 percent of households that had at least one pregnant woman, none of the women in 28.9 percent of these households was receiving antenatal check-up. Similarly, out of the 55.4 percent of households that had at least an under-five, none of the under-five children in 23.9percent of these households was receiving normal doses of vaccines. Fear of contracting EVD was cited as a major reason for non-compliance by 48 percent of households whose pregnant members were not receiving antenatal care. Reports from the DRC showed a 95 percent mortality rate for pregnant women and new born babies who were infected by EVD. Women's vulnerability during this period places them more at risk than men.

A similar reason was cited by 57 percent of households whose under-fives were not receiving normal vaccine doses. Clearly, this situation is fast reversing the earlier progress made towards the Millennium Development Goal (MDG) on maternal and infant mortality in Sierra Leone. Compounding this, the assessment noted an increased risk of gender based violence (GBV) and exploitation of women and girls, due in part to isolation by quarantine or to orphan hood by EVD.

Experiences in the Economic sphere

Agriculture followed by informal employment constituted the major sources of livelihood for both male and female-headed households before the outbreak of the EVD. Until then, the proportion of females in the non-formal employment sector was higher than that of males. Now with limited household resources, girls are predisposed to and forced to engage in income-generating activities including petty-trading without any skill—driven initiative. They only do this by survival instinct. This

[3]Sierra Leone, Standard Demographic and Health Survey, 2013

forced ***coping strategy*** out of necessity has immediate and long term consequences including possible school drop-out for children who were school. The long-term outlook for child-headed or female headed households was good. The combined state of orphan-hood, likely need to drop-out of school would cut off children's education, nutrition, health, shelter and likely GBV, sexual exploitation andabuse of female children. For female headed households, the outlook is similarly grim.

The undermining of agricultural productivity and trade which are the basis of family income and livelihood the EVD outbreak has negative correlation to economic welfare. For men, loss of gainful employment and trade opportunities had similar negative impact. Therefore, Ebola related vulnerability added to the pre-existing social and economic vulnerabilities which included losing means of livelihood, support and income. Similar to the socio-economic studies done earlier by World bank/AfDB, FAO/UNDP, thisstudy established that in a sizeable number of studied households, EVD has had severe economic impact particularly for women and in female headed households.

Economic and social vulnerability was particularly dire in households in which children have lost one or both parents. Even where food packages were availed to such orphaned or child-headed households, children were unable to cope because of lack of adult figure to help with food preparation and addressing the other day-to-day needs of children. Stigma and isolation of households affected by EVD meant that orphaned children had no help forthcoming from extended family system or from government or well-wishers from the community which would have been the case if not because of EVD. Where older children existed following the death of their parents, the older sibling assumed the **care-giver** role. In quarantined homes, this was possible source of more infection by EVD within the family since children were not assisted to prevent infection after their parent/parents died from EVD.

GBV and sexual exploitation programming has been seriously disrupted and schools have been closed as a measure to control EVD transmission. This means orphaned children, especially teenage girls, find themselves exposed to a heightened risk of GBV and sexual exploitation and abuse and pregnancy. Likewise, abandoned health facilities, limitations on people's movement due to quarantine, and reduced use of conventional health services for fear of infection mean that pregnant women are more likely to give birth unattended and forego ante and post-natal care– an addition which has compounded the vulnerability (and needs) of women and girls. This has implications for EVD control and recovery and for other planned national interventions such as the United Nations Development Assistance Framework (UNDAF) and the Sierra Leone National Agenda for Prosperity[4].

While quarantine is critical for controlling the transmission of EVD, it has significantly reduced economic and livelihood activities, which in turn have reduced employment, boosted poverty rates, and increased food insecurity. The shutting of borders, where the majority of traders are women, is affecting cross-border trade. Agriculture and mining sectors, which have significant female workforces, have been equally affected. The fear of EVD infection is breaking down social cohesion and impairing the social networks that women rely on. As a result, women have experienced reversals in economic empowerment. Although women (e.g. in the districts of Kailahun and Kenema) are leading farmers and heads of

[4] Sierra Leone Government: Agenda For Prosperity 2013- 2018

household, their agricultural bases have been severely eroded and, in some cases, completely wiped out by EVD deaths.

Stigma and discrimination

Stigma and discrimination was reported at 90percent of the studied households. However, there is significant difference in how males and female respondents experienced stigma and discrimination. Women were additionally abused and mistreated--being called names and treated as if they had bad omen --being regarded and treated as if they were responsible for bringing Ebola to their families. Many were violently abused before they were chased from their homes having been regarded as "witches". Many had to hide from their communities while many others upon discharge were afraid to go back to their families. In about four districts, interim care facilities offered temporary shelter and food for women and children who had been chased from their homes by family members. While approximately 20 percentof respondents indicated they would accept EVD survivors back into their communities, female survivors of EVD due to their stigmatization and rejection reported that they were afraid of experiencing added gender-based violence as a result of EVD. Stigma and discrimination was experienced by both ordinary female members of the families and also nurses who were chased from their homes.

Water and Sanitation

The study established that non availability of water in the homes and the distance to water points had implications for women and girls whose role is to fetch water. During their quarantine period, women and girls had to find means to get water and most of the time had to negotiate with the guards stationed to ensure they do not leave their houses. This resulted into manipulation and sexual exploitation by the same guards.

A positive finding in relation to water and sanitation was the high knowledge (99%) of the need to wash hands and not to touch people. However, the high knowledge did not correspond to practice since water shortage in the homes compromised effective practice of hand washing. Respondents reported having to chose from using the limited water available for cooking, meeting other primary household water requirements including washing and observing importance of hygiene in EVD control.

Individual Experiences and Coping mechanisms of Women, Men, Girls and Boys

Linked to the finding that EVD in Sierra Leone disproportionately impactedwomen, men boys and girls; households that had experienced EVD were stigmatized and discriminated against as recorded from qualitative in-depth interviews. This meant that the usual forthcoming support system from the immediate family and extended family structures was not forthcoming. Therefore, the EVD outbreak destroyed and eroded individual and family support systems and structures. Segregation and isolation of quarantined homes were particularly pronounced where orphaned children and female headed household. Due figuredto fear of contracting EVD, extended family members and neighbors who had not experienced EVD could not offer any form of assistance to families affected by EVD. This left

individuals in quarantined homes to rely only on the security guards placed to guard the families ensuring that the quarantined persons do leave their homes.

Two major means of coping were to negotiate with the guards to let the affected family member leave the home to go for example to fetch water/firewood/food/kerosene for lighting lanterns in the night or send the guards to get for them these basic necessities. Women and girls were inparticular risk of sexual manipulation in return for the favour they received from the guards. More than 65 percent of female respondents reported manipulation by the security officers stationed at their homes to guard them.

Female respondents in the study reported emotional trauma with resultant depression emanating from the processes pertaining to patient retrieval from their homes and transfer to the holding or treatment centers. The reported traumatic experiences came from rapid response teams who went to homes to take suspected cases of EVD. A major and bitter experiences faced particularly by female Ebola survivors was the poor handling of patients by rapid response teams on arrival in their homes. The respondents described them as ruthlessness.

When the rapid response teams arrived in a home, they were not courteous at all and treated suspected EVD patients as criminals. They were forcefully removed, no explanations were offered to family members or to the patients about which holding center or hospital they were being taken to. Between 5-10 people were bundled in the ambulances without attention to their EVD status. Women, men, children were crammed in very little space in the ambulance and sprayed with chlorine. Respondent men and women described theirbeing manhandledin this process.
Women complained of their indecent exposure in both the transfer from their homes to holding centers where they were more traumatized on arrival at the holding centers to find that every suspected person was crammed in one room.

Male and female patients were put in the same holding ward without adequate attention to their wellbeing. Women some of whom had never been out of their villages found the experience in the holding and treatment centers traumatizing--lack of privacy, indecent exposure and in a room with strangers and mostly with no one to ask questions or get explanations on any aspect of their wellbeing. Women and girls experiencing their menstrual period at the time of removal from their homes reported not even being given time to look for sanitary pads. Many soiled their clothes and had no water or opportunity to wash. The embarrassment from lack of hygienic/sanitary pads and lack of changing of clothing for women and girls who were in holding centers caused them indignifying treatment which was as haunting as the fear of having EVD. In the absence of any family or familial support mechanism, no psycho-social support their traumatic experiences led to their isolation and depression in female survivors of Ebola.

Resorting to their faith/spirituality by praying was immediately the response given by respondents on how they coped during their quarantine as well as through their stigmatization and isolation. In households with had a mobile phone, few respondents said they tried to call on extended family members for help including guidance but no help was forthcoming since movement was restricted

throughout the country. The respondents who reported using their mobile phones soon ran out of credit or cell phone battery and reclined to fate believing in their spiritual fate that what would happen would happen and would have been permitted of God. This was the single most prevalent means of coping for the majority of the households interviewed.

Emerging Gender Related Issues in the Context of Ebola Viral Disease (EVD)

The assessment shows that EVD related vulnerability (and needs) has added to the pre-existing social and economic vulnerabilities of women and girls. A sizeable number of children have either lost both or one parent; a clear signal that they now lack parental care and guidance. Those that have lost a mother are particularly in a more precarious situation because they have lost a care giver.The consequence for a girl-child who has lost a mother is in the risk of assuming the care-giver role for siblings following the untimely death of a mother. The study noted a decrease in the proportion of women collecting water for the household (possibly due to deaths) contrary to a significant increase for the same task for girls. This has a number of implications for the girl child. In the event that schools are reopened girls may resume school but with a new burden of the care-giver role acquired as a result of the EVD outbreak.

In relation to access to non-EVD related health services for women and children services were not accessible by communities studied in all 14 districts; in particular ante-natal, post natal care; reproductive and child health. Fear of contracting EVD and lack of trust amongst communities in available health services were the biggest sources of lack of access.
In the context of numerous rumors and counter rumors surrounding EVD; ignorance, misinformation, inconsistent and conflicting messages, many people especially expectant mothers were afraid of going to health facilities not only for themselves but also for their newborn babies and under-fives who required health services for the children to complete their under five immunizations for fear of their infection with EVD. The risk of childhood epidemics such as measles and whooping cough are indicated. HIV positive women and children and those living with AIDs are even more at risk because they can no longer access health care and related counseling services from the fear of EVD contamination.

The respondents reported fear of stigmatization as EVD suspects as reason for not going to any health facility. The study established that women who did not have adequate information on how to prevent transmission for example from mother-to child through breast milk for lactating mothers, risked infecting their children not only from touching them during their breast-feeding them but also through the very breast-milk for EVD infected lactating mothers (an EVD affected breastfeeding mother, Ebola is transmissible through the breast-milk). The study established that such specific messaging had not reached the majority of studied households.

Focus is required in revamping and rebranding of maternal child health services and providing incentives such specific and targeted education for women and girls, men and boys on EVD prevention and breaking the EVD chain of transmission.

Incentives could also consist of counseling for both ante-natal/post natal mothers; pregnant teenage mothers as well as the wider body of health care workers; EVD survivors and their families. The emerging trend of ante-natal mothers using untrained traditional birth attendants or delivering through non professional attended deliveries is finding warranting attention. This is more so in the light of the fact that in Sierra Leone, teenage mothers contribute to 34 percent of all maternal morbidity and mortality and this study established that there were a significant number of teenage girls who became pregnant within the context of the Ebola crisis and who did not have ante-natal services.

Rebuilding of citizens' confidence as well as health care workers' confidence and effective coping mechanisms to address the impact of Ebola Virus Disease is urgent. Therefore, it will take considerable efforts to reestablish a "Risk Free Environment" as a measure towards rebuilding both trust and confidence in communities and in health care system for both side to feel comfortable to provide safe health care and for the communities to reuse available health services and to address maternal health needs as well as psychosocial needs in families and communities directly affected by the EVD epidemic.

Abandoned health facilities, limitations on people's movement due to quarantine, and reduced use of conventional health services for fear of infection mean that pregnant women are more likely to give birth unattended and forego ante and post-natal care.

Secondly, in the same note, the status of pregnancy itself is major risk factor for women and teenage girls who are pregnant during an EVD outbreak and increases their vulnerability or susceptibility to EVD infection due to suppressed immune system from the pregnancy state itself[5].

A positive finding established by the study was "Zero" FGM cases amongst the studied households. This positive finding was associated to the Moratorium placed on FGM by the President /government of Sierra Leone. This positive finding is an important one in relation to confirming that such deeply embedded socio-cultural norms and practices can be halted in light of a calamity such as EVD. Some measure towards acknowledging and commending the Traditional Women Leaders (the SOWIES) for upholding the Moratorium on FGM should be considered as step towards working with the Council of Sowies in supporting them to altogether abandon the practice when Ebola Virus Disease is brought to an end in Sierra Leone.

Conclusions

This impact assessment established gender differential impact of EVD on men, women, boys and girls related to the specific areas of assessment as defined in the study objectives. In addition to the numerical finding that more women (56.7%) than men (46.3%) have been infected by EVD; the study also identified the socio-cultural determinants and drivers of EVD transmission from a gender perspective using evidence derived from the systematically collected and analyzed data which has been disaggregated by sex. In this context, the socially prescribed gender roles by society for women and girls as caregivers increased their exposure and vulnerability to EVD.

[5] Extracted from the Key Note Address: Dr Muriel Harris, Lecturer-University of Kentucky, UNCT Launching of the Gender Mainstreaming Strategy, October 2014, Radison Hotel, Freetown

The assessment established the fact that the Ebola crisis has further aggravated and added to pre-existing structural, social and economic vulnerabilities and which have even more dire impact on women and girls.The study has established and quantified men's and women's experiences of EVD; the types and levels of vulnerability and the coping mechanisms of women, men, girls and boys in their various specificities.

Lack of access to and utilization of maternal and child health services by 29.1 percent of post-quarantined households mainly due to fear of contracting EVD.Lack of confidence in public health facilities by the same respondents remains a daunting reality with the projected figure of number of affected antenatal mothers is approximately 120,000[6], in Sierra Leone.

Ebola Virus Disease (EVD) has a devastating effect on women; particularly expectant mothers due the status of pregnancy itself which increases women's vulnerability and susceptibility due to their immunodeficiency.

The status of lactation is equally risky for breastfeeding infants should the mother be infected by EVD. The effects of EVD are more severe in pregnant and lactating women should they contract EVD. Firstly, it can cause spontaneous abortions with heavy bleeding especially during the first and second trimesters of pregnancy. Secondly, it can result in severe hemorrhaging and neurological complications with disastrous consequences for the fetus and newborn babies. In the case of Sierra Leone, women who were expectant or in their menstrual cycle at the time of the outbreak of Ebola and at the time of their extraction from their homes and referral to EVD holding centers were treated as if they were confirmed cases of EVD (simply because of the bleeding). This caused tremendous psychosocial anguish from a sense of unjust suspicion form EVD.

Twenty-four percent of post-quarantined households with children under 5 did not receive their child immunization mainly due to EVD.

The stubborn intersection of Ebola, Female, Culture, feminized poverty, has been referred to a *triple jeopardy* for women and girls. This Triple Jeopardy should be factored into national EVD Response in Sierra Leone.

The government Moratorium placed on FGM by the President of Sierra Leone was effective as no (Zero) case of FGM was established by the study. This positive finding is an important finding in relation to confirming that such deeply embedded socio-cultural norms and practices can be halted in light of a calamity such as EVD.

There was access to information and high knowledge about the need ***to WASH hands and No Touch campaign amongst studied households.*** However, lack of access to water and sanitation in the studied households compromised the effective application of the knowledge. Therefore calling for the need to

[6] Randi Davis and Susana Fried 'Ebola Response cannot be gender blind' 'This is Africa' httpp//.thisisafricaonline.com/Ebola-response-cannot-be-gender-blind

accompany behavioural change information/knowledge with supportive measures for them to be translated into beneficial action and sustainable behavioural change.

Ebola Virus has destroyed the family/community coping systems and structures due to the stigma and discrimination associated with it. The stigma and discrimination are themselves although negative a coping mechanism for "*self-preservation*" by those that did not contract EVD. This behaviour stems from fear from the unknown/ignorance as opposed to *malice*. Both the "stigmatizer" and the stigmatized need adequate counselling to understand the issues better and to evolve better ways of coping with this reality. This is particularly important for families and communities to rebuild their relationships.

Girls who were in school before the outbreak of Ebola are particularly at a risk of losing out from continuing with their education when schools re-open. This is so in households where the mother has died due to EVD or any other non-EVD related causes. This is because the girl child automatically assumes the ***care-giver role or mother figure*** in a household where a mother has died. Where children are total orphans (have lost both mother and father); there is rise in child headed households.

Stigmatization of EVD orphans and female headed households due to EVD was established and should be urgently addressed.

The study established a fifteen per cent (15%) change in female households due to EVD

These findings are based on empirical data and point to the need for urgent action using targeted interventions from a gender perspective in bending the EVD transmission curve and towards getting to zero EVD transmission.

Recommendations

The following are specific recommendations relating to the overall strategies as well as sector specific EVD plans:

1. Overall, Gender Mainstreaming is required in all aspects of Ebola prevention, coordination, case management, contract tracing /disease surveillance and social mobilization, food security control and recovery interventions.

2. Because gender is a cross-cutting theme and as evidenced from the findings of the assessment, gender be integrated into all Pillars and should not be placed under one Pillar as is currently the case in the Sierra Leone national EVD Response. Presently Gender is lumped under Psychosocial, Gender and Child Protection Pillar. Considering that the Gender Cluster has never been convened by the Pillar Lead, it is highly recommend as a matter of urgency that a Standalone Gender Pillar be established to provide adequate tools and technical as well as coordination support to all the national EVD Response mechanisms of the NERC.

3. Reinstated and enhanced economic opportunities, including jobs and livelihoods are vital for addressing the challenges that EVD has posed to gender equality and women's empowerment, which has negatively impacted on household livelihoods. To address this, Government and its national and

international partners should put together resources for: (i) livelihoods stabilization through emergency employment, start-up packs and grants to revitalize new and existing enterprises; (ii) revitalizing and/or developing small, micro and medium (agriculture and other) enterprises for women; and iii) inclusive growth and long-term employment creation entailing descent employment and enabling environment.

4.The meaningful participation of women community leaders in the fight against Ebola is critical and they must be involved in all aspects of awareness raising, planning responses at community and household levels. NERC and DERC should actively seek women's participation in social mobilization in partnership with youths, local community health workers.

5. In addition to mainstreaming gender into all the EVD Pillars, specific targeting of women, men, boys and girls should be undertaken. Examples include: (i) Ebola control and recovery messaging should speak to and address social-cultural practices that promote gender inequality and pre-dispose women and girls to be more vulnerable to Ebola infection and transmission – this could include exploring opportunities to change gender roles; (ii) Targeted Procurements of materials e.g. of comfort kits that facilitate girls attend school; (iii) Innovative interventions (e.g. innovative water capture) that release women from daily chores that reduce their participation in EVD recovery activities; and (iv) Exploring and promoting opportunities for changes in traditional gender roles v) Responsive to specific needs/worries of female hospital in-mates .

6. Training is urgently needed on human rights and gender for security apparatus deployed in all EVD responses.

7. Although EVD is largely a medical/health emergency in Sierra Leone; socio cultural attitudes and practices continue to confound EVD prevention and rapid treatment. These attitudes and behavior should be targeted in Ebola Control and Recovery interventions to break the EVD transmission chain perpetuated by socially prescribed roles including that of women and girls traditionally being the ones to prepare dead bodies for burial and in their role as traditional healers, where they have contracted and facilitated the spread of the virus.

8. The training for health workers and non-health workers should include the gender dimensions of EVD that have been articulated in this report. For instance, the unhygienic, undignified and traumatic experiences of women and girls' in holding centres and treatment centres could have been avoided if such training had been given to health workers.

9. Continue to collect and use sex- and age-disaggregated data available now, in both integrated EVD response and in all early recovery planning process.

10. Promote diversification of livelihood options and relevant skills development linking effectively with market for revamping household income.

1. INRODUCTION

1.1 Overview of the Country Context of Sierra Leone

Sierra Leone experienced internal armed conflict for eleven years (1991 -2002) which had dire consequence on all realms--political, social and economic fabric of the society. The war ended in 2002 and successful post-conflict peace building programs were instituted by the government, civil society and the international community. The country had since enjoyed twelve years of peace and stability as witnessed on March 6, 2014 when the United Nations Secretary General, H.E. Ban Ki Moon withdrew the Integrated Peace building Mission in Sierra Leone (UNIPSIL) ending its mission with a Clean Bill of Health and a strong road map to peace, stability and economic recovery although albeit a difficult task ahead as reflected in the Human Development Index (which in 2012) ranked Sierra Leone 177 out of 187. On Gender Inequality Index, Sierra Leone was ranked 139 out of 148 in 2012.

Similarly, the 2013 Demographic and Health Survey noted that maternal and infant mortality rates of Sierra Leone are lagging behind with child mortality rate of 192/1,000 live births; maternal mortality, 1165/100,000 births[7]. Sierra which before the outbreak of EVD was classified as a 'fragile state' "based on several assessments, including the Multilateral Development Bank's framework for assessing fragility as well as the country-led fragility assessment undertaken in 2012 as part of implementing the *New Deal for Engagement in Fragile States* that was endorsed by partner countries and donors at the Fourth High Level Forum on Aid Effectiveness held in Busan in 2011. The country also has poor infrastructure, high unemployment rate which are all noted in the country's Third Poverty Reduction Strategy Paper, the Agenda for Prosperity (2013-2018) (AfP) recognizes disparities in development between urban and rural noting that rural areas are more disadvantaged due to poorly equipped health, education, physical infrastructure with accompanying shortage of qualified health care professionals; shortage of basic medical supplies including essential drugs and even equipment. The poor health infrastructure is reflected by the high maternal mortality rate of 1,165/100,000 live births, infant mortality rate of 192/1000 per births. Life expectancy is 42 using the Human Development Index (UNDP HDR 2013).

The Agenda for Prosperity (2013-2018); (A4P) which is the National Plan that builds on the country's long-term vision of becoming a middle income country by 2035.

In dealing with gender equality and enhancing women's empowerment and participation in governance and addressing sexual and gender-based violence; the government Agenda for Prosperity has a Stand Alone Pillar on Gender (Pillar 8) as well as gender being mainstreamed into all the other 7 Pillars (of the A4P. Sierra Leone also has a National Strategy for Women's Empowerment as well as a Draft Policy on Gender and Women's Empowerment. The government has also enacted various laws to ensure the protection and promotion of the rights of women and children. These arethe commonly referred to as the *Three Gender* Laws: Domestic Violence Act; The Devolution of Estatesand the Customary Law Marriage Act and the Sexual Offences Act of 2012.

[7]Sierra Leone, Standard Demographic and Health Survey (DHS), 2013

The country was in various stages of implementation of the A4P as well as the National Strategy for the Empowerment of women. However, the would be progress towards the A4P and the gains accruing from its implementation were severely halted by the outbreak of the Ebola Virus Disease throughout the country.

The first Ebola outbreak in West Africa was reported in December 2013, in Guéckédou, a forest area of Guinea near the border with Liberia and Sierra Leone. By March, Liberia had reported eight suspected cases. On Monday 25th May 2014, the Government of Sierra Leone through the Ministry of Health and Sanitation declared an outbreak of Ebola Virus Disease in Sierra Leone following the laboratory confirmation of a suspected case from Kailahun district.The outbreak of the Ebola Virus Disease continues to register unimaginable and unprecedented negative impact of death and morbidity for the individual survivors their families, communities and the nation as a whole.

Women in Sierra Leone already face high level of gender discrimination even prior to the EVD crisis. The impact the crisis has put on families, communities and economy are likely to push back the progress that had been made towards promoting gender equality and women empowerment. One of the major steps of gender analysis for infectious diseases is to identify and assesses gender related practices that put women at higher or lower risk than men. Biological factors are difficult to change rather than gender related ascribed roles but, biological vulnerabilities can sometimes be mitigated by behavioral change.

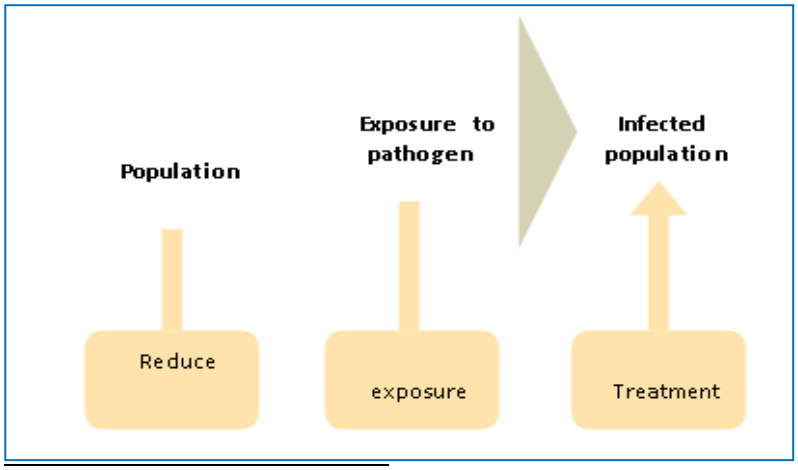
Gender analysis tools[8] currently being used suggest a transmission model that begins the outbreak to occur with a population in which the infectious pathogen is introduced with individuals exposed to it and number of persons that contract the pathogen and become ill. Health interventions are undertaken with three objectives:

a. Reduce the vulnerability (and increase resistance) of people to the effects of infectious pathogens;

b. Reduce exposure to infectious pathogens and

c. Treat people who become infected[9]

Figure 1: Transmission Model



Sourced from WHO, 2009

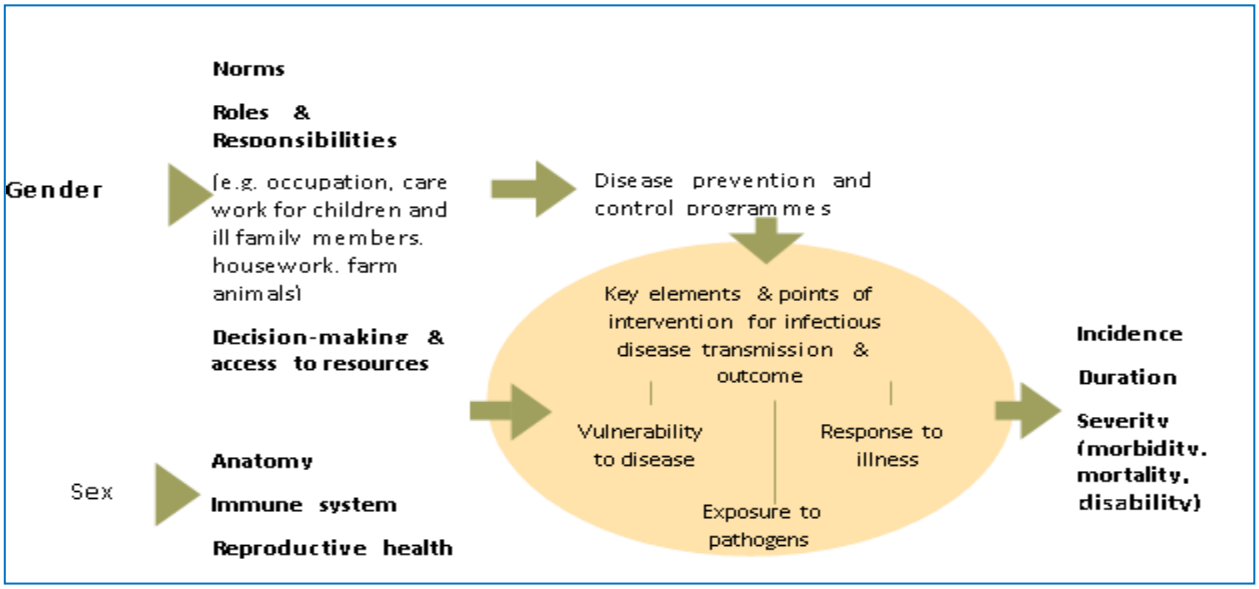
Elaborating this framework by juxtaposing 3 main components of **gender** (norms; roles and responsibilities); **decision & access to resources**) and **sex** (anatomy; immune system & reproductive health) would directly influence the incidence, duration, and severity of the disease by vulnerability, exposure to pathogens, and response illness).

[8] WHO 2009

[9] ibid

These three elements from sex and gender dimensions would help determine the influence they have on the incidence duration and severity, through interactions with health interventions.

Figure 2: How sex and gender affect vulnerability effectiveness of public health interventions



It is important to note that socio-cultural determinants significantly influence both the biological and social constructs and affect the outbreak of disease - from vulnerability to the responses. Henceforth, this report draws its analysis on four areas which are critically influenced by socio-cultural determinants for men, women, boys and girls. These are as follows:

a) Care giving role - *Women* and girls in particular, have traditionally performed the primary roles as mothers and careers for the families. These cultural traditional roles included them as front line health workers or health facility support staff (e.g. cleaners, laundry, etc.) which made them more likely to be exposed to the disease. Women's roles as caretakers of the sick in the home (feeding and bathing of family members infected by Ebola) thus put them in direct body contacts with infected persons and even preparing dead bodies for burial. The high risk for lactating mothers if either the child or the mother was infected also ran parallel.

b) Economic role - The epidemic had a significant impact on the economy of the state especially in the rural areas and cross border trades and agriculture where women are mostly engaged with borders closed and travel restrictions, women had difficulties in sustaining household incomes. According to the ADBG (2014)[10] 70% of women in the MRU could not sell their produces owing to border closures. This raised their vulnerability to violence and abuse further owing to the traditional role of furnishing food and nutrition to the family members.

c) Social role -According to Davis and Fried[11], the UNFPA estimates that 120,000 pregnant women will face childbirth and with this shortage of health facilities and health professional, many will die. Pregnant Women had been particularly left vulnerable facing Ebola as it has affected

[10] African Development Bank Group –Ebola – The need for a gendered approach 2014
[11] Randi Davis and Susana Fried 'Ebola Response cannot be gender blind' 'This is Africa' httpp//.thisisafricaonline.com/Ebola-response-cannot-be-gender-blind

maternal and reproductive health services with a degenerating healthcare facility that needs a longer term institutional strengthening.

On the other hand, involvement of women leaders in their communities on the fight against Ebola is extremely critical. Women's roles as frontline informants as well as survivors are also the best resource in tackling the disease. And hence, they must be involved in all aspects of awareness raising, planning responses at community and household levels and social mobilization in partnership with youths, local community health workers. But owing to higher illiteracy rate among women, radio was identified as the major source of information. But the messages aired out by the radio stations were often gender blind.

Participation of women in decision making and communication is imperative. It is a known fact that, Ebola response is hampered largely by lack of knowledge about the epidemiology of the disease in the midst of fear and deep rooted mistrust between citizen health workers and government. Evidence of this is the inherent denial about the existence of the disease in the context of entrenched traditional belief and practices, for women it is even more complex because they lack the space in traditional settings to be heard and that the power of decision making is dependenton the men.

d) Gender based vulnerabilities - One key area in the gender dimension of Ebola is the abuse of human rights of women and girls. A long term socio-cultural and stereotypical psyche of men in some traditional Africa cultures about the treatment of men and women is nothing new rather has been evidenced and tolerated during conflict and war. As a result, violence against women and girls only intensified during EVD outbreaks. Women were unable to maintain their control over their bodies and had to succumb to the traditional role of entering into sexual relationship with their male counterparts, recovering from the disease, despite the preventive protocols.

The EVD crisis is therefore likely to have disproportionately negative effects on women who are already in vulnerable situation. Under these circumstances a "Multi-Sector Gender Dimension Impact Assessment" was undertaken.

2. PURPOSE AND OBJECTIVES OF THE STUDY

2.1.The Purpose of the Assessment

The main purpose of the multi sector gender dimensions impact assessment of the EVD was to investigate the extent of the impact of the outbreak of Ebola virus on the households that experienced Ebola and to determine the gender dimensions of those experiencesand the impact thereof.

Statistics Sierra Leone Research Team T-Shirt Depicting Study Theme

2.2. The Specific Objectives of the Assessment were to:

*2.2.1*Identify and better understand socio-cultural determinants and drivers of EVD transmission from a gender perspective.

*2.2.2*Identify and understand the impact of Ebola crisis on pre-existing structural, social and economic vulnerabilities including access to basic social services e.g. water sanitation and hygiene

2.2.3 Identify, quantify and qualify the coping mechanisms of women, men, girls and boys in their various specificities;

2.2.4 Identify particular emerging risks that impact on prevalence, Teenage and Early Marriage etc.

2.2.5 Generate comprehensive data disaggregated by sex, age, geographical location on women's, men's, boys', girls' lived experiences of EVD;

2.2.6 Generate empirical data and evidence that would support the basis for the development of gender responsive interventions/ strategies for EVD emergency response and for the recovery period with a particular focus on access to food security and livelihoods

3. METHODOLOGY

The assessment adopted a mixed methodology comprising quantitative and qualitative in data collection. Data collection was done using desk review and Survey. The survey applied Key Informant Interviews (KII) and focus group discussions (FGD). The households and respondents were sampled from post-quarantined households across the four regions (Eastern, Western Northern, Southern) and covering all 14 Districts of Sierra Leone.

Part of Statistics Sierra Leone Team that undertook the study in all the 14 Districts of the Country - November, 2014

3.1. Desk review

A very detailed desk review was undertaken as the starting point for the gender impact assessment of EVD in Sierra Leone. The desk review provided a framework for designing the assessment. For example, the desk review examined and underscored issues of gender equality and women's empowerment in relation to public health and public health emergencies such as outbreaks of cholera and the impact on populations using a gender lens; the literature review also looked at previous outbreaks of EVD in other countries which had experienced EVD and how sociological dimensions of Ebola were treated in those contexts. In so doing, the desk review was useful in identifyingstudy questions; locating communities' experiencesin other countries with EVD. Extensive Literature review was conducted with the following results:(i) refinement and/or confirmation of the assessment questions; and (ii) Extraction of both quantitative and qualitative data from related studies on gender and public health. (iii) The immediate output of literature review contributed to the development of the Inception Report of the conceptualization of this study. The study design therefore benefited from the extensive Literature review.

The study objectives, assessment methodology, tools for the study make use of the literature/desk review which also informed critical comparisons made reference to in the discussion section of this study. The Literature review also helped to generate a list of reference materials on existing studies on EVD in Sierra Leone and beyond.

3.1.1. Quantitative approaches

Sampling

Thesurvey sample was selected in two stages, with districts affected with Ebola as the first-stage and post-quarantined households as the second-stage sampling units. In total, a sample of 3000

households was selected from a list of post-quarantined households that was created by the Directorate of Food and Nutrition (Sierra Leone) as of 14 August 2014.

3.1.3. Qualitative approaches

Key informants, mostly, EVD female survivors were interviewed using an interview guide developed as one of the criteria for ensuring systematic and consistent processes and procedures in the administration of the tools of the assessment. The tools applied in the assessment were pretested and enumerators thoroughly prepared through an elaborate concepts, content, and process training and rehearsals to ensure they understood the concepts, the content and procedures and processes of data collection beforethey were released to the field for data collection. Understanding the contexts for the assessment was as important as the content of the study and Enumerators were released for data collection to the districts only after the trainers were sure they satisfied enumerator prequalifying and qualifying requirements.

3.1.4.Data Collection and Analysis

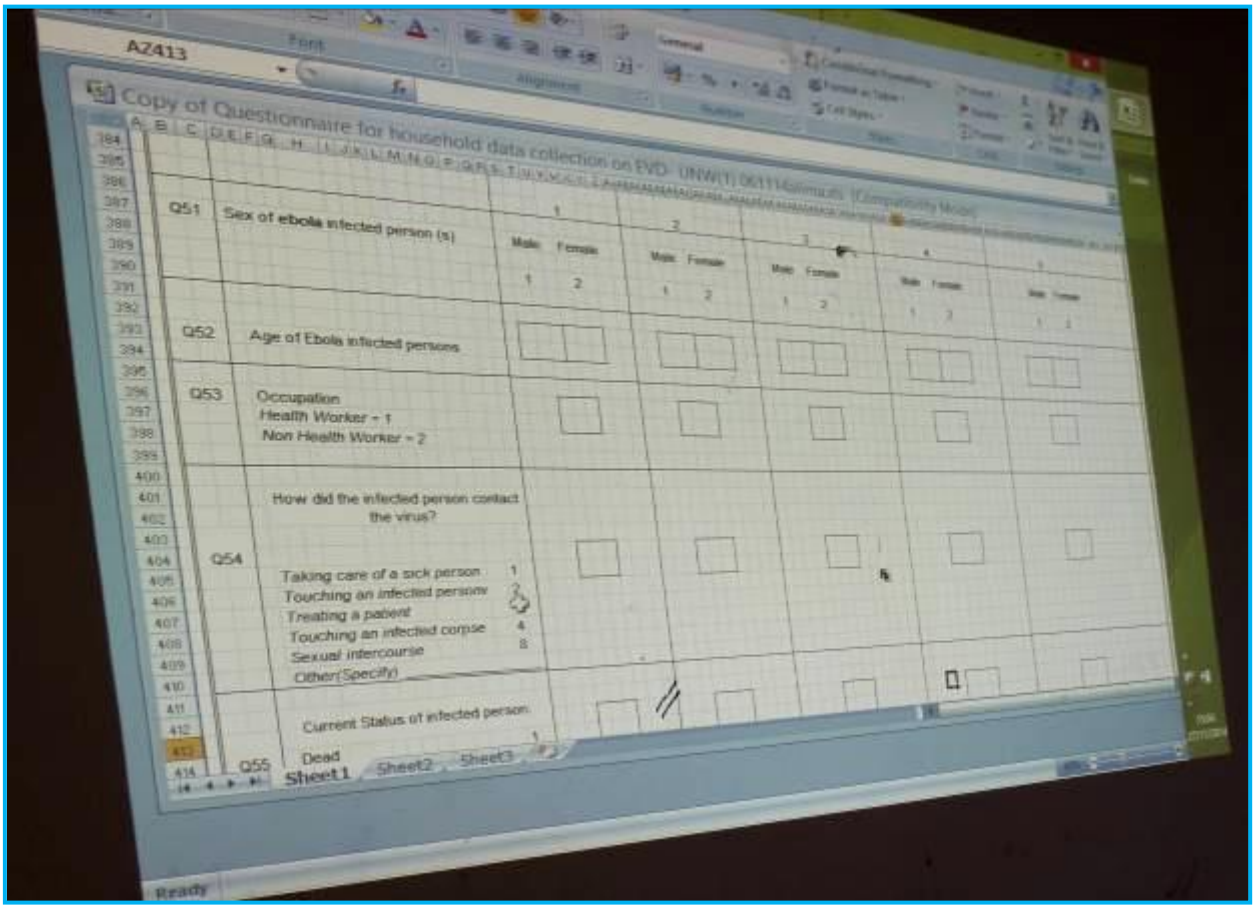
A single household questionnaire was administered to capture life EVD experiences of women, men, girls and boys. Out of the 3000 targeted households, 2788 households were successfully interviewed, yielding a response rate of 93 percent. The data were processed using CSPro (Census and Survey Processing computer package). Data entry and editing were initiated upon the completion of the field exercise.

3.2 Constraints and Challenges of the Assessment

Data collection for thisassessment coincided with the peak of EVD transmission in the country. This was precarious and worrisome time as the partners in the assessment had to ensure close monitoring of adherence to the EVD infection prevention measures.At the same time some of the families and would be respondents in the randomly selected households for interview had moved away while others did not want to participate in the assessment. All of these and other access and safety measures slowed down the process and extended the time for data collection. Although fallout mitigation measures were taken through mobilizing and setting appointments with respondents and taking on board more enumerators than had earlier been planned, challenges in Western area Urban and Western area Rural where EVD outbreak was more pronounced during the data collection posed real access and safetychallenges to the data collection team.This resulted not only into additional costs but also in a shortfall of 220 households of the targeted three thousand sample size.

However, a special tribute must be paid to the Enumerators and the Data Collection Field Supervisors who not adhered to the EVD infection prevention measures to fulfill their TORs but who also risked their own lives in collecting/safeguarding and diligently storing and remitting the data safely to the head office.

The outbreak of EVD epidemic in the country threatened to affect timely data collection for the assessment by delaying assembly of participants andor access to participants. The mitigation strategy for this was early mobilization of participants and identification of appropriate participants for FGDs and time keeping by data collectors.



Copy of the Questionnaire used for Household Data Collection during the study – November, 2014

4. STUDY FINDINGS

This section presents findings of the assessment on women's, men's, girls' and boys' life experiences of EVD – disaggregatedby sex, age, geographical location as appropriate.

4.1 Socio-cultural determinants and drivers of EVD transmission from a gender perspective

Sierra Leonean Woman takes care of her Family food needs while passing on the care- giving gender role to her daughter

Traditionally, little attention is given to sex and gender differences in handling infectious diseases with the general assumption that infectious disease affect both male and female. This view was reflected by participants in the study. Although it would seem sufficient to only focus on public health interventions during an outbreak on control, case management and treatment, this leaves aside the issues of special needs to be addressed either through handling social problems that exist or arise as a result of the disease which includes understanding and addressing gender inequalities pre, during and post outbreaks, which the study noted were prevalent and contributed to the impact of the EVD.

On the other hand, understanding the interface between gender roles and infectious diseases opens up and leads to valuable insights into the mode of transmission patterns, control, prevention from the outbreak - reducing the rate of disease transmission patterns and strategizing for prevention and control of the outbreak. Additionally, such an understanding increases co-operation and collaboration between public health interventions and the institution of health protection and promotion measures. This implies that taking into account of the male-female differences can increase the efficacy of disease control programmes and reduce health and social inequalities between women and men and hence can reduce the harmful practices and promote human rights of all.

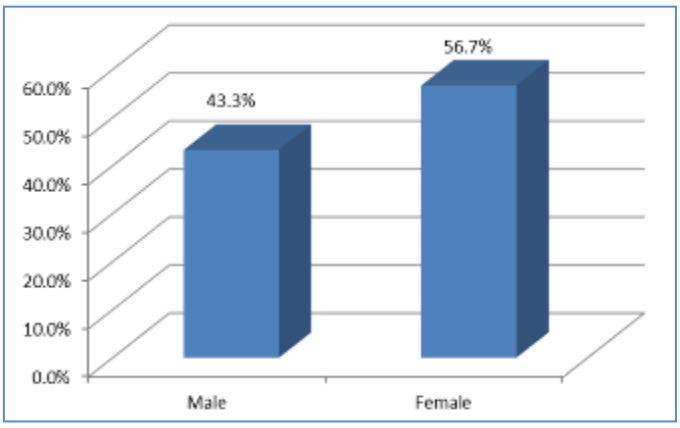
In the EVD outbreak in Sierra Leone, however, the assessment found that women have been part of the transmission chain - from their socially prescribed social roles including that of traditionally being the ones to prepare dead bodies for burial and in their role as traditional healers.In relating to their experiences reflectively, the respondents attributed the EVD causal factors to curses/mystical realms which they could not explain and the fact that men and women, boys and girls died (in their minds) in equal numbers, the sex/gender differential vulnerabilities and ensuing cumulative impact was not obvious to them.

4.2. Impact of Ebola Crisis on Structural and Pre-existing Social and Economic Vulnerabilities

As shown in section 4.1 above, gender and sex differences have had a profound impact on how women and men experience, respond to and recover from EVD. The assessment revealed the disproportionate risk of infection and mortality between women (56.7%) and men (43.3%) from EVD *(see Figure 3* below*)*, which according to the assessment indicates more females were infected. Percent distribution of infections by gender and age-group is shown in *Appendix table A1.*

This differentiated impact is traced to gender norms and behavior that perpetuate gender inequality; the gendered division of labour between men and women; and gender-related differences in access to and control over productive resources. In this light, the EVD outbreak poses an unprecedented challenge in the overall achievement of gender equality and women's empowerment. For example, the pre-existing unpaid care work for women at household and community levels as well as the gendered division of labour have led to women bearing the brunt of the outbreak as indicated on *Figure 3*above.

Figure 3: Infections by Sex

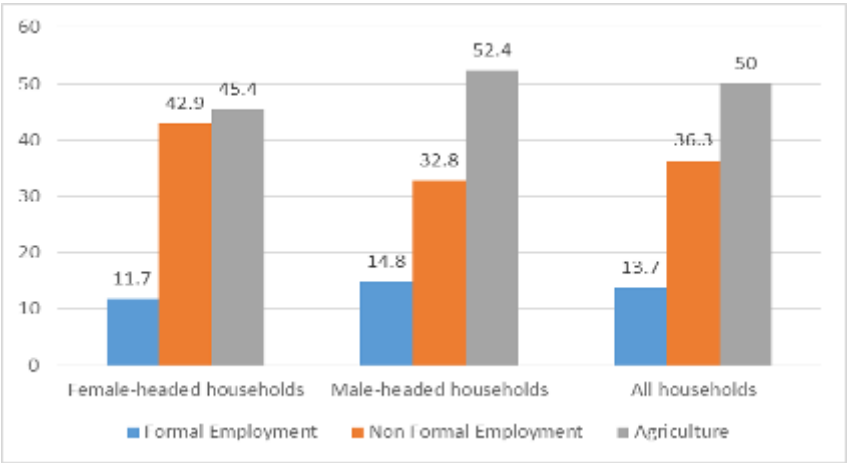


Women in Sierra Leone are expected to perform unpaid care work and reproductive chores for their male kin and children. This women's role determines a household's ability to sustain basic daily consumption. Yet this important role is, more often than not; time, labour and drudgery intensive without corresponding entitlements. The fact that most of the dead from EVD are women means that male kin and children have been denied the caregiving role of women – mothers, daughters, wives, etc. who have died directly or indirectly as a result of EVD.

4. 3. Experiences in the Economic sphere

Ebola related vulnerability added to the pre-existing social and economic vulnerabilities which included losing means of livelihood, support and income. Similar to the socio-economic studies done earlier by World bank/AfDB, FAO/UNDP, this studyestablished that in a sizeable number of post-quarantined households, EVD has had severe economic impact particularly for women and in female headed households.*Figure 4*below and *Appendix table A2*show that agriculture followed by informal employment constituted the major sources of livelihood for(post-quarantined)households before the outbreak of the EVD.

Figure 4: Major sources of livelihood before EVD outbreak



At the wake of EVD outbreak the government instituted stringent measures as a more robust approach to deal with the Ebola.While quarantine[12] is critical for controlling the transmission of EVD, it has significantly reduced economic and livelihood activities, which in turn have reduced employment, boosted poverty rates, and been increased food insecurity. The shutting of borders, where the majority of traders are women[13] sectors, which have significant female workforces, have equally affected. Members of 35%percent of household reportedly lost their jobs following the outbreak of EVD.

Figure 5: The impact of EVD on farming (including livestock and fishing)

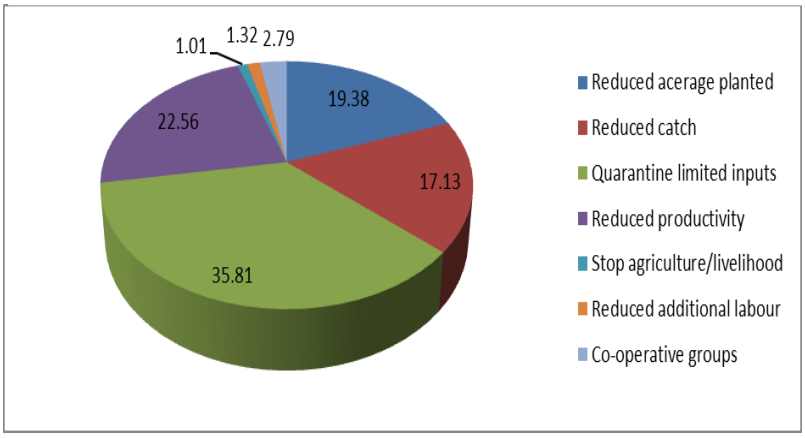


Figure 5 above depicts "Limited supply of inputs" and "reduced productivity" as predominant effects of EVD on farming.The undermining of agricultural productivity and trade which are the basis of family income and livelihood the EVD outbreak has negative correlation to economic welfare. For men, loss of gainful employment and trade opportunities had similar negative impact. Furthermore, fear of EVD infection is breaking down social cohesion and impairing the social networks that women rely on. As a result, women have experienced reversals in economic empowerment.

With limited household resources, girls are predisposed to and forced to engage in income-generating activities including petty-trading without any skill—driven initiative. They only do this by survival instinct. Sometimes, a bid for girls, in their new role, to provide care (e.g. in looking for food and fuel for cooking) caused breaches of the quarantine.This forced *coping strategy* out of necessity has immediate and long term consequences including possible school drop-out for children who were at school. The long-term outlook for child-headed or female headed households was good. The combined state of orphan-hood, likely need to drop-out of school would cut off children's education, nutrition, health, shelter and likely GBV, sexual exploitation and abuse of female children. For female headed households, the outlook is similarly grim.

Economic and social vulnerability was particularly dire in households in which children have lost one or both parents. Even where food packages were availed to such orphaned or child-headed

[12]Preventive and curative quarantine is in force in Sierra Leone as a measure to control EVD transmission.
[13]EVD has forced small-scale miners who are mostly womento abandon diamondmining altogether because of tight bordercontrols aimed at curbing the transmission of EVD. Before the EVD crisis, mining provided a steady and reliable income forwomen.

households, children were unable to cope because of lack of adult figure to help with food preparation and addressing the other day-to-day needs of children. Where older children existed following the death of their parents, the older sibling assumed the care giver role.

Although women (e.g. in the districts of Kailahun and Kenema) are leading farmers and heads of household, their agricultural bases have been severely eroded and, in some cases, completely wiped out by EVD deaths.

Household headship that is disaggregated by sex is important because this is associated with the welfare of the household. Households headed by women, are typically poorer than households headed by men. Study results show that 35 percent of post quarantined households are headed by females. This figure is above the national figure (28 percent) that was obtained in the 2013 SLDHS. Information of household headship by sex for quarantined households at sub-national levelis shown in *Appendix table A3.*

Figure 6: Percent of households that have experienced change of headship

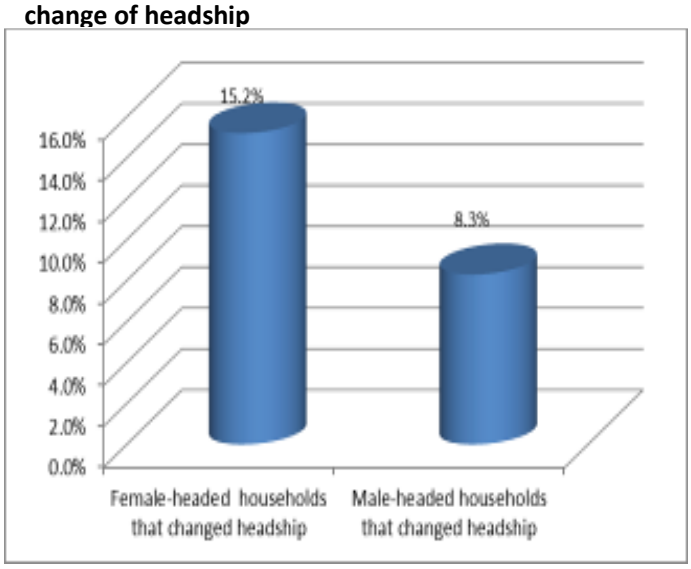


Table 1: Status of household headship

Table 1: Status of household headship

	Female headed-households		Male headed households		All households	
	Yes	No	Yes	No	Yes	No
Percent	15.3	19.9	8.4	56.5	23.6	76.4
Number	424	552	232	1566	656	2118

With the outbreak of EVD, some changes in household headship are noticeable. *Table 1* shows the status of household headship among quarantined households, whilst*Figure* 6 above, graphically depicts a 15 percent increase in female-headed households in contrary to 8.3 percent for male-headed households. Respectively, 79.3 percent and 78.4 percent of male and female headed households attributed the change to the death of previous household-heads, as shown in *Table 2* below. A similar pattern is noticeable across the provinces and districts of Sierra Leone *(see Appendix table A4).*

Table 2: Reasons for change of household headship

	Female-headed HHs			Male-headed HHs			All households (HHs)		
Province	Death	Travel	Other	Death	Travel	Other	Death	Travel	Other
Eastern	22.9	4.4	1.2	8.4	2.6	0.5	18.3	3.9	1.0
Northern	25.9	5.7	1.2	33.7	6.8	1.1	28.4	6.0	1.2
Southern	13.5	6.4	1.0	12.1	11.1	0.5	13.1	7.9	0.8
Western	17.0	0.5	0.2	22.1	0.5	0.5	18.6	0.5	0.3
Total	**79.3**	**17.0**	**3.7**	**76.3**	**21.1**	**2.6**	**78.4**	**18.3**	**3.4**
Number	**322**	**69**	**15**	**145**	**40**	**5**	**467**	**109**	**20**

This situation has far reaching implications for a society in which women play a pivotal care-giving and reproductive role. All actors in EVD control and recovery interventions should be aware of this important finding in their planning of services fororphaned children in particular.

4.4.Maternal and Child Health Care

In 2010, the government of Sierra Leone introduced the Free Medical Care for pregnant women, lactating mothers and children less than five years. This was done in order to combat the high deaths rates that were happening amongst these categories of persons. Universal immunization of children against the six vaccine-preventable diseases-tuberculosis, diphtheria, whooping cough (pertussis), tetanus, polio, and measles- is crucial to reducing infant and child mortality (SLDHS, 2013).

With medical facilities overwhelmed and the prevailing mistrust of health services and the fear of contracting EVD, the health seeking behavior of affected communities generally, and of women in particular, has been negatively impacted. The study found out that 10 percent of post-quarantined households had at least a pregnant woman, of which none of the pregnant women from the 29.1 percent of these households are receiving antenatal services (*see Figure 7.*'Fear to contract EVD' is a predominant reason for not receiving antenatal care (*see Appendix table A5)*. This means expectant mothers are going without pre-natal care and obstetric services

Figure 7: Percent of HHs with pregnant women Receiving/not normal antenatal and postnatal checkup

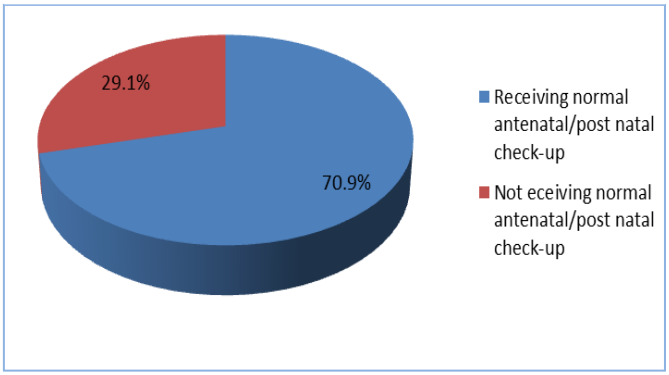
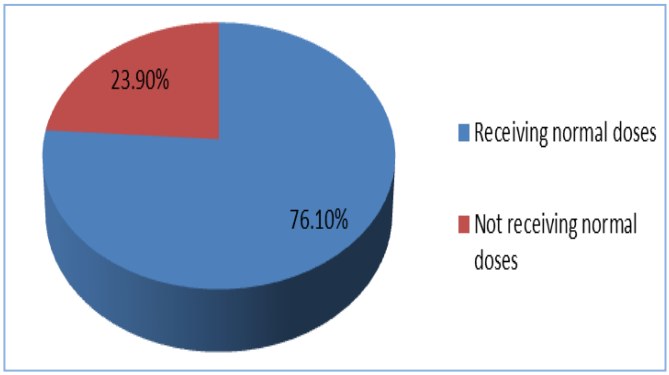


Figure 8: Percent of HHs with Under 5s receiving/not receiving normal vaccination doses



Notably,55 percent of post-quarantined households had at least an under-five child. However, the under- five children from 24 percent of these households indicated that their under-fives are not receiving normal doses of vaccines. The northern region has the highest number of under-fives that are not receiving their normal vaccine doses. Bonthe district has all its under-fives in post

quarantined households interviewed taking their normal vaccine doses*(Appendix table A7).*The major reason for non-compliance is fear of EVD infection*(see Appendix table A6 and A7)*

Although natural processes such as getting pregnant must continue, it is true that being pregnant during EVD outbreak places pregnant women in a very precarious position. Empirical evidence show that female survivors who are pregnant face serious problem during delivery. This is because some of the chain of transmission is through fluids and blood from infected persons. While for those that have given birth relatives and community people are afraid of having contact with their babies. Clearly, this situation is fast reversing the earlier progress made towards the Millennium Development Goal (MDG) on maternal and infant mortality in Sierra Leone. Compounding this, the assessment noted an increased risk of gender based violence (GBV) and exploitation of women and girls, due in part to isolation by quarantine or to orphan hood by EVD.

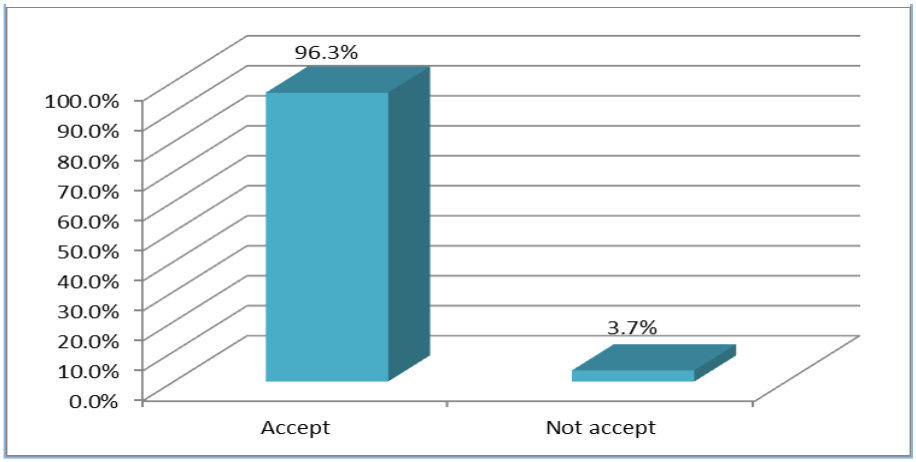
4.5. Emerging Gender Issues andTrendsin Ebola Viral Disease (EVD)

The assessment shows that EVD related vulnerability (and needs) have added to the pre-existing social and economic vulnerabilities of women and girls. A sizeable number of children have either lost both parents, a mother or a father, a clear signal that they now lack parental care and guidance. Those that have lost a mother are particularly in a more precarious situation because they have lost a care giver!

In a context where GBV and sexual exploitation programming has been seriously disrupted and schools have been closed as a measure to control EVD transmission, orphaned children, especially teenage girls, find themselves exposed to a heightened risk of GBV and sexual exploitation and abuse and pregnancy. Likewise, abandoned health facilities, limitations on people's movement due to quarantine, and reduced use of conventional health services for fear of infection mean that pregnant women are more likely to give birth unattended and forego ante and post-natal care. This will take reproductive health services back to traditional health systems like the SOWIES. Indeed, this assessment found EVD has negatively impacted delivery of vital and lifesaving newborn health care services such as vaccinations.

The stigma that goes with Ebola patients is very high. Even when EVD patients are declared by medics as having recovered from the virus, some persons hardly accept them. In some communities such persons are discriminated against. In the study, respondents were asked to ascertain their reaction towards household members who once suffered from EVD. The result shows that people generally would accept, as shown in *Figure 9* below. Households in the North are most willing to accept household members who recover from EVD with a percentage point of 32.9 percent. This is closely followed by people in the South then the East with 31.8 percent and 22.3 percent respectively. The least is recorded by the West with 9.3 percent *(see Appendix table A8.)*

Figure 9: Percent of households that will accept/not accept an EVD survivor



While respondents indicated they would accept EVD survivors back into their communities *(Figure 8 above and Appendix A8)*, female survivors of the disease may find themselves stigmatized and isolated from their communities due to pre-existing social and economic vulnerabilities. In the rural area, there is the common habit of intimidating female Ebola survivors. Intimidation of this nature ranges from preventing them to share their views and make meaningful contribution to societal issues.

Female survivors who were key-informants during the data collection exercise narrated how their human existence in the household, business places, community and places of worship turned out to be a nightmare. The stress and stigma faced by survivorsis aggravated by family members, close relatives and community people who refuse to share food with them in fear of contractingthe virus through eating in the same basin and or sharing common cooking utensils. The other stress is self-inflicted, as demonstrated by a female survivor in Western Area who expressed her fear and dismay of sharing the same toilet and bathroom facility with her family members: *"Since we use the same toilet and bathroom facility, there is a possibility of transmitting this disease to my family members and close relatives".*

4. 6. Coping mechanism of Women, Men, Girls and Boys

The EVD in Sierra Leone continues to disproportionately impact on members of households, particularly women and children. In-depth interviews, administered to EVD survivors found out that Ebola survivors, particularly females, face a lot of emotional trauma, stress, and stigma in the community particularly after they have recovered from the scourge of the infection. Some of these challenges are expressed in the form of experience and perception sharing in their households, compounds, place of work, business places, and relatives and even with their spouses.

Specific traumatic experiences shared by female survivors related to the processes of their extraction from their families when the rapid response teams arrived in their homes to transfer them to holding or treatment centres and from the security imposed on them by the military and police units guarding their quarantined homes. Respondents narrated bitterly their experiences faced particularly by female Ebola suspected persons. Female and male survivors narrated how

inhumane they had been mishandled by the rapid response teams. They narrated how ambulance teams did not even explain to them why and where they were being taken to. No explanations were offered to affected families and children were confused and afraid.No due regards was givento women's sanitary needs especially, for those on their menstrual cycle. Another bitter ordeal was the hospitalization of both male and female patients in the same ward without adequate segregation.The tradition and moral of the typical Sierra Leonean society was totally put asunder as male Ebola patients have no barrier to see the nakedness of other people wives who are infected by the virus. Most female survivors are reportedly sliding into isolation, depression and a deep sense of rejection.It was also discovered through experience sharing that some survivors especially female are easily losing their temperament due to mockery from immediate relatives and community people.

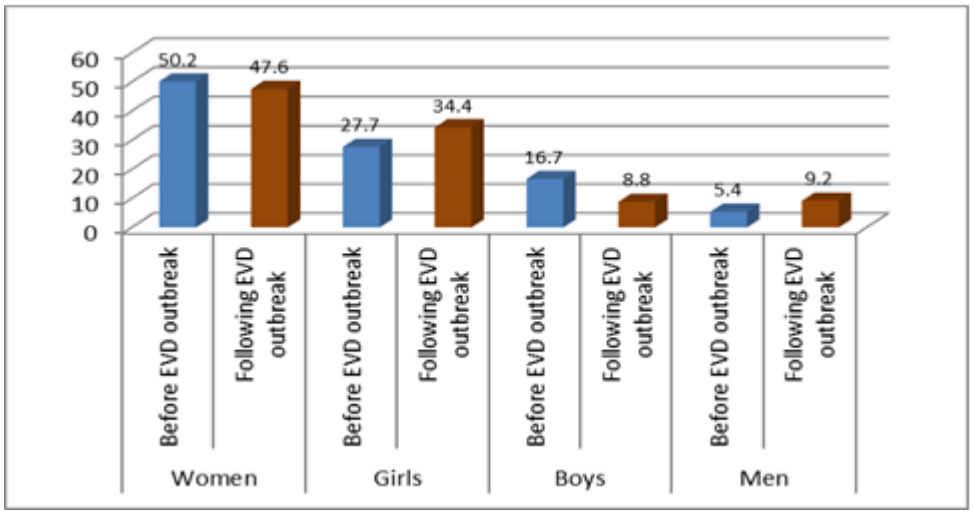
In the Kailahun, Kenema and even in the Port Loko treatment centres, female survivors complained of insufficient supply of food to patients. Food supply/distribution to patients was placed on the ground in the wards for them to collect and eat. There was no soap to wash and launder their clothes neither paste nor sanitary pads for female patients that are experiencing their menstrual periods. Indeed, toiletries supply to these centres was a serious challenge particularly to female patients.

Insufficient food supply was a serious challenge to most of these centres. According to some survivors even the meagre food supply giving to them by the treatment centre authority was not too nutritious to meet the lossof fluids and energy by patients during their period of infection. This according to these survivors is a major reason that accounts for most death in the treatment centres. In some treatment centres, however, survivors acknowledged with good sentiment the decency and delicious nature of the food supply to patients and the kind and accommodative nature of the authority and staff in these centres-eg. "Bandajuma" treatment centre and the Hastings treatment centre in Freetown.

As already discussed in section 4.2 above, agriculture followed by informal employment constituted major sources of livelihood for both male and female-headed households before the outbreak of EVD. Now with limited household resources,as a result of a displaced livelihood, girls are predisposed to engaging into income-generating activities. This form of coping strategy may, however, have severe negative consequences to the long-term welfare of households, given that it has a bearing on children's education, nutrition, health and rights to protection from GBV and sexual exploitation.

As shown in *Figure 9* below, the study revealed that 50.2 percent of women in households as opposed to 5.4 men collected water before the Ebola outbreak. The percentage of women who collects water reduced slightly to 47.6 percent as a result of the change but that of the girls increased to 34.4 percent as opposed to 27.7 percent before the Ebola outbreak.

Figure 10: Comparison of persons collecting water before and after EVD outbreak

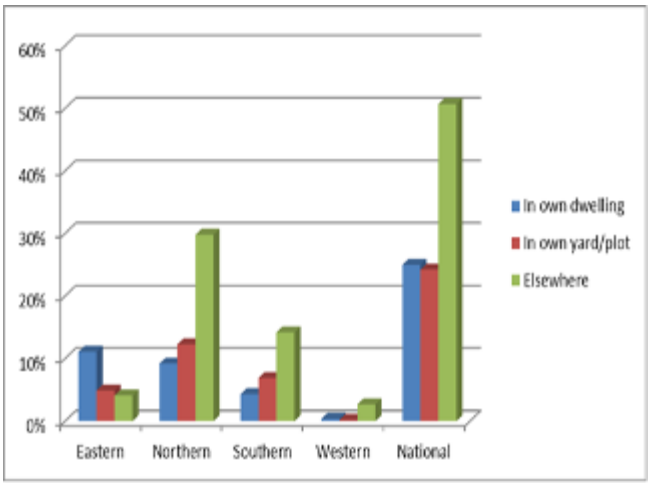


A girl-child being a natural care-giver as well, finds herself taking care of siblings following an untimely departure of a mother. This change affected girls in Kambia district more compared to the other districts. Apparently no woman or boy in the post quarantined households interviewed in Kailahun now collects water- water collection is being done by the girls. *(Appendix table A9).* This sad development has a number of implications for the girl child. First in the event that schools are reopened girls may resume school but with a new burden of the role acquired during EVD.

Children Struggling to fetch water in some parts of the Capital City of Freetown

Another issue of concern is the recent changes in the main water sources for 23% of the households surveyed. Save for the Eastern province, the majority of the new sources of water are neither in the dwelling nor on the yard, but rather elsewhere. Figure 10 shows the percent distribution households by new main sources of water and province. Change in the main source of water is high in Kenema district compared to the other districts.Out of the 22.6 percent households that have a change of main source of water, 50.8 percent have their new source elsewhere. Post quarantined households in Tonkolili district have more new water source elsewhere compared to the other districts*(see Appendix table A10.)*

Figure 11: Households indicating new sources of water

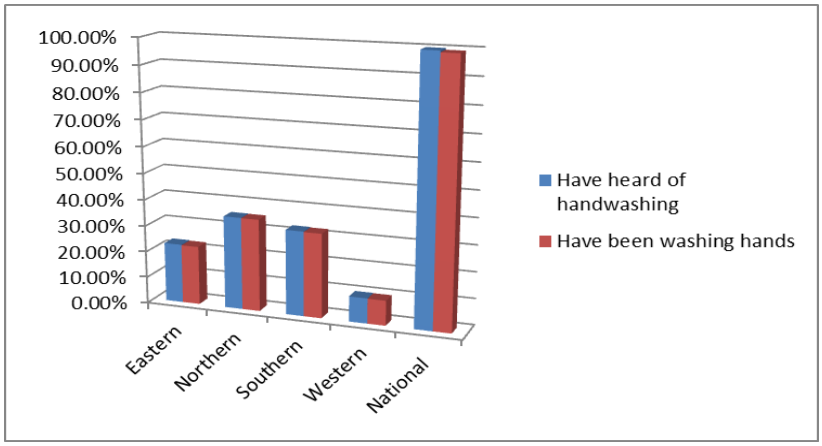


Unfortunately, aswomen and girls try to cope with household water demand, they walk long distances to fetch water; thus exposing themselves to GBV and sexual abuse and teenage

pregnancy. Teenage pregnancy is one of the problems affecting the reproductive health system in Sierra Leone.

In response to the EVD outbreak, the government in partnership with UN agencies, NGOs and private actors embarked on EVD advocacy campaigns on Ebola. Some of the campaigns dwelt on ABC (Avoid Body Contact) and 'hand wash' messages. By the time of this assessment, the uptake and implementation of the "hand wash" message was positive. Figure11 below shows the percentage of households who had heard about the 'hand washing' messages and those households actually practicing "hand washing".

Figure 12: Knowledge and Practice of hand washing



All households interviewed said they have been washing their hands. Knowledge of the hand washing campaign and the practice of hand washing is the same for all the regions saved the East which has a slight variation for knowledge and practice (22.70 and 22.80 respectively). Post quarantined households in Moyamba district are more knowledgeable about the Ebola handing washing campaign and practice hand washing compared to the other 13 districts in the country.
The western area Urban recorded the least number of 4.1 percent of knowledge of hand washing campaign and 4 percent of Ebola hand washing practice by members of the household.

Although the assessment revealed a success story for the 'hand wash' campaign, the same cannot be said so for the ABC campaign. This is because women(culturally) do not fully control decisions taken over their bodies.Harassment from husbands is another issue experienced and shared by most female Ebola survivors in their marital homes. Husbands irrespective of the medical advice given to survivors by medical practitioners that they should observe the three (3) months abstinence from any form naked sexual intercourse with their partners some partners are in the habit of coercing their counterpart to engage in this activity without using condom. A typical example of such incident took place in Kambia where a female survivor was faced with such a dismal experience. The husband of the survivor had to contact the virus and later died at treatment centre.

5. DISCUSSION

If one begins from the premise that Gender Equality is an issue of rights and development effectiveness "and not just a matter of political correctness or kindness to women… " thenthe Global Principle recommending that all Development Policies, Programmes and Processes should promote and achieve Gender Equality through Mainstreaming must ensure their full implementation and accountability to citizens all over the world. In this context, the government of Sierra Leone's AfP 2013-2018 as well as its National Strategy for the Empowerment of women and indeed all the UN Sierra Leone Country Team's efforts to engender the national Ebola Response in Sierra Leone are well founded and plausible courses.

It is in this context that the government of Sierra Leone through a collaborative effort of the Ministry of Social Welfare, Gender and Children's Affairs, the United Nations Entity for Gender (UN Women), Statistics Sierra Leone (SSL) and Oxfarm Sierra Leone joined hands to undertake a comprehensive assessment to examine, identify and ascertain the impact of EVD on women, men, boys and girls in the country.

The assessment investigated the specific, extent and the quantifiable impact of the outbreak of Ebola virus on the women, men, boys and girls in all the regions covering the 14 districts of Sierra Leone; seeking to understand theliving conditions of households; determining their lived experiences with EVD and using gender lens; examined the gender dimensions of the impact of EVD outbreak. The assessment is based on post EVD quarantined and affected households.

The most significant finding of this study is that there is a gender differential impact of EVD on women, men, boys and girls with women and girls bearing the biggest brunt of the EVD epidemic in terms of infection and coping with the disease. By far, women's socially ascribed gender roles of care-giving (domestic chores for well being/care giving of fending for food, fire-wood, fetching water for domestic use, cooking, cleaning, washing etc) within their families and within the wider society including preparing dead bodies for burial as well as traditional healer role were the biggest source of their susceptibility to EVD infection. This first level of vulnerability is followed by susceptibility derived from their biological role of carrying pregnancy and giving birth.

Both social and biological roles increase women's vulnerability and susceptibility to EVD as established by this study. It is important to qualify that it is important to underscore the fact that it is not only the numerical finding that 56.7% of women were infected as compared to 43.3% but also the implication of what that findings signifies. Even if there was no disproportionate impact of EVD between men and women (i.e. even if men and women were infected at the same ratio 50-50), the impact on either gender would be different. This is because the reasons behind and the drivers for women's infection are different than for men and have different implications. This factor is important to understand in the efforts to cut the chain of EVD transmission in Sierra Leone. Women's care role in the family exposes not only women to the EVD infection but the entire family and community at large.

Take for instance, if a married man were to contract EVD, and were to be looked after by his wife who has no information/knowledge/skills or protective apparatus for EVD infection prevention and control; the wife who might be at the same time looking after children in the same household would expose herself and the children. In situations where EVD information on prevention was not accessible for whatever reason, one has to wonder how many membersof a family would have been exposed from one index case due to the care giving role of women coupled with lack of information. This is why recognizing and addressing the gender dimensions of the crisis and any such similar humanitarian crisis is of utmost necessity.

According to Janet Fleischman (2014)[14]the immediate priority in such an epidemic is 'the need to have accurate information/data to inform decision making', this implies that having accurate data that is disaggregated by sex/gender would have been key to the Ebola response strategies. Fleischman further notes that data that has been disseminated is not always available and in some instances as has been in the case of EVD, the available data is sometimes contradictory and poses difficulties on epidemiological data in determining where and how the virus is affecting and infecting women, women, boys and girls disproportionately. Certainly, in the case of Sierra Leone, there were several sources of data and very little on the gender dimensions which resulted in the gender issues being sidelined and not having a basis for adequate attention to the EVD transmission chain in as far as gender dimensions is concerned.

On another level, from the findings of this study which indicates that there were shortfalls in adhering to human rights protocols such as by generating better informed strategies such as in quarantines; in instruction of Uniformed Security Officers (USOs) and the Rapid Response Teams (RRTs) who needed to be adequately monitored to ensure their adherence to gender and human rights, protocols throughout the response; facilitate monitoring of emergency supplies, protect human rights and promote the right to information to mitigate the fight against Ebola. Having empirical data such as generated by this study on the disproportionate impact of Ebola on women and girls and the implications of thereof would have contributed to better protection for women, women, boys and girls from SGBV and undignified treatment they reported having experienced.

At the same time, the involvement of women leaders at their community level in the fight against Ebola remains extremely critical; urgent and a major area of gap in the entire Sierra Leone EVD Response. It was not until community care centers involved women that Sierra Leone started seeing a tapering-off in the EVD transmission chain. Perhaps, there is lesson to be drawn that women's role as care givers and as a vital resource in awareness raising (amongst their peers and womenfolk); planning responses at community and household levels and social mobilization in partnership with youths and Paramount Chiefs would have yielded better dividends in the EVD faster. Furthermore, given the fact that women's economic poverty and vulnerability has direct association to their susceptibility to sexual gender based violence, perhaps EVD strategies and post recovery strategies should devise ways for compensating women's unpaid care giving role

[14] US Ebola Response: Strategies for Women and Girls Posted November 4 2014

including the care of sick members of their families during the EVD outbreak. Women's care-giving role including looking after the sick in the family took them away and availed them less time to earn income as well as exposed them more to the infection. Additionally, the study found a direct correlation of increased household food insecurity and income deficiency at household and community levels because a mother had been taken ill or had died due to EVD.

A genderedapproach to EVD infection control and management is necessary even within the context of a public health emergency such as Ebola. One key area in the gender dimension of Ebola is the abuse of human rights of women and girls. The human rights dimension of the Ebola must take into account, the sexual abuse, domestic violence and broader issues of SGBV in which gender power relations are implicated. In this regard, the national EVBD response should have had measures for women rights protection right at the onset of the response. Such issues as right o adequate information by women and girls taking into account high rate of illiteracy amongst women particularly in the rural areas should have been factored into account.

Additionally, the training and close monitoring of state security apparatus and uniformed officers deployed to sanction movement of persons and guard quarantined homes should have put in place additional human rights oversight measures at all levels of the EVD operations. It is now imperative that national human rights protection machinery be strengthened to undertake investigations of human rights abuses of women,men, boys and girls within the prevailing context of EVD and responsive actionstaken. It is worth noting that human rights abuse of women and girls is not new or only equated to the Ebola emergency.

This phenomenon was observed and addressed by the Transitional Justice systems after the Rwanda, Liberia, and Sierra Leone armed conflicts; in which women and girls as well as boys bore the heaviest brunt of the decadesof wars in which widespread rape and sexual abuse of women and girls including sexual slavery occurred. One would never have imagined that crimes and violations of women's human rights could again surface in such dire situations as the prevailing Ebola crisis that have made women as vulnerable as the world witnessed during the war.

The notion that socio-cultural and stereotypical patriarchal attitudes and practices that conceptualize and treat women as sex objects is deeply entrenched in the psyche of men and is endemic in some traditional Africa cultures should be urgently interrogated and addressed. It is about time that in the present context of EVD in Sierra Leone, the hard and outstanding question about *WHO ANSWERS TO WOMEN b*e asked. It is also important to note that this is not a rhetorical question. A wider question begs an answer around how and why security forces were deployed without adequate instruction and monitoring in the emergency EVD response.

The need for women's central and effective involvement in the fight against Ebola has been registered and underscored. That involvement requires women in the frontline as skilled people in managing family health needs including care-giving role similar to the role many nurses (the majority of whom are female) and not to treat them merely as victims and or transmitters of the EVD infection.. The role of culture and socialization of men to conceptualize and depict women "**as lesser than/witches/bad omen in society"** should urgently be reversed in tackling the EVD crisis.

Women's effective involvement in all aspects of EVD prevention and control --in reaching out to their families, peers and the general community at large is as important as that of their male counterparts. Further, women must be recognized and compensated for their unpaid work as care-givers in the Ebola outbreak. A gender sensitive approach would provide tools with which to analyze these socio-cultural contexts of EVD that cannot only be resolved by epidemiological interventions.

A gender sensitive approach is therefore a key tool in ensuring that women's needs are fully taken into account thus giving a gender lens to the fight against Ebola. Due to the volume of the transmission, more focus was on testing and treatment as opposed to prevention which could have benefitted from empirical data on the gender dimensions.

6. CONCLUSIONS

Socio-cultural determinants and drivers of EVD transmission from a gender perspective and Impact of Ebola Crisis

The assessment revealed the disproportionate risk of infection and mortality between women and men from EVD, which is traced to socio-cultural norms and behavior that perpetuate gender inequality. Indeed, their implications beyond the numerical differential impact of 52.7% (Female) and 47.3% (male) of EVD on women and men. For instance, the lack of a mother- in a home has dire consequences for the family--especially children who are left with care/support/guidance/welfare. Social vulnerability from absence of a mother figure in the home also exposes children to child labour. And forced by the circumstances, girls automatically out of conditioning assume the care-giving role to family. When they lack the basic needs of food, water firewood, they are easily manipulated, exploited and even sexually abused by men. The perpetual cycle of vulnerability is propagated by such crisis as EVD.

In view of the facts that are corroborating a higher incidence of violence and teenage pregnancy, child marriage may also rise as a quick fix to the caregiver role in the family. The traditional roles will contribute to the exacerbation of all sorts of violence and physical risks to women and girls. In addition to that, the EVD outbreak challengein some aspects, reversed achievements made on gender equality and women's empowerment (GEWE).

Emerging Gender Issues and Trends in Ebola Viral Disease (EVD)

Ebola related vulnerability (and needs) added to the pre-existing social and economic vulnerabilities (and needs) in ways that have been elaborated in this report – an addition which has compounded the vulnerability (and needs) of women and girls. On the positive side, the impact of the EVD has opened an opportunity and created a listenership for promotion of GEWE. For instance, the assessment noted that the outbreak of EVD has brought to a halt to femalegenital mutilation (FGM). This is controversially a good emergence in the context of EVD as FGM is detrimental to the reproductive health of women and girls. This apparent halt should be capitalized on. The efforts to mainstream gender should be continued in EVD control and recovery. This has implications for EVD control and recovery and for other planned national interventions such as the United Nations Development Assistance Framework (UNDAF) and the Sierra Leone National Agenda for Prosperity.

Ebola Virus Disease (EVD) has a devastating effect on in particular expectant mothers due the status of pregnancy itself which increases women's vulnerability and susceptibility due to their immunodeficiency.

The status of lactation is equally risky for breastfeeding infants should the mother be infected by EVD. The effects of EVD are more severe in pregnant and lactating women should they contract EVD. Firstly, it can cause spontaneous abortions with heavy bleeding especially during the first and second trimesters of pregnancy. Secondly, it can result in severe hemorrhaging and neurological complications with disastrous consequences for the fetus and newborn babies. In the case of Sierra Leone, women who were expectant or in their menstrual cycle at the time of the outbreak of Ebola and at the time of their extraction from their homes and referral to EVD holding centers were treated as if they were confirmed cases of EVD (simply because of the bleeding). This caused tremendous psychosocial anguish from a sense of unjust suspicion form EVD.

Coping mechanism of Women, Men, Girls and Boys

Some female survivors, who were once hospitalized in the same ward with males without segregation, are still haunted with this traumatic experience. They still live with the bitterness of having exposed their nakedness to male in-mates. Nonetheless, these survivors can still get over it with proper psycho-social support and their experiences serve to inform the need to begender responsive on all aspects of EVD interventions. Women's and girls' vulnerabilities should be addressed in all Ebola control and recovery interventions.

Some household coping mechanisms are making a girl-child even more vulnerable.For instances, when a mother succumbs to EVD, a girl-child finds herself in a double tragedy as she has to forgo her 'childhood' to continue with increased household chores and other income generating activities as illustrated in the assessment findings.This new burden of roles acquired during EVD will not only affect her educationbut also predisposes her to GBV and sexual abuse and teenage pregnancy.Furthermore, a bid for girls, in their new role, to provide care (e.g. in looking for food and fuel for cooking) caused breaches of the quarantine. This sad development is a reality check on how child rights, child protection (including safety nets) and girl-child's educational and reproductive health needs can be integrated into the EVD response. And if this cycle of vulnerability if not curtailed at this stage it will continue into adulthood.

Ebola campaigns messages are yielding positive results as the acquired knowledge (e.g. hand-wash) is being put into practice. However, observing "ABC" message is still a nightmare for some women because (culturally)women do no control their bodies.

The government Moratorium placed on FMG by the President of Sierra Leone was effective as no (Zero) case of FGM was established by the study. This positive finding is an important in finding in relation to confirming that such deeply embedded socio-cultural norms and practices can be halted in light of a calamity such as EVD.

There was access to information and high knowledge about the need to WASH hands and No Touch campaign amongst studied households. However, lack of access to water and sanitation in the studied households compromised the effective application of the knowledge. Therefore calling

for the need to accompany behavioural change information/knowledge with supportive measures for them to be translated into beneficial action and sustainable behavioural change.

Ebola Virus has destroyed the family/community coping systems and structures due to the stigma and discrimination associated with it. The stigma and discrimination are themselves although negative a coping mechanism for "self-preservation" by those that did not contract EVD. This behaviour stems from fear from the unknown/ignorance as opposed to malice. Both the "stigmatizer" and the stigmatized need adequate counselling to understand the issues better and to evolve better ways of coping with this reality. This is particularly important for families and communities to rebuild their relationships.

Girls who were in school before the outbreak of Ebola are particularly at a risk of losing out from continuing with their education when schools re-open. This is so in households where the mother has died due to EVD or any other non-EVD related causes. This is because the girl child automatically assumes the care-giver role or mother figure in a household where a mother has died. Where children are total orphans (have lost both mother and father); there is rise in child headed households.

Stigmatization of EVD orphans and female headed households due to EVD was established and should be urgently addressed. The study established a prevalence of fifteen per cent (15%) in female households due to EVD.

7. RECOMMENDATIONS

This Multi sector Gender Dimensions Impact Assessment of the EVD has identified, quantified and availed in-depth and critical understanding on the emerging gender issues and trends inthe EVDprevention/control and recovery interventions in Sierra Leone. All the EVD prevention and control measures and the recovery plans should draw for the results of the multi-sector gender dimensions impact assessment of EVD.

In particular, the remaining efforts towards completely cutting the infection chain in getting to Zero EVD in Sierra Leone and the recovery plans of the United Nations Development Assistance Framework (UNDAF) as well as the government early recovery plans towards the achievement of the national Agenda for Prosperity (2013-2018) of Sierra Leone should be engendered.

The following are specific recommendations relating to the overall strategies as well as sector specific EVD plans:

7.1. Overall, Gender Mainstreaming is required in all aspects of Ebola prevention, coordination, case management, contract tracing /disease surveillance and social mobilization, food security control and recovery interventions.

7.2. Because gender is a cross-cutting theme and as evidenced from the findings of the assessment, gender be integrated into all Pillars and should not be placed under one Pillar as is currently the case in the Sierra Leone national EVD Response. Presently Gender is lumped under Psychosocial, Gender and Child Protection Pillar. Considering that the Gender Cluster has never been convened by the Pillar Lead, it is highly recommend as a matter of urgency that a Standalone Gender Pillar be established to provide adequate tools and technical as well as coordination support to all the national EVD Response mechanisms of the NERC.

7.3. Reinstated and enhanced economic opportunities, including jobs and livelihoods are vital for addressing the challenges that EVD has posed to gender equality and women's empowerment, which has negatively impacted on household livelihoods. To address this, Government and its national and international partners should put together resources for: (i) livelihoods stabilization through emergency employment, start-up packs and grants to revitalize new and existing enterprises; (ii) revitalizing and/or developing small, micro and medium (agriculture and other) enterprises for women; and iii) inclusive growth and long-term employment creation entailing descent employment and enabling environment.

7.4. The meaningful participation of women community leaders in the fight against Ebola is critical and they must be involved in all aspects of awareness raising, planning responses at community and household levels. NERC and DERC should actively seek women's participation in social mobilization in partnership with youths, local community health workers.

7.5. In addition to mainstreaming gender into all the EVD Pillars, specific targeting of women, men, boys and girls should be undertaken. Examples include: (i) Ebola control and recovery messaging should speak to and address social-cultural practices that promote gender inequality and pre-dispose women and girls to be more vulnerable to Ebola infection and transmission – this could include exploring opportunities to change gender roles; (ii) Targeted Procurements of materials e.g. of comfort kits that facilitate girls attend school; (iii) Innovative interventions (e.g. innovative water capture) that release women from daily chores that reduce their participation in EVD recovery activities; and (iv) Exploring and promoting opportunities for changes in traditional gender roles v) Responsive to specific needs/worries of female hospital in-mates .

7.6. Training is urgently needed on human rights and gender for security apparatus deployed in all EVD responses.

7.7.Although EVD is largely a medical/health emergency in Sierra Leone; socio cultural attitudes and practices continue to confound EVD prevention and rapid treatment. These attitudes and behavior should be targeted in Ebola Control and Recovery interventions to break the EVD transmission chain perpetuated by socially prescribed roles including that of women and girls traditionally being the ones to prepare dead bodies for burial and in their role as traditional healers, where they have contracted and facilitated the spread of the virus.

7.8. The training for health workers and non-health workers should include the gender dimensions of EVD that have been articulated in this report. For instance, the unhygienic, undignified and traumatic experiences of women and girls' in holding centres and treatment centres could have been avoided if such training had been given to health workers.

7.9. Continue to collect and use sex- and age-disaggregated data available now, in both integrated EVD response and in all early recovery planning process.

7.10.Promote diversification of livelihood options and relevant skills development linking effectively with market for revamping household income.

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APPENDICES

Appendix A

Table A1:Sex of Infected Persons by Age Group

Age group	sex of infected person		Total
	Male	Female	
0-4	1.8	2.3	4
5-9	1	1.8	2.7
10-14	2	2.1	4.1
15-19	1.7	2.2	3.9
20-24	1.8	2.6	4.4
25-29	2.2	2.5	4.7
30-34	0.9	1.4	2.3
35-39	2.8	3.3	6.1
35-39	1.7	3.7	5.4
40-44	2.2	3.1	5.3
45-49	1.1	1.6	2.7
50-54	2.9	3.8	6.7
55-59	2.1	3.1	5.2
60-64	2.1	2.9	4.9
65-69	4.1	5.3	9.4
70-74	2.4	1.4	3.8
75-79	2	2.7	4.7
80-84	2.4	3.9	6.3
85-89	2.2	3.1	5.2
90-94	2.4	2.6	5
95-99	1.7	1.8	3.5
Total	43.3	56.7	100

Table A2: Households' Livelihood Status before the Outbreak of EVD.

	Female-headed households			Male-headed households			All households		
Province	**Formal Employment**	**Non Formal Employment**	**Agriculture**	**Formal Employment**	**Non Formal Employment**	**Agriculture**	**Formal Employment**	**Non Formal Employment**	**Agriculture**
Eastern	2.3	9.8	12.0	3.3	8.3	10.0	3.0	8.8	10.7
Northern	3.7	11.4	16.6	4.4	9.2	23.5	4.2	10.0	21.1
Southern	4.9	11.3	15.9	5.3	9.1	18.6	5.2	9.8	17.6
Western	0.8	10.4	0.8	1.7	6.2	0.4	1.4	7.6	0.5
	11.7	42.9	45.4	14.8	32.8	52.4	13.7	36.3	50.0
District									
Kailahun	0.7	1.0	4.3	0.8	0.9	2.0	0.8	1.0	2.8
Kenema	0.6	6.0	5.9	1.8	5.1	5.5	1.4	5.4	5.6
Kono	0.7	2.6	1.6	0.7	2.2	2.2	0.7	2.3	2.0
Bombali	0.3	3.2	1.4	0.6	3.2	2.6	0.5	3.2	2.2
Kambia	1.4	1.3	2.9	1.3	1.3	5.1	1.3	1.3	4.3
Koinadugu	0.2	0.0	2.6	0.1	0.5	2.5	0.1	0.3	2.5
Port Loko	0.8	3.4	2.7	1.1	2.8	4.7	1.0	3.0	4.0
Tonkolili	0.9	3.6	7.3	1.4	1.4	8.8	1.2	2.2	8.3
Bo	3.2	4.8	5.8	1.2	3.9	6.6	1.9	4.2	6.3
Bonthe	0.2	0.4	0.1	0.6	0.4	0.7	0.5	0.4	0.5
Moyamba	1.3	4.3	6.0	2.8	3.7	7.3	2.3	3.9	6.8
Pujehun	0.3	1.7	4.0	0.6	1.1	4.1	0.5	1.3	4.1
Western Rural	0.6	6.2	0.8	0.8	3.4	0.3	0.7	4.4	0.5
Western Urban	0.3	4.3	0.1	0.9	2.8	0.1	0.7	3.4	0.1
Total	**11.7**	**42.9**	**45.4**	**14.8**	**32.8**	**52.4**	**13.7**	**36.3**	**50.0**
Number	**114**	**417**	**442**	**266**	**590**	**944**	**380**	**1007**	**1386**

Table A3: Household Headship

	Male-headed households	Female-headed households
Province		
Eastern	14.1	8.5
Northern	24.2	11.2
Southern	21.3	11.3
Western	5.4	4.2
	65.0	35.2
District		
Kailahun	2.5	2.2
Kenema	8.1	4.4
Kono	3.3	1.7
Bombali	4.1	1.7
Kambia	4.9	2.0
Koinadugu	2.0	1.0
Port Loko	5.7	2.5
Tonkolili	7.6	4.2
Bo	7.6	4.8
Bonthe	1.1	0.3
Moyamba	8.9	4.1
Pujehun	3.8	2.1
Western Rural	2.9	2.7
Western Urban	2.5	1.6
Total	65.0	35.3

Table A4: Reasons for the Change in the Household Headship

	Female-headed HHs			Male-headed HHs			All households (HHs)		
	Death	**Travel**	**Other**	**Death**	**Travel**	**Other**	**Death**	**Travel**	**Other**
Province									
Eastern	22.9	4.4	1.2	8.4	2.6	0.5	18.3	3.9	1.0
Northern	25.9	5.7	1.2	33.7	6.8	1.1	28.4	6.0	1.2
Southern	13.5	6.4	1.0	12.1	11.1	0.5	13.1	7.9	0.8
Western	17.0	0.5	0.2	22.1	0.5	0.5	18.6	0.5	0.3
District									
Kailahun	9.6	0.0	0.7	4.2	0.5	0.0	7.9	0.2	0.5
Kenema	11.3	3.7	0.2	3.7	1.6	0.0	8.9	3.0	0.2
Kono	1.7	0.7	0.2	0.5	0.5	0.5	1.3	0.7	0.3
Bombali	5.2	0.2	0.0	12.1	2.1	0.0	7.4	0.8	0.0
Kambia	1.0	2.0	0.2	0.5	1.6	0.5	0.8	1.8	0.3
Koinadugu	2.2	0.0	0.5	2.1	0.0	0.0	2.2	0.0	0.3
Port Loko	6.2	0.0	0.0	8.4	0.5	0.5	6.9	0.2	0.2
Tonkolili	11.8	3.4	0.5	10.5	2.6	0.0	11.4	3.2	0.3
Bo	4.9	3.9	0.2	2.1	8.4	0.5	4.0	5.4	0.3
Bonthe	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Moyamba	6.9	1.0	0.5	8.9	1.6	0.0	7.6	1.2	0.3
Pujehun	1.2	1.5	0.2	1.1	1.1	0.0	1.2	1.3	0.2
Western Rural	9.1	0.5	0.2	11.6	0.5	0.5	9.9	0.5	0.3
Western Urban	8.1	0.0	0.0	10.5	0.0	0.0	8.9	0.0	0.0
Total	**79.3**	**17.0**	**3.7**	**76.3**	**21.1**	**2.6**	**78.4**	**18.3**	**3.4**
Number	**322**	**69**	**15**	**145**	**40**	**5**	**467**	**109**	**20**

Table A5: Reasons for not receiving antenatal care

	Reasons for not taking up normal antenatal						
	Hospital Facility	Distance to Hospital	Fear of contacting the EBOLA virus	No medical personnel president	Other Specify	Total	Number
Province							
Eastern	9.1	18.2	36.4	18.2	18.2	100.0	11
Northern	5.7	0.0	51.4	22.9	20.0	100.0	35
Southern	42.9	0.0	28.6	14.3	14.3	100.0	7
Western	21.4	7.1	42.9	7.1	21.4	100.0	14
District							
Kailahun	0.0	0.0	50.0	25.0	25.0	100.0	4
Kenema	14.3	28.6	28.6	14.3	14.3	100.0	7
Kono	0.0	0.0	0.0	0.0	0.0	0.0	0
Bombali	0.0	0.0	40.0	20.0	40.0	100.0	5
Kambia	20.0	0.0	20.0	60.0	0.0	100.0	5
Koinadugu	0.0	0.0	100.0	0.0	0.0	100.0	1
Port Loko	0.0	0.0	55.6	22.2	22.2	100.0	18
Tonkolili	16.7	0.0	66.7	0.0	16.7	100.0	6
Bo	0.0	0.0	0.0	0.0	0.0	0.0	0
Bonthe	0.0	0.0	0.0	0.0	0.0	0.0	0
Moyamba	50.0	0.0	33.3	16.7	0.0	100.0	6
Pujehun	0.0	0.0	0.0	0.0	100.0	100.0	1
Western Rural	33.3	11.1	33.3	11.1	11.1	100.0	9
Western Urban	0.0	0.0	60.0	0.0	40.0	100.0	5
Total	13.4	4.5	44.8	17.9	19.4	100.0	67

Table.A6: A: Reasons why children are not receiving normal doses of vaccines

	Reasons why children are not receiving normal doses of vaccines						
District	Hospital Facility	Distance to Hospital	Fear of contacting the EBOLA virus	No medical personnel president	Other Specify	Total	Number
Kailahun	0.0	11.1	88.9	0.0	0.0	100.0	9
Kenema	19.4	25.8	29.0	25.8	0.0	100.0	31
Kono	50.0	0.0	25.0	0.0	25.0	100.0	4
Bombali	0.0	8.3	50.0	16.7	25.0	100.0	12
Kambia	8.3	8.3	60.0	23.3	0.0	100.0	60
Koinadugu	36.0	4.0	60.0	0.0	0.0	100.0	25
Port Loko	2.7	1.4	67.6	24.3	4.1	100.0	74
Tonkolili	12.5	0.0	87.5	0.0	0.0	100.0	16
Bo	10.0	40.0	20.0	0.0	30.0	100.0	10
Bonthe	0.0	0.0	0.0	0.0	0.0	0.0	0
Moyamba	4.2	0.0	41.7	50.0	4.2	100.0	24
Pujehun	16.7	16.7	66.7	0.0	0.0	100.0	6
Western Rural	11.4	4.5	50.0	22.7	11.4	100.0	44
Western Urban	10.0	0.0	66.7	13.3	10.0	100.0	30

Total	10.7	7.0	57.1	19.7	5.5	100.0	345

Table.A7:Vaccination up-take by children Under-five and Reasons why Children are not Receiving Normal Doses of Vaccines

Children receiving their normal doses of vaccines			**Reasons for not receiving their normal doses of vaccines**				
Province	**Yes**	**No**	**No hospital Facility**	**Distance to Hospital**	**Fear of contacting the EBOLA virus**	**No medical personnel present**	**Other Specify**
Eastern	20.4	3.1	2.3	2.6	5.2	2.3	0.6
Northern	22.5	13.3	5.2	2.3	35.3	9.8	1.7
Southern	27.1	2.7	0.9	1.4	4.6	3.5	0.9
Western	6.1	5	2.3	0.6	12.1	4	2.3
	76	**24**	**10.7**	**6.9**	**57.2**	**19.7**	**5.5**
District							
Kailahun	4.5	0.6	0	0.3	2.3	0	0
Kenema	10.9	2.1	1.7	2.3	2.6	2.3	0
Kono	4.4	0.3	0.6	0	0.3	0	0.3
Bombali	5.4	0.9	0	0.3	1.7	0.6	0.9
Kambia	2.8	4.2	1.4	1.4	10.7	4	0
Koinadugu	2	1.7	2.6	0.3	4.3	0	0
Port Loko	4.2	5.2	0.6	0.3	14.5	5.2	0.9
Tonkolili	8.4	1.2	0.6	0	4	0	0
Bo	9.8	0.8	0.3	1.2	0.6	0	0.9
Bonthe	1.1	0	0	0	0	0	0
Moyamba	11.1	1.6	0.3	0	2.9	3.5	0.3
Pujehun	5.1	0.4	0.3	0.3	1.2	0	0
Western Rural	3.8	2.9	1.4	0.6	6.4	2.9	1.4
Western Urban	2.5	2.1	0.9	0	5.8	1.2	0.9
Total (percent)	**76**	**24**	**10.7**	**6.9**	**57.2**	**19.7**	**5.5**

Table A8: Acceptance of an EVD survivor

	Female-headed households		Male-headed households		All households	
Province	Accept	Not accept	Accept	Not accept	Accept	Not accept
Eastern	24.0	0.3	21.1	0.4	22.1	0.4
Northern	29.0	2.7	35.1	2.0	33.0	2.3
Southern	30.8	1.1	32.4	0.6	31.9	0.8
Western	11.7	0.3	8.1	0.2	9.4	0.2
District						
Kailahun	6.1	0.0	3.7	0.0	4.6	0.0
Kenema	12.4	0.2	12.1	0.3	12.2	0.3
Kono	4.9	0.1	4.9	0.1	4.9	0.1
Bombali	4.8	0.2	6.0	0.3	5.6	0.3
Kambia	5.7	0.0	7.4	0.3	6.8	0.2
Koinadugu	2.8	0.0	3.2	0.0	3.0	0.0
Port Loko	6.1	0.6	8.1	0.5	7.4	0.5
Tonkolili	9.9	1.9	10.8	1.0	10.4	1.3
Bo	13.6	0.3	11.7	0.1	12.4	0.2
Bonthe	0.6	0.1	1.6	0.1	1.3	0.1
Moyamba	10.6	0.5	13.3	0.4	12.3	0.4
Pujehun	5.9	0.2	5.9	0.1	5.9	0.1
Western Rural	7.5	0.2	4.5	0.1	5.6	0.1
Western Urban	4.5	0.1	3.7	0.1	4.0	0.1
Total	**95.5**	**4.5**	**96.8**	**3.2**	**96.3**	**3.7**
Number	**918**	**43**	**1719**	**57**	**2637**	**100**

Table A9: Water collection responsibilities

	Percentage distribution of persons charged with the responsibility of collecting the water for the household before the EBOLA outbreak				Percentage distribution of change in who collects water in the household since the EBOLA outbreak		Percentage distribution of who now collects water for use by the household members			
Province	Women	Girls	Boys	Men	Yes	No	Women	Girls	Boys	Men
Eastern	11.1	6.9	3.1	1.6	1.9	21	5	5.9	0.7	1.7
Northern	19.3	8.2	6.5	1.3	6.1	29	21.1	17.8	4.5	4
Southern	16.8	9.2	4.6	1.9	4.4	27.8	19.9	9.5	2.1	1.9
Western	3	3.4	2.5	0.6	1	8.7	1.7	1.2	1.4	1.7
District										
Kailahun	2.9	1	0.7	0.1	0.3	4.6	0	1.2	0	0.5
Kenema	6	3.8	1.7	0.9	1.4	11.2	4.3	4.3	0.5	0.9
Kono	2.1	1.8	0.7	0.5	0.2	4.9	0.5	0.2	0.2	0.2
Bombali	2.6	2.3	0.8	0.2	0.8	5.1	2.6	1.2	0.9	0.2
Kambia	2.6	2	2.2	0.1	1.6	5.1	2.6	8.3	1.9	0.2
Koinadugu	2.3	0.4	0	0.1	0.1	2.9	0.5	0	0	0
Port Loko	3.9	2.1	1.7	0.5	1.7	6.4	8.8	3.8	0.9	2.4
Tonkolili	8.1	1.5	1.8	0.4	1.9	9.7	6.9	4.5	0.7	1.2
Bo	6.8	3	1.6	1.2	2.1	10.3	11.1	2.4	0.7	1.2
Bonthe	0.6	0.4	0.2	0.1	0.2	1.1	0.2	0.7	0.2	0
Moyamba	6.8	3.7	1.9	0.5	1.3	11.4	5	4	1.2	0.5
Pujehun	2.6	2.3	0.8	0.1	0.8	5	3.6	2.6	0	0.2
Western Rural	2	2	1.3	0.3	0.6	5.1	1.2	0.7	0.5	0.9
Western Urban	1.1	1.5	1.2	0.3	0.4	3.8	0.5	0.5	0.9	0.7
Total	**50.2**	**27.7**	**16.7**	**5.4**	**13.4**	**86.6**	**47.6**	**34.4**	**8.8**	**9.2**

Table A10: New Sources of water

	Changes in the main source of water		Location of new sources		
District	Yes	No	In own dwelling	In own yard/plot	Elsewhere
Kailahun	0.9	5.2	0.2	0	1.5
Kenema	5.2	7.3	10.2	4.6	2
Kono	0.6	6.3	0.7	0.2	0.2
Bombali	0.7	1.1	2.3	3	5.9
Kambia	1	6.1	1.1	1.5	2.9
Koinadugu	0.2	0.1	3.1	0.5	3.1
Port Loko	3.5	4	2.4	3	7.4
Tonkolili	1.2	6.5	0.5	4.6	10.7
Bo	3.7	11.7	3.2	0.6	5.4
Bonthe	0.3	1.4	0.2	0.5	0.2
Moyamba	1.8	10.1	0.9	4.9	6.5
Pujehun	1.4	6.3	0.1	0.8	2.3
Western Rural	0.8	7.2	0.2	0.2	0.8
Western Urban	1.5	4.3	0.2	0	2
Total	**22.6**	**77.4**	**25**	**24.2**	**50.7**
Number	**445**	**1526**	**308**	**298**	**624**

Appendix B: Tools

Questionnaire

MINISTRY OF SOCIAL WELFARE, GENDER AND CHILDRENS AFFAIR

Multi Sector Gender Dimension Impact Assessment on Ebola

2014

IDENTIFICATION

PROVINCE NAME AND CODE _____

DISTRICT NAME AND CODE_____

CHIEFDOM NAME AND CODE _____

SECTION NAME AND CODE_____

LOCALITY NAME _____

NAME OF HOUSEHOLD HEAD _____

INTERVIEWER'S NAME _____

DATE ____/____/_____
DD MM YYYY

Hello. My name is _____. I am working with Statistics Sierra Leone. We are conducting a survey about the knowledge and prevalence of the Ebola virus in Sierra Leone. The information we collect will help the government to plan health services. Your household was selected for the survey. I would like to ask you some questions about your household. The questions usually take about 20 to 30 minutes. All of the answers you give will be confidential and will not be shared with anyone other than members of our survey team. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important. If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time.
In case you need more information about the survey, you may contact the person listed on this card.

Do you have any questions?
May I begin the interview now?

SIGNATURE OF INTERVIEWER: _____ DATE:_____

RESPONDENT AGREES TO BE INTERVIEWED . . . 1 ↓ RESPONDENT DOES NOT AGREE TO BE INTERVIEWI . . . 2 → END

SECTION 1: HOUSEHOLD CHARACTERISTICS

No.	Questions and Filters	Coding categories	Skip
Q1	How many persons slept in your household last night?	☐☐	

LINE NO.	USUAL RESIDENTS OF	RELATIONSHIP	SEX	AGE	IF 0 - 17 YEARS SURVIVORSHIP OF BIOLOGICAL PARENTS			EBOLA DEATHS	EDUCATIONAL LEVEL		Skip
	2	3	4	5	6	7	8	9	10	11	
	Please give me the names of the persons who usually live in your household and guests of the household who stayed here since May 25th 2014, starting with the head of the household.	What is the relationship of (NAME) to the head of the household?	Is (NAME) male or female?	How old is (NAME)?	Is (Name) natural mother alive? IF N OR DK, GO TO Q7A	If mother is dead; was the death due to the Ebola virus?	Is (Name) natural father alive? IF N OR DK, GO TO Q8A	If father is dead; was the death due to the Ebola virus?	Has (NAME) ever attended school?	What is the highest level of school (NAME) has attended?	
0 1		☐☐	☐	☐☐	Y N DK 1 2 3	Y N 1 2	Y N DK 1 2 3	Y N 1 2	☐	☐	
0 2		☐☐	☐	☐☐	Y N DK 1 2 3	Y N 1 2	Y N DK 1 2 3	Y N 1 2	☐	☐	
0 3		☐☐	☐	☐☐	Y N DK 1 2 3	Y N 1 2	Y N DK 1 2 3	Y N 1 2	☐	☐	
0 4		☐☐	☐	☐☐	Y N DK 1 2 3	Y N 1 2	Y N DK 1 2 3	Y N 1 2	☐	☐	
0 5		☐☐	☐	☐☐	Y N DK 1 2 3	Y N 1 2	Y N DK 1 2 3	Y N 1 2	☐	☐	
0 6		☐☐	☐	☐☐	Y N DK 1 2 3	Y N 1 2	Y N DK 1 2 3	Y N 1 2	☐	☐	
0 7		☐☐	☐	☐☐	Y N DK 1 2 3	Y N 1 2	Y N DK 1 2 3	Y N 1 2	☐	☐	
0 8		☐☐	☐	☐☐	Y N DK 1 2 3	Y N 1 2	Y N DK 1 2 3	Y N 1 2	☐	☐	

0 9		☐☐	☐	☐☐	Y N DK 1 2 3	Y N 1 2	Y N DK 1 2 3	Y N 1 2	☐	☐	
1 0		☐☐	☐	☐☐	Y N DK 1 2 3	Y N 1 2	Y N DK 1 2 3	Y N 1 2	☐	☐	

CODES FOR RELATIONSHIP TO HEAD OF HOUSEHOLD

01 = HEAD
02 = WIFE OR HUSBAND
03 = SON OR DAUGHTER
04 = SON-IN-LAW OR DAUGHTER-IN-LAW
05 = GRANDCHILD
06 = PARENT
07 = PARENT-IN-LAW
08 = BROTHER OR SISTER
09 = OTHER RELATIVE
10 = ADOPTED/FOSTER/STEPCHILD
11 = NOT RELATED
98 = DON'T KNOW

LEVEL

1 = PRIMARY
2 = JSS (MIDDLE SCHOOL)
3 = SSS (HIGH SCHOOL)
4=VOCATIONAL/TECH./NURSING/TEACHER
5=HIGHER
8 = DON'T KNOW

SECTION 2: MARITAL STATUS AND TEENAGE PREGNANCY

12	Has there been a change of the head of this household since Ebola outbreak?	Yes 1 / No 2 →	14
13	If Yes, what was the reason for the change of the household head?	Dead 1 / Travelled 2 / Other (Specify) 3 _____	
14	What is the current marital status of the household head?	Married 1 / Not Married 2 →	16
15	When did the household head got married?	Before the Ebola outbreak 1 / During the Ebola outbreak 2	
16	Are there any girls in this household who are betrothed for marriage?	Yes 1 / No 2 →	19
17	How many are there in this household?	☐☐	
18	Reason(s) for not getting married?	Because of the EVD outbreak 1 Other (specify) _____ 2	

SECTION 3: HOUSEHOLD INCOME

19	What is the household main source (s) of income for livelihood before the outbreak of the Ebola virus?	Formal employee 1 Non formal employee 2 Agriculture 3 →	21
		(If "1 or 2" Continue with Q20 and skip Q21 and Q 22)	
20	How has the status of your livelihood change as a result of the ebola outbreak?	No change 1 Changed jobs 2 Laid off 3 Compulsory /adminitrative leave 4 Got job/employment 5 Other (Specify) _____ 9	
21	How has the status of your livelihood change as a result of the outbreak?	Shut down/stopped farming 1 Reduced demand/reduced foodstuff 2 Market outlet (Lumas) Closed 3 Reduced income 4 Increased income 5 Other (Specify) _____ 9	
22	How has the ebola outbreak affected your farming(including livestock and fishing activities)?	Reduced the acerage planted 1 Reduced catch 2 Quarantine limited inputs 3 Reduced productivity 4 Stop agricultural/livestock goods 5 Reduced additional labour (usually got through) 6 cooperativegooups 7 Other, (Specify) _____ 9	

SECTION 4: MATERNAL AND CHILD HEALTH

23	Do you have any pregnant woman in this household?	Yes 1 / No 2 →	27

24	How many of these pregnant women are below age 18?	☐☐	
25	Does this (these) pregnant woman/ women receive her normal antenatal checkups?	Yes 1 / No 2 *If yes, SKIP to Q27*	
26	Why has/have this/these pregnant woman/ women not receive her/their normal antenatal checkups?	Hospital facility 1 Distance to hospital 2 Fear of contacting the EBOLA virus 3 No medical personnel present 4 Other (Specify) _____ 5	
27	Do you have any under five child in this household?	Yes 1 / No 2 → 30	
28	Is/are child (ren) under the age of five in the household receiving their normal doses of vaccines?	Yes 1 / No 2 If yes, SKIP to Q30	
29	Why Is/are child (ren) under the age of five in the household not receiving their normal doses of vaccines?	Hospital facility 1 Distance to hospital 2 Fear of contacting the EBOLA virus 3 No medical personnel president 4 Other (Specify) _____ 5	
	SECTION 5: KNOWLEDGE ON EVD		
30	Have you ever heard of a virus called Ebola?	Yes 1 / No 2 → SECTION 6	
31	From what source did you hear about Ebola? Anything else? RECORD ALL MENTIONED	Newspapers and Magazines A Radio B TV C Billboards D Brochures,posters and other printed materials E Health workers F Family, friends, neighbours and colleagues G Religiou leaders H Teachers I Social Workers J Others, (Specify) _____ Z	
32	What are the signs and symtoms of the Ebola Virus? RECORD ALL MENTIONED	Fever A Red Eyes B Nausea & Vomiting C Raised rash D Diarrhea E Chest Pain and Cough F Stomach Pain G Severe weight loss H Bleeding I Other(Specify) _____ Z	
33	Do you know of ways through which one can prevent him/herself from contacting the Ebola virus?	Yes 1 / No 2 → 34	

34	If yes, which ways? (Circle as reported)	Avoid body contact A Aviod touching infected persons B Avoid touching infected corpse C Avoid eating bush meat like bats and monkeys D Regular Hand washing E Don't have sex with infected person F Other (Specify) _____ Z	
35	If a family member show signs of Ebola, what will you do?	Take care of Him/Her at home 1 Report to medical Teams 2 Other Specify _____ 3	
36	Give reasons for 1 OR 2 in Q35 above **(RECORD THE RESPONSE IN THE SPACE PROVIDED)**	_____ _____ _____	
37	If any member of your household was infected with the Ebola virus and later cured, will you accept him/her in your household?	Yes No 1 2 → 39	
38	Reason(s) for not accepting the cured individual in your household? (**RECORD THE RESPONSE IN THE SPACE PROVIDED)**	_____ _____	
	SECTION 6: WATER AND SANITATION		
39	Have you head of the Ebola hand washing campaign?	Yes No 1 2	
40	Have members of your household been washing their hands including yourself?	Yes No 1 2 If yes, SKIP to Q43	
41	Reason(s) for not washing your hands? Specify	1 2 _____	
42	Has there been a change in the main source of water for members of your household?	Yes No 1 2 If NO, SKIP to Q44	
43	Where is that source located?	In own dwelling 1 In own yard/plot 2 Elsewhere 3	
44	Who was/were charged with the responsibility of collecting the water for the household before the Ebola outbreak?	Women 1 Girls 2 Boys 3 Men 4	
45	Has there been a change in who collects water in the household since the Ebola outbreak?	Yes No 1 2 → 47	
46	Who now collects water for use by the household member?	Women 1 Girls 2 Boys 3 Men 4	
47	Who controls the use and allocation of water among household members?	Women/Girls 1 Men/Boys 2	
48	Is the water available enough for use by pregnant and lactating women?	Yes No 1 2	
49	Do women and adolescent girls have access to enough water during their menstruation?	Yes No 1 2	

SECTION 7: EVD PREVALENCE

50	Has any member of your household been confirmed positive of contacting the Ebola virus?	Yes 1 / No 2 →	End

If question Q50= 1 then answer questions Q51 to END ***If more than four persons eligible use continuation sheet***

		1	2	3	4	5
Q51	Sex of ebola infected person (s)	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2
Q52	Age of Ebola infected persons					
Q53	Occupation *Health Worker = 1* *Non Health Worker = 2*					
Q54	How did the infected person contact the virus? *Taking care of a sick person* 1 *Touching an infected personv* 2 *Treating a patient* 3 *Touching an infected corpse* 4 *Sexual intercourse* 8 *Other(Specify)* _____					
Q55	Current Status of infected person: Dead 1 Recovered 2 Currently on treatment 3					
Q56	How many dependants does the infected person have? *(If none enter 00 and end interview)*					*If "00" END interview*
DP1	Sex of the dependant's	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2
	Age of the dependant's					
DP2	Sex of the dependant's	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2
	Age of the dependant's					
DP3	Sex of the dependant's	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2
	Age of the dependant's					
DP4	Sex of the dependant's	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2
	Age of the dependant's					
DP5	Sex of the dependant's	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2
	Age of the dependant's					

DP6	Sex of the dependant's	Male Female 1 2	Male Female 1 2	Male Female 1 2	Male Female 1 2	Male Female 1 2
	Age of the dependant's					
DP7	Sex of the dependant's	Male Female 1 2	Male Female 1 2	Male Female 1 2	Male Female 1 2	Male Female 1 2
	Age of the dependant's					
DP8	Sex of the dependant's	Male Female 1 2	Male Female 1 2	Male Female 1 2	Male Female 1 2	Male Female 1 2
	Age of the dependant's					
DP9	Sex of the dependant's	Male Female 1 2	Male Female 1 2	Male Female 1 2	Male Female 1 2	Male Female 1 2
	Age of the dependant's					
DP10	Sex of the dependant's	Male Female 1 2	Male Female 1 2	Male Female 1 2	Male Female 1 2	Male Female 1 2
	Age of the dependant's					

AP3: Interview guide

Multi Sector Gender Dimension Impact Assessment on Ebola

Key informant Questions

Q1a. Are the WASH facilities in theEbola health facilities and treatment centre's, designed to cater for the needs of women and girls?[Recommended for INGOs like MSF, IMC, IRC, SCUK, IFRC/Red Cross, survivors and medics working in the ETCs].

Q1b. Have women and girls been consulted about:

- the location
- design of WASH facilities? [Oxfam, ACF, Goal, Concern etc]

Q2. Are both men and women represented on WASH committees? Are they both actively involved in:-

- decision-making
- financial control;
- the construction, operation and maintenance of facilities; and finally
- Participate in technical trainings?

[Locate the WASH committees and probe their composition and activities].

Q3. Are there any gender-specific challenges that female Ebola survivors face? If there are any challenges can you please list them.*Probe by mentioning some of the challenges like sanitary provision, privacy, been listened to, opportunity to decide on transaction on sex, stigmatization etc.*

[Female interviewers are recommended to ask these questions to female survivors][*Ask organizations focusing on women like WRESL, Office of the 1st Lady, Women's forum, Gender Advisor]*

Q4. Is there an increased sexual and gender based violence (SGBV) in the community due to Ebola crisis? Reasons *[could check records from Rainbo centres, police stations and ask key informants like chiefs, women leaders FSU police and triangulate with some community members including parents and young women]*

Q4b. Are SGBV support mechanisms weakened due to the EVD outbreak? If so, can you please explain how the SGBV support(s) mechanisms have been weakened due the Ebola outbreak? [Preferably for MSWGCA and NGOs working on SGBV, FSU and Rainbo centre operators. Info could be triangulated from community members especially women]