

11 November 2015

Ebola outbreak in West Africa



Challenges to the reintegration of affected groups into communities

INTRODUCTION

Reintegrating those most affected by Ebola back into their communities is central to a country's post-Ebola recovery. The reintegration process helps those affected to cope with the impact of the outbreak and to regain a sense of normality. It is also an essential part of increasing community preparedness and building resilience to possible future emergencies such as a new epidemic or a natural disaster.

Out of approximately 28,500 suspected, probable and confirmed cases, nearly 11,300 people have died since December 2013. With such a significant caseload, everyone living in Sierra Leone, Guinea and Liberia was affected by the Ebola outbreak in some way. Ebola survivors and their households, grieving families, orphans, quarantined people and frontline workers are among the most affected groups. This report outlines the key challenges these groups face as they reintegrate into their communities, and explores the main challenges for the response in supporting them through the process.

KEY FINDINGS

- + **Stigma:** The major consequences of stigma include the limited access to and use of basic services, loss of livelihoods, negative social and psychosocial impacts, marginalisation from community dialogue and violence towards those affected. The extent of this stigma remains unclear. Uncertainty about Ebola viral persistence in body fluids might also increase the intensity of stigma towards Ebola survivors.
- + **Health:** The outbreak caused mental health issues throughout the affected population while Ebola survivors often experience secondary medical complications hampering their return to a state of normality and ability to reintegrate.

- + **Socio-economic issues:** The outbreak has reduced the incomes of affected groups' for a variety of reasons including the death of income-generating family members, an inability to do agricultural work while in quarantine and the loss of work relating to the response as international programmes scale down. All these factors make it difficult for those affected to reintegrate to the social and economic life of their communities.
- + **Child protection:** Orphans and other affected children face a heightened risk of marginalisation and of dropping out of school, potentially leading to further protection issues.
- + **Challenges for the response:** Response activities aimed at supporting the reintegration of those most affected by Ebola are ongoing and planned. However, the response in all three countries faces issues related to a lack of community ownership of reintegration activities, lack of national capacity to plan and provide services and the potential lack of hand over once most international humanitarian programmes close at the end of 2015. There is also a danger that affected groups could be further ostracised if programmes are seen to target them at the expense of wider populations in need.

Information gaps and needs

- Severity and duration of stigma
- Number and needs of child survivors and survivor households
- Duration and acuteness of survivor health needs
- Impact of Ebola on the teenage pregnancy rate and related reintegration needs
- Nutritional needs of Ebola affected children
- Extent of homelessness of affected populations
- Number of frontline workers who have not received full hazard compensation

The ACAPS Ebola Project aims to support strategic decision making, programme design and advocacy work surrounding the Ebola outbreak by providing analysis on current priority needs and ongoing issues. Funded by the European Commission's department of Humanitarian Aid and Civil Protection (DG ECHO), it builds on the contextual knowledge and sectoral analysis forged through the ACAPS Ebola Needs Analysis Project (ENAP).

OUTLINE

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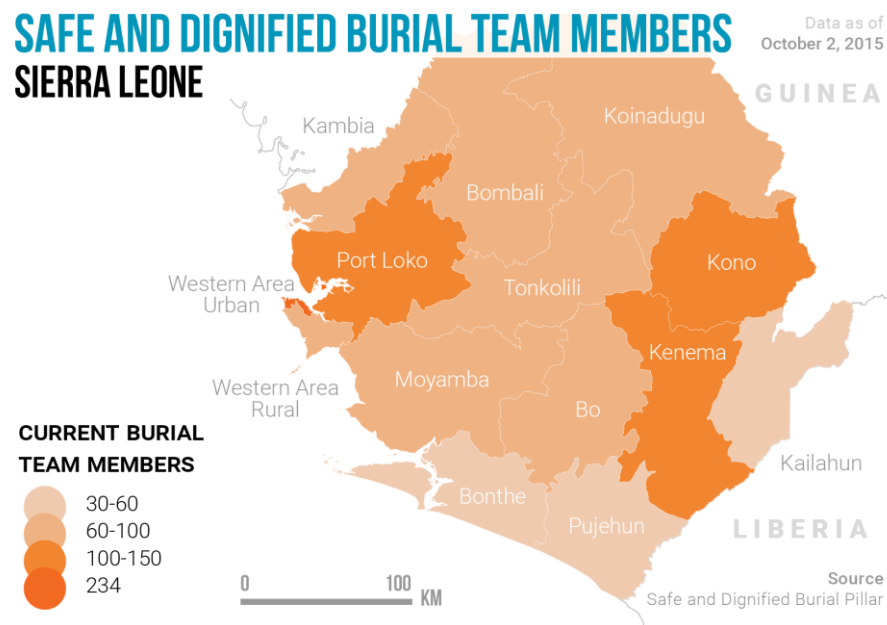
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MOST AFFECTED GROUPS

- + **Survivors and their households:** There are approximately 5,800 registered Ebola survivors in Sierra Leone (3,032), Guinea (1,259) and Liberia (1,500). In Guinea, there are 7,632 immediate family members of Ebola survivors affected by the epidemic (WHO, 07/10/2015).
- + Exact survivor numbers are difficult to determine as not all of them have registered, mainly due to broken information chains when discharged from Ebola Treatment Centres (ETCs), and a lack of interest in, or fear of registering with, authorities. Estimating survivor numbers using available data on Ebola cases and deaths is inaccurate, as data on cause of death is not disaggregated (WHO, 04/11/2015; Al Jazeera, 01/10/2015).
- + In Sierra Leone, there are fewer registered survivors in the first districts affected by Ebola, which could point towards lower response capacities there at the beginning of the outbreak.



- + **Grieving families:** Grieving families are household members who lost a relative to Ebola. In Guinea, there are nearly 15,200 people who lost a relative (WHO, 07/10/2015). In Sierra Leone and Liberia, based on household average sizes and confirmed Ebola deaths, they are an estimated 19,740 and 24,040 (WHO, 04/11/2015; Euromonitor, 2014).
- + **Orphans:** An orphan is a child who has lost one or both primary caregivers to Ebola. Nearly 22,000 children are reported as orphans across the three countries, including 12,000 in Sierra Leone, 6,190 in Guinea and 3,620 in Liberia (Street Child, 13/02/2015; OCHA, 07/10/2015; UNICEF, 10/07/2015).
- + **Frontline workers:** Frontline workers include mainly healthcare workers, safe and dignified burial teams, swabbers, ambulance drivers, and cooks. In Sierra Leone, there were 1,398 safe and dignified burial team members as of October 2015. The higher team presence in Western Area, Port Loko, Kono and Kenema is due to a high Ebola case prevalence and to compensate for additional time needed by teams when accessing remote areas, especially during the May–November rainy season.
- + **Quarantined people:** Quarantine is separating and restricting the movement of people who may have been exposed to Ebola. It allows health authorities to prevent further spread of the disease, in the event that a quarantined individual develops clinical symptoms. Different quarantine measures have been used during the outbreak in Sierra Leone: individual quarantine, household level quarantine, village level quarantine and chiefdom or district level quarantine.
- + **People who reported cases or deaths:** The neighbours, health workers or relatives who reported suspected Ebola cases or Ebola deaths in their communities to health authorities.



STIGMATISATION

Stigmatisation is understood in this report as the act of stereotyping and discriminating against an identifiable group of people and can occur when people associate an infectious disease, such as Ebola, with a population (CDC, 08/2014). In the context of Ebola it has a range of harmful effects, notably in terms of access to and use of basic and essential services, socialisation, emotional distress and livelihoods (ERAP, 11/12/2014; IFRC, 23/03/2015). Addressing these effects is essential to promoting the reintegration of groups affected by stigma into communities.

There are at least three main root causes of stigma in the Ebola context:

- + **New disease:** It was the first time people in West Africa were affected by Ebola, so they did not know the disease, its origin, or how to protect themselves from it (ERAP, 11/12/2014). Fear of contracting the disease and of the responders in the affected communities further fuelled the stigmatisation, deterring people from seeking treatment at healthcare centres (ODI, 16/10/2015).
- + **Messaging:** Inadequate messaging coverage, content and inappropriate communication channels prevented people from accessing information. For example written messages were less effective given the high illiteracy rates in the three countries. This led to the spread of myths and rumours about the origin and transmission of Ebola which in turn led to increased stigma associated with the disease.
- + **Changes in burial practices:** The treatment of patients by ambulance workers and corpses by burial teams was perceived as disrespectful, especially at the beginning of the epidemic when appropriate protocols were lacking (Kinsman and al., 15/04/2015). In Liberia, the decision to cremate bodies created large and long-lasting negative perceptions towards safe and dignified burial teams, leading to their rejection by communities. (PI, 05/10/2015).

The extent of stigmatisation remains unclear, although the affected population seems to have suffered varying degrees of stigmatisation within their families and communities during the outbreak. Stigmatisation seems to be closely linked to the number of Ebola cases, lessening as case numbers decrease (PI, 01/10/2015). Measuring the change in stigma levels, or attributing reduced stigma to any interventions, remains challenging.

CAUSES OF STIGMA

Distrust / Blame

Affected groups are being blamed for keeping Ebola in the communities, infecting loved ones or preventing traditional burials, leading to distrust and relationships issues.

Reminder

Affected groups are rejected by communities who do not want to be involved with Ebola anymore.

Perceived Risk

Affected groups are perceived as a risk of possible further transmission.

STIGMATISED GROUPS

Survivors and their households



In some cases, survivors are resented for benefiting from specific support while the rest of the community is also in need of assistance. (PI, 05/10/2015).

Grieving families



In some cases, grieving families are integrated into societies but people do not want to have a relationship with them and be involved with what reminds them of the disease (PI, 01/10/2015). There is a lack of information on this issue.

Orphans



Children without a caretaker face difficulties finding a home due to the pervasive stigma around Ebola. Those whose parents were the first to contract the virus in a community have been particularly stigmatised. (Huffington Post, 10/2015; PI, 01/10/2015).

Frontline workers



Safe and dignified burial teams have suffered strongly from stigmatisation due to communities resenting them for not being able to bury their loved ones as they wish to. Communities also blame ambulances drivers as they took away their loved ones and did not bring them back. (PI, 05/10/2015)

People who reported cases



People who reported suspected Ebola cases or deaths suffer from stigmatisation as they are being perceived as being responsible for the "disappearance" of their loved ones who were taken away in an ambulance to an ETU. (PI, 30/09/2015)

Quarantined people



An assessment found that quarantines bring shame and stigma on people because of the perception that they are infectious (Oxfam, 03/2015). There is a lack of information on this issue.

Causes for the stigmatisation of each group were highlighted in the data collected; there is a lack of understanding with regards to which causes remain predominant as of today.

When considering interventions to reduce stigma, it is important to consider why people are being stigmatised. Community-level Ebola sensitisation may be a more appropriate approach when dealing with perceived risks of infection, while conflict resolution and mediation approaches may be more appropriate when dealing with distrust and blame. Guaranteeing equal services throughout the population may help to avoid stigmatisation of affected populations.

CURRENT IMPACT OF STIGMATISATION

- + **Challenges to the use of basic services:** Stigmatisation and discrimination against survivors sometimes hampers their ability to use basic services. The Ebola Survivor and Affected Families Assessment (SAFA), conducted July–August 2015 in Koinadugu district Sierra Leone, reports that 29% of assessed survivors suffered stigmatisation; half said it affected their use of health services, either due to discrimination from others or their own fear about the reaction they would receive (MdM, 18/09/2015). In Liberia, there have been reports of pregnant survivors being denied safe delivery at healthcare centres, and the report of a survivor who miscarried being shunned by doctors and nurses at the hospital she was taken to (local media, 30/09/2015; local media, 30/09/2015). A possible solution to this kind of stigma may be additional training and sensitisation for healthcare workers.
- + The association of Ebola with services has deterred people from using them, including ambulances, hospitals and channels used to report suspected Ebola cases (for example calling 117 in Sierra Leone). Communication campaigns, such as community ambulance exhibitions, help reduce negative perceptions towards basic services. In Sierra Leone and Liberia, there were cases of people refusing to have their children vaccinated against communicable diseases due to fear and suspicion over Ebola vaccines and other vaccines being brought to their villages (PI, 05/10/2015; Ebola Deeply, 19/02/2015).
- + **Loss of livelihoods:** People affected by Ebola have been stigmatised by employers, preventing them from finding new jobs or returning to old ones. Unofficial figures from Liberia estimate that 50–70% of former Ebola frontline workers (approximately 12,000 people) are currently unemployed, particularly in and around the hard-hit Margibi county (PI, 23/09/2015; IRIN, 11/06/2015). However, pre-Ebola data highlights that 78% of the primarily young labour force were engaged in “vulnerable employment”, without an assured salary, partly due to lack of jobs in the country (ADB, 04/2012). Training for young people who lack a formal education or job skills is required, together with livelihood support (local media, 10/02/2015).
- + **Social and psychosocial impact:** Stigmatisation has created tensions in communities and caused social and psychosocial issues for the affected population (PI, 01/10/2015; PCCR, 30/09/2015; Child Protection sub-cluster, 2015). The SAFA reports that 13% of grieving families noticed a sudden decline in their social interactions with their communities after the death of a family member, causing feelings of isolation and abandonment. In most cases, relationships and interactions within communities returned to normal over time (MdM, 18/09/2015).
- + The psychological impact of stigma on frontline workers has left some of them suffering alone and turning to negative coping mechanisms (The Guardian, 03/08/2015). Those working alongside frontline workers, such as drivers and cooks, have also been stigmatised, have less support from responders, and as a result suffer trauma (PI, 05/10/2015).
- + **Marginalisation from community dialogue:** Stigmatisation has marginalised affected populations from community dialogue, limiting their ability to express their needs, even if some interventions are in place. In the SAFA, survivors and their households point to a high rate of rejection from community activities after Ebola infection, although community acceptance was reported over time in the majority of cases (MdM, 18/09/2015). Some associations, set up by survivors, in Sierra Leone, Liberia and Guinea are advocating on the behalf of survivors, but are not representative of all survivors and their needs. In Guinea, plans to assess and advocate for survivor needs have yet to be finalised, although a first workshop took place in October 2015 and called for the creation of a technical group to finalise them (international organisation, 01/10/2015).
- + **Homelessness:** There are reports of survivors being evicted from their homes after being discharged from ETCs, due to stigma. Frontline workers have also been evicted from their homes (PCCR, 30/09/2015; international media, 30/09/2015; BRC, 25/09/2015). In Sierra Leone the issue of homelessness among survivors is alarming, especially in rural areas and slums. There are reports of some survivors living in abandoned vehicles, or landlords doubling rents to drive them out of their apartments (Communication Pillar, 20/10/2015; PI, 06/10/2015; Reuters, 21/10/2015).

- + **Risk of violence:** Stigmatisation increases the risk of violence towards affected groups. There are rumours of chasing, lynching and death threats towards survivors in the Bombali and Kambia districts of Sierra Leone, together with rumours of local leaders imprisoning survivors on suspicion of transmitting Ebola (PI, 12/10/2015; PI, 30/09/2015). There is a need for clearer messaging and a legal framework to protect affected groups.

AGGRAVATING FACTOR

- + **Viral persistence of body fluids:** It is not yet known how long the Ebola virus might be found in the bodily fluids of survivors, and whether it could be sexually transmitted (see Annex I). Rumours might feed stigmatisation, as the risk has not yet been clearly identified and correct messaging around the issue was not agreed on fast enough (international NGO, 25/09/2015).
- + Early recommendations by international health agencies were that Ebola survivors should abstain from sex for at least three months or use condoms. These recommendations have recently changed to integrate new findings on viral persistence. Until more information becomes available, WHO currently recommends that safe sex is practiced until an Ebola survivor's semen has twice tested negative. If an Ebola survivor's semen has not been tested, they should practice safe sex for at least six months after the onset of symptoms. The emphasis is also on avoiding all contact with semen (WHO, 08/05/2015).
- + In Sierra Leone, communication campaigns targeting male survivors, including advocacy for the use of condoms, are ongoing, but more emphasis on safe sex is needed in Liberia and the region (local media, 28/09/2015; Reuters, 26/09/2015). The very fact that survivors have to regularly test their semen, and that specific services have been set up for this, could lead to them being further ostracised by communities. The process of semen testing leads to patients feeling more exposed as they lose confidentiality, which could create resistance and affect uptake of these services.

LESSONS LEARNED ON STIGMATISATION

- + **Lessons from HIV-related stigmatisation:** While useful, there are limits to comparisons between HIV and Ebola. HIV is a chronic infectious disease, while we are unclear about the length of Ebola persistence. People most at risk of HIV, for example sex workers, men having sex with men and people injecting

drugs, usually suffer from pre-existing stigma, while with Ebola, everyone is at risk of stigmatisation (AVERT, 01/2015; International AIDS/HIV alliance, 2011).

- + Lessons can be drawn however, as with both diseases, stigma develops from fear. In the context of HIV, removing stigma is seen as a crucial step to removing barriers to universal access to prevention, care and treatment. Lessons learned from addressing HIV-related stigma suggest that it is essential to empower and mobilise various groups such as prominent members of the community, those who have recovered from the disease, and organisations working at the grassroots level to disseminate clear and accurate information about transmission and prevention and to promote stigma reduction. In the long-term, education and clarity on preventative measures are the best ways to reduce stigma (Davtyan and al., 19/09/2014).
- + **Lessons learned from the Ebola outbreak in West Africa:** Any strategy to stop Ebola must address the excessive fear that can develop from rumours and misconceptions. Regularly providing communities with clear information about the outbreak is vital to reduce stigma and prevent other negative outcomes.

HEALTH

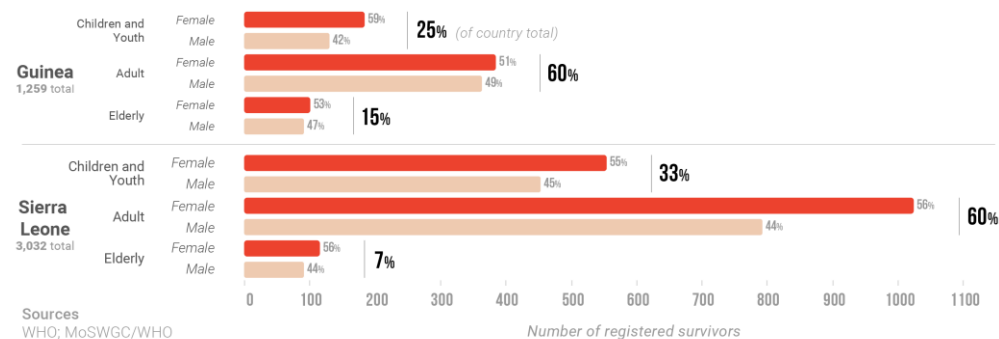
Lingering health-related problems have to be addressed to sustainably reintegrate vulnerable individuals into their communities. Vulnerable individuals include survivors who are suffering from a wide range of medical complications and other vulnerable groups whose mental health has been affected as a consequence of the Ebola outbreak. Addressing these issues is made more difficult by weak healthcare systems across the three countries, and pre-existing mental health needs in Sierra Leone and Liberia.

MEDICAL ISSUES OF SURVIVORS

- + **Medical complications:** The majority of survivors suffer from medical complications that prevent them from returning to a normal life, such as joint pain, vision problems, neurological disorders and cognitive issues (Government, 04/09/2015; OCHA, 10/07/2015). As of August 2015, at least 25% of survivors across the three countries were suffering from vision problems, including near blindness (IRIN, 12/08/2015). It is unclear how long the health needs of survivors are going to last. While there are a lot of on-going studies related to viral persistence in bodily fluids, enhanced research and capacity is needed to understand the length and seriousness of these medical complications (PI, 17/09/2015; NERC, 27/07/2015).
- + **Impact of medical complications on livelihoods:** Some survivors have lost their livelihood, partly because the recovery phase of the disease left them without the strength or capacity to do their normal work. Reduced income as a result of inability to work affects their livelihoods and therefore their access to food and other basic goods. This particularly affects the working population in Sierra Leone and Guinea, as 60% of survivors are adults aged 18–49 (PI, 29/09/2015; Al Jazeera, 01/10/2015; MdM, 18/09/2015).

SURVIVOR DEMOGRAPHICS

October 2015



MENTAL HEALTH

People affected by Ebola face multiple mental health issues, including anxiety or stress, depression, complex grief and trauma. These result from emergency-induced psychological difficulties – due to exhaustion and fear of contracting Ebola for frontline workers, but also grief and trauma linked to burial practices affecting wider populations – and from pre-existing vulnerabilities (UCC, 07/07/2015). There is a need to understand how affected groups are coping with the psychological impact of the outbreak, and for targeted support to promote their reintegration within communities and to build community resilience (MdM, 18/09/2015).

- + **Coping with traumatic experiences:** Survivors, their households, and grieving families face considerable mental health issues as a result of their experience of the disease and from witnessing death and suffering during the Ebola outbreak. The mental health of safe and dignified burial team members has been significantly affected by exhaustion and trauma related to burying so many bodies, and constant fear of contracting the disease in their daily jobs (international media, 30/09/2015; BRC, 25/09/2015). There are concerns that their stress might become more acute without intervention, especially as the crisis is prolonged in some areas (PI, 23/09/2015)¹.

¹ Teams are expected to continue safe and dignified burials for 90 days after countries are declared Ebola free. In the case of Sierra Leone, this means until at least February 2016.

- + **Grief:** Complex grief, associated with multiple deaths during to the epidemic, has been reported among the majority of people affected by Ebola. This has led to significant emotional reactions, such as sadness or stress. In some cases, it has been amplified by the shock caused by people' inability to care for their loved ones and by transportation of sick people to treatment centres (UCC, 07/07/2015). In the SAFA, 90% of survivors reported having lost family members during the outbreak, leading to varying feelings of depression and sadness. 45% of these said losing family members was the main impact of Ebola (rising to 78% of survivor children) (MdM, 18/09/2015). Trauma caused by the loss of relatives and friends is also an important issue among some children (Child Protection sub-cluster, 2015; Save the Children/UNICEF/WVI/Plan, 06/2015).
- + **Additional trauma linked to burial practices:** People's experiences of bereavement and loss were complicated and, in some cases, heightened by culturally inappropriate burials (UCC, 07/07/2015).² In the SAFA, 44% of respondents expressed dissatisfaction with the burial process, mostly because they were unable to observe rituals or to participate in funerals when they were under quarantine, or because of the lack of emotional consideration shown by safe and dignified burial teams (MdM, 18/09/2015).
- + Such distress is prolonged for some families that remain unaware of where their loved ones have been buried and whether they were buried in a dignified manner. This is particularly true for people who died during the peak of the outbreak, in places where burials were done in a rush and without coordination with families (PI, 05/10/2015; UCC, 07/07/2015; international NGO, 25/09/2015). In Sierra Leone for instance, outside of Freetown there are no grave markers in cemeteries so grieving families cannot visit their loved ones. (PI, 06/10/2015). In Liberia, mandated cremation during the outbreak heightens populations' trauma as there are no places to mourn people who died from Ebola (IFRC, 13/03/2015). There is a need to better understand how to support communities in their efforts to find closure after the outbreak, for instance by creating some form of widespread and public memorial to commemorate the lives lost to Ebola.

² Ebola infection can occur from touching the bodies of those who have died from the virus. To prevent the spread of Ebola, handling of dead bodies should be kept to a minimum and burial should be carried out by trained burial teams. Touching the body is a traditional funerary practice in the affected countries, and rituals and practices were modified (WHO).

PRE-CRISIS VULNERABILITY

- + **Weak healthcare systems:** Systemic weaknesses in health systems and services across the three affected countries aggravate the ability to respond to health issues. In Sierra Leone and Liberia, this can be linked to the protracted and brutal civil wars, which ended in 2002 and 2003 respectively (ODI, 10/2015). The Ebola outbreak has rendered the health systems in all three countries even more vulnerable. They suffer from insufficient funding, inadequate workforce, poor infrastructure, shortages of medicines and supplies, and weak health information and disease surveillance systems. These issues affect the ability of public institutions to respond to the health issues of affected groups.
- + **Pre-existing mental health needs:** The severe mental health impact of the Ebola outbreak has exacerbated pre-existing mental health needs in Liberia and Sierra Leone. These were caused by the impact of more than a decade of civil wars, the lack of mental healthcare training for health professionals and insufficient medication supplies. Before the outbreak, it was estimated that around 300,000 people in Liberia, or 7% of the total population, were suffering from mental illness (Carter Centre, 28/08/2015).

LESSONS LEARNED ON MENTAL HEALTH

- + **Addressing mental health issues in emergencies:** Lessons learned on comprehensive responses to mental health issues in past emergencies include developing sustainable coordination structures, such as linking health ministries' activities with development activities, conducting regular monitoring and assessment of needs, supporting community reintegration of people affected by all forms of violence and ensuring appropriate mourning (IASC, 2007).
- + **Ebola mental health response:** A first regional forum was held on the mental health response to Ebola in June 2015 in Liberia. Among the cross-cutting issues raised was the need to engage communities before, during and after health disasters, to invest in mental health training and supervision, and to integrate psychosocial interventions into the public health response at the outset of a health emergency (WHO, 11/06/2015). In Sierra Leone, some pre-Ebola work to improve access to mental health across the country has been prolonged to build on past activities (PI, 12/10/2015).

- + **Positive/negative coping mechanisms:** Studies show that reactions to stress have to be dealt with early to stop any negative behaviour becoming the norm. Without appropriate support to deal with traumatic experiences, people might turn to negative coping mechanisms such as substance use, violence, unprotected sex and other risk-taking behaviours (The Guardian, 03/08/2015). On the other hand, affected populations have highlighted positive coping strategies that help them to handle the stress and difficulties related to the outbreak. These include maintaining positive thoughts, relying on social support from community and family members, spending time with children, and practicing their faith (MdM, 18/09/2015).

SOCIO-ECONOMIC ISSUES

Changes to household structures affected grieving families' income, while inability to harvest their fields affected farmers' agricultural output and income when they were in quarantine. These groups are even more vulnerable as baseline poverty levels are high, hazard compensations have not been received by all frontline workers and there is an unemployment risk as the response is transitioning away from the emergency activities which provided some work opportunities. All these factors make it difficult for those affected to reintegrate to the social and economic life of their communities

INCOME REDUCTION/INCOME LOSS

- + **Economic impact of changes in household structures:** The high number of Ebola-related deaths has profoundly affected household structures. In most cases, it increases the burden on heads of households. They have to survive on a lower income and may have to take additional responsibility for orphaned children. Cases of women who lost several family members to Ebola and were caring for up to ten additional children have been reported (UCC, 07/07/2015). In the Sierra Leone SAFA, 38% of grieving families said the main impact of Ebola was the loss of relatives and consequent burden on the head of household, leading to financial and food supply problems (MdM, 18/09/2015).
- + Some women were left widowed by Ebola and have to assume new and greater responsibilities. Women who used to rely on their husbands as the primary household breadwinner are particularly affected. Traditionally in Sierra Leone, women have limited ways of generating income compared to men. They now have limited access to land that was previously owned by their husbands, who died from Ebola. This exacerbates their vulnerability and ability to provide for their households (PI, 19/10/2015).
- + Widowers are also concerned about being alone without their wives' support, as they become responsible for children left behind while their traditional roles requires them to provide financially for their households (MdM, 18/09/2015).
- + **Agricultural losses for quarantined people:** Agriculture was seriously crippled during the 21-day quarantine periods, as fields could not be adequately looked after and cultivated. Consequently, farmers lost a major income source and struggled to purchase goods and food for their families (PI, 19/10/2015; FAO,

28/09/2015, PI, 17/09/2015). Agriculture is the largest employing sector in all three economies (65% of the labour force in Sierra Leone, 76% in Guinea, 48.9% in Liberia (ENAP, 2015)) and the majority of people rely on agriculture to survive. In Sierra Leone, some areas were quarantined for long periods, which further affected their ability to return to normal (Al Jazeera, 13/09/2015). Looking at how to support farmers who experienced a delay in their income remains an important step towards their recovery.

INCREASED VULNERABILITIES

- + **Poverty:** Many of the families looking after children who lost their caregivers were already poor and have been made even more vulnerable by Ebola (UNICEF, 10/07/2015). Poverty incidence in Sierra Leone was 52.9% in 2011, with almost all districts except for Freetown having a poverty incidence ranging between 50–62%. Tonkolili and Moyamba districts have the highest poverty levels, at 76% and 70.8% (World Bank, 2013). In Liberia and Guinea, poverty levels are similar, at 56% and 57% respectively as of 2010 and 2012 (WFP, 01/2014).
- + **Lack of compensation benefits:** Frontline workers should have received hazard pay from the Government during the outbreak, but often received it too late or not at all, despite ongoing programmes targeting them (international media, 19/05/2015). In some cases, NGOs and international organisations stepped in to provide the payments where governments lacked resources (UNDP, 20/10/2015). As recently as October 2015, some volunteers working in ETUs across Liberia were protesting to receive their salaries and risk benefits from the government (local media, 16/10/2015; PI, 30/09/2015). Health workers were already on strike in Liberia before the Ebola outbreak, asking for better benefits (PI, 30/09/2015).
- + **Unemployment risk:** There is a need to address the unemployment risk for people employed and trained by UN agencies and international NGOs as Ebola activities are being reduced. There is also a need to find ways to match their new expectations and new skills with opportunities in the affected countries (PI, 06/10/2015).

CHILD PROTECTION

The impact of Ebola on affected groups in terms of stigmatisation, health and socio-economic issues created significant protection risks for children within those groups. They are notably at risk of dropping out of school, which makes them vulnerable to abuse. These risks need to be overcome to promote children's reintegration into communities and build their resilience.

MARGINALISATION

- + Families who have lost their main breadwinner have suffered significant income losses. This increases children's risk of neglect and marginalisation from community structures and limits their access to basic services such as health and education. Nutritional deficiency is also a potential risk (international NGO, 24/09/2015; Street Child, 13/02/2015).
- + Orphans are particularly vulnerable. They have either stayed in their household or are being cared for by immediate family members, new families or foster-carers. Within their households, older boys may become the new head of household, while older girls become responsible for chores and siblings, which raises a range of education and protection concerns (Child Protection sub-cluster, 2015). The risk of marginalisation is also high for rehomed orphans, with a new carer who may be inclined to prioritise the needs of their biological children (Street Child, 13/02/2015). An unknown number of children have been left orphaned in the streets and have to resort to begging (IRIN, 07/10/2015).

SCHOOL DROPOUTS

The Ebola outbreak heightened the risk of children dropping out of school, for three main reasons:

- + **Significant financial burden:** One of the main concerns raised by children in Sierra Leone is their inability to return to school due to the economic impact of Ebola on their households (MdM, 18/09/2015). Families have difficulty affording school fees, uniforms, clothes and footwear. They may need children to contribute to the family economy to compensate for additional expenses, for

example if they are taking care of orphaned children. Now that schools have reopened, there is a need to better understand the extent of this issue.

- + **Lack of incentive:** Schools were closed during the outbreak. Once they reopened in Sierra Leone, in September 2015, a drop in the number of students was reported. This is partly because children who sought work when their school was closed and are now engaged in economic activities are rarely encouraged to return to school. Their families either now rely on the income they generate, or they had to relocate to other cities to find a job or support relatives (Street Child, 14/10/2015).
- + **Fear and miscommunication:** Remaining concerns about schools prevented some families from sending their children back to school in 2015. In Sierra Leone, parents waited to see if it would be safe and if schools would reopen for good (PI, 30/09/2015; PI, 23/09/2015).

from a boyfriend and one consequence for some was pregnancy, which prevented them from returning to the normal school system (Street Child, 14/10/2015). In Sierra Leone, pregnant teenagers are not accepted back in schools, which creates a need for targeted programmes to support their reintegration into studies after they give birth (PI, 30/09/2015).

VULNERABILITIES RELATED TO SCHOOL DROPOUTS

- + **Child abuse:** Children who dropped out of school face an increased risk of abuse, such as child labour, sexual exploitation and early marriage. Orphans are at particular risk: they may be subject to violence and abuse in the long-term as they may represent an economic burden to their adopted families (Child Protection sub-cluster, 2015; IRIN, 07/10/2015; Street Child, 13/02/2015; VOA, 11/10/2015). The Children's Ebola Recovery Assessment was conducted in Sierra Leone, in March 2015. Some girls reported being involved in petty trading or collecting firewood for sale to compensate for their household's reduced income. Boys were involved in mining, driving motorbikes between towns and petty trading in urban areas (Save the Children/UNICEF/WVI/Plan, 06/2015).
- + **Teenage pregnancies:** Children having to drop out of school increases the risk of teenage pregnancies as girls spend more time at home on their own and are thus more exposed (Street Child, 13/02/2015; Save the Children/UNICEF/WVI/Plan, 06/2015). While anecdotally, teenage pregnancies are often reported as a priority concern in Sierra Leone, no comprehensive study has yet established whether teenage pregnancies have increased or decreased during the Ebola outbreak (PI, 19/10/2015; PI, 15/10/2015). In September 2015, a drop in the number of students returning to schools was reported. Some girls were encouraged to seek money

RESPONSE

Targeted support and community engagement activities are ongoing, or being planned, to address the reintegration of affected groups. Some of these activities are highlighted below, as are challenges for the response.

TARGETED SUPPORT

Healthcare services for survivors

- + **Reintegration package:** In Sierra Leone, a Comprehensive Package for Ebola Survivors (CPES) is being developed by the Ministry of Health and Sanitation (MoHS) and the Ministry of Social Welfare, Gender, Children's Affairs (MoSWGCA). This will support the reintegration of survivors within communities, including through health promotion. It is supplemented by a short to medium term package of risk mitigation measures (known as Project Shield), which will provide basic medical care and establish semen testing facilities in three districts. The project was launched on 6 October 2015 in four wards in Freetown (Government, 10/2015; UNICEF, 14/10/2015; Communication Pillar, 20/10/2015).
- + **Survivor clinics:** Specific healthcare programs have been set up for survivors. For example, they have received free treatment (including eye care) at clinics for Ebola survivors in Sierra Leone and Liberia. In Sierra Leone, survivor clinics are only available in half of the districts (Communication Pillar, 20/10/2015). Discussions are ongoing in Guinea regarding survivor clinics.

Counselling and psychosocial support

- + **Psychological counselling and promotion:** In Sierra Leone, the CPES will support the reintegration of survivors within communities by addressing their psychosocial needs (Government, 10/2015). Also in Sierra Leone, in August 2015, UNDP and IFRC launched a 12-month post-Ebola project for 800 burial team workers who worked with the Sierra Leone Red Cross. The project seeks to rehabilitate and reintegrate these workers into their communities, by providing them with psychosocial counselling (local media, 15/08/2015). Agencies in charge of safe and dignified burial teams during the outbreak have trained the teams in psychological first aid and encouraged them to provide their colleagues with

support through positive coping mechanisms (The Guardian, 03/08/2015). In Guinea, psycho-social activities are concentrated in the four most active prefectures (Conakry, Forecariah, Boke and Dubreka). The Red Cross for instance is implementing psycho-social activities to support Ebola affected families and frontline workers, including safe and dignified burial teams, to become more resilient (IFRC, 10/2015).

- + **Supporting communities through the mourning process:** There is a significant need to support affected populations as they go through stages of grief and try to find closure. Discussions are ongoing within governments to create a widespread and public memorial for the lives lost to Ebola such as a National Memorial Day, the construction of a mass grave with the names of all those who had been cremated, or a formal memorial service at the end of the outbreak (Abramowitz et al., 04/2015). There are also discussions over adapting "Decoration Day" in Liberia to collectively mourn those lost to Ebola. Decoration Day is a national holiday that takes place in March to honour dead relatives and ancestors, and involves families gathering at cemeteries, painting and decorating gravestones, and singing (Ebola Deeply, 03/2015).

Livelihood and NFIs support

- + **Livelihood recovery:** In Sierra Leone, the CPES will support the reintegration of survivors within communities by promoting their livelihood recovery through skills training and employing them as ambassadors (Government, 10/2015). In Guinea, WFP began providing cash support to Ebola survivors in July 2015. The program aims to provide a cash transfer, every month for six months, to survivors to help them rebuild their lives (WFP, 30/10/2015). The Red Cross also provides livelihood support to grieving families through condolence kits that include household items such as rice, soap and chlorine (IFRC, 10/2015).
- + **Farming support:** Recent programs employing people in farming or taking over businesses of those under quarantine have reinforced confidence in the government's response in Sierra Leone. Some farmers have received support from the government and NGOs in the form of seed distributions (Al Jazeera, 13/09/2015; international NGO, 25/09/2015).
- + **NFIs support:** To facilitate their reintegration within communities, the Red Cross provided 2,500 kits (clothing, cooking, bedding, hygiene equipment) to survivors

when they left ETCs in Sierra Leone (IFRC, 30/09/2015). In Guinea, the Red Cross also provides NFIs to populations affected by stigma (IFRC, 08/2015).

Training support

- + **Vocational training:** UNDP and IFRC's project for frontline workers seeks to rehabilitate and reintegrate them into their communities by helping them with vocational training (local media, 15/08/2015).
- + **Survivor advocates:** In Sierra Leone, Project Shield will train survivor advocates to promote individual and peer group support to survivors (Communication Pillar, 20/10/2015).

COMMUNITY ENGAGEMENT

Community mobilisation is central to supporting the reintegration of affected groups within communities and is essential to preventing transmission of the disease. In Sierra Leone, it is viewed as a critical success factor in the National Ebola Response Centre's 'Getting to a resilient zero' strategy, and considered central to all aspects of the response (NERC, 24/07/2015).

Social mobilisation

- + **Survivor engagement:** Many survivors are enlisting in the fight against Ebola, and are seen as valuable partners by health agencies. They played an important role in spreading messaging to prevent further Ebola transmission, for example explaining what happens in ETUs. Some were hired to deliver food and water to communities in quarantine (PI, 25/09/2015; UNICEF, 17/09/2015; WHO, 07/2014). In Sierra Leone, survivors' blood is being used for the plasma trial as treatment against Ebola (PI, 17/09/2015). Community engagement workshops are planned in Sierra Leone to promote a better understanding of survivors' role in containing the Ebola outbreak (WHO, 09/2015).
- + **Faith leaders** have played an important role in promoting messages of acceptance and changing community perceptions, while taking into account local traditions. They have worked with communities that have received Ebola survivors to communicate accurate messages about Ebola, coupled with religious references about compassion (Cafod and al., 01/07/2015).

Communication

- + **Messaging on Ebola:** Promoting acceptance, by improving communities' understanding of the disease and associated risks is central to tackling stigma. Messaging and familiarisation with new practices as the crisis evolved have played a central role in changing populations' attitudes towards frontline workers, safe burials, protective equipment and other factors that were initially marked by fear and scepticism (IRC, 2015; NERC, 24/07/2015).
- + **Messaging on promoting acceptance:** Campaigns to celebrate frontline workers as "heroes of the nation" have improved the way they are perceived in society (international NGO, 25/09/2015; PI, 01/10/2015). Communication campaigns have reduced the intensity of stigmatisation towards orphans in Sierra Leone (Street Child, 13/02/2015; Child Protection sub-cluster, 2015). Also in Sierra Leone, WHO has started a project to provide compassionate community engagement training within each district to build trust within communities and trust towards ambulance drivers and safe and dignified burial teams (PI, 12/10/2015).

Community reconciliation

Post-Ebola activities such as reconciliation are vital for the reintegration of affected groups and for overall community peace and development, particularly when stigma comes from blame and resentment.

- + **Ongoing reconciliation processes:** Reconciliation processes at the community level took place in some districts in Sierra Leone, but remain an important need (international NGO, 25/09/2015; local media, 17/08/2015). Community-driven approaches and strategies to Ebola prevention and recovery are being prepared in some chiefdoms of Kailahun district. One plan is to train village mediators in communication, mediation, reconciliation and accountability skills (local media, 17/08/2015).

Limitations to the ongoing response

Community mobilisation is still lacking or ineffective in some areas, leading to lack of community ownership. A better understanding of community structures is required to tailor and reinforce messages promoting the reintegration of affected groups. Overall, there is a feeling that it is difficult to manage sustainable behavioural change as it

needs continuous capacity building, supported by deeper structural changes (international NGO, 24/09/2015; PI, 23/09/2015). Lack of community ownership results in several issues:

- + **Some people still refuse to believe in Ebola:** Some people in Conakry in Guinea refer to Ebola as the “disease of the President”, as they have never seen cases (international organisation, 01/10/2015). Lack of knowledge of the virus and its transmission tends to fuel fears and suspicions. It also fuels the spread of wrong messages by some people. In Sierra Leone for instance, there is concern that some religious leaders are preventing people from talking to or approaching survivors (PI, 29/09/2015).
- + **Ongoing resistance:** In Guinea, some organisations emphasised that behaviours had not yet changed and cases of resistance to the response continued, although they were not as violent as during the peak of the outbreak (PI, 09/2015). Endemic distrust of the Ebola epidemic and its responders in Guinea led to a myriad of adverse reactions, from violence against health workers to withdrawal of public services, most notably health and education (OCHA, 10/07/2015; international organisation, 04/09/2015). Secret and unsafe burials reportedly continue across all three countries, highlighting the need for sustained community mobilisation (WHO, 07/10/2015; PI, 01/10/2015). The impact of community messaging has been hampered in some areas where people do not feel the need to follow all the protocols, believing that the rules do not apply to them (international NGOs, 13/10/2015; PI, 28/09/2015).

SHIFTING PROGRAMMES TOWARDS RECOVERY

- + **Coordination and capacity:** There is a need to coordinate approaches in all three countries to avoid duplication of services, while building national capacity to respond to remaining population needs. In Guinea, a national strategy for survivors is being prepared with the support of national and international agencies. Capacity is reportedly lacking and coordination between national ministries and national and international agencies is insufficient (PI, 07/10/2015). Coordinating approaches to care services and service delivery projects have also been challenging in Sierra Leone (PI, 11/09/2015). The danger of affected groups being further ostracised if programmes are seen to target them at the expense of wider populations in need should also be taken into account in the coordination of response activities.

- + **Ebola fatigue:** A number of key informant interviews conducted by ACAPS in Freetown revealed that people are exhausted and they do not want to talk about Ebola. This is true of the affected population but also of health workers and international staff (PI, 28/09/2015). There is a risk that Ebola fatigue may lead to reduced funding and fewer programs to support the reintegration of affected groups within communities. It might also lead to resistance to new responses aimed at overcoming the challenges to reintegration.
- + **Transitioning:** There is a risk that issues related to the outbreak might be deprioritised or ignored as the response shifts from emergency to post-Ebola development. Most international humanitarian programs are expected to shut down in December 2015, but there is a lack of handover planning for some activities. The reintegration of affected groups and the longer-term resilience of communities could be hampered if reintegration activities are not coordinated or handed over (PI, 08/10/2015; PI, 24/09/2015).

INFORMATION GAPS AND NEEDS

A certain number of information gaps have been identified in the preparation of this report, which urgently need to be tackled to overcome barriers to the reintegration of affected groups and to build longer-term community resilience.

- + **Severity and duration of stigma:** It is difficult to evaluate the extent of stigmatisation, and therefore the level of response required. Data is lacking on the perception of the population towards survivors, their households, grieving families, orphans, frontline workers, people who reported cases and people in quarantine.
- + **Number of needs of child survivors and survivor households:** There is a lack of clarity on the needs of child survivors and survivors' households. It is unclear whether child survivors are covered in reports about survivors or national strategies aimed at survivors, although they also need to benefit from reintegration support.
- + **Duration and acuteness of survivor health needs:** More research is needed on the types and frequency of the medical complications reported by most registered survivors, on best practice for clinical management, and to better understand the risks related to viral persistence in body fluids.
- + **Impact of Ebola on the teenage pregnancy rate and related reintegration needs:** In Sierra Leone, there is a reported increase in teenage pregnancies; however there is a lot of uncertainty around the data and whether it relates to an increase in sexual gender-based violence during the Ebola outbreak (PI, 01/10/2015),
- + **Nutritional needs of Ebola affected children:** Information is lacking regarding nutrition, although related issues hamper the ability of affected groups to return to normal lives. Children who were left behind when parents were admitted to Ebola treatment units, and young children of Ebola survivors whom are advised not to breastfeed, may also have their nutritional status and food intake impacted (international NGO, 24/09/2015).
- + **Extent of homelessness of affected populations:** There is a lack of data on the extent of the issue of homelessness in groups affected by Ebola highlighted in this report, and whether there is an ongoing response to address the issue.
- + **Number of frontline workers who have not received full hazard compensation:** There is a lack of understanding about whether or not frontline workers have received compensation benefits.

ANNEX I: VIRAL PERSISTENCE IN BODY FLUIDS

The Ebola virus has been found in various bodily fluids at key points in time after recovery from the disease. The virus was found in semen 199 days after the onset of symptoms, 40 days in sweat, 31 days in urine, and 98 days in ocular fluids. From previous Ebola outbreaks in Africa, the virus had also been found 33 days after the onset of symptoms in vaginal secretion, 22–29 days in rectum swabs and 15 days in breast milk. The mean and maximum duration of persistence of either live virus or generic fragments in these body fluids is largely unknown.

The ongoing Ebola Viral Persistence Cohort Study in Freetown aims at investigating the persistence of Ebola virus in body fluids in a cohort of Ebola survivors using the Reverse Transcription Polymerase Chain Reactions (RT-PCR) and viral isolation technologies. While results using the RT-PCR technology can show whether the virus is still present in semen, they cannot imply that the virus is infectious. It is only through viral isolation that one can evaluate whether live virus is present in semen (in which case it could lead to a new infection) or only viral fragments (in which case infection is not possible). That stage of the study will take more time as laboratory capacity is limited. Preliminary results from the first round of semen testing show that semen can be RT-PCR positive at least nine months after the onset of symptoms. At the same time, semen has been also tested negative earlier.

There have been speculations about cases of sexual transmission in all three countries in recent months, in particular in the case of a woman with a history sexual contact with an Ebola survivor, but so far no evidence has supported this claim. New cases from sexual transmission, or exposure to infected semen, could start new chains of transmission and prolong the outbreak. This is particularly problematic as there is a potential for people to become ill with Ebola once the outbreak has been declared over³, when there will be less capacity to handle the outbreak.

Earlier recommendations for Ebola survivors were that they should abstain from sex for at least three months or use a condom every time. Interim recommendations by WHO until more information becomes available, is that safe sex should be observed until Ebola survivors' semen has twice tested negative or for at least six months after the onset of symptoms if an Ebola survivor's semen has not been tested. Where available, semen testing should be offered to male survivors three months after onset of the

disease and for those who tested positive, every month thereafter, until their semen tests twice negative by RT-PCR, with an interval of one week between tests. The emphasis is on avoiding contact with semen, by using condoms, safely disposing of the condoms, and good hand washing practices and personal hygiene (MoH/WHO/CDC, 13/10/2015; Sprecher, 14/10/2015).



The views expressed in this report should not be taken, in any way, to reflect the official opinion of the European Union, and the European Commission is not responsible for any use that may be made of the information it contains

³ 42 days after the discharge of the last case, followed by 90 days of heightened surveillance.