EBOLA IMPACT REVEALED

An Assessment of the Differing Impact of the Outbreak on Women and Men in Liberia

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“It was not easy for us to live; it is just by the grace of God we continue to be alive. We ate anything and all kinds of food just to live. We even ate the seeds for the next farming season, and used the little money we had to survive until Ebola cools down. We even borrowed money to live, and only God knows how the money will be repaid.”

Male participant in a focus group discussion in Grand Kru county

ACKNOWLEDGEMENTS

In March of 2014 the EVD outbreak hit Liberia, taking with it many lives in its wake. As a move to ensure that further programming is rooted in evidence, this study was conducted to shed light on the gender dimensions of the EVD outbreak. Many thanks to UN Women, Oxfam, Ministry of Gender, Children and Social Protection and the WASH Consortium for seeing it prudent to undertake this assessment. This document epitomizes their quest to support evidence-based practice in policy formulation and effective program design especially during the Ebola recovery phase; and it stands as a testament of their strategic focus on gender equality and women's empowerment.

The assessment would not have been possible without the tireless contributions of a broad team of people. We acknowledge all the men and women who took time off to participate in the assessment. We also thank all the local government officials, community and traditional leaders who cooperated with, and supported the teams across the country. We owe an enormous depth of gratitude to the team of enumerators, supervisors, monitors and transcribers whose unique professional contributions enhanced the quality of data gathered by the assessment.

There are few people who went the extra mile to make outstanding technical and logistical contributions; it is only proper that they are mentioned personally. To this end, recognition is given to the Oxfam team: Country Director, Mamudu Salifu, Cathy Stephen, Tess Dico-Young, Samuel Quermorllue and Alieu Swary for technical backstopping on the questionnaire design, PDA programming, training of enumerators and monitoring of field teams. From UN Women, the support and leadership is much appreciated particularly from the Country Representative, Awa Ndiaye Seck, and the Deputy Representative Peterson Magoola, with technical and logistical support from Blerta Aliko, Mahmoud Koroma and Ramon Garway. Francis Wreh, Thomas Davis and Joseph Nyan from LISGIS led efforts on the identification of enumeration areas and data analysis, respectively.

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FOREWORD

The Ministry of Gender, Children, and Social Protection including UN Women, Oxfam and the Liberia WASH Consortium with other relevant partners, grounded in the vision of equality enshrined in the Charter of the United Nations, work for the elimination of discrimination against women and girls; the empowerment of women; and the achievement of equality between women and men as partners and change agents of development, human rights, humanitarian action and peace and security.

This gender assessment report provides key information on the comparable impacts of the Ebola Virus Disease (EVD) on women and men in Liberia. In addition to providing evidence on the gender disaggregated effects of EVD, this report reveals the growing discourse on gender in emergency, articulating gender perspectives of knowledge, beliefs and practices regarding Ebola; women's leadership and participation in the national response, and communities' coping mechanisms and perception regarding the promotion of early recover.

Liberia's EVD crisis disrupted the development progress achieved since the restoration of peace and democracy in Liberia. As of 10 December 2014, nearly 18,000 people had been infected and more than 6,400 had already died in the region. In Liberia, health facilities were not well equipped to fight the disease, and the crisis eventually outstripped their ability to stem its spread by the lull of the virus in March 2015 about 4806 deaths had recorded in Liberia alone.[1] The disease had far reaching impact on women and girls such as: the closure of borders that affected regional trade, thus, the livelihoods of thousands were affected within the Mano-River Union region. The Association of Women in Cross Border Trade in Liberia reported a significant decrease in savings as a result of the borders being closed. Rural women in agriculture and small businesses also reported a drop in earnings, and this contributed to increased hardship, especially for women and girls. Teenage pregnancy rates experienced a sharp increase and number of girls expected to return to school were also negatively forecasted.

In all of this, the Government of Liberia continues to work with the United Nations, along with relevant UN Country Teams, Member States and partners, in order to ensure full alignment and seffective overall action in support of the recovery process.

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Country Representative,
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Mr. Mamudu Salifu
Country Director,
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Hon. Julia Duncan-Cassell,
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[1] *http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html*

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ABBREVIATIONS

ADB	African Development Bank
CDC	Centers for Disease Control and Prevention
CSO	Civil society organization
ECC	Ebola care centre
ETU	Ebola treatment unit
EU	European Union
EVD	Ebola virus disease
FBO	Faith-based organization
FGD	Focus group discussion
GBV	Gender-based violence
HCW	Healthcare worker
HIV	Human immunodeficiency virus
IGA	Income-generating activity
IRB	Institutional Review Board
KAP	Knowledge, Attitude and Practice
KII	Key informant interview
LISGIS	Liberia Institute of Statistics and Geo-information Services
MFI	Micro-finance institution
MoHSW	Ministry of Health and Social Welfare
MRU	Mano River Union
NGO	Non-governmental organization
OVCs	Orphans and vulnerable children
PDA	Personal digital assistant
PPE	Personal protective equipment
PPS	Population proportion sample
SPSS	Statistical Package for the Social Sciences
SRH	Sexual and reproductive health
UL-PIRE	University of Liberia – Pacific Institute for Research and Evaluation
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNMIL	United Nations Mission in Liberia
VSLA	Village Savings and Loans Association
WASH	Water, sanitation and hygiene
WHO	World Health Organization

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EXECUTIVE SUMMARY

The epidemic of Ebola virus disease (EVD) that has plagued West Africa since December 2013 has been the most devastating outbreak in the history of the disease. Until December 2014, there was no gender-focused reporting on the impacts of the crisis, and in particular no specific reports on the impact of the epidemic on women. UN Women has therefore worked in partnership with Oxfam, the UN Mission in Liberia (UNMIL), other UN agencies and civil society, through the leadership of the Liberian Ministry of Gender, Children and Social Protection, to conduct a national assessment of the impacts of EVD on men and women in Liberia. The Liberia Institute of Statistics and Geo-Information Services (LISGIS) served as the technical lead for the assessment.

The aim of the assessment was to determine the different impacts of EVD on men, women, girls and boys in Liberia. The assessment also sought to explore women's leadership and participation in the national response, and the coping mechanisms and perceptions of communities regarding the promotion of early recovery. It focused on four main thematic areas: livelihoods/agriculture; access to health services; water, sanitation and hygiene (WASH); and gender-based violence (GBV).

The assessment utilized a mixed methodological approach, combining both quantitative and qualitative techniques, as well as desk reviews and direct observation. Primary data were collected using surveys, focus group discussions (FDGs) and key informant interviews (KIIs). A total of 1,562 persons were surveyed, 20 community leaders were interviewed and 180 local residents participated in FGDs. To make the assessment nationally representative, participants were selected from the counties of Grand Cape Mount, Grand Gedeh, Grand Kru, Lofa and Montserrado, each representing one of the five health regions or health administration in the country. The data were collected in January and February 2015.

KEY FINDINGS

The assessment found that both males (94.5 percent) and females (95.2 percent) were largely aware about EVD, and 98 percent of those who were aware also believed that Ebola was present in Liberia. Some myths and superstitions about Ebola persist, however, and there were low personal risk perceptions about contracting the disease amongst males (54.1 percent) and females (55.2 percent), as people were basically confident that they carefully practised the proper prevention measures, or that God would protect them. Females believed that both men (22.4 percent) and women (24 percent) were equally susceptible to Ebola, but males believed that women were more vulnerable (32 percent) to EVD infection than men (13.8 percent).

Throughout the EVD crisis, men and women have played different roles in fighting the disease at community and family levels. More males (34.4 percent) have participated in organized community Ebola response activities than females (24 percent). Explaining the lower rate of participation by

females, it was reported that women either did not have spare time to attend activities or they were not invited to participate or informed about such programmes. A higher proportion of males were involved with the distribution of prevention materials (10.7 percent) compared with females, who were more involved with caring for the sick (11.6 percent).

Analysis of EVD data from the Ministry of Health revealed that more cases of EVD were reported among males (53 percent) than females (47 percent). Nonetheless, women were disproportionately affected by the social and economic impacts of Ebola. Generally, various overlapping vulnerabilities made women more susceptible to the effects of the outbreak. Although different demographic drivers played a role in people's levels of vulnerability to the epidemic and its social and economic impacts, gender, geography and disability proved to be the most indicative. For example, while the health impact of the epidemic was severe in urban centres, economic ramifications appeared most evident in rural communities, where business and farming activities were virtually halted.

Ebola has dealt a serious blow to the whole country, leaving in its wake a shambolic public health system and a myriad of social and economic problems. The outbreak has adversely affected the basic livelihoods and agricultural activities of most people in Liberia. Unemployment (among assessment participants) has soared from 18.8 percent before Ebola to 56.2 percent since the outbreak began, leading to huge income deficits in households. Small businesses have collapsed, markets have closed down and farming activities have been abandoned.

A World Bank survey conducted in February 2015 found that nearly 41 percent of household heads who were working at the start of the Ebola crisis were unemployed at the time of the research. Women have been particularly affected by EVD-related unemployment and subsequent loss of income. Due to lower levels of education and limited marketable skills, the majority of women were self-employed, engaged in petty trade (42.6 percent) and food processing (19.3 percent), while men engaged in higher-income, waged employment in jobs such as skilled labourers or teachers. Most self-employed women were engaged in food businesses and the sale of perishable goods such as fruits and vegetables, which went to waste because customers were afraid to 'eat in the street', fearing that they would contract Ebola. Men, however, were involved in businesses that dealt in non-perishable goods such as running shops or currency exchange, and so they were able to continue their businesses or immediately reopen when the situation permitted.

The proportion of those holding household savings diminished from 61.5 percent pre-Ebola to 27.1 percent post-Ebola, as people used up all their money to support their families (66.4 percent). The assessment data suggested that more males suffered loss of savings (39.3 percent) than females (29.6 percent). However, women have used up their business capital and savings and have deployed other strategies to cope with the hardship created by the Ebola crisis, which may deplete their future economic capacity and the viability of their small enterprises. Travel restrictions limiting the access of traders to key markets, along with the closure of Liberia's borders at the peak of the EVD crisis, resulted in losses for women, who account for 70 percent of small-scale traders. During the EVD crisis, men were more likely to borrow money from friends (40.9 percent) or families (30.1 percent), while women relied on savings clubs (48.5 percent) and *susu* lending clubs[2] (23.4 percent). As a result, men had better leverage in negotiating loans than women, because families and friends were much more understanding about interest rates and repayments when lending money in

[2] *Susu clubs are community-based lending facilities, from which members and other community members can borrow money at relatively low interest rates. Sometimes money is pooled by group members and disbursed to one person on a weekly or monthly basis. Otherwise, the money is shared annually.*

comparison with savings and *susu* clubs. In addition, during the EVD outbreak these sources from which women could readily access loans closed down, further constraining their access to finance.

Many experts have stated that EVD simply exposed a very weak healthcare system that was ill equipped to tackle any emergency of such magnitude. Despite significant improvements over the past decade, Liberia's healthcare system still bears scars from the civil war, including inadequate infrastructure and technology, low human resource capacity and insufficient supplies of drugs and medical equipment. It was reported by 71.3 percent of respondents that, during the Ebola outbreak, government hospitals in their area were either completely or partially closed to patients and basic health services such as vaccination programmes were suspended, leaving children vulnerable to common childhood diseases. Where health services were available, 68.6 percent of respondents complained that they simply could not afford to pay for healthcare at the time.

Although no concrete evidence was generated by the assessment, anecdotal evidence suggests that women and children suffered the most because of a lack of access to routine maternal and child health services such as sexual and reproductive healthcare, care in pregnancy and delivery, immunization, etc. There were many stories of pregnant women being denied access to clinics and having to give birth in the street, in cars or at their homes, and this may have implications for indicators of maternal and child mortality. A male participant in the youth FGD in Zorzor said: 'Most pregnant women gave birth by themselves... all we could do is pray to God for safe delivery, but some babies died at birth.'

Overall, the Ebola outbreak has had an influence on improving hygiene practices across Liberia, as people have increasingly adopted regular hand washing as part of their daily health routine. However, this has come at a cost for women and children, for whom the burden of collecting water has increased in terms of both frequency and the amount of water they have to collect daily. While men are mostly responsible for the provision of physical materials, such as buckets made from locally available materials such as reeds, women provide water for hand washing and education for their children on how to use chlorinated water. Moreover, the longer women and girls are away from the safety of their homes collecting water, the greater the safety and protection implications.

GBV is a subject that people are reluctant to talk about; however, 22.9 percent of respondents reported that cases of GBV were still happening even during the Ebola crisis. Respondents in urban areas were more likely (32 percent) to acknowledge the existence of GBV than those in rural areas (24 percent). Different forms of GBV took place, including domestic violence, sexual abuse, rape, etc. GBV affects the physical, mental and social well-being of women and girls, stifling their growth and development and undermining their ability to contribute to national development. The assessment found that 52.6 percent of respondents recognized that women and girls had been bearing a greater burden in the household since the Ebola outbreak began. Respondents believed that the main reasons for this were that there is now too much work in the home (75 percent) and men are not contributing to income (64.4 percent). There were also reports of widespread stigma and discrimination against Ebola survivors and affected families, though no evidence of targeting of particular groups of people based on their sex or age.

Twenty-eight percent of respondents reported that the practice of early marriage of girls was common in their communities. Cape Mount, Lofa and Montserrado were the three counties with the highest number of reports of child marriage. Significantly, these three counties were also reported to have the largest proportion of children orphaned by EVD. Without intervention to protect these orphans, girls are at significant risk of falling victim to sexual exploitation and abuse, while boys are likely to end up either as child labourers in hazardous work environments, as street hawkers or as petty thieves.

The findings of the assessment are essential not only for helping to fill the existing hard evidence gaps on the Ebola gender discourse, but also for policy formulation and effective programme design to help shape post-Ebola recovery and the long-term agenda for Liberia.

RECOMMENDATIONS

Based on the findings of the assessment, the following recommendations for action are put forward for careful consideration in order to respond to and defeat any further outbreak of Ebola. Just as importantly, the recommendations set out a plan for stimulating early recovery, with the aim of mitigating the impacts of EVD on women, men, boys and girls in Liberia.

Scaling up the effectiveness of the national Ebola response

- Service providers need to strengthen the knowledge and skills of women for effective Ebola prevention and control. Women, and especially elderly women, have continued to play the role of care-givers, so they need all relevant information and skills to provide better care, as well as to protect themselves against contracting the disease. In addition, targeting women for capacity-building will ensure that children are well informed about Ebola, since it is women who take the lead in sensitizing their children.
- There is a need for improvement in levels of community engagement and social mobilization in order to foster maximum participation by communities, which remains critical to national preparedness and recovery efforts. In this light, it is imperative that the government and donors enhance outreach efforts to community leaders and local health workers, as ordinary people trust information provided by such people more than other sources. Stakeholders planning such initiatives need to ensure that the leadership role and agency of women are visible, and the full participation of women should be promoted at all levels of community engagement.
- The government and its partners in social mobilization need to give more attention to mobilizing and training religious leaders, as most people have strong faith. Equipping religious leaders with the relevant knowledge, skills and attitudes could put them in a better position to become effective change agents in the recovery agenda. Targeting religious leaders is critical to reaching out to women; women and men are equally religious, irrespective of the faith they profess.

Promoting income generation and food security

- Given the scale of the economic hardship facing many families, it is recommended that the government implement social safety net programmes such as unconditional cash transfers and food-for-work for vulnerable households, which should be identified through vulnerability assessments. These interventions should be designed as Ebola-specific and should be aimed at bringing short-term relief from the acute financial challenges faced by local populations.
- Donors and development partners need to help increase women's access to finance by strengthening credit facilities such as savings clubs and the Village Savings and Loans Association (VSLA) programme to surmount the barriers that women face in establishing or expanding small businesses. This strategy will be more effective if collaborations are forged with microfinance institutions and banking entities, in order for them to make direct investments that would expand the capital of savings and *susu* clubs, to enable more women to borrow money to invest in their businesses.
- The government and donors should prioritize the provision of agricultural inputs such as farming tools and seeds to rural women and their families to encourage local participation in agriculture and better productivity. Women have been moving into farming as a coping strategy to provide employment and generate income.

Increasing access to health services

- As part of national preparedness efforts, the Ministry of Health (MoH) and its partners need to improve the availability of sexual and reproductive health (SRH) services, mainly for women and girls and especially in rural communities, where services are not readily available. One key consideration is for donors to support stand-alone SRH facilities that are not necessarily located in health facilities, so that women and girls would still have access to services in the case of future EVD outbreaks leading to the closure of main health facilities.
- Subsidies should be provided for maternal and child healthcare as part of efforts to stimulate early recovery, as many households are unable to pay for services. Alternatively, the MoH and its partners should design and implement a policy that ensures that all maternal and child healthcare services are delivered free of charge in public health facilities for about the next six months. Donors and other development partners need to invest resources in the provision of free SRH services on a long-term basis.
- In promoting early recovery, the MoH must continue to expand immunization coverage so that children are fully protected against various childhood diseases; service provision was interrupted because of the EVD crisis, leaving many children unprotected. As women's participation in the Ebola response has been low, it is recommended that more women are mobilized to play leadership roles in national immunization campaigns.

Improving access to water, sanitation and hygiene services

- Prevention of Ebola remains critical, and the MoH and its partners need to ensure a reliable supply of clean water at all health facilities. This will help to promote effective prevention and control of infection by healthcare providers. At community level, donors need to support the government in installing new hand pumps and repairing old ones in order to increase households' access to clean water, and ultimately to help reduce the burden of water collection on women and children. WASH programmes need to be promoted in schools to help keep children safe.
- More latrine facilities must be provided to discourage the common practice of open defecation. The construction of such facilities should take into consideration the concerns of women regarding safety, privacy/dignity and hygiene so that their use of these facilities can be maximized.

Curbing GBV and child abuse

- In collaboration with the Ministry of Justice and the Ministry of Gender, Children and Social Protection, donors and other development partners need to provide technical and financial support to local community mediation structures, such as community leadership bodies and peace huts – community space for women to discuss issues surrounding SGBV and SEA, etc. This will encourage sustainable local initiatives for conflict resolution, peace-building and security, and will build local capacity for monitoring and reporting GBV.
- The government, through the Ministry of Gender, Children and Social Protection, needs to promote social protection and welfare programmes to support orphans and other children made vulnerable by Ebola. Programmes should prioritize areas such as scholarships, food rations and medical care and the provision of psychosocial support to affected families, including children. Scholarship programmes should promote girls' education in particular in order to counter the current gender disparity in literacy levels.
- The government and its partners should strengthen strategies for engaging men in the promotion of gender equality. The increasing care burden on women and girls must be addressed in recovery plans, and men and women need to work together to address this issue.
- The Ministry of Gender, Children and Social Protection and the Ministry of Justice need to strengthen the enforcement of instruments and protocols for ending GBV. In the short term, the government and its development partners need to promote civil society participation in GBV monitoring and reporting, with a key focus on increasing the involvement of women.

INTRODUCTION AND BACKGROUND

UN Women worked in partnership with Oxfam, the United Nations Mission in Liberia (UNMIL), other UN agencies and civil society, through the leadership of the Ministry of Gender, Children and Social Protection, to conduct a national assessment on the impacts of Ebola virus disease (EVD) on women and men in Liberia. The Liberia Institute of Statistics and Geo-Information Services (LISGIS) served as the technical lead in conducting the assessment.

The ongoing EVD crisis, which started in West Africa in early December 2013, is the biggest ever outbreak of the disease and has been designated as posing a public health threat of international magnitude. By early March 2015, the World Health Organization (WHO) had reported 24,282 cases cumulatively. The epicentre of the outbreak was in the Mano River Basin, with three countries –Guinea, Sierra Leone and Liberia – accounting for nearly all (99.8 percent) of EVD cases (suspected, probable and confirmed). The situation in Liberia has been particularly grave, with the country accounting for 38.5 percent of all cases in the region (WHO, 2015a). From the onset of the second wave of EVD in Liberia, from 23 May 2014 through to 24 March 2015, the Ministry of Health and Social Welfare (MoHSW) reported 9,800 cases, with a fatality rate of 44.2 percent (MoHSW, 2015a). The outbreak in Liberia has seen hotspots spread over a wide area, in Montserrado, Margibi, Lofa, Bong, Bomi and Grand Bassa counties.

Anecdotal evidence suggests that more women have contracted the virus than men, owing to their care-giving roles within the home and wider community. One report indicated that 75 percent of those who were infected by or had died from Ebola in Liberia were women (AWID, 2014). In the absence of functional health facilities and with Ebola treatment centres overstretched, women and girls have continued to bear the burden of the epidemic as they have been at the frontline in providing care to infected relatives and the sick, as wives, mothers, daughters, nurses and midwives.

Contradicting this evidence, however, preliminary surveillance data from the MoHSW indicated that more males than females had contracted the disease. By early December 2014, an analysis of national MoHSW data on EVD suggested that there were more cumulative cases reported among males (53 percent) than females (47 percent) (UN Women, 2014). Similarly, the data showed that more deaths from EVD had been reported among men (55.2 percent) than women (44.8 percent).

It might have been expected that more females would be infected by Ebola, but at this stage no research had been undertaken to explore the reasons for this apparent anomaly. Without adequate gender-disaggregated data, it is difficult to assess the differential impacts of EVD on women and men. Based on the information available to date, it was crucial that an investigation be conducted to determine the gender dimension of the EVD crisis in order to inform an effective response for recovery and reconstruction in both the long and short terms (Fleischman, 2014). It was against this backdrop that the Ebola Gender Assessment was commissioned.

RESEARCH AIM

The aim of the assessment was to determine the comparable impacts of EVD on women and men in Liberia. In addition to generating evidence on gender-disaggregated aspects of EVD, it sought to contribute to the growing discourse on gender in emergency situations, articulating gender perspectives on knowledge, beliefs and practices regarding Ebola, on women's leadership and participation in the national response and on communities' coping mechanisms and perceptions regarding the promotion of early recovery.

Specific Objectives

- Identify knowledge, attitudes, practices and other socio-cultural determinants and drivers of EVD transmission from a gender perspective.
- Generate EVD-related data, disaggregated by sex, age, geographical location, etc., in relation to the experiences of women and men.
- Identify the impact of EVD on pre-existing structural social and economic vulnerabilities, including equal access to livelihoods and basic social services e.g. health, water, sanitation and hygiene and issues of gender-based violence (GBV)/protection.
- Identify the various coping mechanisms employed by women, men, girls and boys during and after the EVD epidemic.
- Generate evidence that will provide a basis for the development of gender-responsive interventions and strategies for EVD emergency response and for the recovery period.

Research Areas

- **Livelihoods/agriculture:** access to finance, loan repayments, savings, impacts on business revenue, cross-border trading, employment, trade/markets, impact on households e.g. food security, income generation.
- **Access to health services:** functionality of clinics/hospitals, availability of services (e.g. pregnancy, sexual and reproductive health (SRH)), perceptions of health practitioners' attitudes, access to child healthcare, cost of healthcare, alternative health services available to communities.
- **Water, sanitation and hygiene (WASH):** access to services, maintenance of facilities, water practices, hygiene and sanitation practices, especially hand washing.
- **GBV/protection:** incidence and recurrence of GBV, types of violence, ability to access protection, HIV testing and treatment, GBV reporting and referral mechanisms.

Research Questions

In order to contribute to the development of evidence on the differential gender impacts of EVD, the assessment sought to answer the following questions:

- What prevailing knowledge, attitudes and practices do community members have in relation to EVD?
- What categories of people – e.g. by sex, age, literacy levels, disability, high risk (HIV status, elderly) – have been hardest hit by Ebola (incidence of infection, access to services such as WASH, GBV/protection, livelihoods, employment, earnings, savings and loans)?
- What strategies have community members employed to cope with the Ebola crisis (prevention, burial/cremation of loved ones who have died, livelihoods), and what are their perceptions and agency for early recovery?
- How do the effects of Ebola vary among respondents in urban and rural areas?
- What differences and what similarities have there been in the involvement of women and men in local community and national Ebola response efforts? What factors have facilitated or limited the extent of involvement of women and men in the EVD response?

RESEARCH METHODOLOGY

DESIGN AND SAMPLING

The assessment utilized a mixed-method approach, combining both quantitative and qualitative techniques. Secondary data were collected via a literature review to give a better context for the primary data gathered from the fieldwork. The field team also utilized direct observation methods.

The assessment was conducted in five targeted regions in Liberia, using combined cluster and stratified sampling techniques to ensure that the sample was representative of the general population. The assessment used surveys, focus group discussions (FGDs) and key informant interviews (KII) to elicit information from participants. The desired sample size for the survey was calculated at 1,562 respondents, using the population proportion sample (PPS) method to outline the demographic characteristics of participants enrolled in the assessment. There were 15 FGDs comprised of homogenous groups of 12 participants each (men, women or youth), while the 20 KIIs targeted one person per interview.

DATA COLLECTION

Data collection was conducted by a trained team of 20 enumerators, five supervisors and four monitors. The research team attended a one-week intensive training workshop to acquire knowledge about the assessment's aim and objectives and to develop skills in administering the questionnaire using personal digital assistant (PDA) devices, powered by AKVO Flow software.

All FGDs and KIIs were digitally recorded with the consent of the participants. The audio files were later transcribed by a team of five transcribers, who also attended the enumerators' training workshop. Field data were collected between mid-January and early February 2015, for a combined period of four weeks.

ETHICAL CONSIDERATIONS

The research protocol was reviewed and approved by the University of Liberia – Pacific Institute for Research and Evaluation (UL-PIRE) Institutional Review Board (IRB). The assessment posed no risk to participants' health. All participants were duly informed that participation was voluntary and that they had the right to withdraw their consent to participate at any stage of the research, without incurring any penalty.

DATA ANALYSIS AND QUALITY ASSURANCE

Two separate data analyses were carried out to synchronize quantitative and qualitative data. Quantitative data were analyzed using Statistical Package for the Social Sciences (SPSS) software and data tables were exported to MS Excel, where appropriate graphical presentations were produced and incorporated into the final report.

Field supervisors were supplied with Internet modems, which allowed for daily revisions and online submission of all completed surveys. The server was monitored by key staff at LISGIS and Oxfam, and a team of four monitors worked with the field team to provide technical support and ensure compliance with the assessment protocol.

The report was validated through a one-day validation workshop, attended by 24 participants representing 12 relevant institutions, agencies and organizations. After a broad stakeholders' review of the report, participants made relevant inputs and comments that were incorporated to enhance its quality, and asserted that the report fairly articulated the impact of Ebola on women and men in Liberia (see Appendix A for a full description of the methodology).

KEY FINDINGS

CHARACTERISTICS OF RESPONDENTS

Response Rate

The assessment achieved a 100 percent response rate, with roughly equal male (50.1 percent) and female (49.9 percent) participation. There was a rural-to-urban participation ratio of approximately 1:1.

Age, Marital Status, Educational Level and Religion

The biggest group of respondents (46.4 percent) were aged between 20 and 34 years old. The least represented age groups were teenagers (5.8 percent) and elderly people (4.3 percent). Although an equal proportion of males (50.5 percent) and females (49.5 percent) were married, more single males took part (56.6 percent) than single females (43.4 percent). Christianity (79.8 percent) and Islam (19 percent) were the two dominant religions reported by respondents, and males and females were equally religious, irrespective of the faith they professed.

Sources of Livelihoods

The main sources of livelihood reported by the respondents were farming or bush work (21.6 percent), petty trade (19.5 percent) and private business (16.7 percent). In urban communities, residents were more likely to be engaged in petty trade (23.7 percent) and private business (20.3 percent). In rural areas, on the other hand, 18.6 percent of respondents made their living mainly from farming or bush work to (see Appendix B for a full description of respondents' characteristics).

KNOWLEDGE, ATTITUDES AND PRACTICES RELATING TO EBOLA

The onset of the Ebola epidemic saw widespread public denial and the prevalence of myths about the disease, which accelerated its spread. While EVD was claiming lives, authorities in Liberia were fighting the deadly virus on multiple fronts, including dispelling public doubts and myths – including denial that the disease even existed. Kpadeh (2014) reported Assistant Health Minister Tolbert Nyensuah lamenting that widespread disbelief and doubt were major factors in the rising death toll. At that time, some Liberians believed that the Ministry of Health (MoH)'s announcement of the outbreak of Ebola was intended to scare people away from traditional practices of hand shaking and giving dead family members a fitting burial, and a ploy to attract funding from the international community.

However, at the time the assessment was undertaken, respondents were quite aware of the existence of EVD. Most participants in the FGDs had knowledge of how EVD is transmitted and

prevented. It was found that respondents had adopted certain attitudes and implemented behavioural changes to favour EVD prevention. As a result, the assessment revealed that most participants were adopting at least some of the preventive measures and guidelines provided by the health authorities to curb the spread of the disease.

Ebola awareness

At the time of the assessment, respondents demonstrated a near universal level of awareness about EVD. When asked, 'Have you ever heard or learned of Ebola before this interview?', 94.5 percent of males and 95.2 percent of females said 'Yes' (see **FIGURE 1**). Similar findings were made by LISGIS in a Knowledge, Attitude and Practice (KAP) survey which showed that 99.8 percent of respondents had heard of Ebola and 98.1 percent believed that the disease was in Liberia (LISGIS, 2014).

This high level of awareness was shared equally by males and females, irrespective of age, educational level or area of residence. The lowest level of EVD awareness (69.8 percent) was reported in Grand Kru County, but residents in the other four counties surveyed reported high levels of awareness (exceeding 90 percent in each county).

The assessment also found that 98 percent of all respondents who were aware of EVD also believed that the disease was present in Liberia – with both males (98 percent) and females (97 percent) sharing this belief. This level of awareness and belief about Ebola presents an excellent entry point for future interventions in responding to any new Ebola outbreak. This opportunity should be exploited by the government and its partners to undertake appropriate social mobilization efforts and foster local community participation in planning and implementing EVD response strategies. However, Grand Kru presents a challenge that needs special attention: the highest levels of disbelief were recorded this county, with 19 percent of respondents not believing that Ebola was present in Liberia.

Ebola prevention

To demonstrate their understanding of EVD awareness messages, respondents were able to outline the necessary health and safety measures that should be practised in order to avoid contracting Ebola. As shown in **FIGURE 2**, nearly equal proportions of males (93.3 percent) and females (91 percent) correctly responded that the key ways to avoid contracting the disease were to 'avoid touching anyone who is sick', followed by 'avoid contact with body fluids (stool, urine, blood, saliva, sweat, tears, semen)' and 'avoid funeral and burial rituals of handling corpses'.

The assessment established that other preventive measures adopted had seen changes in social and customary practices, such as 'no public gathering' and 'not sitting together'. It was reported that most men had scaled down their social activities, such as going to video clubs, playing football, etc. Most people avoided eating together and

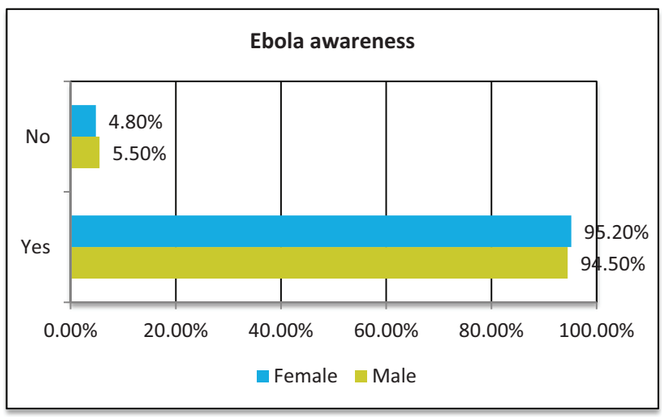

FIGURE 1: Ebola awareness

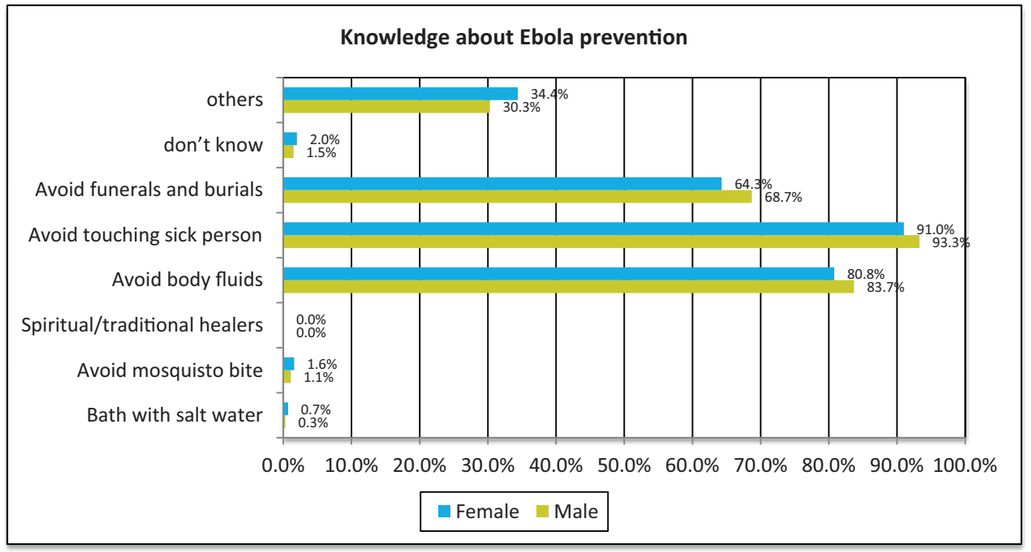

FIGURE 2: Knowledge about Ebola prevention

group working on farms. Other social behaviours adopted to prevent catching the virus included avoiding kissing and reducing the number of multiple sexual partners.

The assessment team observed that improved hygiene practices such as hand washing with soap and water were being practised by participants at the family and community levels. There were also gender roles for the prevention and control of the spread of EVD. While men were mostly responsible for the provision of physical materials, such as buckets or materials made locally from reeds, etc., women provided water for hand washing and education for their children on how to use chlorinated water. There have also been changes to diet, such as not eating bush meat, and restrictions on social and customary practices such as not shaking hands or hugging while greeting. There have also been changes in clothing habits, such as wearing long-sleeved shirts.

However, the degree of conviction about these safety practices is not as strong as the professed level of awareness of the disease. For example, while awareness is almost universal among men and women, only 68.7 percent of males and 64.3 percent of females reported that 'avoiding funeral and burial rituals of handling corpses' was one of the chief means of stopping the spread of EVD. This seems problematic because it might be expected that community members would readily recognize this as one of the most effective ways of stopping the spread of Ebola. This finding, therefore, has crucial implications for designing unambiguous and well-targeted Ebola education campaigns. Communication messages need to emphasize behaviour change away from this common religious and cultural practice.

Moreover, it seems atypical that not even a single respondent mentioned the myth that 'treatment from a spiritual/religious leader' was a way to prevent EVD. This is strange because typically in Liberian society superstition and myths abound, and it seems unlikely that everyone had suddenly dismissed strongly held traditional and cultural practices of 'consulting oracles' or 'getting prayers and holy baths' in times of crisis. There may be two plausible explanations: 1) that the ongoing community awareness and sensitization programmes on EVD have been very successful in changing

minds and attitudes; or 2) this is simply under-reporting to mask high levels of myth and denial and the trust that people have that some divine intervention can save them from Ebola.

Sources of Ebola information

The assessment found that government officials and civil servants played a role in providing information on EVD. Information was provided in local languages and in Liberian English through various media, including radio, posters, billboards, daily newspapers, songs and T-shirts. In addition, private establishments, non-government organizations (NGOs), civil society organizations (CSOs), religious and faith-based organizations (FBOs), cultural groups and private individuals have contributed immensely to efforts to support the work of healthcare workers (HCWs).

To optimize the effectiveness of EVD messages, it is important to utilize the services of a workforce that communities will largely trust and believe. As shown in **FIGURE 3**, respondents more readily trusted or believed health workers from outside the country (67.7 percent), health workers from their own community (54.9 percent), community leaders (42.7 percent) and government staff (39 percent). Among respondents, 86.9 percent believed that health workers were working to protect them from Ebola. A majority (85.1 percent) had no objection to receiving help from health workers from outside their communities. Rural communities (77 percent) were less trusting of health workers from outside compared with urban communities (90.4 percent). This finding is quite instructive: in order for EVD social mobilization and awareness campaigns to yield maximum community buy-in and the best results, it is strongly recommended that the lead players should be health workers, community leaders and government staff. On average, men (33 percent) and women (34 percent) shared these perceptions to a similar extent.

The assessment found a general lack of knowledge and awareness about Ebola care centres (ECCs). These are modestly resourced facilities that are being or have been built in local communities so that people do not have to travel long distances to reach Ebola treatment units (ETUs). A large majority (72.4 percent) of respondents had not heard about ECCs. For those who had heard about them, educational levels correlated strongly with their knowledge; hence males were more likely (27 percent) to have heard about ECCs than females (20 percent). There is a need for more education among females since they are likely to be the main care-givers in these facilities. Those who had knowledge about ECCs identified two main benefits, on account of which they would be happy for such centres to be built in their communities. These were facilitating care for sick people in the community (84.5 percent) and stopping

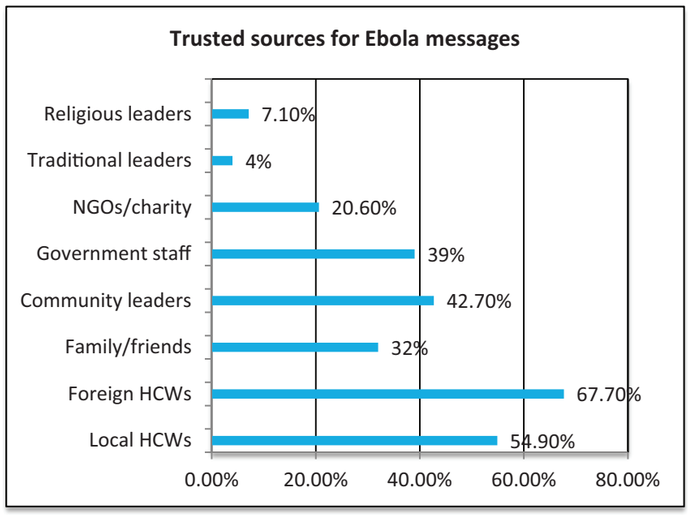

FIGURE 3: Trusted sources for Ebola messages

family members from getting sick at home (62.4 percent).

Perceived risk of contracting Ebola

Broadly speaking, 54.1 percent of males and 55.2 percent of females believed that they had no risk of getting Ebola in the next three months. This was much lower than the 73 percent risk perception reported by LISGIS (2014). Perhaps this shows that levels of risk perception reduce with time.

A mere 2.1 percent of the sample population felt that they had a high risk of getting Ebola in the same time interval. As shown in **FIGURE 4**, respondents felt that they had little or no risk of catching the disease because they practised prevention measures (83.1 percent) and/or they were very careful (53.5 percent). Nonetheless, 40.4 percent believed that God would protect them from Ebola, indicating high levels of faith or superstition and reliance on supernatural or divine intervention for protection. As such, it should be recognized that religious institutions and leaders could have an important role to play as change agents for Ebola prevention and in recovery and long-term work. To play this role well and to win the trust of community members on matters regarding Ebola, religious leaders will require adequate training and technical support.

Perceptions of gender-based vulnerability to Ebola

FGD and KII participants believed that more males had been infected and had died from Ebola than females. The reason cited for this was the involvement of men in business activities, which meant more travel and increased contact with other people. Other reasons cited were that men had multiple sexual partners and that their workplaces in hospitals or health facilities and their attendance of public places such as sports events, clubs and entertainment centres contributed to higher levels of vulnerability.

However, as shown in **TABLE 1**, the survey data suggested that the perception among males was that women were more vulnerable (32 percent) to EDV infection than men (13.8 percent). Respondents believed that there were three main reasons why women were more vulnerable: taking care of the sick (73.7 percent), going to the market (57 percent) and looking after children (51.8 percent). While females believed that both men (22.4 percent) and women (24 percent) were equally susceptible to Ebola, men had a misunderstanding that women run a higher risk of catching EVD.

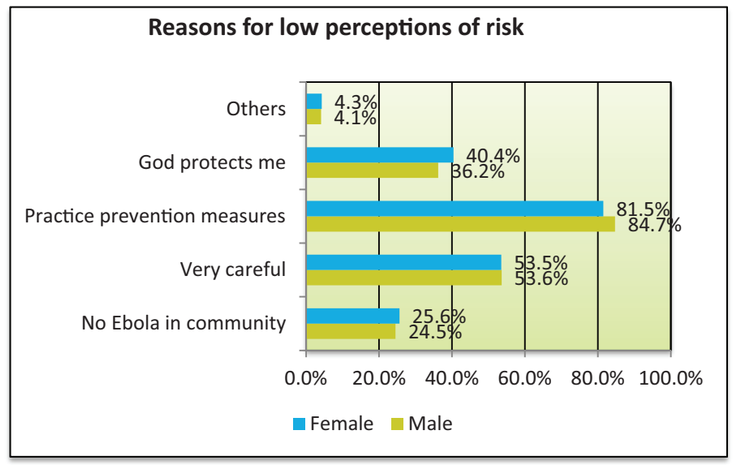

FIGURE 4: Reasons for low perceptions of risk

TABLE 1: PERCEPTIONS OF GENDER-RELATED VULNERABILITY TO EBOLA

Who you think is emore likely to catch Ebola – men or women?

	Men		Women		Both		Don't know		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Female	175	22.4	185	24	322	41.3	98	12.5	779	100
Male	108	13.8	247	32	347	44.3	82	10.4	783	100
Total	283	18.1	432	28	668	42.8	179	11.5	1562	100

Source: Ebola Gender Assessment data tables

Health-seeking intentions

The assessment found positive health-seeking intentions amongst respondents. FIGURE 5 shows that 90.7 percent of respondents reported that they would go to a health facility or ETU if they thought they had Ebola. A small proportion (6.2 percent) of respondents were either not sure what they would do or made no response; however, 3.1 percent said that they would definitely not go to a health facility.

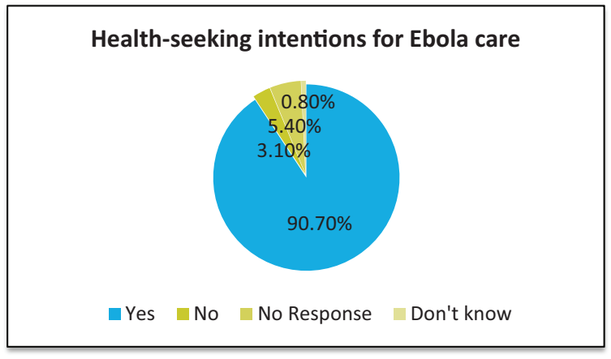

FIGURE 5: Health-seeking intentions for Ebola care

The lowest level of health-seeking intentions was reported among respondents in Grand Kru county. Overall, for those who reported that they would not go to a health facility, the main reasons were that they would not survive (85.2 percent), they would be cremated (50.1 percent) or they would be sprayed with chlorine (44.1 percent). Males tended to be slightly more worried about not surviving (87.1 percent) than females (84.2 percent), while females were more concerned about being cremated or sprayed with chlorine.

At the onset of the epidemic, national response efforts were marred by the inexperience of health workers, inadequate coordination of partners and weak community engagement and social mobilization. However, tremendous progress has been made since then and people are reporting to health facilities early enough, thereby improving survival rates.

In addition, community members and key stakeholders are engaged at all levels of the response; communication with patients in ETUs and their family members has improved; and the bodies of those who have died from Ebola are now accorded dignity and respect for burial. Therefore, there is a need for continued public education and community engagement to encourage everyone with Ebola-related conditions to take advantage of the improved health services now available at ETUs.

On the other hand, those who said that they would go to a health facility thought that a person would receive better care at an ETU than at home (79.7 percent), get a safe place

for treatment (50.2 percent), receive medicine including medicine for other sicknesses (44.8 percent) and be fed with nutritious food and safe water (32.6 percent). There were no notable differences in the opinions of men and women on why they would go to an ETU; in general, there was strong optimism that going to an ETU would enhance one's chances of survival (82.8 percent).

This finding also makes a strong case for continued collaboration with Ebola survivors, getting them involved in sharing their stories and sensitizing communities about the benefits of seeking healthcare at ETUs. The psychosocial, medical and financial welfare of survivors should remain a priority to enable them to continue to make meaningful contributions to efforts in EVD prevention and recovery.

When a family member was sick with Ebola, respondents preferred that care for the sick person should be provided by older family members, particularly women. Older women were twice as likely to be preferred (60.5 percent) as older men (30.4 percent) to be the ones to care for sick family members.

As part of the efforts to promote national EVD preparedness and prevention, it is imperative that older women are specifically targeted for training in patient care, with an emphasis on the prevention and control of infection.

Community Ebola response activities

One key shortfall seen at the beginning of the national Ebola response was the inadequacy of local community participation. During the assessment period, however, many improvements were made to enhance local community participation. This was achieved by collaborating with CSOs, local NGOs, traditional and religious leaders and youth and women's groups, as well as with professional bodies.

FIGURE 6 shows that the main Ebola response activities in which community members have been involved are awareness campaigns (82.5 percent), community training (25.2 percent) and meetings/conferences (23 percent). Despite these gains, however, local community members still feel left out of the national Ebola response, with 65.2 percent of respondents claiming that they had not participated in any organized community activity to fight the disease. For those who have participated in Ebola response activities (29.2 percent), there was nearly equal representation between rural (30.8 percent) and urban (28.2 percent) residents. However, more males (34.4 percent) have participated in EVD response activities than females (24 percent). Males and females have been similarly engaged in all activities, except in the distribution of prevention materials (10.7 percent of males compared with 6.9 percent of females) and caring for the sick (8.0 percent and 11.6 percent respectively).

On average across the counties, 89.7 percent of respondents reported that they were satisfied with the level of work done by the

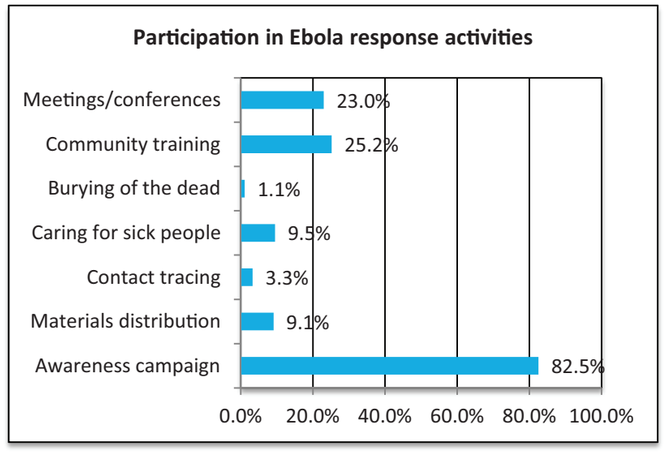

FIGURE 6: Participation in Ebola response activities

Government of Liberia to stop Ebola; the satisfaction rating was lowest in Grand Kru (79.2 percent). These views were held by 88.5 percent of males and 91 percent of females, and by 90.8 percent of rural residents and 89.1 percent of those in urban locations. When probed on their reasons for dissatisfaction, those who said they were not satisfied argued that the government response was too slow (60.3 percent) or that support had not reached their communities (53.4 percent), and many claimed (42.3 percent) that money earmarked for Ebola had been misused.

No further was attempts were made to ascertain the facts behind these allegations of abuse of funds; in any case, such concerns may simply be expressions of annoyance that flare up when people are not sufficiently informed or educated about such matters. Nevertheless, both men and women held such views, except on the slowness of response, which was asserted by significantly more females (66.8 percent) than males (46 percent).

LIVELIHOODS AND FOOD SECURITY

The EVD crisis has been raging in West Africa for more than a year now, with severe and far-reaching effects – an unprecedented death toll, the reversal of development gains, increased poverty and food insecurity and halted livelihood activities (UNDP Africa policy note, 2015). Economic gains made in the past few years in Guinea, Liberia and Sierra Leone have been reversed by the EVD epidemic. The incidence of poverty – which already stood as 49.8 percent in Guinea, 31.2 percent in Sierra Leone and 63.5 percent in Liberia – has been worsened by the outbreak (UNDG, 2015). In Liberia, the outbreak has adversely affected the basic livelihood and agriculture activities of most people. Most FGD participants reported that, before Ebola, they engaged in farming, petty trading, formal cross-border transactions, gold mining and other informal activities, which provided sustainable sources of livelihoods.

The participants in the assessment observed that their ways of making a living or acquiring income and food have changed since the EVD crisis began. Nearly 65 percent of agricultural households believed that their harvest would be smaller this year than it had been in the previous year, and labour shortages and inability to work in groups continued to pose a problem for agricultural households (World Bank, 2015). Many people have not been able to engage in farming activities, travel to trade or do business, go to market or hunt animals. Many have lost gainful employment because of the crisis, leaving them jobless and idle. The EVD outbreak has thus stifled livelihoods and led to a serious loss of family income. These experiences have been vividly described by UNDP (Africa policy note, 2015), which confirmed that the EVD crisis has halted livelihood activities and has increased poverty and food insecurity.

Income-generating activities before Ebola

Prior to the outbreak of the Ebola epidemic, Liberians generally engaged in economically productive activities that promoted local commerce and trade. **FIGURE 7** shows that on average 82.9 percent of males and 79 percent of females claimed to have been engaged in some form of income-generating activity (IGA) before Ebola started. High levels of engagement in IGAs were reported in both rural (84 percent) and urban settings (78.9 percent) prior to the outbreak.

FIGURE 8 shows that, on average, 75.6 percent of all respondents who undertook IGAs before Ebola did so largely on a self-employed basis, compared with 21.3 percent in waged-employment. The majority of those who were self-employed were females (85.5 percent) relative to males (66.3 percent). Respondents in rural communities were more likely to be engaged in self-employment (86.7 percent), compared with 67.9 percent of urban residents. The highest proportion of waged employment (28.2 percent) was reported in Montserrado County. Studies have shown that women have borne the brunt of the crisis in terms of work, especially those involved in non-agricultural self-employed activities (Kotilainen, 2015).

Those who were not engaged in any IGAs before Ebola supported their livelihoods mainly through allowances from parents/guardians (4.9 percent), support from boyfriends/girlfriends (37.4 percent) and transfers from family members (27.1 percent). Male respondents tended to rely more on parents/guardians (53.4 percent), while females relied on husbands/boyfriends (51.6 percent). This trend reinforces socio-economic dependency, with the implication that unemployed females face an increased likelihood of sexual exploitation and abuse as they depend on husbands/boyfriends for support. There is a need to promote job creation and support entrepreneurship to stimulate opportunities for both waged and self-employment for local residents; the agriculture sector holds great promise in this regard.

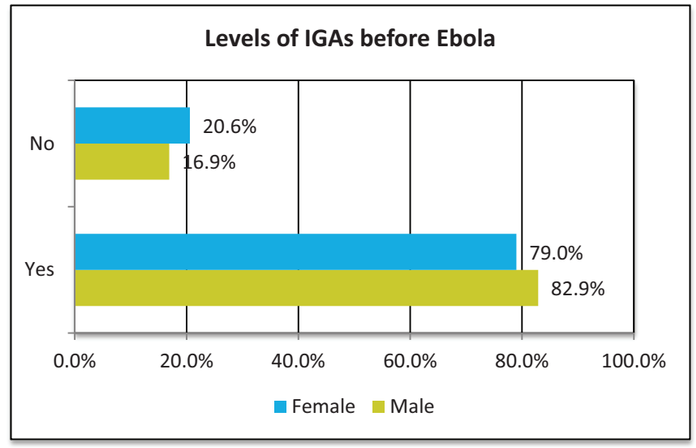

FIGURE 7: Levels of IGAs before Ebola

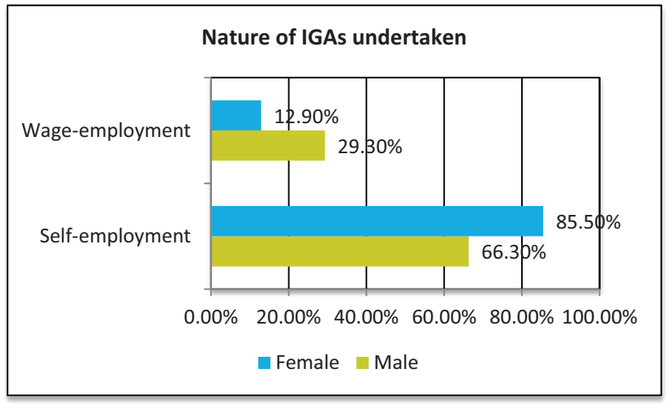

FIGURE 8: Nature of IGAs undertaken

Type of income-generating activities

Respondents engaged mainly in petty trade (34.1 percent), farm labour (19.7 percent), skilled labour (12 percent) and food processing (11.3 percent). As shown in FIGURE 9, the majority of women participated in petty trade (42.6 percent) and food processing (19.3 percent), while the majority of men participated in more secure IGAs – skilled labour (21.9 percent) and school teachers (7.6 percent).

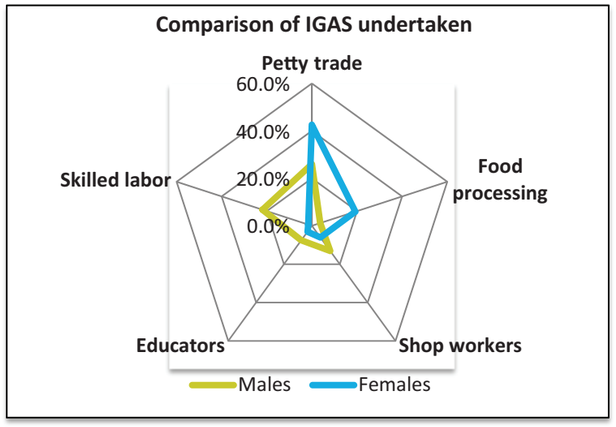

FIGURE 9: Comparison of IGAs undertaken

Because women are engaged largely in vulnerable forms of employment,[3] their IGAs do not generate sustainable income and lack capacity to absorb shocks from any sudden negative impact on the economy, as has been seen with the Ebola outbreak. While those in waged employment (mainly men) – for example, in the education sector in public schools – have been maintained on the payroll, those in self-employment (mainly women) have lost their incomes with the closure of businesses. Moreover, women's food processing businesses were quick to collapse because generally they deal in perishable goods, while shop workers did not suffer the same loss of commodities.

The EVD epidemic affected men too but in a totally different way, because their sources of income are not the same as women's. Most self-employed women were engaged in food businesses which they had to halt because customers were afraid to 'eat in the street', fearing that they would contract Ebola from improperly cooked food. Men, however, were involved in businesses related to non-perishable goods such as currency exchange, cutting hair and marketing electrical and solar appliances (i.e. solar lights, stoves, etc.). Such items were still sought after by the few who could afford them (Kotilainen, 2015).

Participation in economic activities before and after Ebola

Since the outbreak of Ebola, Liberians have experienced a remarkable decline in the rate of participation in IGAs. As shown in FIGURE 10, an average pre-Ebola employment figure for males and females of 81.0 percent reported by respondents has fallen to an average of 43.7 percent in the post-Ebola environment. Meanwhile, the average pre-Ebola unemployment rate for males and females (18.8 percent) has tripled (56.2 percent) since the outbreak began. On average, the employment rate has declined by approximately 37 percentage points, from 82.9 percent to 45.3 percent for males and from 79 percent to 42 percent for females.

A socio-economic impact survey conducted by the World Bank in February 2015 found that nearly 41 percent of household heads who had been working at the start of the Ebola crisis were out of jobs during that period, down from 48 percent in December

[3] People in 'vulnerable employment' are defined as those whose employment status is 'own-account worker' or 'contributing family member'. They are less likely to have formal work arrangements or access to benefits or social protection programmes, which puts them at risk when there is a downturn in the economic cycle (Liberia Labour Force Survey – LISGIS and Ministry of Labour, 2010).

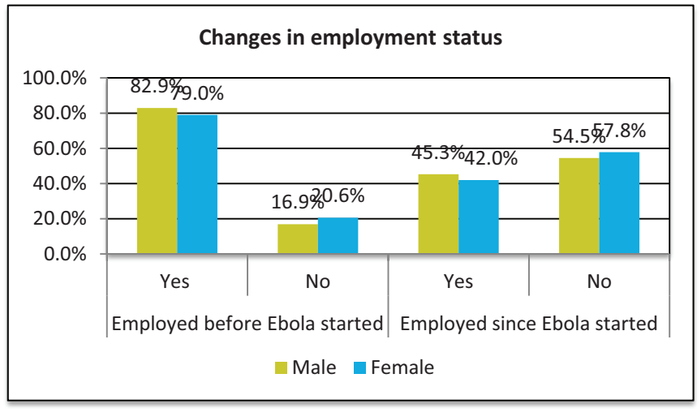

FIGURE 10: Changes in employment status

2014. This partial recovery was driven mainly by those in the waged employment sector, but also by non-farm self-employment in urban areas and by a moderate increase in agricultural employment in rural areas (World Bank, 2015).

The growing level of unemployment – from an average of 18.8 percent to 56.2 percent – can be attributed to different factors. When asked why they were not employed, 45.8 percent of unemployed respondents reported that they simply had 'nothing to do'. This was followed by 'breakdown of business' (30.7 percent) and 'loss of job' (16.1 percent). Consequently, levels of dependency have deepened further, with 37.5 percent of unemployed people depending on spouses/lovers, 35.4 percent on transfers from family members and 24.3 percent on allowances from parents/guardians. This finding corroborates the observation of UNDG (2015) that the EVD crisis has pushed many people who were already struggling with food security and livelihood issues deeper into the abyss of poverty, making them more vulnerable. Although the data show no notable difference in the level of participation by women and men in multiple IGAs, it is important to note that since the Ebola outbreak women (15.9 percent) have slightly overtaken men (14.2 percent) in IGA participation. This finding seems to corroborate assertions that in times of crisis women tend to demonstrate greater resilience and industry to cope with the situation, beating the odds in order to enhance their families' survival chances.

There has not been much change in the main kinds of IGA that respondents engaged in before and after Ebola, except for those in education and skilled workers such as mechanics, security personnel, drivers, etc. As shown in FIGURE 11, more people have shifted from the education field to skilled work; the closure of schools during the Ebola crisis may be the reason for this movement. However, a gender trend also emerges – whereas males largely retained their pre-Ebola type of IGA participation, women have generally shifted from petty trading and education to farm work.

Irrespective of gender, the majority of respondents (89 percent) worked for cash rather than in-kind payment. For those who worked for in-kind payment, the main items received were food (77.4 percent) and clothes (39.2 percent).

Incomes of respondents

With respect to the amount of money earned from various IGAs, more males (31.9 percent) reported earning higher incomes than

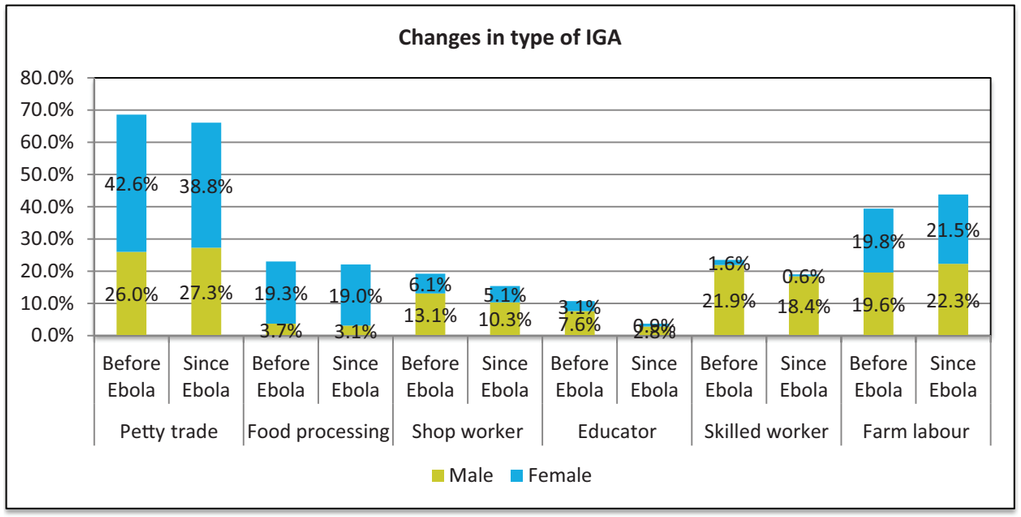

FIGURE 11: Changes in type of IGA

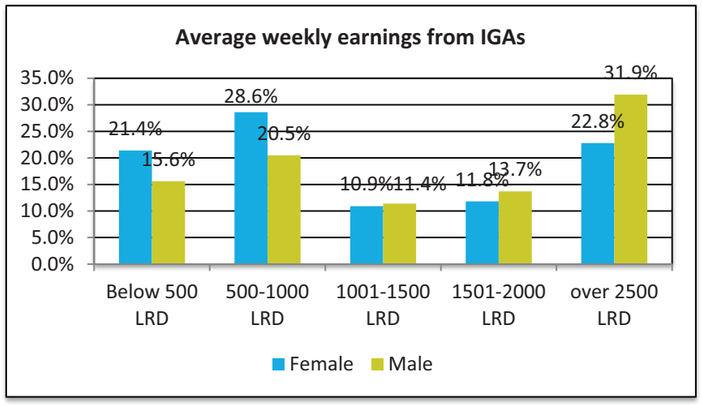

FIGURE 12: Average weekly earnings from IGAs

females (22.8 percent). As can be seen in FIGURE 12, the majority of women participated in low-income IGAs, while males participated in the upper-income brackets. According to the data, 27.5 percent of respondents reported having average weekly earnings of higher than LRD 2,500 (US$30.00). Nonetheless, three-quarters (74.9 percent) of respondents said that they were earning less money than before Ebola. The assessment indicates in particular that the EVD epidemic has significantly decreased women's incomes, since 'people were afraid of buying food items from the street'. During the first weeks of 2015, their businesses had started to grow slightly but were still very quiet in comparison with pre-EVD levels (Kotilainen, 2015).

Local commerce and trade

As the Ebola epidemic ravaged the Mano River Basin region last year, governments took some drastic measures in an attempt to bring the situation under control. The most radical interventions included the closure of borders to curb the cross-border spread of the virus, the closure of all schools, the imposition of national curfews and regional

travel restrictions, and the closure of many local markets. While these measures proved to be effective public health interventions, they provoked largely negative social and economic consequences. For example, the closure of schools for nearly a whole academic year deepened the social vulnerability of Liberian children by denying them access to education.

At the peak of the crisis, market closures and transportation issues were the main obstacles to revitalizing enterprises, but working capital has now become the main constraint to remaining in business or reopening. Lack of customers was the main reason given (39 percent) for businesses not reopening (World Bank, 2015). Additionally, travel restrictions have led to the loss of staple foods, which perished due to the lack of transport to markets. Moreover, restrictions on the number of traders who could access key markets in Liberia at the peak of the EVD crisis resulted in disproportionately large losses for women traders, who make up 70 percent of this group (UNDG, 2015).

In the assessment, 60.4 percent of respondents reported that local markets in their communities were either fully or partially closed at the height of the Ebola crisis. This situation affected rural communities (56.5 percent) more than urban communities (9.1 percent). Across the country, the worst affected areas were in Lofa (83.4 percent), Grand Kru (43.4 percent) and Grand Cape Mount (36.8 percent). Irrespective of geographic location, 80.4 percent of respondents reported that cross-border trade had been hindered by these restrictions – and women were the main victims because of their higher participation in cross-border trade.

The closure of borders deepened already pervasive economic hardship and further challenged the livelihoods of communities. As shown in FIGURE 13, the main problems faced by ordinary people were the breakdown of small businesses (75.5 percent) and increases in the prices of basic commodities (57.8 percent). Because the majority of women were engaged in self-employment, mainly in petty trade, it can be assumed that many women lost their sources of income because of these measures.

Gender differences aside, increase in prices have affected everyone, but people in Grand Gedeh (100 percent), Grand Cape Mount (96.4 percent) and Grand Kru (90.6 percent) have suffered the most. This has left most traders unable to support their families or pay back loans to creditors like the Central Bank of Liberia. Therefore, these traders need to be assisted either through debt waiver or

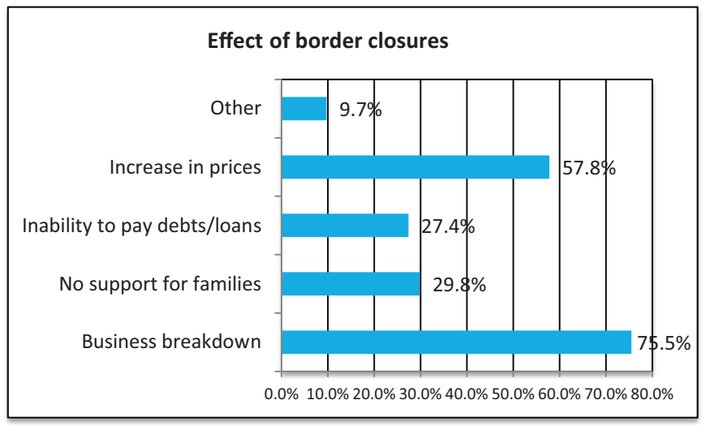

FIGURE 13: Effect of border closures

relaxation of their repayment periods in order for them to get back into business. With the Central Bank of Liberia, this is feasible.

Though business people have been similarly affected by this situation, they have encountered additional challenges. As shown in FIGURE 14, the key challenges are increases in prices (63.9 percent), a lack of buyers (63.6 percent) and few or no goods available on the market (49.5 percent). Both women and men have been affected equally by these problems, except for the increase in foreign exchange rates, which concerned males (21.2 percent) more than females (16.5 percent).

Personal savings practices

Both women and men have experienced a similar crucial shortfall in their ability to save money since the Ebola crisis started. As FIGURE 15 shows, 63.9 percent of males and 59.1 percent of females reported that they were saving money before Ebola began. Since the outbreak, the ability to save has declined to 24.6 percent among males and 29.5 percent among females; thus on average the ability to save has fallen from 61.5 percent pre-Ebola to 27.1 percent now, representing a 56 percent reduction in saving amongst respondents.

The data suggest that more males have suffered actual loss of existing savings (39.3 percent) than females (29.6 percent). The most notable loss of savings has been felt by people in Grand Cape Mount, where a reduction of 46.5 percentage points was recorded among respondents. Respondents in Grand Cape reported a decline in savings

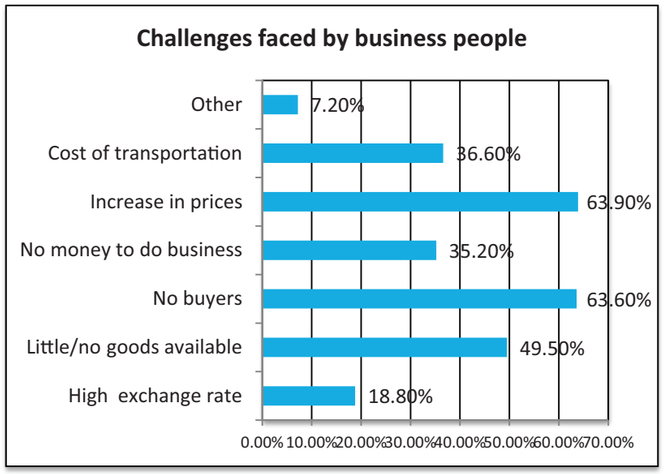

FIGURE 14: Challenges faced by business people

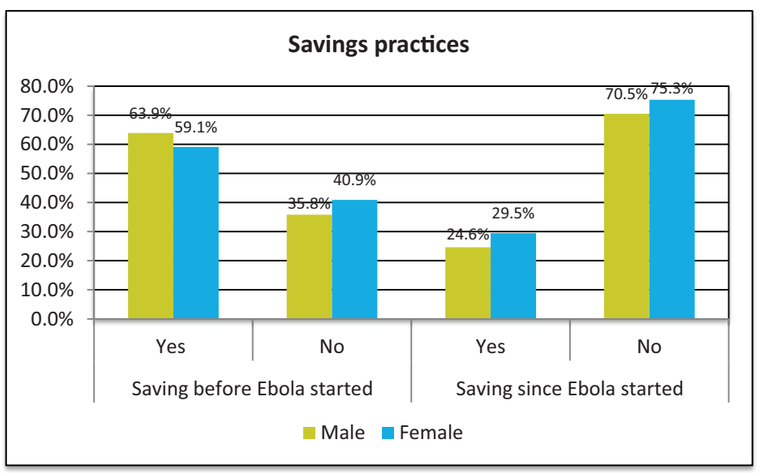

FIGURE 15: Savings practices

practice of well over ten percentage points greater than any of the other counties assessed. The principal reason for this decline was that two-thirds of respondents (66.4 percent) had used up all their savings on family welfare. Women have been using their business capital and savings and deploying other strategies to cope with the hardship imposed by the Ebola crisis, and this may deplete their future economic capacity and the viability of their small enterprises (UN, World Bank, EU and ADB, 2015).

Access to finance

As FIGURE 16 shows, people have had very limited access to finance during the Ebola crisis. In all, 78.6 percent of respondents expressed frustration at not being able to borrow money from any individual or institution during the outbreak. According to respondents, the main inhibition to their ability to borrow money was that no one was willing to lend (82.5 percent), and if loans were available the interest rates were just too high (20.9 percent).

As FIGURE 17 demonstrates, the few people (18.8 percent) who were able to borrow money did so primarily through informal opportunities offered by savings clubs (46.3 percent), friends (37.9 percent), family (28.2 percent) and *susu* clubs (19.8 percent). Males were more likely to borrow money from friends (40.9 percent) or families (30.1 percent), while females were more likely to access finance from savings clubs (48.5 percent) or *susu* clubs (23.4 percent). Men have thus had better leverage in loan negotiations than women: normally, families and friends are much more understanding about interest rates and repayment periods when lending money than savings and *susu* clubs. In addition, during the EVD outbreak, these sources from which women can normally readily access loans closed down, further limiting their access to finance. An average of 24.4 percent of respondents had outstanding loans, irrespective of gender or geographic location.

Banking has not been broadly accepted in Liberia as a necessity for economic security. The experience of the civil war, when depositors lost their life savings with the collapse of the economy, have remained fresh in the minds of many ordinary people. In addition, there are innumerable obstacles that plague the banking and finance sector: for example, limited service outlets across the country, erratic quality of service resulting from fluctuations in Internet connectivity and high interest rates and short repayment intervals of most micro-finance institutions (MFIs).

Consequently, many community members in both rural and urban settings have resorted to establishing their own social clubs such as daily *susu* groups, birthday clubs, monthly clubs and yearly clubs. Typically, the funds collected are divided either monthly or at the end of the year. In most towns and villages, the money can sometimes be used as collateral to take out loans from banks. More needs to be done to improve services and to minimize the risk of depositors losing their savings. This will help to spur public

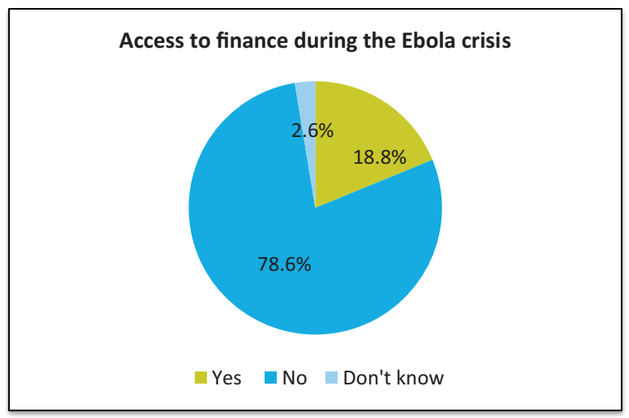

FIGURE 16: Access to finance during the Ebola crisis

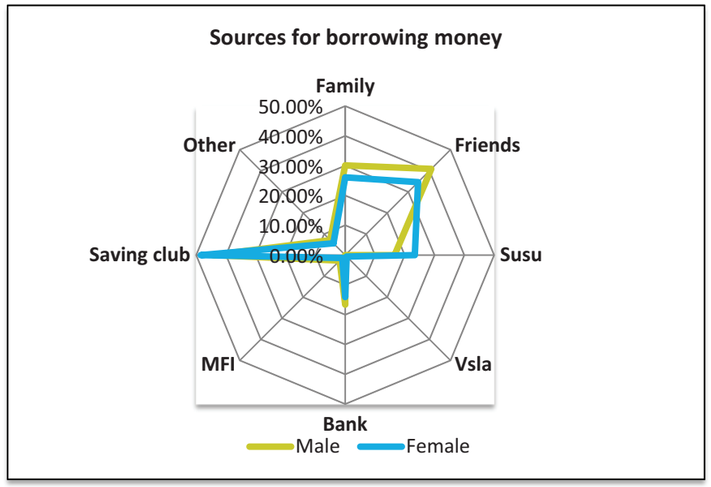

FIGURE 17: Sources for borrowing money

confidence and influence better banking practices and will bring services closer to local populations, especially those in rural communities.

Effect of Ebola on vulnerable populations

The FGD findings suggested that some household heads (disabled persons, females and orphans) became sick and died because their sources of income declined and they could not cope with the situation. Some 72 percent of respondents believed that Ebola had created more hardship and greater burdens for people with disabilities, elderly people and those living with HIV. People with a traditional religion were more likely (75 percent) to believe this. On average, the level of awareness increased with the respondents' level of education. As shown in **FIGURE 18**, respondents blamed the situation on the fact that ordinary people could not afford to give alms (78.4 percent) and on shortages of food (72.8 percent).

Participants indicated that this situation had also affected widows and orphans. As more men became sick and died, they left behind food-insecure families. Participants did not believe that widows would be disinherited; according to some, existing customs allowed women/widows to own property through marriage, their children and long residence in communities. It was, however, not actually clear to what extent this customary system protects widows and orphans from being disinherited by relatives of deceased husbands or fathers. This may need to be further explored, as the sharp increase in the numbers of widows and orphans may overwhelm the capacity of customary property and inheritance laws to handle. Furthermore, these findings do not corroborate assertions by UNDG (2015) that women who have lost their husbands to EVD in the three worst affected countries are facing problems in the application of customary laws on land and inheritance due to discrimination.

The assessment indicated that either mothers or fathers made decisions about food sharing in most households. Children and pregnant mothers received the most food while other adult members of the household shared what little remained. The situation was further aggravated by rumours that wicked people were poisoning food and water to infect communities with Ebola, making it even more difficult to access food and water.

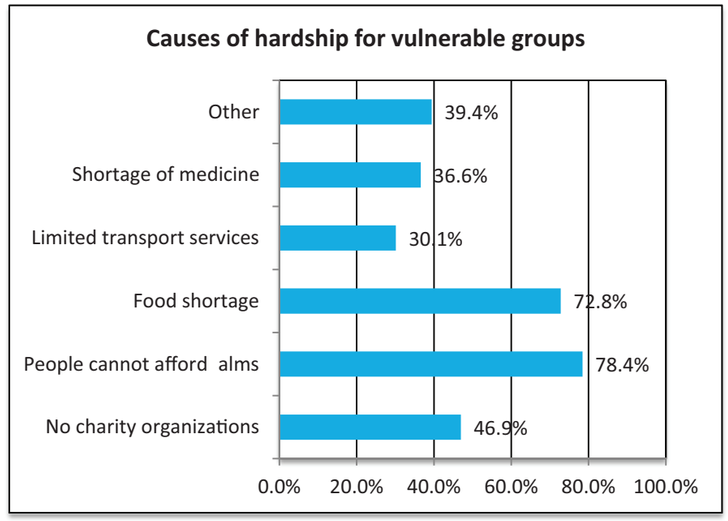

FIGURE 18: Causes of hardship for vulnerable groups

ACCESS TO HEALTH SERVICES

Liberia, Guinea and Sierra Leone, which have been hardest hit by the epidemic, all suffer from weak public health systems (Siedner et al., 2015). The EVD crisis in the region was unprecedented, with consequences so devastating that the World Health Organization (WHO) has designated it a public health emergency of international concern. However, the full impact of EVD on health provision, access and utilization is only now becoming clear (Witteveen, 2015). Many experts have stressed that EVD simply exposed the very weak healthcare infrastructure in these countries, which was ill equipped to tackle any emergency of such magnitude. This observation is reinforced by Siedner et al. (2015), who emphasize that countries with weak and struggling public health systems have almost no chance of coping with a large-scale outbreak of a disease such as EVD if no external help is provided.

The assessment established that most people did not have access to clinics or hospitals even before the outbreak: healthcare services were too costly. Despite significant improvements over the past decade, Liberia's health system still bore scars from the civil war: inadequate infrastructure and technology, low human resource capacity, an insufficiency of drugs and medical supplies, etc. WHO has set a global minimum standard of 2.3 doctors, nurses and midwives per 1,000 population. In countries affected by EVD, the number of healthcare providers (nurses, doctors, and midwives) is grossly inadequate, especially in rural areas; consequently, there is insufficient provision of care and activities related to monitoring and supportive supervision of the quality of care are not carried out. Liberia, Sierra Leone, Guinea and neighbouring Guinea-Bissau collectively require $420m to train the 9,020 medical doctors and 37,059 nurses and midwives needed to fill the gaps in their health workforces (Oxfam, 2015).

Health workers in Liberia have paid a high price due to the Ebola epidemic. By early April 2015, the MoH had reported a total of 372 EVD cases among healthcare workers, with a fatality rate of 49.5 percent (MoHSW, 2015b). As health workers saw their colleagues dying, many panicked and fled for their lives, leaving facilities with no one to look after those in need. Participants reported that,

because of the closure of health services, many people died from other illnesses that were not directly related to EVD. Those healthcare workers who dared to remain at their posts in health facilities were afraid to touch or treat sick persons, including pregnant women.

Consequently, most people sought self-treatment from drug/medicine stores, quack doctors, herbalists and friends during the Ebola crisis. A male FDG participant in Grand Kru commented, 'We did anything, even pray to God, just to get well when we were sick or anyone felt ill.' The EVD situation clearly exacerbated poor health conditions in the country. An FGD participant in Lofa County said, 'We do not have any healthcare delivery in our community, and because of bad road conditions, when somebody gets sick we put them on our shoulders to take them to the nearest health facility.'

Pre-existing health problems

Even before the Ebola crisis, access to health services and safe drinking water and sanitation was inadequate across West Africa. Where health facilities existed, many were unable to safely provide the services needed as they lacked staff, medicines and health information. When Ebola struck, the affected countries had little capacity for surveillance, laboratory testing, contact tracing or infection control. Basic health services such as vaccination programmes were suspended, leaving a million children vulnerable to common childhood diseases (Oxfam, 2015). Hence the EVD crisis simply exacerbated the pre-existing public health challenges that people were struggling with daily. When asked what they thought were the major health problems facing their communities, respondents identified malaria (42 percent), malnutrition (30 percent) and lack of safe drinking water (18 percent), among others (10 percent). Men and women shared similar opinions about these problems.

Availability of health services during the Ebola crisis

The symptoms of EVD are similar to more familiar diseases such as malaria and typhoid fever, and some healthcare facilities have denied access to patients with high fevers, diarrhea oor other symptoms indicative of EVD. There are no data available on victims of such marginalization, but it can be assumed that the numbers are quite high (Kotilainen, 2015). In all, 71.3 percent of respondents in the assessment reported that during the Ebola outbreak government hospitals in their area remained either completely or partially closed to all patients, regardless of their gender, educational level or geographical location.

The proportion of people following a traditional religion who reported a lack of access to health services was much higher (87.5 percent) compared with other religions. People following a traditional religion reside mostly in rural areas where there are fewer public health facilities, so the closure of the few government hospitals in these areas severely affected the population; this was especially true of counties where high numbers of Ebola cases were reported. Although Grand Gedeh is a rural county, very few cases of Ebola were reported there and so the population was least affected (29.6 percent) by the closure of government hospitals, although transportation to hospitals was a constraint.

Although the assessment provided no concrete evidence, anecdotal reports suggest that women and children suffered the most due to a lack of access to routine maternal and child health services such as SRH services, care during pregnancy and delivery and immunization. Immunization services that protect children from common childhood diseases were interrupted, and there were many reports that pregnant women were forced to deliver their babies in the street, in cars or at their homes, as no health facilities were willing to accept them. Hence, maternal

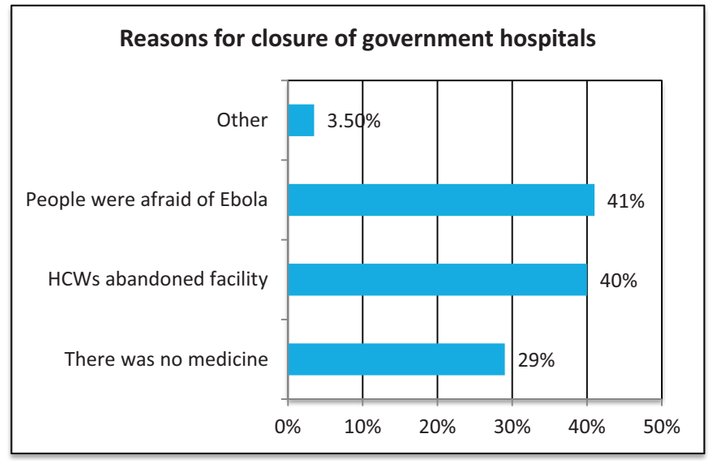

FIGURE 19: Reasons for closure of government hospitals

mortality is again on the rise, due to the EVD crisis (Kotilainen, 2015).

As health facilities closed down, persons living with HIV also experienced serious constraints in accessing antiretroviral drugs.

As shown in FIGURE 19, respondents believed that the main reasons for government hospitals closing down were that people were afraid of Ebola (41 percent) or that health workers abandoned the facilities (40 percent).

On average, there was little difference between the reasons provided by men and women for not attending government hospitals.

Alternative sources of healthcare

Due to the closure of health facilities, community members resorted to accessing healthcare from alternative sources. Many families reportedly stocked different kinds of medicine at home and self-treated themselves during the crisis. Such precautions were needed as many clinics and even larger hospitals were closed during the worst months of the epidemic (Kotilainen, 2015). As shown in FIGURE 20, 83.3 percent of respondents reported obtaining health services from unlicensed drug peddlers and half (50.1 percent) reported seeking care from pharmacies. These figures were similar for both men and women.

Of those reporting that government hospitals remained open in their communities, 72.8 percent said that hospitals catered for women, while 66.2 percent reported that they catered to the needs of children. Overall, health facilities better served the needs of women (78 percent) and children (76 percent) in rural areas than they did those of women (59 percent) and children (62 percent) in urban communities. This finding is expected, because Ebola cases were more prevalent in urban areas than in rural areas. Those who reported that women and children were not treated at government hospitals cited two main reasons for this: healthcare workers were afraid of patients (89.4 percent), and the hospitals had no medicine (36.8 percent).

The assessment indicated that pregnant women suffered greatly from this state of neglect and abandonment. In FGDs, participants said that care-givers during pregnancy were women themselves, husbands, mothers, other relatives, herbalists, or traditional midwives. In many instances, deliveries occurred at home and were often

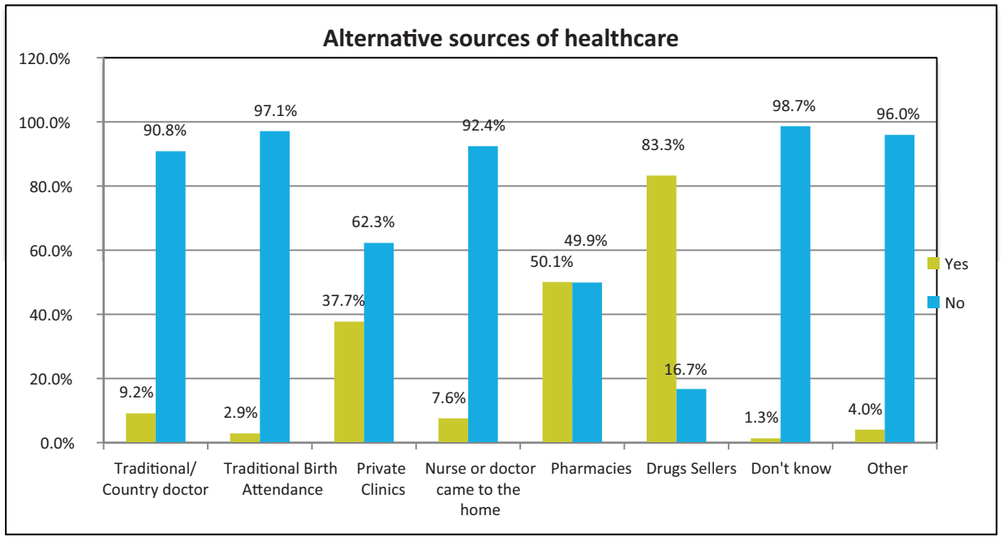

FIGURE 20: Alternative sources of healthcare

attended by people without the necessary skills or safe equipment. Additionally, pregnant women did not have access to adequate nutritious food. A male participant in the youth FGD in Zorzor said, 'Most pregnant women gave birth by themselves... all we could do was pray to God for safe delivery but some died giving birth.'

It was reported that in some cases family, friends and community members had to help pregnant women search for places to deliver their babies. Healthcare was also expensive, especially if the mother needed surgery. It was common for family members to carry pregnant women in hammocks because no ambulances were available, as nearly all vehicles had been commandeered by the Ebola response taskforce. Ambulance services increased during the Ebola crisis, but they were limited mainly to Ebola-related cases. In rural communities pregnant women were sometimes carried in hammocks even before the Ebola crisis, but the outbreak made the situation much worse.

Cost of healthcare

Generally, it was reported that healthcare was completely unaffordable during the Ebola crisis. As shown in **FIGURE 21**, 68.4 percent of respondents complained that they simply could not afford to pay for healthcare at the time.

Even before the Ebola outbreak, out-of-pocket payments accounted for 35 percent of total health expenditure in Liberia (Oxfam, 2015, citing Liberia National Health Accounts). However, when asked to compare the cost of healthcare before Ebola and during the outbreak, an overwhelming 83.8 percent replied that costs were far higher than they usually were.

The high cost of healthcare was a generalized problem, affecting everyone regardless of gender, religion, geography or education. As shown in **FIGURE 22**, respondents reported that medicines were very expensive (83 percent) and that people basically did not have money to pay for healthcare (53.8 percent) as they had used up personal savings to address other pressing family needs such as food. These factors were cited by all respondents, but those in Grand Kru and Grand Gedeh also had specific concerns about the high cost of getting to health facilities.

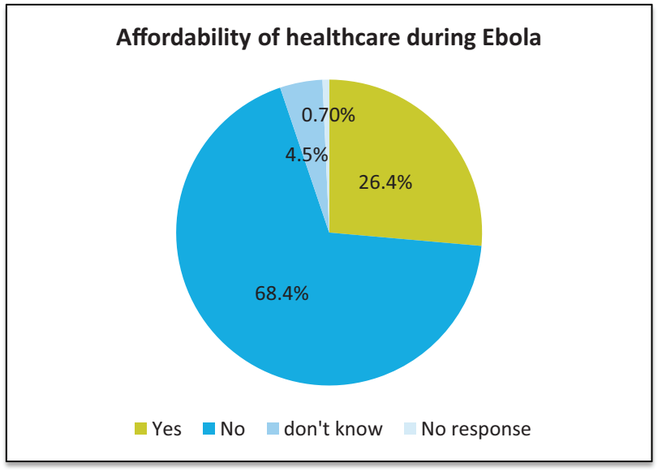

FIGURE 21: Affordability of healthcare during Ebola

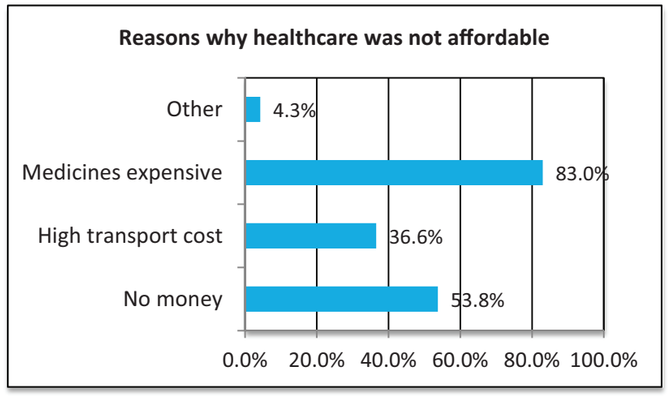

FIGURE 22: Reasons why healthcare was not affordable

Access to PPE and other medical resources

Respondents reported that, on average, healthcare workers were more likely (45.4 percent) than not (34.2 percent) to use personal protective equipment (PPE) when treating patients in hospital. Some 18.6 percent of respondents said they did not know and 'no responses' totaled 1.6 percent – however, even 34.2 percent of healthcare workers not wearing PPE is far too many. This finding is not surprising, however, as most health facilities have been seriously under-resourced and ill equipped, lacking adequate supplies and essential drugs to serve the health needs of local populations. This was confirmed by UNDG (2015), which asserted that health systems in Guinea, Liberia and Sierra Leone lacked sufficient drugs, ambulances, infrastructure, trained health personnel and medical supplies, including PPE, that were essential to contain the epidemic.

WATER, SANITATION AND HYGIENE

Access to safe drinking water and basic sanitation is essential to human health and survival, but for many people living in low-resource settings these vital services remain out of reach (WHO, 2014). The provision of water and sanitation plays an essential role in protecting the health of humans during all outbreaks of disease, including EVD. Good and consistently applied WASH practices, both in health facilities and in community settings, further help to prevent human-to-human transmission of EVD and many other infectious diseases. Contaminated water is a major cause of illness and death, and therefore the quality of water is a determining factor in levels of human poverty, education and economic opportunity.

Globally, water quality is declining unfortunately, threatening the health of populations (CDC, 2015). The provision of clean and adequate WASH facilities is essential for people's general health and well-being, as well as for the prevention of infectious

diseases. The assessment revealed that some participants, both women and men, were actively involved in WASH activities in their communities. Some communities collected money to purchase chlorine to treat their hand pumps, while others participated in sanitation activities such as cleaning wells and toilets. Some other participants provided training, information and education on water and sanitation, including the use of 'Ebola buckets' distributed by the government or the UN for hand washing in communities. Some respondents monitored wells and pumps, serving as security guards for water points.

WASH education played a critical role in effective Ebola prevention and control. Ebola is transmitted primarily through contact with the body fluids of a sick person, and so the strategy for its effective prevention and control is rooted in avoiding direct contact with sick persons or dead bodies and the adoption of a 'new' socio-cultural practice of a thorough hand-washing routine. This need is even more pressing in health settings where the sick are cared for.

Access to water points

As shown in FIGURE 23, 84.2 percent of respondents said that their local communities had access to water points (including hand pumps, streams, etc.). It appears that geographic location is the main determinant for access to water points, as more people in rural communities (89 percent) reported access compared with 76 percent in urban communities – although respondents in Grand Kru, a rural county, reported the lowest level of access (70 percent). Across Liberia as a whole, the access rate to water supply in rural settings is 42 percent and access to sanitation 17 percent, while in urban locations the access figures are respectively 79 percent and 53 percent (Schmitzer, 2014).

However, it seems likely that many reported water points in rural communities are open sources such as streams and creeks, which are commonly used for collecting water. A key informant in Grand Kru County asserted, 'We do not have any hand pump, so we drink from creeks in this community. Some of us get sick, with diarrhoea ... we are dying.'

Changes in the condition of water points

As shown in FIGURE 24, 66.5 percent of respondents believed that there had been no changes to the condition of their water points since Ebola started. Those who reported changes said that the key problems were too many people collecting water (32.5 percent), water points drying up or the water level being low (22 percent) and hand pumps being damaged (12.5 percent). It is likely that the problem of too many people collecting water may simply be a consequence of seasonal changes in water supply: the water table is low during the dry season and 42 percent of rural water coverage decreases, even taking into account seasonal hand-dug wells (Schmitzer, 2014). In addition, there have been rumours about people poisoning

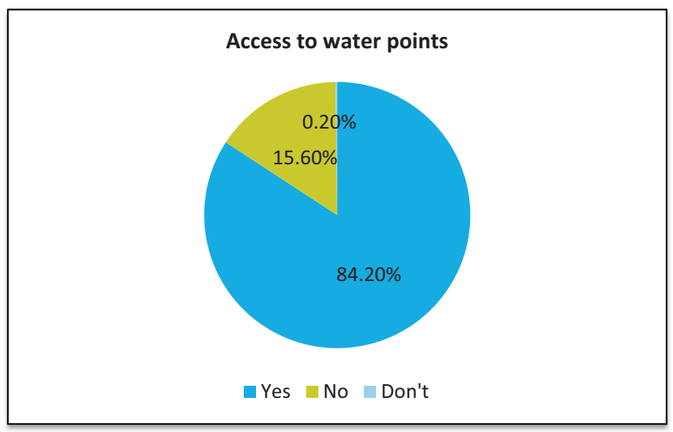

FIGURE 23: Access to water points

pumps and wells with the Ebola virus to infect communities. These factors have made it difficult for people to collect water. Some communities have established WASH teams and community Ebola taskforces, whose main functions are to provide security, information and education on sanitation and Ebola prevention measures.

Responsibility for water collection

As shown in FIGURE 25, the assessment found that girls (45.4 percent), boys (44.3 percent) and women (40.3 percent) had the primary responsibility for collecting household water. Regardless of gender, geography, religion and education, nearly everyone reported that women and children were responsible for collecting household water.

The EVD epidemic has not changed this gender construct, as women and children continue to bear the burden of household water collection. Irrespective of demographic characteristics, 97.2 percent of respondents believed that women and children were still primarily responsible for this task. They believed that, as a result of the Ebola outbreak, two key factors helped to sustain the status quo. As shown in FIGURE 26, respondents claimed that adults (i.e. women) were protecting children (56.1 percent) from contracting Ebola. But at the same time, some reasoned that since children were already out of school (28.2 percent), it was obvious that they were helping out with household chores, including water collection.

Consequently, the changes identified in access to water points have important gender and child protection implications. It is likely that women and children are being compelled by circumstances to forego other valuable productive uses of

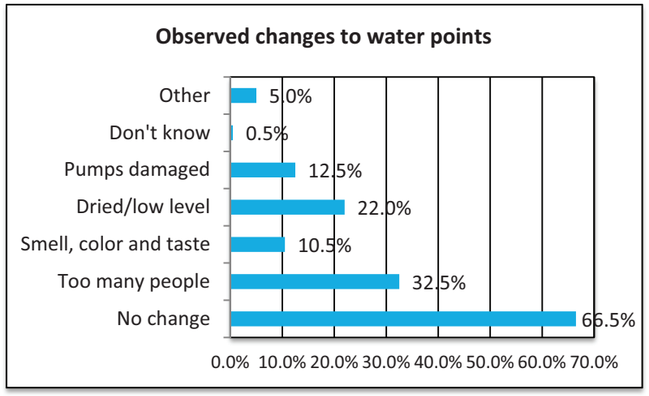

FIGURE 24: Observed changes to water points

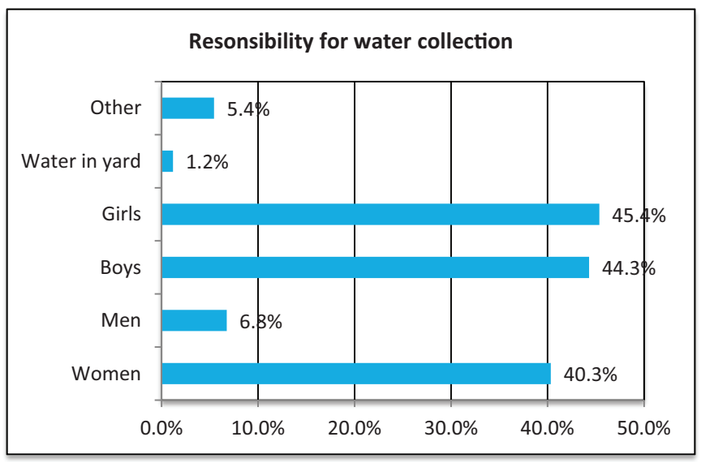

FIGURE 25: Responsibility for water collection

their time, such as childcare, business activities, sports and entertainment, etc., as they spend more time competing for water.

Household defecation practices

The assessment found that Liberians continue to engage in a range of practices for disposing of faeces that have obvious public health implications. FIGURE 27 shows that 31.8 percent of respondents reported that defecation in open places such as bushes, beaches, rice fields, rivers, etc. was a common practice in many communities. In total, 24.4 percent of respondents said that people usually use plastic bags/ buckets and hanging toilets (over water bodies) to defecate.

These practices contribute to the contamination of water sources, leading to water-borne diseases such as diarrhoea and cholera, which have similar symptoms to Ebola. There were reports that at the height of the Ebola outbreak, especially in July–September 2014, some people died from diseases that were not necessarily Ebola-related as healthcare workers were afraid to treat anyone showing symptoms related to Ebola, such as vomiting and diarrhoea.

Overall, the Ebola outbreak has led to improved hygiene practices across Liberia, as people have increasingly adopted regular hand-washing as part of their daily health routine. However, this has come at a cost for women and children, on whom the burden of collecting water has increased, both in the frequency and amount of water they have to collect daily. The longer women and children,

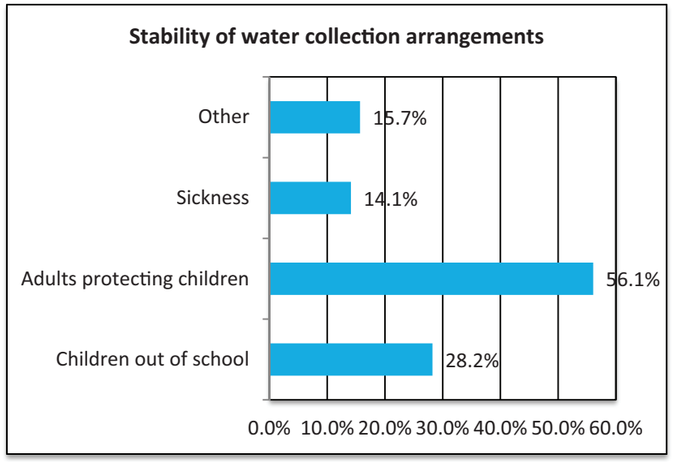

FIGURE 26: Stability of water collection arrangements

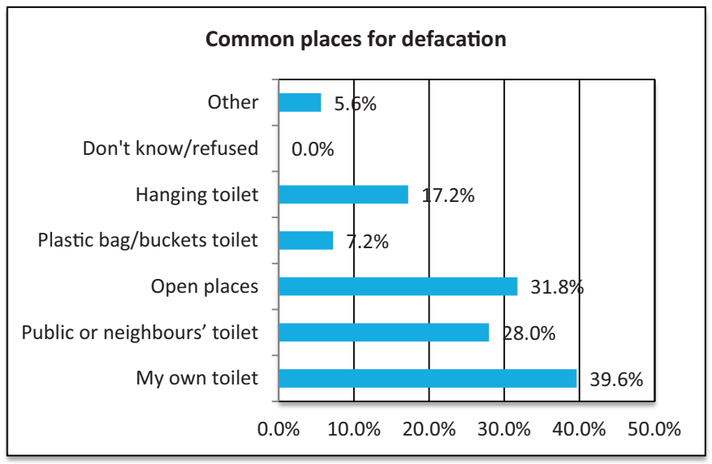

FIGURE 27: Common places for defecation

especially girls, are away from their homes collecting water, the greater the implications for their safety and protection.

Hand-washing behaviour

As shown in FIGURE 28, 43.2 percent of respondents reported that they did not practise regular hand washing prior to the Ebola outbreak. In urban areas 22 percent reported that they did not practise regular hand washing, but in rural areas this grew to 54 percent of people. It was found that the level of education was directly proportional to the regularity of hand washing. However, since the Ebola outbreak, the proportion of respondents who said they did not regularly wash their hands has fallen to 12.5 percent. The majority of respondents (87.4 percent) who reported regular hand washing post-Ebola said that they were doing so because they were afraid of the disease (77.4 percent).

Hand washing continues to be promoted due to its enormous public health benefits – not only for Ebola – but equal attention must be given to other Ebola prevention measures. This includes in particular intensifying public education and social mobilization for the timely identification of people suffering from Ebola and isolation, contact tracing and safe burials.

It seems that the spread of the virus in urban areas was accelerated by increased social mobility, unsafe handling of sick family members during home-based care and transport to ETUs, and unsafe handling of the deceased during burial. It should be noted that, as well as ETUs being overwhelmed by the mounting caseload of Ebola patients, there was growing mistrust and public agitation about the quality of care and the overall management of the Ebola response. The situation was further fermented by widespread fear, myths and denial about this strange new disease. Now, however, participants in FGDs asserted that most of their families and friends seemed to have abandoned religious and cultural practices involved in bathing and burying corpses, due to the risk of EVD transmission.

At the community level, it seems that people are more focused on hand washing than anything else. Therefore, as health promoters continue to educate the public on hand washing, there is a need to continue to create awareness around the need for prompt identification and isolation of Ebola cases from households. This requires continued targeting of messages on the timely detection and transfer of patients to ETUs and the safe burial of those who have died. Most participants observed that the advice that stopped people from bathing and burying bodies during the outbreak was meant to protect people and prevent the spread of Ebola, but they also complained that the practice of cremation was traditionally unacceptable.

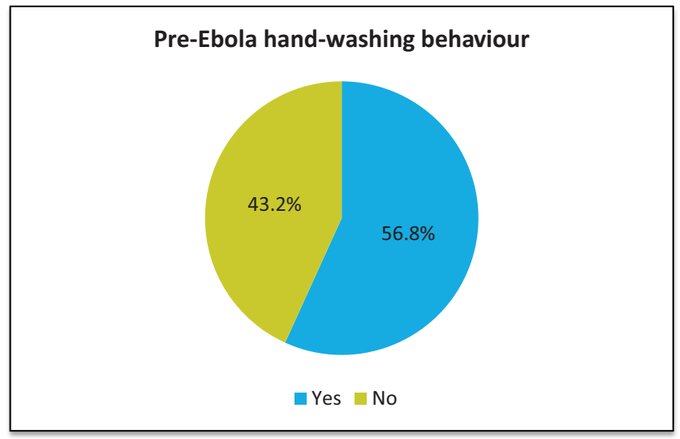

FIGURE 28: Pre-Ebola hand-washing behaviour

Distribution of Ebola prevention materials

A total 45.4 percent of respondents reported that they had not received any Ebola prevention materials (i.e. chlorine, hand sanitizers, buckets, etc.) People in rural areas have benefited more (50 percent) from the distribution of such materials than those in urban areas (35 percent). Far fewer people of traditional religion (37 percent) and no religion (9 percent) have received any of the materials distributed in their communities. Of those who have received prevention materials, 80.6 percent complained that they were dissatisfied because the materials were insufficient (80.6 percent). People in urban areas were more dissatisfied (81.9 percent) than those in rural areas (76.3 percent).

Aside from Ebola prevention materials, FIGURE 29 shows other support items received by respondents: food and water (58.1 percent), malaria prevention items such as bed nets (47.7 percent) and clothes (25.6 percent). Overall, people in Grand Gedeh reported receiving the least support (11.3 percent), while those in Grand Kru reported the most support (37.1 percent). Despite the overwhelming economic hardship that people have experienced, no financial relief (social cash) whatsoever has been provided to community members, not even families affected by Ebola.

WASH and Ebola response activities

The level of participation by women in community WASH committees and Ebola taskforces was reported to be partial, with 52.1 percent of respondents saying that women were not actively involved in such activities. The highest participation rates for women were recorded in Lofa (65.5 percent) and in Grand Gedeh (55.1 percent).

Respondents identified two main factors as hindering the participation of women in these community development initiatives. As shown in FIGURE 30, they claimed that women were either not informed or not invited (43.3 percent) or they did not have time to attend such meetings (32.2 percent). The latter finding resonates with the fact that women's household burdens have increased as a result of the Ebola outbreak, exacerbated by the increased burden of collecting water for their households.

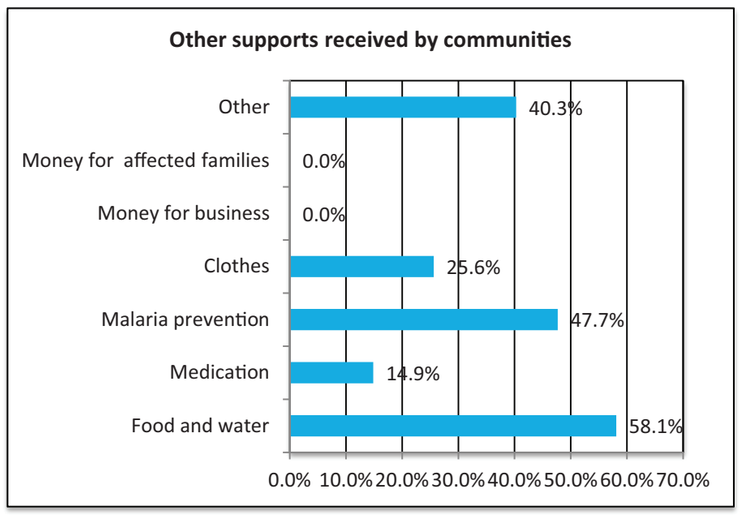

FIGURE 29: Other support received by communities

GENDER-BASED VIOLENCE AND PROTECTION

The EVD outbreak in West Africa has had a greater socio-economic impact on females than on males overall. In traditional African settings, women are the primary care-givers for sick family members, and this increases their vulnerability to infection. In addition, with a labour force participation rate of 59.9 percent (Labour Force Survey, 2010), women play a critical role in keeping their families fed, clothed and sheltered. As a result, they have taken risks in the midst of EVD restrictions and have exposed themselves to the disease. According to sex-disaggregated data compiled by UN Women, using figures from the MoH, females constitute 47 percent of cumulative EVD cases (UN Women, 2014).

Violence perpetrated against women and children was pervasive in Liberia even before the EVD crisis. Discrimination against women is rampant; in 2013, the Gender Inequality Index ranked Liberia 143rd out of 149 countries (Kotilainen, 2015). A male-dominated society underpins the perpetuation of GBV, and the assessment shows how Ebola stirred up a brew of predisposing factors, deepening gender inequality. Women's lower educational levels and limited marketable skills continue to push them into low-income self-employment. At the same time, the increasing demands of household chores such as preparing meals, caring for the sick and collecting water have hindered their participation in community Ebola prevention activities. GBV affects women's and girls' physical, mental and social well-being, stifling their growth and development and undermining their ability to make an optimum contribution to national development. Unfortunately, decision makers developing the national Ebola response plan have given little or no attention to gender differences in the prevention and control of EVD (AWID, 2014). Hence, as part of the post-Ebola recovery agenda, service providers need to prioritize a wide range of programmes to tackle GBV so that women can realize their full potential.

GBV during Ebola

Participants in FGDs noted that some men were not fully sensitized on gender issues. Some women participants disclosed that their partners still beat or abused them. Different forms of GBV take place, including domestic violence, sexual abuse, etc. A female respondent in Grand Cape Mount asserted, 'Some men in this community are still beating

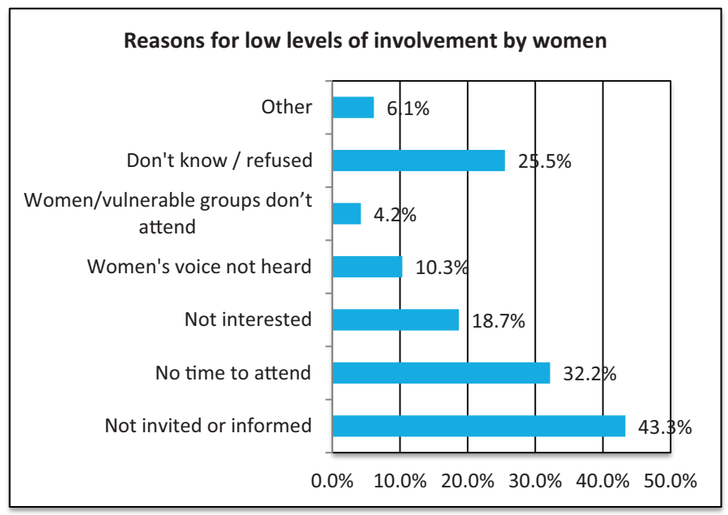

FIGURE 30: Reasons for low levels of involvement by women

and abusing women and not taking care of their children.' Other participants specified that verbal abuse, non-reporting of income, unfaithfulness and extramarital sexual affairs were some of the bad ways in which men treated women. The assessment explored the extent to which Ebola had influenced cases of GBV, including rape, wife battering, child marriage, etc.

As shown in FIGURE 31, 22.9 percent of respondents reported that cases of GBV were still occurring even during the Ebola crisis. It is important to highlight that people tend to be reluctant to talk about GBV issues. Respondents in urban areas were more likely (32 percent) to acknowledge cases of GBV than those in rural areas (24 percent), with those from Grand Cape Mount the least likely (14 percent) to do so. FGD participants reported that some men were not fully supporting their households because many men are polygamous, and leave care of their children to the women. The data suggested that the more educated a person is, the higher the chances of openness on this subject.

Perceived trends in cases of GBV

As shown in FIGURE 32, 65 percent of respondents believed that the incidence of GBV in Liberia had decreased since the onset of the Ebola crisis, while 22.8 percent believed that the situation had not changed. This finding does not support the claim by Caspani and Anderson (2015) that GBV was increasing even before Ebola; indeed, few people (2.6 percent) reported that the number of cases had actually increased. Religion was the key determinant of people's opinion on this subject. Those with no religion (72.7 percent) largely thought that the incidence of GBV had decreased. Those with faith in traditional religion (37.5 percent) believed that the situation was the same as before, while Christians and Muslims believed that the situation had worsened.

Perceptions about child marriage

Without specific reference to Ebola, respondents were asked whether they had noticed the practice of early marriage of girls in their community. Overall, 28 percent reported that this practice was common in their communities. As shown in FIGURE 33, the practice of child marriage is reportedly most common in Lofa (40.6 percent of respondents), Cape Mount (32.8 percent) and Montserrado (26.8 percent). The practice was recognized to be most popular amongst people who observe traditional religion.

Respondents observed that sending children away to live with strangers was a growing trend in Liberia. More often than not, these children are exploited and abused by their so-called foster parents or guardians. This problem was identified by 17.4 percent of

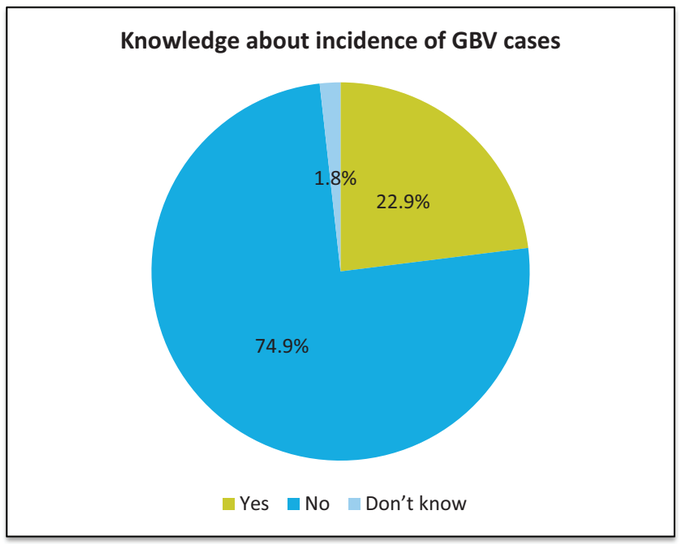

FIGURE 31: Knowledge about incidence of GBV cases

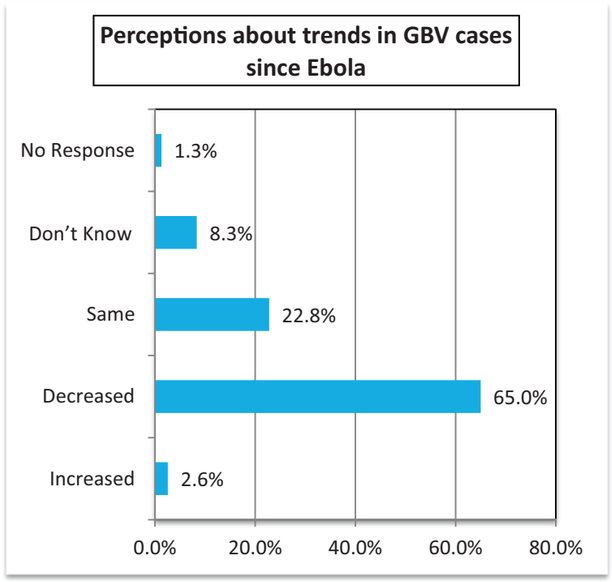

FIGURE 32: Perceptions about trends in GBV cases since Ebola

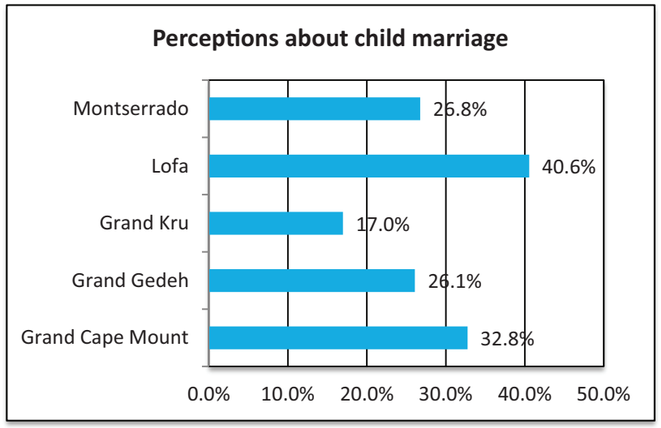

FIGURE 33: Perceptions about child marriage

respondents; the counties where this practice was most commonly reported were Cape Mount (24 percent), Lofa (21 percent) and Montserrado (18 percent).

These findings highlight the tragedy of child abuse. The three counties reported to have the largest proportion of children orphaned by EVD are also the counties where the practice of child marriage is reportedly most prevalent. Without interventions to protect orphans, girls are at great risk of falling victim to sexual exploitation and abuse, while boys are likely to end up in hazardous work environments as child labourers or as street hawkers or petty thieves.

Stigma and discrimination

Families affected by Ebola have suffered badly from stigma and discrimination. The whole country has been terrified by the disease, irrespective of people's social status or creed, and this fear has led to widespread stigma and rejection of affected families and individuals in many aspects of daily life, including access to water and sanitation facilities, purchase of basic essentials, etc.

As can be seen in FIGURE 34, respondents reported that the most common problems faced by Ebola-affected families were that they were quarantined and avoided by friends and neighbours (80.4 percent) and they were often denied access to wells and pumps (29.9 percent).

Additionally, there were reports of Ebola survivors and healthcare workers being forcibly evicted by landlords who feared for the safety of other tenants. Rejection and stigma did not come only from strangers and neighbours, however: family members, relatives and friends also commonly stigmatized their own. The assessment found no specific evidence of stigma and discrimination related to

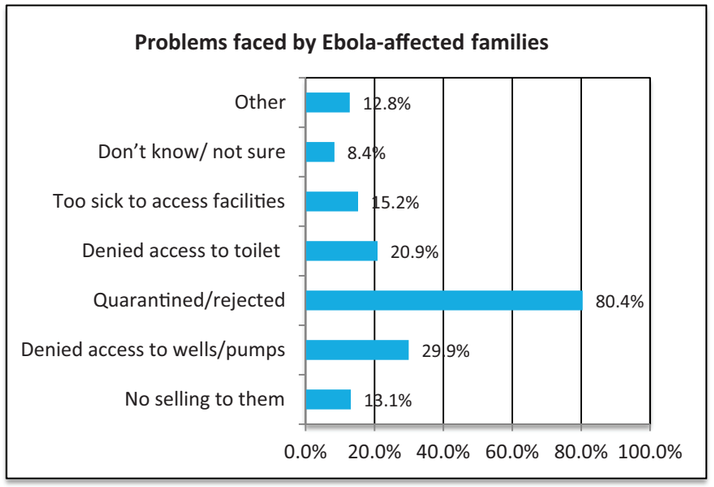

FIGURE 34: Problems faced by Ebola-affected families

gender – men and women, as well as boys and girls, affected by Ebola were commonly stigmatized and discriminated against. There were no reports of systematic stigmatization of particular groups of people based on their sex or age.

Social protection for orphans and vulnerable children

The assessment revealed that many parents who died from Ebola left their children in socially and economically unstable situations. As at 31 December 2014, UNICEF had registered 4,128 children orphaned by EVD. The physical, emotional and psychological trauma experienced by these children may have long-term, debilitating developmental impacts. Some 12.4 percent of respondents reported that there were Ebola-related orphans and vulnerable children (OVCs) in their communities, and that these children were without any suitable care-givers. The counties with the highest reports of Ebola-related orphans were Lofa (21 percent), Montserrado (19 percent) and Grand Cape Mount (10 percent). These findings are not surprising, as these counties are three of the main Ebola hotspots.

An FGD participant in Ziama, Lofa county said: 'Those whose parents died as a result of Ebola are many in Zorzor and they are orphans. I think that they will not go to school this year because no one is willing to support them. Their relatives or close friends who are taking care of them will not continue to do so for long because they do not have much themselves.'

A large majority, 63.8 percent of respondents, noted that there were no organizations or groups in their communities to fight for the rights of women, children or others such as persons living with HIV The lack of such organizations was reported by 81 percent of people in Grand Kru, 80 percent in Cape Mount and 75 percent in Montserrado, and was noted more in urban communities (73 percent) than in rural communities (58 percent).

Increased burdens on women and girls

Irrespective of geography or education, 52.6 percent of respondents recognized that women and girls were bearing a greater burden of household activities since Ebola began. Respondents believed that the main reasons for this were that there was now too much work in the house (75 percent) and that men were not providing (64.4 percent). Not surprisingly, males were less likely (45 percent) to acknowledge this than females (61 percent). On average, female respondents had stronger concerns (29.7 percent) on this matter than males (22 percent).

Perceptions about the work of the courts and police during Ebola

Respondents were asked about the adequacy of the legal system's response in addressing cases of GBV during the Ebola crisis. As shown in **FIGURE 35**, 27 percent of respondents reported that the courts and police had not been working properly to handle GBV cases since the Ebola crisis began. The work of the courts and police in properly handling these cases was less evident to residents in rural communities (56 percent) than in urban centres (80 percent).

The worst perceptions of police performance (87 percent) were reported in Lofa County. Respondents who were committed to no religion (82 percent) had stronger feelings about the performance of the courts and police.

On the question of whether members of the security forces perpetrated GBV during the Ebola crisis, respondents registered a near unanimous (92.2 percent) opinion that there were no records of women or girls being treated badly (beaten, raped or sexually harassed) by police or security personnel.

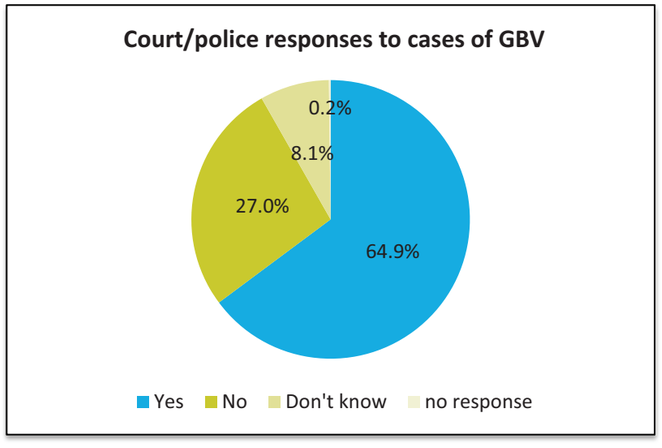

FIGURE 35: Court/police responses to cases of GBV

Alternative justice systems

In response to what they perceive as the limited availability of judicial services, community members have begun to pursue justice through alternative means, mainly by turning to local community structures. As shown in **FIGURE 36**, the most common way for people to seek justice or settle disputes is through mediation by community leaders (93.3 percent), followed by the traditional justice system (30.6 percent) and peace huts – a space for women to dialogue on issues related to SGBV/SEA (25.9 percent). The least likely route that people would choose to settle their differences was via NGOs and CBOs. Women were slightly more likely (13.4 percent) to go to peace huts than men (12.6 percent), and they were also slightly more likely (1.6 percent) to fight back when their rights were abused than men (1 percent).

With limited access to judicial services, as seen during the Ebola crisis, it is imperative that peace-building and reconciliation programmes should support these local structures, because they already have the confidence of communities. This is not in any way suggested as a substitute for the judicial system of the courts and police, but nonetheless criminal justice and law enforcement agencies need to increase their visibility in communities and improve public relations. One way to achieve this is to collaborate with local communities to jointly undertake development projects, as well as

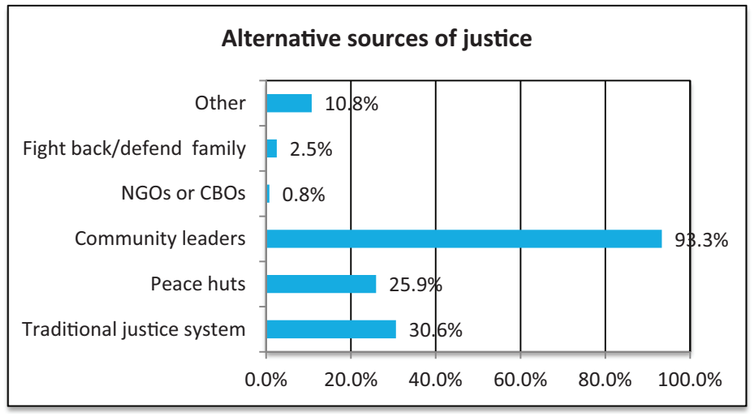

FIGURE 36: Alternative sources of justice

taking steps to increase collaboration with community watch forums – a mechanism for monitoring, tracking, and reporting on development projects at the community level.

CONCLUSION AND RECOMMENDATIONS

Ebola has dealt a serious blow to the whole of Liberia, leaving in its wake a shambolic public health system and a myriad of social and economic problems that the nation will have to grapple with for many years to come. Even in communities where no EVD cases have been reported, the social and economic ramifications are staggering. Ebola has created huge household income deficits and has limited access to food, leaving many families unable to provide for basic social needs such as healthcare and education for children.

The Ebola gender assessment has shown that, although more cumulative cases of EVD infection have been reported among males, females have been disproportionally affected by the social and economic consequences of the epidemic. Women are not a homogenous population; different factors influence the severity of Ebola-related vulnerabilities to which different sub-sets of the population are susceptible. The gendered impacts of Ebola have strong links to the overlapping vulnerabilities of men, women, girls and boys; factors such as gender, social class, geography, disability and age play a vital role in determining an individual's well-being and vulnerability to the impacts of EVD.

Women have generally lower levels of education and more limited marketable skills, and their income-generating activities are more vulnerable to Ebola-related economic shocks. While men have moved from (for example) the education sector to skilled labour (such as construction work), women have diversified their petty trading activities and have moved to farming as a strategy to compensate for loss of income. Overall, females have shown slightly more resilience in re-establishing their IGAs than their male counterparts. However, men have been more successful in accessing credit from informal sources (families and friends), while women have tended to rely more on savings and *susu* clubs – and because most of these female-friendly lending facilities have closed down or suspended their activities during the Ebola crisis, women have had limited access to finance.

Even before the outbreak of Ebola, people experienced limited access to health services and faced pre-existing problems such as malaria, malnutrition and lack of safe drinking water. The outbreak has further exacerbated the problem of access to health services due to the closure of health facilities. Consequently, many people have resorted to self-medication, relying mainly on unlicensed drug peddlers, pharmacies and private clinics. Although the assessment has provided no concrete evidence, anecdotal evidence suggests that women and children have suffered the most because of a lack of access to routine maternal and child health services such as SRH services, care in pregnancy and delivery, and immunization. Immunization services that protect children from common childhood diseases have been interrupted, and there have been reports of women having to deliver their babies in the streets, in cars or in their homes as no health facilities were willing to accept them.

In general, Ebola has led to an improvement in WASH practices, as most people have adopted improved personal hygiene behaviours such as regular hand washing. However, this has come

at a high cost for women and children, whose daily burden of water collection has increased, leaving them with less time to engage in other productive undertakings.

The assessment has established that cases of GBV were still taking place during the Ebola crisis, although respondents were generally reluctant to talk about such issues. Although a majority of respondents believed that the incidence of cases of GBV had decreased, there were concerns that responses by the courts and police in handling GBV cases were not adequate. Nonetheless, respondents generally agreed that there had been no reports of security personnel perpetrating GBV offences during the Ebola crisis. As unemployed females tend to rely on husbands or boyfriends for livelihood support, there is an increased likelihood of sexual exploitation and abuse as more females have lost their sources of income and livelihoods due to EVD. With the growing number of children orphaned by Ebola, there are serious concerns that these children risk being exploited, with girls falling prey to child marriage and boys likely to end up in hazardous work environments. The assessment established that the three counties with the highest proportion of orphans (Montserrado, Lofa and Cape Mount) are also the locations where child marriage is most prevalent.

The assessment's findings are essential not only for helping to fill the existing gaps in hard evidence on the Ebola gender discourse – they can also inform policy formulation and effective programme design for shaping Liberia's post-Ebola recovery agenda. As such, it is imperative that urgent, strategic interventions are undertaken to help the nation get back on its feet as quickly as possible. Additionally, early recovery response and long-term interventions should address the causes of poverty and inequality, in order to promote human rights and to contribute to gender equality.

RECOMMENDATIONS

Based on the findings of the assessment, the following actionable recommendations are put forward for careful consideration, in relation to preparedness and prevention. More importantly, the recommendations set out a programme for stimulating recovery, with the aim of mitigating the impacts of EVD on women, men, boys and girls in Liberia.

Scaling up the effectiveness of the national Ebola response

- Service providers need to strengthen the knowledge and skills of women for effective Ebola prevention and control. Women, especially elderly women, have continued to play the role of care-givers and so they need all relevant information and skills to provide better care, as well as to protect themselves against contracting the disease. In addition, targeting women for capacity building will ensure that children are well informed about Ebola, since women play the primary role in sensitizing their children.
- There needs to be improvement in levels of community engagement and social mobilization in order to foster maximum participation by local communities, which remains critical to national preparedness and recovery efforts. It is imperative that the government and donors enhance their outreach efforts to community leaders and local health workers, as ordinary people tend to trust information from these sources more than any others. Stakeholders planning such initiatives need to ensure that the leadership role and agency of women are visible, and the full participation of women should be promoted at all levels of community engagement.
- The government and its social mobilization partners need to pay more attention to the mobilization and training of religious leaders, as most people have strong faith. As such, equipping religious leaders with relevant knowledge, skills and attitudes could put them in a better position to become effective change agents in the recovery agenda.

Promoting income generation and food security

- Given the scale of economic hardship facing many families, it is recommended that the government implement social safety net programmes such as unconditional cash transfers for vulnerable households, who should be identified through effective vulnerability assessments. These should be designed as Ebola-specific interventions aimed at bringing short-term relief from the acute financial challenges faced by local populations.
- Donors and development partners need to help increase women's access to finance by strengthening credit facilities such as *susu* clubs and the Village Savings and Loans Association (VSLA) programme to surmount the barriers that women face in establishing or expanding their small businesses. This strategy will be more effective if collaborations are forged with microfinance institutions and banking entities, in order for them to make direct investments that would expand the capital of savings and *susu* clubs to enable more women to borrow money to invest in their businesses.
- The government and donors should prioritize the provision of agricultural inputs such as farming tools and seeds for rural women and their families to increase local participation in agriculture and better productivity.

Increasing access to health services

- As part of national preparedness efforts, the Ministry of Health and its partners need to improve the availability of sexual and reproductive health (SRH) services, mainly for women and girls and especially in rural communities, where services are not readily available. One key consideration is for donors to support stand-alone SRH facilities that are not necessarily located in health facilities, so that women and girls would still have access to services in the event of any future EVD outbreak that leads to the closure of health facilities.
- Subsidies should be provided for maternal and child healthcare as part of efforts to stimulate early recovery, as many families are unable to pay for health services. Alternatively, the MoH and its partners should design and implement a policy that ensures that all maternal and child healthcare services are delivered free of charge in public health facilities for about the next six months. Donors and other development partners need to invest resources in the provision of SRH services free of charge on a long-term basis.
- With regards to the promotion of early recovery, the MoH needs to expand immunization coverage so that children are fully protected against various childhood diseases, as

service provision has been interrupted due to the EVD crisis, leaving many children unprotected. As women's levels of participation in the Ebola response have been low, it is recommended that more women are mobilized to play a leadership role in national immunization campaigns.

Improving access to WASH services

- As prevention of Ebola remains critical, the MoH and its partners need to ensure a reliable supply of clean water at all health facilities. This will help to promote effective infection prevention and control by healthcare providers. At the community level, donors need to support the government in installing new hand pumps and repairing old ones in order to increase households' access to clean water, and ultimately to help reduce the burden of water collection on women and children.
- More latrine facilities should be provided to discourage the common practice of open defecation. The construction of these facilities should take serious consideration of women's concerns around safety, dignity and hygiene so that women's use of these facilities can be maximized.

Curbing GBV and child abuse

- In collaboration with the Ministry of Justice and the Ministry of Gender, Children and Social Protection, donors and other development partners need to provide technical and financial support to local community mediation structures such as community leadership bodies and peace huts. This will encourage sustainable local initiatives for conflict resolution, peace building and security, as well as building local capacity for GBV monitoring and reporting.
- The government, through the Ministry of Gender, Children and Social Protection, needs to promote social protection and welfare programmes to support orphans and other children made vulnerable by Ebola. Such programmes should prioritize areas such as scholarships, food rations and medical care and the provision of psychosocial support to affected families and children. Scholarship programmes should promote girls' education in particular in order to counter the gender disparity in literacy levels.
- The government and its partners should strengthen strategies for engaging men as a means to promote gender equality. The increasing burden of care borne by women and girls must be addressed in the relevant recovery plans, and men and women need to work together to address this issue.
- The Ministry of Gender, Children and Social Protection and the Ministry of Justice need to strengthen the enforcement of instruments and protocols for ending GBV. In the short term, the government and its development partners need to promote civil society participation in GBV monitoring and reporting, with a key focus on increasing the involvement of women in local community development.

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APPENDICES

A. RESEARCH METHODOLOGY

Research design

The assessment utilized a mixed-method approach, combining both quantitative and qualitative techniques. Through a literature review, secondary data were collected to give better context for the primary data gathered from the fieldwork. In addition, the field team used direct observation.

Sampling and sampling size

The assessment was conducted in five targeted regions, using combined cluster and stratified sampling techniques to ensure that the sample was representative of the Liberian population. In each region, counties were selected for inclusion in the assessment if they satisfied at least two-thirds of the following criteria: 1) counties hardest hit by EVD (also medium and low epidemic burden); 2) counties situated on borders with neighbouring countries; 3) counties with existing interventions and local partners working with UN Women and Oxfam; 4) both rural and urban or semi-urban; and 5) other unique characteristics such as population.

The assessment used surveys, focus group discussions (FGDs) and key informant interviews (KIIs) to elicit data from participants. The desired sample size for the survey was calculated at 1,562 people, using the population proportion sample (PPS) method to outline the demographic characteristics of participants enrolled in the assessment. Considering gender and rural/urban populations, the sample size was allocated proportionately among the counties selected for inclusion.

Male and female participants were enrolled in the survey in equal numbers, each accounting for 50 percent of participants. Urban and rural populations (including both males and females) across the counties made up 53.1 percent and 46.9 percent of the sample respectively. More than 50 percent of the survey population was recruited from Greater Monrovia, based on its higher population.

FDGs and KIIs were conducted to add a broader understanding of shared perspectives. They also helped to give context to quantitative data from the survey. There were 15 FGDs comprising homogenous groups of 12 participants each (men, women or youth), while the 20 KIIs targeted one person per interview. Three FGDs and four KIIs took place in each county.

The survey targeted local community members (women, men and youth), while the KIIs targeted traditional leaders, women leaders, community-based women's organizations, local government officials and health and other related service providers. Deliberate efforts were made to gather information about special-need populations within communities, including single female-/male-headed households, children (especially orphans and vulnerable children (OVCs)), elderly people, persons with disabilities and people living with HIV.

Data collection

While survey participants were identified through simple random sampling of eligible

TABLE 1: SAMPLE SIZE DETERMINATION (POPULATION OF FIVE TARGET COUNTIES: 1,705,351)

	Male	Female	Total
Population (1:1 sex ratio)	852,676	852,675	1,705,351
Sample (PPS formula)	384	386	768
	Urban	**Rural**	**Total**
Population (0.53:0.47 location ratio)	903,836	801,515	1,705,351
Sample (PPS formula)	382	338	720
		Sample size	1,488
	Desired sample size (sample size + 5%)		**1,562**

Source: Ebola Gender Assessment terms of reference

household members, FGD and KII participants were purposively chosen in respect of their knowledge, experience and positions of leadership to speak on behalf of their communities. Data collection was conducted by a trained team of 20 enumerators, five supervisors and four monitors. The research team attended a one-week intensive training workshop to acquire knowledge on the aim and objectives of the assessment and to develop skills in administering the questionnaire using personal digital assistants (PDAs) powered by AKVO Flow open source software. The training also covered topics of data quality control, community canvassing, Ebola prevention protocols, research principles and ethics and participatory techniques for conducting FGDs and KIIs. After participants had gained theoretical insight and had familiarised themselves with the survey tools through mock exercises, the tools were field-tested in three communities in Monrovia that had characteristics similar to the areas targeted for assessment.

All FGDs and KIIs were digitally recorded with the consent of the participants. The audio files were later transcribed by a team of five transcribers, who also attended the enumerators' training workshop. Field data were collected between mid-January and early February 2015, for a combined period of four weeks.

Ethical considerations

The research protocol was reviewed and approved by the University of Liberia – Pacific Institute for Research and Evaluation (UL-PIRE) Institutional Review Board (IRB). The assessment posed no risk to participants' health. All participants were duly informed that participation was voluntary and that they could withdraw their consent to participate at any stage of the research, without incurring any penalty. All those who participated in the assessment gave their voluntary, verbal informed consent. Appropriate measures were instituted to ensure that no one became exposed to EVD as a result of their participation. Field teams were supplied with Clorox bleach for disinfecting vehicles and other equipment; hand sanitizers for personal use were supplied to each staff member; and digital thermometers for monitoring the temperatures of both staff and participants were available to all teams. All field team members travelled with full-body ordinary clothing and personal bedding and consciously acted to minimize social contacts with local populations, as much as the circumstances would allow.

Data analysis

Two separate data analyses were carried out to synchronize the quantitative and qualitative data collected. Quantitative data were analyzed using Statistical Package for the Social Sciences (SPSS) software, while data tables were exported to MS Excel where appropriate graphical presentations were produced and incorporated into the report. As applicable, the data were cross-tabulated by sex, age, geography, religion and education. Qualitative data, on the other hand, were subjected to content analysis to identify emerging central concepts and patterns related to research questions. This helped to guide the organisation of ideas and to define overarching themes. Finally, the quantitative and qualitative data were merged to constitute this final report.

Data management and quality assurance

Field supervisors were supplied with Internet modems that allowed for daily online submission of all completed surveys. The server was monitored by key staff at LISGIS and Oxfam. The AKVO Flow dataset was converted to an Excel file, and data cleaning was carried out. This precluded the need for data entry, but generated additional problems with data cleaning because the software produces data labels instead of the values of response codes. Hence, making manual conversions for each question was a painstaking task.

Challenges

The implementation of the assessment was not without problems. The major challenge was faced in data management, with respect to retrieving data for some PDAs that failed to submit data online automatically. As the data analysts identified data gaps, contacting team members for rectification was a slow business. Moreover, the analysts encountered some technical difficulties in exporting the data from AKVO Flow to SPSS. They had to reformat, recode and clean the data in Excel format before converting to SPSS.

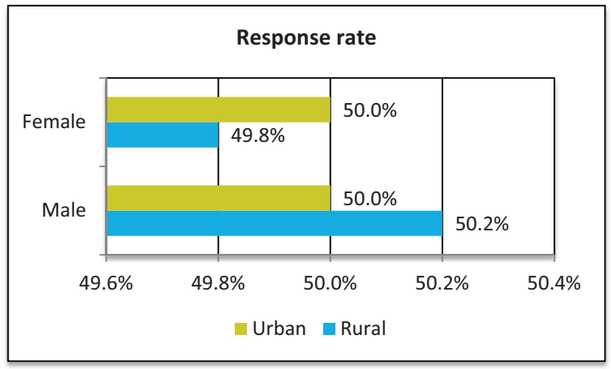
In some communities, particularly in rural ones, enumeration areas were not always accessible by car, so team members had to risk travelling by commercial motorbike to get to hard-to-reach towns and villages. There was also a logistical challenge with the arrangement for rented vehicles. Besides encountering mechanical problems, it was realized that the survey days required for Montserrado had been under-estimated, causing some delays before the agreement was renegotiated with the vehicle rental company. One of the teams from Lofa was involved in an accident while returning to Monrovia. Fortunately, there were no fatalities or serious injuries; those involved received treatment at the regional hospital in Phebe and have all since fully recovered.

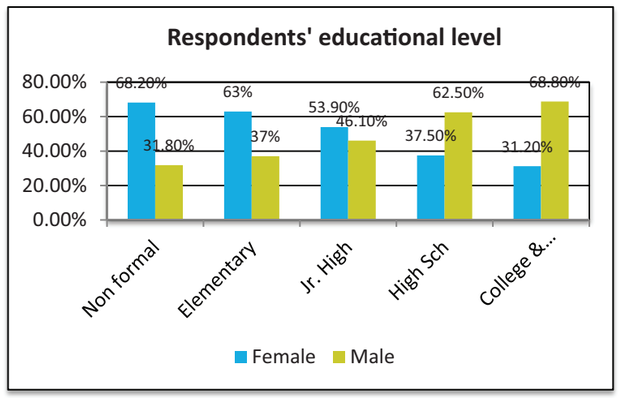
The report was validated through a one-day validation workshop, attended by 24 participants representing 12 relevant institutions, agencies and organizations. After a broad stakeholders' review of the report, relevant inputs and comments from participants were incorporated to enhance the quality of the report, and the participants asserted that the report fairly articulated the impact of Ebola on women and men in Liberia.

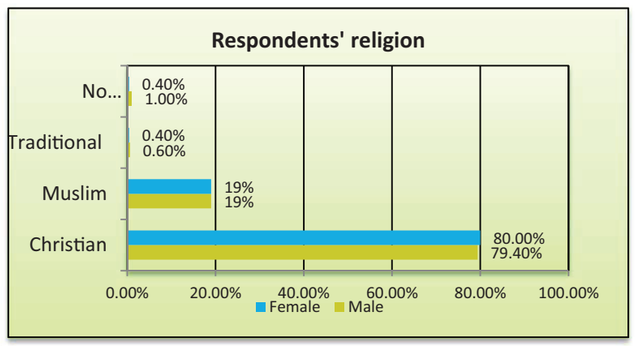
B. CHARACTERISTICS OF RESPONDENTS

Response rate

The study achieved a 100 percent response rate from the 1,562 persons targeted. This was possible because the methodology allowed the replacement of any household respondent who became unavailable. In such cases, the next available respondent was selected according to the household listing generated through the community canvassing. Slightly more males (50.1 percent) than females (49.9 percent) participated in the assessment, with a rural-to-urban ratio of approximately 1:1. The respondents were







equally balanced between males and females in both rural and urban communities.

Age and marital status

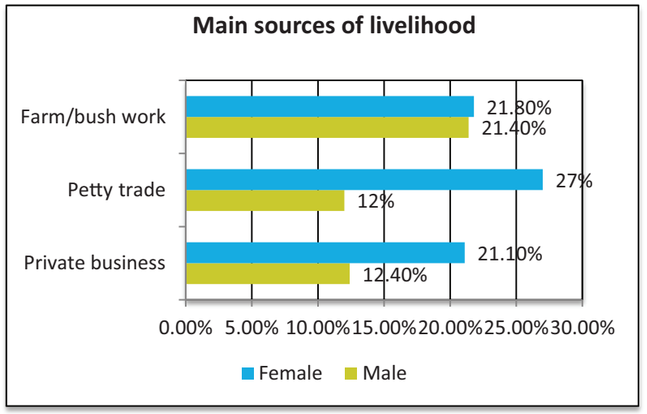
The majority of the respondents (46.4 percent) were aged between 20 and 34 years. The least represented age groups were teenagers (5.8 percent) and elderly people (4.3 percent). Although an equal proportion of males (50.5 percent) and females (49.5 percent) were married, there were more single males (56.6 percent) than females (43.4 percent). On the other hand, there were more cohabiting females (56.2 percent) than males (43.8 percent).

Level of education

Consistent with other demographic findings, men taking part in the assessment enjoyed higher educational achievement than women. There were twice as many men as women in the higher education category. For the 'college plus' category, males constituted 68.2 percent compared with 31.8 percent for females, while for the high school category 62.5 percent were males and 37.5 percent were females. As shown in the figure, the proportion of men doubled from the non-formal education to the college category, while the proportion of women halved. In general, as the proportion of men increased along the educational ladder, the proportion of women decreased.

Living arrangements

Nearly eight in every ten households (78.2 percent) had at least one child aged below five years old. A small number of households (2 percent) reported having as many as six to eight children under five years. The majority of children (59.8 percent) lived in urban households. Multiple occupancy is common in shanty towns and suburbs around urban



centres, which may account for this finding. A total 15.3 percent of respondents reported having a person in their households who was considered to be disabled; the majority (56 percent) of households with a disabled person were located in urban communities.

Religion

Christianity (79.8 percent) and Islam (19 percent) were the two dominant religions reported by respondents. Except for Grand Cape Mount where Islam was the dominant religion (92 percent), all the counties reported Christianity as being the leading religion. Men and women were equally religious, irrespective of the faith they professed.

Sources of livelihood

The main sources of livelihoods stated by respondents were farming or bush work (21.6 percent), petty trade (19.5 percent) and private business (16.7 percent). In urban communities, more residents were engaged in private business (20.3 percent) and petty trade (23.7 percent), while in rural areas nearly half of respondents (48.6 percent) made their living mainly from farming or bush work. Nearly equal proportions of men (49.7 percent) and women (50.3 percent) reported these activities as their main sources of livelihood.

C. LIST OF PERSONS INTERVIEWED IN KEY INFORMANT INTERVIEWS

SN	Name	Position	County	District
1	Ma Wata L. Kamara	City Inspector	Lofa	Voinjama
2	Edward F. Santay	Chairman, National Teacher Association	Lofa	Foya
3	Edwin G. Baysah	General Quarter Chief	Lofa	Voinjama
4	Mulbah Massa	School Principal	Lofa	Voinjama
5	Bendu Holder	School Principal	Montserrado	Todee
6	Daniel Solomon Mulbah	Youth Advisor to the Chairman	Montserrado	Todee
7	David Sumo	Town Chief	Montserrado	Todee
8	Dai P. Kollie	Youth Chairman	Montserrado	Todee
9	Mamie D. Mallah	Chairlady	Grand Gedeh	Konobo
10	Janet Gaye	Registrar/A.G. Mission School	Grand Gedeh	Tchien
11	Bill A. Garlo	Community Chairman	Grand Gedeh	Tchien
12	Armstrong Tweh	Deputy Camp Master	Grand Gedeh	Konobo
13	Edison Pannoh	Community Police Chairman	Grand Kru	Forpoh

14	Harris Chea	Pastor	Grand Kru	Forpoh
15	William W. Sieh	Town Chief	Grand Kru	Dorbor
16	E. Suku Wah	Magistrate	Grand Kru	Dorbor
17	Ma Hawa Varney	Chairlady	Grand Cape Mount	Gola Konneh
18	Ami Sheriff	Clan Chairlady	Grand Cape Mount	Tewor
19	Imam Dauda A. Massaquoi	Imam (Muslim Pastor)	Grand Cape Mount	Tewor
20	Sando Konneh	Town Chief	Grand Cape Mount	Gola Konneh

BIOGRAPHY OF LEAD RESEARCHERS

Dala T. KORKOYAH, Jr. is a researcher, project management specialist and master trainer, with professional experience working on public health, gender equality, and livelihoods, including women's and adolescent girls' rights and economic empowerment. He has a background in human and institutional capacity development; and expertise in monitoring and evaluation. As an independent consultant, Mr. Korkoyah has recently worked in Liberia as national and lead consultant for research and evaluation projects funded by USAID, UN Women, UNICEF, Oxfam, Save the Children, etc. Mr. Korkoyah has cultivated a wealth of international development work experience from assignments undertaken in Sierra Leone, Uganda, Tanzania and Rwanda.

He currently holds a part-time consultancy post as Senior Program Advisor for the World Bank Economic Empowerment of Adolescent Girls and Young Women (EPAG) Project at the Ministry of Gender, Children and Social Projection. He serves as Lecturer of Health Sciences at the Cuttington University Graduate School in Monrovia. He is committed to evidence-based practice and quality service delivery, which have underpinned his work in monitoring and evaluation, and human and institutional capacity building.

Francis Fonanyeneh Wreh is a career statistician and demographer working with the Liberia Institute of Statistics and Geo-Information Services (LISGIS) on research, training, survey design, data analysis, and interpretation. He has a background in technical demography, substantive demography, advanced techniques in demographic analysis, survey design, data analysis, and computational methods.

He holds a Master of Arts degree in Population Studies with special emphasis in Population Statistics and Population and Development Interrelationships from the United Nations Regional Institute for Population Studies, University of Ghana and currently serves as the position of Deputy Director-General for Statistics and Data Processing at the Liberia Institute of Statistics and Geo-Information Services (LISGIS) and also served as the National Coordinator for the design of the National Strategy for the Development of Statistics (NSDS) in Liberia. Significant contributions have been made by him in the area of academia by serving as part-time instructor at the University of Liberia, teaching Demography and Statistics at the Institute for Population Studies