



BASELINE SURVEY REPORT

For the USAID/OFDA funded project:

Emergency Response Against Ebola

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Abbreviations

CA	Christian Aid
CBOs	Community Based Organisations
CDC	Centre for Disease Control
CHW	Community Health Workers
CSOs	Civil Society Organisations
DERC	District Ebola Response Committee
DHMTs	District Health Management Teams
EVD	Ebola Virus Disease
GoSL	Government of Sierra Leone
FGD	Focus Group Discussion
KAP	Knowledge, Attitude and Practice
KII	Key Informant Interviews
MSWGCA	Ministry of Social Welfare, Gender and Children's Affairs
NNDSS	National Notifiable Disease Surveillance System
OFDA	Office of Foreign Disasters Emergency
PDA	Personal Digital Assistance
PHU	Primary Health Unit
PUI	Person under Investigation

Executive Summary

Christian Aid Sierra Leone began implementing its first phase emergency response project on 1 November 2014, following the outbreak of EVD in Sierra Leone on the 25th May 2014. This was followed by a six month Ebola emergency response project funded by USAID-OFDA for which this baseline survey had been conducted. This project is geared towards contributing to achieving zero new cases of the Ebola Virus Disease (EVD) in Sierra Leone, through increased surveillance, contact tracing and referral of EVD patients to holding facilities, community care and treatment centres, and through social mobilization in remote communities to promote the necessary behavioural changes for reducing transmission. Christian Aid has implemented this project in partnership with five local partners¹, who are the subrecipients.

The project is being implemented in four districts: Bombali, Tonkolili, Kambia and Bo. Key activities are behaviour change communication, case identification, contact tracing and timely patient referrals; psychosocial support for Ebola survivors and affected families; non-food item support for families in quarantine; and enhancing coordination and accountability. The project also addresses stigma, fear and denial through reintegrating Ebola survivors into their communities and supporting them to become Ebola 'champions' for behaviour change.

The overall aim of the baseline survey was to determine key information required for monitoring performance towards the key results including:

1. Communities are mobilized to break the chain of EVD transmission through information, surveillance, contact tracing and referrals
2. Support provided to Ebola survivors and families affected/in quarantine
3. Communities engaged in improving local governance and coordination of the EVD response

Methodology: The survey tools employed using simple random sampling techniques were: Knowledge, Attitudes and Practice (KAP) survey with 385 respondents in project areas and 40 in control areas; Stigma Survey with 200 Ebola survivors in project areas; 40 Focus Group Discussions (FGDs), 10 in each district, and 28 key informant interviews (KIIs) with stakeholders, 7 in each district.

Key findings are as follows:

Direct experience of EVD

1. Over a third of respondents (37.5%) in project areas had immediate family members who had been infected by EVD, of whom 12.5% are male and 25% female; compared to 27.3% in control areas.
2. In the project location, 11% male and 14% female respondents affirmed that they lost an immediate family to the virus and 10% male and 15% female respondents in control areas said the same.
3. 91% and 98% respondents in project and control communities respectively had never observed the occurrence of any secret burial in their communities.

¹ Centre for Accountability and Rule of Law (CARL), Community Action for Human Security (CAHSec), Real Women in Action Programme (REWAP), Health Poverty Action (HPA) and Sierra Leone Social Aid Volunteers (SLSAV)

Objective 1: Knowledge, Attitudes and Practices of respondents.

Levels of knowledge about Ebola, the symptoms, prevention and treatment were very high in both project and control groups with <85% of respondents providing correct responses to most questions. However, there are some gaps in knowledge and some negative attitudes and practices still prevail need to be addressed with this project.

1. All but one respondent in Kambia had heard of the Ebola.
2. A very small proportion of respondents in project and control locations (3% and 5% respectively) defined Ebola as a myth or punishment by God. All respondents in both project location and control communities were able to identify at least one main symptom of EVD: fever, diarrhea or vomiting
3. Only 2 out of 196 male respondents and 5 out of 189 women respondents said they did not know the mode of transmission, said in project areas. Touching the fluid of an infected person was identified as the most popular mode of transmission.
4. There is high understanding among the population about the prevention and control measures. From the survey findings, hand washing was identified as the most appropriate means of preventing someone from catching the virus mentioned by 62% and 87% male respondents in project and control communities respectively. Also, approximately 66% and 64% of female respondents in project location and control communities respectively mentioned hand washing.
5. There is widespread understanding among respondents regarding what to do when a member of a household becomes infected. 97% male and 93% female respondents agreed that an infected person should go to a hospital and not be touched. The control communities had similar results: 93% and 88%.
6. Nonetheless, the majority of the respondents were hesitant to present themselves to a Ebola health care facility due to the fear of people's reaction if they tested positive.: 67% male and 66% female respondents in project location; and 73% male and 64% female respondents in control communities. This level of fear suggests there remains deep seated stigma associated with EVD.
7. The majority of respondents in both communities agreed that people with Ebola could survive: 93% male respondents and 89% female respondents in project location; 93% male and 84% female in control areas. 85% male and 77% female respondents in project location agreed with the statement that infected persons survived because they were taken to health facilities
8. 95% of respondents in project community affirmed survivors should be allowed to return to their homes, which is a positive sign for the easy rehabilitation and reintegration of survivors into their respective communities. However, a small number of respondents in all areas did not agree that survivors should return. This could create difficulties in the rehabilitation and reintegration of survivors
9. Asked whether one could contract the disease from a neighbor who was an Ebola survivor should they return to their homes, 68% - 47% male and 60-64% female respondents in project and control districts respectively thought they could not contract Ebola. However, quite a significant proportion of the respondents did not agree. This response indicates that there remains controversy around the issue of the possibility of contracting EVD from survivors.

Objective 2: Perceived levels of stigma and discrimination by Ebola survivors

1. Levels of stigma appear to be fairly low from the response that 90% and 98% of respondents in project and control location respectively ascertained they would talk to survivors; and there is willingness among communities to accept survivors which is a

positive sign of reduced stigmatization: 98% male respondents, and 96% female respondents in project areas agreed survivors should return to their jobs.

2. 90% male and female respondents in project location ascertained they would talk to survivors. In the control community, 98% said they would talk to an Ebola survivor. However, a greater percentage of the respondents affirmed that people talk badly about those who had contracted the virus or are thought to have contracted the virus. The above shows that survivors are still stigmatized
3. The longest number of days survivors spent by approximately 30% of respondents at treatment facilities was 80 days and shortest number of days spent by only 1% in project location was 2 days.
4. It is positive to note that all the survivors returned to their communities and their previous residence in both project location and control communities in all four districts and survey communities. Also, all of them returned to their previous occupation in both project location and control communities.
5. In project communities, 63% male and female survivors and families reported they had never been gossiped about, 21% said they had often been gossiped about, 7% indicated they had always been gossiped about and 9% confirmed they had been gossiped about but only once. In the same tone in the project location, 93% reported they had never been physically assaulted, 5% said they were often physically assaulted, and another 6% confirmed they had been physically assaulted but only once.
6. Only 82 of the 200 survivors were very confident to leave their homes, 72 were confident, 20 were very nervous and another 24 quite nervous in project location. It reiterates the fact that stigmatization of survivors was still existing in communities.
7. 70 of 200 survivors, comprising 24 male and 46 female and 21 out of 40 consisting of 8 male and 13 female survivors in project location and control communities respectively reported experiencing adverse health hazards after their recovery.
8. 37% of the survivors in project location and 26% in control communities were not aware of the means survivors could spread the disease. Those survivors who knew the means by which they could Ebola said they should not participate in unprotected sex.

Essential non-food needs of quarantined homes and survivors.

1. 34% male and 33% female respondents in project location and 26% male and 63% female respondents in control communities expressed dissatisfaction in relation to support to quarantine homes.
2. While many were grateful to the government and other development actors for their support and their survival, Ebola survivors' final comments were in the form of appeals for continuous support to meet their urgent, immediate and long term priority needs. Support could either be in form of basic necessities such as clothing, food or medical needs or enabling them to continue their education or revive their economic activities including agricultural inputs and gainful employment options.

Objective 3: Coordination and governance in the EVD response at community and district level

1. In project location, 98% male and 88% female respondents affirmed their confidence in the health center and in control communities, all the male and 58% female respondents trusted going to their health center.
2. All male respondents and 58% female respondents in the control communities had confidence in the ability of the government response to EVD.

3. 22% male and 21% female had experience a health needs other than EVD in project locations and 18% male and 23% female in control communities have had same experience in the last one month.
4. The prevalent non-related EVD health needs were mostly common colds, pneumonia, fever, diarrhea, pregnancy related illnesses, and HIV.
5. The most common services provided by the health facilities were FHCI related services in the form of anti-natal and post-natal care and skilled assistance with delivery. Other services provided included malaria and treatment for diarrhea.
6. The insufficient availability of experts, slow response of actors to calls, the neglect of government towards its workers, attitude of some health workers towards the public, contradictory messages on Ebola, the persistence of the virus in the country, unfulfilled promises and weak health systems were given by the 15 respondents (13 in project; 2 in control areas) who did not have confidence in the ability of the government

From the findings, the following recommendations are proposed:

1. The need for awareness raising interventions to continuously increase the knowledge of the people on EVD and influence their attitudes, behavior and practice is necessary, particularly to inform people how survivors can still transmit Ebola through unprotected sex up to 3 months after having recovered; to dispel myths such as witchcraft associated with Ebola; and stop harmful practices including keeping people with Ebola at home and conducting unsafe burials rather than taking them to a health facility.
2. The essential non-food needs of survivors and people in quarantine should be addressed, within the remit of the project. This includes provision of food and non-food items, support towards gainful employment, provision of agricultural inputs and support to school going children
3. Sustainability mechanisms should be established and supported to ensure local community stakeholders, including traditional authorities and other stakeholder groups own the EVD response process and play a lead role in the post Ebola response.
4. Further interventions are necessary to eradicate stigma against survivors and families affected.
5. Gaps² were identified in the operations of the various actors involved in the coordination and governance of interventions geared towards the fight to eradicate the EVD. Further probing and analysis of these gaps would be required and base on the findings, specific support would be provided on a case by case bases.

² For example, Financial support, training and IT supports

1. Background

1.1 Overview of the project

Christian Aid Sierra Leone began implementing its first phase emergency response project on 1 November 2014. With funding from the USAID Office of Foreign Disasters Emergency (OFDA), Christian Aid and its partners are now implementing a six months Ebola response project to contribute to achieving zero new cases of the Ebola Virus Disease (EVD). This will be achieved through increased surveillance, contact tracing and referral of EVD patients to holding facilities, community care and treatment centers, and through social mobilization in remote communities to promote the necessary behavioural changes for reducing transmission.

The project is being implemented in four districts – Bombali, Tonkolili, Kambia and Bo. Key activities include behaviour change communication at household and community level to ensure safe practices for EVD prevention; case identification, contact tracing and timely patient referrals; psychosocial support for Ebola survivors and affected families; non-food item support for families in quarantine; and enhancing coordination and accountability at community and district level for an improved response. Stigma, fear and denial are being addressed through reintegrating Ebola survivors into their communities and supporting them to become Ebola ‘champions’ for behaviour change.

1.2 Aim and purpose of the survey

In order to effectively manage and implement the EVD response project, CA and its 5 local implementing partners wanted to understand current knowledge, attitude and practices of the target population and of other key stakeholders.

The aim of the survey was to collect quantitative and some qualitative base line data aligned with approved programme indicators and results. At the end of the project, a follow up survey will be conducted to compare the results of the baseline with any changes achieved through the project.

1.3 Specific scope of the survey

The baseline survey will determine key information required for monitoring performance towards the key results of this programme, which are as follows:

1. Communities are mobilized to break the chain of EVD transmission through information, surveillance, contact tracing and referrals
2. Support provided to Ebola survivors and families affected/in quarantine
3. Communities engaged in improving local governance and coordination of the EVD response

2. Methodology

The main approaches employed were: Knowledge, Attitudes and Practice (KAP) and Stigma Survey, Focus group discussions (FGDs) with stakeholder groups, and key informant interviews (KIIs).

2.1 Sampling Design and Sample Size

Sample size calculation employed critical examination of both qualitative and quantitative information. Simple random sampling was carried out through three hundred and eighty five (385) KAP questionnaires, two hundred (200) stigma questionnaires, and thirty six (36) FGDs. Sample size calculation was done based on the projected 2014 census population data provided by the Ministry of Health and Sanitation (MOHs). The margin of error for this sample is +/-5%, at 95% confidence level, using a point estimate (a statistic) of 50%, given a binomial distribution. A randomized control trial sample of 10% was collected in non-intervention areas to compare outcomes.

2.1.1 Knowledge, Attitude and Practice Survey (KAPS)

Knowledge, Attitude and Practice Survey structured questionnaires targeted community members and gathered a range of information on knowledge of case definition, symptoms, mode of transmission, preventive measures, and necessary actions to control the disease by the citizens, confidence in the health service delivery in the provision of the needed service, perception of Government of Sierra Leone's (GoSL's) ability to respond to the EVD crisis, and NGO actions towards the EVD response, quarantine measures and EVD survivors at community and household levels.

2.1.2 Stigma Survey

Structured questionnaires designed to capture EVD related stigma targeted 200 survivors across the 4 chiefdoms. Respondents were randomly selected and verified by a certified certificate of discharge.

2.1.3 Focused Group Discussions (FGDs)

The tool designed targeted community influencers and members to assess the knowledge, skills, attitude, norm, and perceptions related to EVD including; transmission, spread, prevention and control measures. The following groups were targeted for the FGD:

- Level 1: Community Influencers – Local authorities, Religious Leaders, Youth/Women Leaders
- Level 2: Community Group/Peers - youth, Men & Women groups

Gender and age dynamics were taken into account by ensuring that the sample chosen includes representatives from different gender groups and individuals within relevant age brackets. The age brackets chosen to assess age dynamics of the crisis and response were 0-5, 6-17, 18-50, 51-65 and above 65+ years of age. Ten FGDs by district were held with the various age and gender groups amounting to 40 FGDs in total.

2.1.4 Key Informant Interviews (KIIs)

Key informant interviews (KII) were conducted to gather information on existing coordination and local EVD governance. The KII targeted CSOs, community leaders and local authorities (DHMTs, DERC and MSWGCA). Seven questionnaires were administered per district giving a total of 28 KIIs.

The detail sampling size for the various tools is indicated in table 1

Table 1: Number of samples collected by selected partner enumerators in each district for the entire survey

Survey	Partner	CARL	CAHSec	HPA	SLSAV	REWAP	Total
	District	Bo	Bombali		Kambia	Tonkolili	
KAP	Sampling	111	81		75	118	385
STIGMA	Sampling	57	43		39	61	200
FGD	Sampling	9	9		9	9	36
Key Informant Interview	Sampling	08	08		08	08	24
RANDOMISED CONTROL TRIAL (Non-operational areas)	Sampling	10	10		10	10	40

2.4 Training and Data Collection

Enumerators were selected by partners implementing the OFDA project from their operational areas on pre-set criteria and trained on questionnaire administration using the Personal Digital Assistance (PDA) device. Selection criteria for enumerators included the following;

- Must be residence in the locality where the assessment will be carried out
- Most fully understand/speak the local languages
- Experiences and trainings in assessment.
- Must have understanding in using smart phone.

This was followed by training of the 25 enumerators for a period of three days from the 21 to 23 March, 2015 in Freetown. The training covered sample size selection in sample location and the understanding and interpretation of questionnaires. All necessary logistics including the device, spare batteries and chargers were provided to enumerators. The survey was simultaneously conducted in all four districts from the 25th to 29th, April, 2015.

2.5 Limitations

Respondents expressed their frustration over the many surveys they had participated by different organizations with little follow up action or feedback once the data had been collected. This challenge was tactfully managed by the enumerators through precise explanation of the purpose of the exercise. Making provision for feedback sessions to communities would be useful to mitigate the respondents' frustration in the future.

Another limitation with the technology was associated with the poor internet facility in the country. Attempts to send the documents direct from the field did not work for most of the enumerators. This limitation is beyond the capacity of the CA and partners, rather it a national challenge that should be addressed by the Government of Sierra Leone.

Comparatively, generating and inputting of the data proved to be far cheaper than using paper. Once collected and where the internet was effective, it was easily transferred to the centralized data based system managed at CA. From the assessment of the M and E personnel of CA, the data was clean, with minimal blank spaces, which usually is not the case when paper instrument are used.

3. Survey Findings

3.1 Respondents profile

The baseline survey was conducted in four districts, Bombali, Kambia and Tonkolili in the north and Bo in the south.

3.1.1 KAP Survey

For the Knowledge, Attitudes and Practice survey, 425 respondents were selected from the project and control communities with an almost equal proportion of males and females, although the numbers varied from one district to another as indicated in Table 2.

Table 2: Respondents profile by sex, district, occupation and age

	Profile	Bo (n=121)	Bomba li (n=91)	Kambi a (n=85)	Tonkolil i (n=128)	Total	%
Gender	Man	57	46	44	64	211	49.6
	Woman	64	45	41	64	214	50.4
Age	6-17	4	12	7	4	27	6.4
	18-50	91	55	63	104	313	73.6
	51-65	21	20	13	17	71	16.7
	65+	5	4	2	3	14	3.3
Religion	Christian	66	35	16	31	148	34.8
	Muslim	55	56	69	97	277	65.2
Occupati on	Big Business	13	8	3		24	5.6
	Community Health Volunteer	1	3			4	0.9
	Farmer	40	43	40	68	191	44.9
	Fishing		1	2		3	0.7
	Health Worker	3	3	2	7	15	3.5
	Petty Trader	27	16	22	35	100	23.5
	Religious Leader	2	4	1	1	8	1.9
	Teacher	10	4	11	11	36	8.5
	Other	25	9	4	6	44	10.4

From table 2, the majority of the respondents were adults and young men and women, approximately 74% within the age range of 18 and 50 years, followed by the elderly, 17% in the age bracket of 51 and 65 years. Children between the ages of 6 and 17 years were the third largest number of respondents and the least were the aged, comprising of men and women above 65 years. In Sierra Leone, the ages 18 and above are the productive and official working age and the retirement limit is 65 years. It means, the survey targeted mainly those who are within the productive age bracket.

Nearly two-third of Sierra Leoneans are Muslim which is reflected in the number of Muslim respondents of which there were 64%. History explains that in the early 1800s, when the missionaries first came to Sierra Leone, they settled in the southern part of the country, and several years moved towards the north. It is therefore not surprising that the majority of the respondents in the north identified themselves as Muslims.

Most of Sierra Leone's estimated six million population are subsistence farmers, a trend the survey confirm with about 45% of the respondents identifying themselves as farmers. In a country with less than 50% literacy level, the simplest means of generating income is through petty trading which accounts for about 24% of the respondents, followed by teaching as the largest employment opportunity in the country.

Though Sierra Leone's households are mainly the extended family type, an average household size of 12 per household is quite high. The average household sizes by districts indicated in table 3 are: Bo – 10; Bombali – 13; Kambia – 12; and Tonkolili – 11.

Table 3: House size of respondents by gender, district and age

District	0-5		6-17		18-50		51-65		65+		Total	%
	M	F	M	F	M	F	M	F	M	F		
Bo	128	120	166	186	183	273	64	56	18	23	1,217	24.9
Bombali	113	108	193	164	188	217	70	64	24	32	1,173	24.0
Kambia	117	154	157	151	153	180	52	58	11	6	1,039	21.3
Tonkolili	206	189	226	208	204	224	66	82	21	34	1,460	29.9
Total	564	571	742	709	728	894	252	260	74	95	4,889	100.0
	11.5	11.7	15.2	14.5	14.9	18.3	5.2	5.3	1.5	1.9	100.0	

3.1.2 Stigma Survey

The stigma survey targeted 200 survivors in communities in the four project districts and another 40 from control communities within the same districts. In the project locations, 56% of the 200 respondent survivors were female and 71% of them were Muslim. The largest number of respondents was survivors aged between 18 and 50 years (69%). Farmers made up 43% of the respondents, followed by petty traders (23%).

Survivor respondents from the control communities were mostly women (68%) and four-fifth of them Muslim. Most of the respondents were within the ages 18 and 50 years. Detailed profile of the respondents selected for the stigma survey is indicated in table 4.

Table 4: Stigma Survey Respondents Profile by District

		Bo (n=57)	Bombali (n=43)	Kambi a (n=39)	Tonkolili (n=61)	Total	%
GENDER							
CONTROL	Male	4	4	1	4	13	32.50
	Female	6	6	9	6	27	67.50
	TOTAL	10	10	10	10	40	100.00
PROJECT	Male	25	21	20	22	88	44.00
	Female	32	22	19	39	112	56.00
RELIGION		57	43	39	61	200	100.00
CONTROL	Christian	3	5	0	0	8	20.00
	Muslim	7	5	10	10	32	80.00
	TOTAL	10	10	10	10	40	100.00
PROJECT	Christian	21	14	7	16	58	29.00
	Muslim	36	29	32	45	142	71.00
AGE		77	63	59	81	200	100.00
CONTROL	6-18	1	4	5	3	13	32.50
	18-50	7	3	5	7	22	55.00
	51-65	2	3	0	0	5	12.50
	65+	0	0	0	0	0	0.00
	TOTAL	10	10	10	10	40	100.00
PROJECT	6-18	14	5	6	16	41	20.50
	18-50	40	26	30	42	138	69.00
	51-65	3	8	3	2	16	8.00
	65+	0	4	0	1	5	2.50
OCCUPATION		77	63	59	81	200	100.00
CONTROL	Big Business	1	0	0	1	2	5.00
	Community Health Volunteer		1	0	0	1	2.50
	Farmer	1	3	2	5	11	27.50
	Health Worker	1	2	0	0	3	7.50
	Other	3	1	3	3	10	25.00
	Petty Trader	3	3	5	1	12	30.00
	Teacher	1	0	0	0	1	2.50
	TOTAL	10	10	10	10	40	100.00

							0
PROJECT	Big Business	0	2		1	3	1.50
	Community Health Volunteer	0	0	1	1	2	1.00
	Farmer	32	14	15	25	86	43.00
	Fishing	0	2	0	0	2	1.00
	Health Worker	0	4	0	3	7	3.50
	Other	13	4	13	14	44	22.00
	Petty Trader	12	13	8	14	47	23.50
	Religious Leader	0	2	0	3	5	2.50
	Teacher	0	2	2	0	4	2.00
	TOTAL	57	43	39	61	200	100.00

3.2 Knowledge about EVD

3.2.1 Case definition

The Centre for Disease Control (CDC), defined Ebola virus disease (EVD) as a rare and deadly viral illness³ that is reportable to the National Notifiable Disease Surveillance System ([NNDSS](#)) in all U.S. states and territories. The critical means of controlling the infection is through early recognition of EVD which requires health-care personnel to be alert for and evaluate any patients suspected of having the disease.

In its definition, it goes further to add that a person who has both consistent signs or symptoms and risk factors as follows should be considered a Person under Investigation (PUI):

1. Elevated body temperature or subjective fever or symptoms, including severe headache, fatigue, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage; and
2. An [epidemiologic risk](#) factor within the 21 days before the onset of symptoms.

Unlike the control communities where every respondent admitted to have heard of the disease, one person in project implementation community in the kambia district responded not to have heard about Ebola as highlighted in Table 5. If true, then that one person could be a barrier to the control of the disease in the community and the country at large.

Table 5: Heard of Ebola

Location	Response	Bo	Bombali	Kambia	Tonkolili	Grand Total
Project	No			1		1
	Yes	111	81	74	118	384
	Total	111	81	75	118	385
Control	Yes	10	10	10	10	40
	Total	10	10	10	10	40

While all but one had heard of the disease, only one person in Kambia had not. 1 person in the project area thought it was a myth and 2 people in the control community thought the disease was punishment from God. Reinforcing the response of the one person in Kambia of not having heard of the disease, this misconception could contribute to increase level of disbelief in communities, and consequently result into non adherence in the control of the disease. Table 6 shows respondents' level of knowledge on the definition of the EVD.

³ Centre for Disease Control and Prevention, Atlanta, USA

Table 6: Respondents' knowledge on definition of EVD

Location	Response	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Project	Disease	108	78	70	118	374	97.14
	Myth	1				1	0.26
	Punishment	2	3	5		10	2.60
	Total	111	81	75	118	385	100.00
Control	Disease	10	10	8	10	38	95.0
	Punishment			2		2	5.0
	Total	10	10	10	10	40	100.0

The 3 respondents, 2 in the control and 1 in the project community that defined the disease to be a punishment from God or a myth were women. Considering the role played by women in the running of homes, their ignorance could serve as catalyst to deter efforts in the fight against the disease. Although the intervention should not exclude the male population in the project communities, special attention should be given to the women in raising awareness about the disease.

3.2.2 Symptoms

All respondents in both project location and control communities were able to identify at least one main symptom. Among the 385 respondents scoped in the project communities, 14% of them named three symptoms of the EVD correctly – fever, diarrhea and vomiting; and approximately 5% named five symptoms including fever, diarrhea, vomiting, and joint pain and bleeding. In the control communities, only 8% named fever, diarrhea and vomiting which is far less than the percentage from the project location. None of the respondents in the control community named nine symptoms; and 10% identified five symptoms..

3.2.3 Mode of Transmission

In the project communities, more women than men showed greater unawareness of the EVD in terms of mode of transmission. While only 2 out of 196 male respondents said they did not know the mode of transmission, 5 out of 189 women responded that they did not know the mode of transmission. Touching the fluid of an infected person was identified as the most popular by equal number of male and female respondents of 97 each. This mode of transmission was echoed in almost all FGDs held in almost every community in the project four districts. Together with fluids, unprotected sex with an infected person was the next most popular mode of transmission indentified by both male and female respondents – male 59 and female 49. Again, this was confirmed by the many FGDs in project locations.

The same trend was recorded in the control communities with 6 men and 8 women identifying fluid as the most likely mode of transmission followed by 6 male and 7 female by unprotected sex.

The mentioning of witchcraft by 5 respondents could lead to disbelief among the population about the existence of EVD. It could influence attitudes and beliefs of the respondents and and serve as a barrier in the control of the EVD.

A popular mode of transmission that was repeatedly mentioned during the FGDs was the eating of bush meat or remains of fruit eaten by bats. On the contrary, the issue of bush meat was not identified as mode of transmission in the KAP survey.

Table 7: Mode of transmission

Location	Gender	Response	Bo	Bombali	Kambia	Tonkolili	Grand Total
Control	Man	Fluids	4	1	1		6
		Fluids injected unprotected sex			1		1
		Fluids unprotected sex		3		3	6
		Fluids unprotected sex other		1			1
		Fluids witchcraft			1		1
	Man Total		4	5	3	3	15
	Woman	Don't Know	1		3		4
		Fluids	2	1	2	3	8
		Fluids injected unprotected sex	1		1		2
		Fluids other		1		2	3
		Fluids unprotected sex	2	2	1	2	7
		Unprotected sex		1			1
	Woman Total		6	5	7	7	25
Control Total			10	10	10	10	40
Project	Man	Don't know			2		2
		Fluids	34	8	20	35	97
		Fluids don't know				1	1
		Fluids injected	2	2	2	2	8
		Fluids injected don't know				1	1
		Fluids injected other		1			1
		Fluids injected unprotected sex	1	2	11		14
		Fluids injected unprotected sex other		1			1
		Fluids other		1			1
		Fluids unprotected sex	15	23	5	16	59
		Fluids unprotected sex don't Know				2	2

		Fluids unprotected sex other		1			1
		Fluids witchcraft	1			1	2
		Fluids witchcraft unprotected sex			1	3	4
		Unprotected sex		2			2
	Man Total		53	41	41	61	196
	Woman	Don't know	1		3	1	5
		Fluids	38	13	13	33	97
		Fluids don't know	1	3	2		6
		Fluids injected	2	2	7	2	13
		Fluids injected other		1			1
		Fluids injected unprotected sex		1	6	3	10
		Fluids injected unprotected sex other		1			1
		Fluids unprotected sex	12	17	3	17	49
		Fluids witchcraft don't know				1	1
		Injected	1				1
		Injected unprotected sex	1	1			2
		Unprotected sex		1			1
		(blank)	2				2
	Woman Total		58	40	34	57	189
Project Total			111	81	75	118	385
Grand Total			121	91	85	128	425

3.2.4 Source of Knowledge about EVD

In the project and control communities, the media was identified as the main source of knowledge for both men and women. 25% and 36% of male and female respectively in the project communities selected the media as the main source of information. A similar pattern, 33% of male and 27% women in control communities identified the media as the key source of information. With the high level of illiteracy in the country, it would mean that the electronic media must have been the major source of knowledge especially with the availability of community radios in every survey district. The role of Community Health Workers (CHW) and health promotion messages by Primary Health Unit (PHUs) personnel were also recognized as the second and third popular source of information by male and female respondents in communities in project locations and control locations as highlighted in table 8. The

information is useful in identifying the choice of transfer of information in project communities for awareness raising interventions.

Table 8: Source of information on EVD

Location	Gender	Response	Bo	Bombali	Kambia	Tonkolili	Grand Total	%	
Control	Man	Health Promotion	1				1	2.5	
		Media	1	4	3	2	10	25	
		Sensitization CHW	1			1	2	5	
		Sensitization Leader	1	1			2	5	
	Man Total			4	5	3	3	15	37.5
	Woman	Health Promotion			2			2	5
		Media	4	2	4	5		15	37.5
		Other				1		1	2.5
		Sensitization CHW	1	1		1		3	7.5
		Sensitization Leader	1		3			4	10
	Woman Total			6	5	7	7	25	62.5
	Control Total			10	10	10	10	40	100
Project	Man	Health Promotion	6	8		4	18	4.68	
		Media	28	18	35	45	126	32.73	
		Other	1				1	0.26	
		Sensitization and CHW	17	10	5	11	43	11.17	
		Sensitization and Leader	1	5	1	1	8	2.08	
	Man Total			53	41	41	61	196	50.91
	Woman	Health Promotion	13	10		9	32	8.31	
		Media	26	19	24	34	103	26.75	
		Other				1	1	0.26	
		Sensitization and CHW	18	7	4	12	41	10.65	
		Sensitization and Leader	1	4	6	1	12	3.12	
	Woman Total			58	40	34	57	189	49.09
Project Total			111	81	75	118	385	100.00	
Grand Total			121	91	85	128	425		

3.2.5 Immediate family member of respondents infected

Over a third of respondents (37.5%) in project areas had immediate family members who had been infected by EVD, of whom 12.5% are male and 25% female; compared to 27.3% in control areas. **Table 9** presents the survey data on immediate family members infected by the disease in project location and control communities.

Table 9 Immediate family members infected by EVD by district

Location	Gender	Response	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	No	3	3	3	1	10	25.00
		Yes	1	2		2	5	12.50
	Man Total		4	5	3	3	15	37.50
	Woman	No	5	3	6	1	15	37.50
		Yes	1	2	1	6	10	25.00
	Woman Total		6	5	7	7	25	62.50
Control Total			10	10	10	10	40	100.00
Project	Man	No	44	29	35	39	147	38.18
		Yes	9	12	6	22	49	12.73
	Man Total		53	41	41	61	196	50.91
	Woman	No	44	25	28	36	133	34.55
		Yes	14	15	6	21	56	14.55
	Woman Total		58	40	34	57	189	49.09
Project Total			111	81	75	118	385	100.00
Grand Total			121	91	85	128	425	

In specific terms, more immediate family members were infected by the disease in the Bombali Shebora chiefdom (6%) in the Bombali district followed by Kholifa Rowala and Tane chiefdoms (approximately 4% each) in the Tonokolili district as indicated in table 10.

Table 10 Immediate family members infected by chiefdom

Location	Response	Chiefdom	Man	Woman	Grand Total	%
Control	No	Makari Gbanti	3	3	6	15.00

		Baoma	3	5	8	20.00
		Gleh Dixon	3	6	9	22.50
		Kunike Sanda	1	1	2	5.00
	No Total		10	15	25	62.50
	Yes	Makari Gbanti	2	2	4	10.00
		Baoma	1	1	2	5.00
		Gleh Dixon		1	1	2.50
		Kunike Sanda	2	6	8	20.00
	Yes Total		5	10	15	37.50
Control Total			15	25	40	100.00
Project Total	No	Bombali Shebora	8	10	18	4.68
		Bum	1		1	0.26
		Bumpeh	17	15	32	8.31
		Gbonkeleken	6	6	12	3.12
		Kakua	12	17	29	7.53
		Khalifa Rowala	2	2	4	1.04
		Kholifa Rowala	24	19	43	11.17
		Magbema	10	13	23	5.97
		Mambolo	15	5	20	5.19
		Masungbala	10	10	20	5.19
		Sella Limba	14	9	23	5.97
		Tambaka	7	6	13	3.38
		Tane	7	9	16	4.16
		Tikonko	14	12	26	6.75
	No Total		147	133	280	72.73
	Yes	Bombali Shebora	10	11	21	5.45
		Bumpeh	2	2	4	1.04
		Gbonkeleken	10	4	14	3.64
		Kakua	3	8	11	2.86
		Khalifa Rowala	2	1	3	0.78
		Kholifa Rowala	6	8	14	3.64
		Magbema	2	3	5	1.30

		Mambolo	2	3	5	1.30
		Masungbala	2		2	0.52
		Sella Limba	1	1	2	0.52
		Tambaka	1	3	4	1.04
		Tane	4	8	12	3.12
		Tikonko	4	4	8	2.08
	Yes Total		49	56	105	27.27
Project Total			196	189	385	100.00
Grand Total			211	214	425	

Those whose immediate family members were infected were mostly adult male and female respondents with the greater number from the Bombali and Tonkolili districts.

3.2.6 Death of Respondents' Immediate Family Members

In the project location, 11% male and 14% female respondents affirmed that they lost an immediate family to the virus and a similar statistics, 10% male and 15% female respondents was also recorded in the control communities. Of these 98 children lost their immediate relatives. **Table 11** shows respondents' who lost their immediate family members by age category. Most of the 98 children were in the Tonkolili district, 18 and 34 male and female children respectively, and 27 male and 7 female in the Bombali district.

Table 11: Respondents who lost immediate family members by age category and by district

EVD Death in Households	Location	Bo	Bombali	Kambia	Tonkolili	Total
Adult Male	Control	0	6	0	14	20
	Project	28	30	3	60	121
	Adult Male Total	28	36	3	74	141
Adult Female	Control	0	3	0	11	14
	Project	21	39	1	57	118
	Adult Female Total	21	42	1	68	132
Male Children	Control	0	1	0	7	8
	Project	10	27	1	18	56
	Male Children Total	10	28	1	25	64
Female Children	Control	1	2	0	6	9
	Project	7	7	4	24	42

	Female Children Total	8	9	4	30	51
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3.2.7 Prevention of Ebola Virus Disease

Related to the touching of the fluid of infected persons, respondents in both project and control communities, selected hand washing as the most appropriate means of preventing someone from catching the virus. 31% and 33% of male respondents in project and control communities respectively identified hand washing and means of prevention of the disease. Similarly, approximately 33% and 40% of female respondents in project location and control communities respectively identified hand washing as best prevention method from catching EVD. In concurrent with this prevention method, not touching others or touching corpses of infected persons was identified as the second best means of preventing the EVD from spreading as shown in table 12. The two are closely related mechanism of preventing the disease as in the event that one by error touches an infected person, washing one's hand would mitigate the incidence of catching the virus.

Table 12: Prevention of spread of EVD by gender in project location and control communities

Location	Gender	Response	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	Hand Washing	3	4	3	3	13	87
		Not Touching People	1	1			2	13
	ManTotal		4	5	3	3	15	100
Control	Woman	Hand Washing	4	2	7	3	16	64
		Not Touching Corpses		1			1	4
		Not Touching People	2	2		3	7	28
		Other				1	1	4
	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	Hand Washing	34	20	27	40	121	62
		Not Touching Corpses	10	11	5	1	27	14
		Not Touching People	9	9	8	20	46	23
		Other			1		1	1
		Protective Clothing		1			1	1
		Man Total		53	41	41	61	196
	Woman	Grace	1				1	1

		Hand Washing	35	28	25	37	125	66
		Not Touching Corpses	11	1	3	3	18	10
		Not Touching People	11	11	6	15	43	23
		Protective Clothing				1	1	1
		Missing				1	1	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

Every respondent, including students or school going children, weavers, traffic wardens, mechanics, backyard gardeners, blacksmiths, company workers, electricians and engineers reiterated the washing of hands or avoiding touching people as the most reliable means of preventing the EVD. Also, in the FGDs held in all four districts, the issue of hand washing and avoiding the touching of others was repeatedly emphasized.

3.2.8 Actions taken on EVD suspected Cases

Responding to the question of what one should do if one was suspected of having contracted EVD, almost every male respondent in project location, 97% agreed that the person should go to a hospital and should not be touched. A lower percentage of female respondents, about 93% also agreed that the person should be taken to a hospital. The same high percentage was registered in the control communities among the male and female respondents, approximately 93% and 88% respectively. Taking the person to a hospital would understandably involve calling 117 or health personnel. Despite this high response, some respondents in the project locations mentioned two worrying options: two female respondents said the person should stay at home, one each from Kambia and Bombali districts, and one male respondent from Bo and one female from Bombali districts said the person should see a witch doctor. Though insignificant in terms of percentage, it is a cause for concern due to the fact a sick person staying at home or going to a witch doctor, as indicated in table 13, would compromise the preventive or control measures of the disease. It must be noted a single case is a threat to the entire nation. Therefore, such views should be addressed in all project communities. It could involve CHWs emphasizing the message that reporting early at treatment centre would increase a person's chance to survive.

Table 13: What should happen if one is suspected to have contracted the EVD

Location	Gender	Response	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	Do Not Touch	1				1	7
		Hospital	3	5	3	3	14	93

	Man Total		4	5	3	3	15	100
	Woman	Do Not Touch			1		1	4
		Hospital	6	5	6	5	22	88
		Other				2	2	8
	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	Do Not Touch		1		2	3	2
		Hospital	53	39	40	58	190	97
		Stay At Home			1	1	2	1
		Witchdoctor		1			1	1
	Man Total		53	41	41	61	196	100
	Woman	Do Not Touch	2	3	1	4	10	5
		Hospital	55	35	33	52	175	93
		Stay At Home	1	1			2	1
		Witchdoctor		1			1	1
		Missing				1	1	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

Responding to a related question, the majority of respondents in project location and control community mentioned that if there was a suspected case, the people around the suspected case should avoid touching the person's fluid and call 117 for the person to be taken to a holding or treatment center. The response cut across both male and female respondents in project location and control communities. There was not a single person that suggested any other response that could lead to the spread of the disease.

3.2.9 Perception on Survival of Infected Persons

On the question on whether someone could survive if the person contracted EVD, 93% male respondents and 89% female respondents in project location responded in the affirmative. Similarly, a high percentage in control communities and shown in table 14, 93% male and 84% female respondents opined that an infected person could survive. , 14 male and 19 female respondents in project location denied an infected person would survive. Responses of this nature could have caused some people to keep their loved ones in homes or taken them to witch doctors for treatment.

Table 14: Respondents' opinion on whether one can survive if infected with EVD

Location	Gender	Response	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	No			1		1	7
		Yes	4	5	2	3	14	93
	Man Total		4	5	3	3	15	100
	Woman	No	1		1	2	4	16
		Yes	5	5	6	5	21	82
	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	No	1	1	7	5	14	7
		Yes	52	40	34	56	182	93
	Man Total		53	41	41	61	196	100
	Woman	No	5	3	6	5	19	10
		Yes	53	36	28	51	168	89
		Missing		1		1	2	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

3.2.9 Possibility of Contracting the Disease from Survivors

Responding to the question on whether one could contract the disease from someone that contracted the disease and survived, 54% male and 56% female respondents in the project area, and 33% male and 52% female in the control area disagreed as indicated in table 15. The conditions under which one could contract or not contract the EVD from a survivor need to be better explained to the public to address any misunderstanding.

Table 15: Respondents' opinion on whether one could contract the disease from a survivor

Location	Gender	Is it Possible To Catch EVD from a survivor?	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	No	2		1	2	5	33
		Yes	2	5	2	1	10	67
	Man Total		4	5	3	3	15	100
	Woman	No	4	1	3	5	13	52
		Yes	2	4	4	2	12	48

	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	No	22	8	29	47	106	54
		Yes	31	33	12	13	89	45
		Missing				1	1	1
	Man Total		53	41	41	61	196	100
	Woman	No	31	14	18	43	106	56
		Yes	27	26	16	13	82	43
		Missing				1	1	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

On the same question, there is a balance among the Christian respondents on whether one could catch EVD from a survivor which justifies the need for this aspect of the information on EVD to be carefully explained. While the difference among the Muslim respondent is significant, the number of those that responded in the affirmative (103 respondents) against those who did not agree (143) calls for in depth clarification.

On the reason why some people survived, table 16 ascertained that the majority of respondents in both project and control communities believed it was due to the fact that the infected persons were taken to health facilities, especially treatment facilities. 85% male and 77% female respondents in project areas agreed with the statement that it was because they were taken to health facilities. In the FGDs this view was confirmed by many of those who participated in the discussions in all the districts. . Whether one was taken to treatment facilities, one's chances of survival depended on the early realization that one had been infected. A small number of respondents thought God was the reason people survived.

Table 16: Reasons why some people survived the EVD

Location	Gender	Why Do Some Survive	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	Early Realisation		2			2	13
		God	1				1	7
		Health Centre	3	3	3	3	12	80
	Man Total		4	5	3	3	15	100
	Woman	Cure				2	2	8
		God	2	1	4	2	9	36
		Health Centre	4	4	3	3	14	56

	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	Cure		1			1	1
		Early Realisation	7	4		10	21	11
		God	2	1	2	1	6	3
		Health Centre	44	35	39	49	167	85
		Rehydration				1	1	1
	Man Total		53	41	41	61	196	100
	Woman	Cure		1		2	3	2
		Early Realisation	9	7		12	28	15
		God	3	1	4	2	10	5
		Health Centre	46	30	30	39	145	77
		Missing		1		2	3	2
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

2.3.10 Action Taken on Death of an Ebola Infected Person

Respondents in both project location and control communities agreed that 117 should be called in the event an infected EVD suspect died in the home, which is the most appropriate thing to do. As indicated in table 17, 80% male, 76% female respondents in control communities; and 95% male and 89% female respondents subscribed to this position,. Of concern is the fact that 14 respondents, mostly in Bo and Bombali thought a person should be buried. While the manner of burial has significantly improved, there are still concerns among the population regarding the unsafe manner in which burials are taking place, especially in the Western area. Failing to address these concerns could expose relatives to risk if they choose to embark on secret burials of the dead loved ones.

Table 17: Actions for EVD suspected death

Location	gender	What Should You Do After Household Death	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	man	Bury		2			2	13
		Call 117	3	3	3	3	12	80
		Call Police	1				1	7
	man Total		4	5	3	3	15	100

	woman	Bury		1			1	4
		Call 117	6	2	6	5	19	76
		Don't Touch		2	1	1	4	16
		Other				1	1	4
	woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	man	Bury	3	1			4	2
		Call 117	47	38	41	60	186	95
		Call Police	1				1	1
		Don't Touch	2	2		1	5	3
	man Total		53	41	41	61	196	100
	woman	Bury	3	4			7	4
		call117	50	34	31	53	168	89
		callPolice	3				3	2
		dontTouch	1	2	3	3	9	5
		Hide	1				1	1
		Missing				1	1	1
	woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

3.3 Attitude and behaviour towards EVD survivors, update of health services, and confidence in the health service delivery

To almost all of the respondents in both project location and control communities, it made sense for survivors to return to their homes. As shown in table 18, 96% male and 93% female respondents giving a total of 95% in project communities affirmed survivors should be allowed to return to their homes. Similarly, all male respondents, and all but one female respondent in control communities favored the idea of survivors returning to their homes. It is a positive sign for the easy rehabilitation and reintegration of survivors in their homes and subsequently their respective communities. However, a small number of respondents in all areas did not agree that survivors should return. This could be a sign of stigma and could create difficulties in the rehabilitation and reintegration of survivors.

Table 18: Respondents towards the return of survivors back to their homes

Location	Gender	Survivors	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
		Should Return To House						
Control	Man	Yes	4	5	3	3	15	100
	Man Total		4	5	3	3	15	100
	Woman	No	1				1	4
		Yes	5	5	7	7	24	96
	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	No		2	3	1	6	3
		Yes	52	39	38	60	189	96
		Missing	1				1	1
	Man Total		53	41	41	61	196	100
	Woman	No	4	5	1	1	11	6
		Yes	54	35	33	55	177	94
		Missing				1	1	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

About 2% Christians and 3% Muslim respondents did not agree that survivors should not return to their homes. Therefore, interventions geared towards addressing this critical issue should target both Muslims and Christians.

Asked whether one could contract the disease from a neighbor survivor should they return to their homes, 68%-47% male and 60-64% female respondents in project and control areas respectively thought they could not contract Ebola. On the other hand, quite a significant proportion of the respondents did not agree as indicated in table 19. These responses indicate that there remains controversy around the issue of contracting EVD from survivors.

Table 19: Attitude of respondents on whether people could contract EVD from survivor neighbor

Location	Gender	Could Contract From Neighbour	Bo	Bombali	Kambia	Tonkolili	Grand Total	Grand Total
Control	Man	No	3	1	2	1	7	47
		Yes	1	4	1	2	8	53
	Man Total		4	5	3	3	15	100

	Woman	No	3	3	4	6	16	64
		Yes	3	2	3	1	9	36
	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	No	38	23	30	43	134	68
		Yes	15	18	11	18	62	32
	Man Total		53	41	41	61	196	100
	Woman	No	33	20	18	43	114	60
		Yes	25	19	16	13	73	39
		Missing		1		1	2	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

A related question to the return of survivors to their homes was on whether they should be allowed to return to their jobs. 96%-100% male respondents, and 95%-92%% project/control groups agreed survivors should return to their jobs as shown in table 20. Not allowing them to returning could aggravate the trauma they would have gone through in their struggle to recover from the disease.

Table 20: Respondents attitude towards survivors returning to their jobs

Location	gender	Survivors Should Return to Job or School	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	Yes	4	5	3	3	15	100
	Man Total		4	5	3	3	15	100
	Woman	No	1			1	2	8
		Yes	5	5	7	6	23	92
	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	No		2	2		4	2
		Yes	53	39	39	59	190	97
		Missing				2	2	1
	Man Total		53	41	41	61	196	100
	Woman	No	3	3	3		9	5
		Yes	55	37	31	56	179	95

		Missing				1	1	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

3.4 Perception of target population about health service delivery, government ability to response to the EVD crisis, and NGO actions towards the EVD response

There is high level of confidence in the health care delivery service among the public as shown in **table 21**. Respondents in both project location and control communities in all the districts affirmed their confidence in the health care centre. In the project location, 95% male and 89% female respondents affirmed their confidence in the health centre. Also in the control communities, all the male and 92% female respondents agreed to go to their health centre. More female than male respondents expressed their reservation about visiting their health centre.

Table 21 Respondents' confidence in the Health Service

Location	gender	Survivors Should Return to Job or School	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	Yes	4	5	3	3	15	100
	Man Total		4	5	3	3	15	100
	Woman	No	1			1	2	8
		Yes	5	5	7	6	23	92
	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	No		2	2		4	2
		Yes	53	39	39	59	190	97
		Missing				2	2	1
	Man Total		53	41	41	61	196	100
	Woman	No	3	3	3		9	5
		Yes	55	37	31	56	179	95
		Missing				1	1	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

To most of the respondents who expressed their reservation, their main reason is the fear of not contracting the EVD, given its potency to easily spread. Other reasons provided were that: the facility was far off and that the facility did not have the equipment to conduct thorough checking.

In the same tone, most of the respondents expressed their confidence in the ability of the government to respond to the EVD. All male respondents and 92% female respondents in the control communities were positive regarding their confidence in the ability of the government. The same picture came from the project location with 97% male and 94% female respondents affirming their confidence as shown in table 22.

Table 22: Respondents' confidence in the ability of government to respond to EVD

Location	Gender	Confident in Govt Response	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	Yes	4	5	3	3	15	100
	Man Total		4	5	3	3	15	100
	Woman	No	1		1		2	8
		Yes	5	5	6	7	23	92
	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	No	1		2	2	5	3
		Yes	52	41	39	59	191	97
	Man Total		53	41	41	61	196	100
	Woman	No	3	1	2	2	8	4
		Yes	55	39	32	53	179	95
		Missing				2	2	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

The insufficient availability of experts, slow response of actors to calls, the neglect of government towards its workers, attitude of some health workers towards the public, contradictory messages on Ebola, the persistence of the virus in the country, unfulfilled promises and weak health systems were given by those respondents who did not have confidence in the ability of the government.

With exception of only two respondents in both project location and control communities in all four district, all the respondents shared their satisfaction with NGOs in their response during the survey as shown in table 23. To the two

respondents, the unfulfilled promised of supplying food and the non-availability of an action plan was cited as reasons for their position.

Table 23: Level of respondents' satisfaction with NGOs

Location	Gender	Satisfied with NGO Actions	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	Yes	4	5	3	3	15	100
	Man Total		4	5	3	3	15	100
	Woman	Yes	6	5	7	7	25	100
	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	No				1	1	1
		Yes	53	41	40	60	194	99
		Missing			1		1	1
	Man Total		53	41	41	61	196	100
	Woman	No				2	2	1
		Yes	58	40	34	54	186	98
		Missing				1	1	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

On the question of support to quarantined homes, a reasonable percentage of respondents expressed their dissatisfaction with the support. As shown in table 24, 20% and 27% male respondents in project location and control communities, and 13% and 24% female respondents were not satisfied with support received in quarantined homes. The inadequate and insufficient supply to quarantined homes, particularly food and non-food items, medication, finances and agricultural inputs were the reasons for the unsatisfactory opinion about support provided to quarantined homes.

Table 24: Respondents satisfaction of support to quarantined homes

Location	Gender	Quarantined Homes Enough Support	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	No	3			1	4	27
		Yes	1	5	3	2	11	73
	Man Total		4	5	3	3	15	100

	Woman	No	1		2	3	6	24
		Yes	5	5	5	4	19	76
	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	No	14	8	9	9	40	20
		Yes	39	33	32	51	155	79
		Missing				1	1	1
	Man Total		53	41	41	61	196	100
	Woman	No	9	4	9	4	26	14
		Yes	49	36	25	52	162	86
		Missing				1	1	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

According to table 25, while 87% of respondents including men and women in project location responded that survivors of Ebola were receiving enough support. Few of them, approximately 13% opined there was need for more to be done. In fact, a greater percentage, approximately 18% of those in the control communities also believed there was room for improvement regarding support to EVD survivors. The respondents in this category noted that food and non-food items were in short supply as some of the survivors lost all their property; Some were unemployed making it difficult for them to meet their basic needs; some were still contending with other health issues for which they were not receiving any medication; some were in need of financial support which they had not yet received; and some school going children who were survivors needed support to continue their education and to address stigma.

Table 25 Respondents' satisfaction with support to survivors of Ebola

Location	Gender	Survivors enough Support	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	No	1				1	7
		Yes	3	5	3	3	14	93
	Man Total		4	5	3	3	15	100
	Woman	No	1		2	3	6	24
		Yes	5	5	5	4	19	76
	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	

Project	Man	No	13	6	1	6	26	13
		Yes	40	35	40	55	170	87
	Man Total		53	41	41	61	196	100
	Woman	No	11	5	4	2	22	12
		Yes	47	35	30	54	166	88
		Missing				1	1	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

The survey searched into whether people were hesitant to present themselves to Ebola health care facility due to the fear of people's reaction if they tested positive. From table 26, the majority of the respondents feared: 67% male and 66% female respondents in project location; and 73% male and 64% female respondents in control communities. This level of fear suggests there remains deep seated stigma associated with EVD.

Table 26 Respondents' fear of testing positive if they visited a health facility

Location	Gender	People Hesitant to Present	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	No	1	1	1	1	4	27
		Yes	3	4	2	2	11	73
	Man Total		4	5	3	3	15	100
	Woman	No	1	3	1	4	9	36
		Yes	5	2	6	3	16	64
	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	No	4	21	7	32	64	33
		Yes	49	20	34	29	132	67
	Man Total		53	41	41	61	196	100
	Woman	No	14	14	4	30	62	33
		Yes	44	26	30	25	125	66
		Missing				2	2	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

Alongside the fear of been tested positive, a greater percentage of the respondents affirmed that people talk badly about those who had contracted the virus or are thought to have contracted the virus. In table 27, data shows that 42% male and 47% female respondents in project areas agreed that people talk badly about Ebola infected persons. In the control communities more male respondents, 60% compared to 36% female respondents, said people talked badly about Ebola infected persons.

Table 27: Respondents' view on whether people talk badly about EVD infected persons

Location	Gender	People Talk Badly	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	No	2		1	3	6	40
		Yes	2	5	2		9	60
	Man Total		4	5	3	3	15	100
	Woman	No	5	2	5	4	16	64
		Yes	1	3	2	3	9	36
	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	No	29	24	13	48	114	58
		Yes	24	17	28	13	82	42
	Man Total		53	41	41	61	196	100
	Woman	No	29	18	13	38	98	52
		Yes	29	22	21	18	90	48
		Missing				1	1	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

3.4 Social, cultural and traditional norms and practices of the citizens and community influencers towards EVD and its related stigma

In practice, most of the respondents affirmed they would talk to an Ebola survivor in the street as indicated in table 28. 90% male and female respondents in project location ascertained they would talk to survivors. In the control community, 98% said they would talk to an Ebola survivor. This data suggests that people understand that the virus cannot be transmitted to another person just by talking to an infected person let alone one that has recovered.

Table 28: Respondents' feedback on whether they would talk to survivors in the street

Location	Gender	Would Talk To Survivor	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	No				2	2	13
		Yes	4	5	3	1	13	87
	Man Total		4	5	3	3	15	100
	Woman	No		1			1	4
		Yes	6	4	7	7	24	96
	Woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	No	3	4	1	12	20	10
		Yes	50	37	40	49	176	90
	Man Total		53	41	41	61	196	100
	Woman	No	5	6	1	5	17	9
		Yes	53	34	32	51	170	90
		Missing			1	1	2	1
	Woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

Regarding attending meetings, 30% male and 26% female respondents in project communities affirmed they would attend community meetings. Ebola messages disseminated and discussions from the focus groups identified avoiding crowds as major mechanism established in bylaws to break the chain of transmission of the virus. As a result, there had been a moratorium on social activities including football, cinemas or clubs.

It is surprising to note that 15 male respondents, 7 from Bo, 3 each from Bombali and Tonkolili districts and 3 from Bombali; and 6 women – 5 from Bo and 1 from Tonkoli indicated in table 29 said they would touch the copse of their relative even if the person died of EVD. A possible factor for this could be the love relatives would have for their loved ones. Another factor could be the complications surrounding the burial of corpses of relatives.

Table 29: Respondents feedback on touching the copse of an EVD relative

Location	Gender	Would Touch Corpse	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	No	4	4	3	3	14	93
		Yes		1			1	7
	man Total		4	5	3	3	15	100

	woman	No	6	5	7	7	25	63
	woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	
Project	Man	No	46	38	39	58	181	92
		Yes	7	3	2	3	15	8
	man Total		53	41	41	61	196	100
	Woman	No	53	40	34	55	182	96
		Yes	5			1	6	3
		Missing				1	1	1
	woman Total		58	40	34	57	189	100
Project Total			111	81	75	118	385	
Grand Total			121	91	85	128	425	

50% of all respondents, 43% of males and 42% of females had experience a health needs other than EVD in project locations in the last one month as indicated in Table 30. Also, many respondents 46% male and 36% female in control communities had had same experience in the last one month.

Table 30: Respondents' experience with health needs other than EVD

Location	gender	Response	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Man	No	2	2	2	2	8	53
		Yes	2	3	1	1	7	47
	man Total		4	5	3	3	15	100
	woman	No	4	1	4	7	16	64
		Yes	2	4	3		9	36
	woman Total		6	5	7	7	25	100
Control Total			10	10	10	10	40	100
Project	Man	No	30	17	20	43	110	56
		Yes	23	24	21	18	86	44
	man Total		53	41	41	61	196	100
	woman	No	36	19	21	32	108	57
		Yes	22	21	13	24	80	42
		Missing				1	1	1
	woman Total		58	40	34	57	189	100

Project Total			111	81	75	118	385	100
Grand Total			121	91	85	128	425	

The prevalent non-related EVD health needs were mostly common cold, pneumonia, fever, diarrhea, pregnancy related illnesses, and ongoing conditions such as HIV. For those respondents who said they had had experience with non-related health needs, 38% in project location confirmed they attended a health facility, while 35% did not. Similarly, 30% in the control communities responded they attended a health facility and 35% did not as shown in table 31.

Table 31: Respondents with not related EVD health needs that attended a health facility

Location	Did Attend Health Facility	man	woman	Grand Total	%
Control	No	3	11	14	35
	Yes	7	5	12	30
	(Missing)	5	9	14	35
Control Total		15	25	40	100
Project	No	70	63	133	34.55
	Yes	74	71	145	37.66
	(Missing)	52	55	107	27.79
yes Total		196	189	385	100.00
Grand Total		211	214	425	

The most common services provided by the health facilities were FHCI related services in the form anti-natal and post-natal care and skilled assistance during labour and delivery. Other services provided included malaria treatment, diarrhea, respiratory and HIV medication, and family planning.

The distance to the health facility was one of the reasons that prevented some of the respondents from attending the facility. A total of 10 respondents in project location – 4 from Bo, 1 Bombali, 2 Kambia and 3 from Tonkolili districts attributed their non-attendance of a health facility to long distances to the facility. Because of the fear of Ebola infection, approximately one third of respondents, 31%, in project location refused to attend the health facility. The cost of the services and stigma were other factors that prevented respondents from attending the facilities as shown in table 32.

Table 32: Reasons for not attending a health facility

Location	Reason For Not Attending Health Centre	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
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Control	Centre Too Far	1				1	0.24	2.5
	Fear Of Infection	2	2	6		10	2.35	25
	Other	2				2	0.47	5
	Stigma				2	2	0.47	5
	(Missing)	5	8	4	8	25	5.88	62.5
Control Total		10	10	10	10	40	9.41	100
Project	Centre Too Far	4	1	2	3	10	2.35	2.60
	Closed	1				1	0.24	0.26
	Cost	6	1	2	2	11	2.59	2.86
	Fear Of Infection	26	28	33	31	118	27.76	30.65
	Other	18	7	1		26	6.12	6.75
	Stigma	1		1	6	8	1.88	2.08
	Wont Be Seen		2	1	3	6	1.41	1.56
	(Missing)	55	42	35	73	205	48.24	53.25
Project Total		111	81	75	118	385	90.59	100.00
Grand Total		121	91	85	128	425	100.00	

Secret burials continue to pose a challenge in the eradication of the EVD. While 91% and 98% respondents in project and control communities respectively had never observed the occurrence of any secret burial in their communities, the survey finding revealed that secret burials were often or sometimes occurring in communities as indicated in table 33. In the fight against Ebola, secret burials should not take place in communities, as a single case could lead to continuing transmission of the virus. Interventions geared towards checking secret burials in communities need to be prioritized.

Table 33: Observation of respondents regarding secret burials

Location	Secret Burials Occurrence	Bo	Bombali	Kambia	Tonkolili	Grand Total	%
Control	Never	10	10	9	10	39	97.5
	Sometimes			1		1	2.5
Control Total		10	10	10	10	40	100
Project	Never	101	75	60	114	350	90.91
	Often			10	2	12	3.12
	Sometimes	10	6	2		18	4.68
	(blank)			3	2	5	1.30
Project Total		111	81	75	118	385	100.00

Total							
Grand Total		121	91	85	128	425	

In their final comments, respondents requested several post Ebola interventions in the form food and non food items, educational support, agricultural inputs and medication. Also, they expressed the need for strengthening and monitoring the health and education systems. Support to survivors and orphans were also recommended.

3.7 Level of stigma affecting EVD survivors at community and household levels particularly occupation and housing challenges

The longest number of days survivors spent at treatment facilities by the majority of the respondents, approximately 30%, was 80 days. Only about one percent of the survivors had spent 2 days which is the shortest number days at any of the treatment facilities in project location. In the control communities, the longest number of days spent by the majority, 34% of survivors were 27 days and shortest numbers days spent by the least number of survivors, approximately 1% was a day.

It is positive to note that all the survivors returned to their communities and their previous residence in both project location and control communities in all four districts and survey communities. Also, all of them returned to their previous occupation in both project location and control communities. Tallying with these facts, none of the survivors had been excluded in participating in religious or family activities in both project location and control communities. This level of success must be attributed to development actors’ interventions including CA and its partners to reduce the stigma at community level.

Despite this success, the stigma survey revealed some evidence of stigma. For instance, the survey showed that many survivors felt they were the subjects of gossip by the public: In project community, 63% male and female respondents reported they had never been gossiped about, 21% said they had often been gossiped about, 7% indicated they had always been gossiped about and 9% confirmed they had been gossiped about but only once. In the same tone in the project location, 93% reported they had never been physically assaulted, 5% said they were often physically assaulted, and another 6% confirmed they had been physically assaulted but only once. Similarly in the control communities, 95% reported they had never been physically assaulted and another 5% mentioned they had been physically assaulted but only once.

Further, approximately 87% and 93% in project location and control communities respectively had never been verbally abused. In spite of this impressive score, approximately 2% in project location were always verbally abused, 3% always and 9% only once.

Reasons for the people’s behavior vary from factor to the other. Most of the survivors mentioned that they were subjected to stigma and discrimination because people believed they were still infected with the virus. Though not very significant in terms of percentage, a few survivors reported the public attributed their survival to

being linked to witchcraft. In Sierra Leone, any link to witchcraft would lead to the person to be marginalized and excluded from most social and economic and ultimately development activities. Managing this belief is necessary to ensure the survivors are able to fully reintegrate back into society.

As a result of fear of stigma as well as trauma survivors might have experienced, in the project location, only 82 of the 200 survivors were very confident to leave their homes, 72 were confident, 20 were very nervous and another 24 quite nervous. In the control communities, 37 survivors were either confident or very confident to leave their homes and the remaining 3 nervous or very nervous.

3.8 Adverse health effects of EVD on survivors and knowledge of control measures required from survivors

Less than half of the survivors (70, comprising 24 male and 46 female) in project location and about half (21 consisting of 8 male and 13 female survivors) in control communities respectively reported experiencing adverse health hazards after their recovery. The adverse health effects varied from depression, sleeplessness, drowsiness, joint pain, panic attacks, and headaches, hearing defects, lethargy, malnutrition, menstrual pain and visual impairment.

Still worrying is the fact that 37% in project location and 26% in control communities were not aware of the means survivors could spread the disease. Those survivors who knew the means by which they could spread the virus said they should not participate in unprotected sex until three months after their recovery. This calls for two interventions: awareness raising for survivors about the risk of transmitting Ebola through unprotected sex; and promoting the use of condoms if they were to be involved in sexual activity.

While many were grateful to the government and other development actors for their support and their survival, their final comments were in the form of appeals for continuous support to meet their urgent, immediate and long term priority needs. Support could either be in form of basic necessities such as clothing, food or medical needs or enabling them to continue their education or revive their economic activities including agricultural inputs and gainful employment options.

3.9 Communities Engagement in Improving Local Governance and Coordination of the EVD response

From the key informant interviews, it was clear several actors had been playing different roles in the fight to eradicate the EVD in the country. These include international and national NGOs and CBOs, the National Ebola Response Committee structures at regional and district level, related MDAs, the Local Government structures and traditional authorities.

Roles performed by these structures range from coordination, awareness raising and supporting victims of EVD. Key structures involved in coordination were the councils, which had the primary mandate of coordinating all development and its related interventions in their localities. The Regional and District Ebola Response structures had also been playing coordination roles in many aspects including surveillance and providing technical support based on needs and demands.

Related line ministries, departments and agencies, such as, the District Medical Health Team (DHMT) and the Ministry of Social Welfare, Gender and Children's Affairs (MSWGCA) had been in the provision of specialized service delivery. For example, the MSWGCA had been engaged in coordinating and collecting data on survivors, orphans and widows to ensure their specialized needs, including the protection of children were addressed. Also, the DHMT had been involved in district surveillance intervention, case investigation and extracting suspected EVD cases to holding and ultimately treatment centers depending on the status of the individual. They had also been involved in the training of Primary Health Care unit personnel to improve their skills in the handling of their clients in the midst of the incidence of the EVD.

At community level, local authorities had mainly been involved in educating and raising awareness of their subjects about the EVD. Local authorities had also been involved in jealously guarding the enforcement of bylaws to prevent the spread of the virus in their communities and providing EVD prevention kits including veronica buckets and soap for hand washing. In the performance of this role, other actors, especially NGOs and CBOs had been complementing the role of local authorities. The NGOs and CBOs had also been involved in playing specialized role, such as, social mobilization, livelihood support including support to schools, psychosocial counseling and protection of vulnerable groups. Specifically, some of CSOs had been involved in providing specialized services such as ensuring actors in fight against EVD were accountable and embarking on decontamination exercises.

Collectively, these organisations had been engaging and networking with one another through structures such as district coordination meetings and fora or specialized events. The use of information technology through text messages and emails had been very instrumental. Because of the information sharing and exchange, Ebola messages had been coherent and consistent through the use of different channels.

The performance of these roles and interventions significantly contributed to keeping the incidence of EVD cases to a minimum, at times to zero in some communities. Nevertheless, there are gaps and constraint in these operations. They include:

1. The non-clarity on activities of some organisations including their programmes and budgets. For instance, the Bo City Council reported that some organisations were operating within their locality without following the protocol of registering with the council and working within their intervention framework.
2. There is capacity needs in several areas, such as insufficient funding, IT facilities, logistics and mobility.
3. Equipment to protect actors who visited holding and treatment facilities.
4. Training on how to hold actors accountable and guidance on how to consult with others.
5. Inadequate funding was cited as a popular concern to most of the actors including local authorities, NGOs and CBOs and some of the councils.
6. There is mistrust among the citizens about results of laboratory test and the work of some actors as they saw them as outsiders.
7. The communities were yet to own the process and product of the interventions.

4.0 Conclusions and Recommendations

The concerted efforts of the diverse actors has contributed towards mitigating the impact of EVD and reducing incidence significantly to within reach of the zero target. Knowledge on EVD has improved significantly and has positively changed attitudes, behavior and practice among the public. In spite of the improved knowledge, there remain misconceptions among the population, for example, conditions under which survivors could spread virus is not very clear among the population; and fear of the disease is still rife. Furthermore, some communities are still conducting harmful practices, such as secret burials that could lead to an increase in the spread of the disease. The stigmatization of survivors is gradually subsiding, although the survey showed that pockets of stigma still exist in communities. Specific needs of some survivors are still unmet. Also, gaps were identified among actors to judiciously perform their roles for a cohesive and comprehensive response. Based on the survey findings, the following recommendations are proposed:

1. The need for awareness raising interventions to continuously increase the knowledge of the people on EVD and influence their attitudes, behavior and practice is necessary, particularly to inform people how survivors can still transmit Ebola through unprotected sex up to 3 months after having recovered; to dispel myths such as witchcraft associated with Ebola; and stop harmful practices including keeping people with Ebola at home and conducting unsafe secret burials rather than taking them to a health facility.
2. The essential non-food needs of survivors and people in quarantine should be addressed, within the remit of the project. This includes provision of food and non-food items, support towards gainful employment, provision of agricultural inputs and support to school going children.
3. Sustainability mechanisms should be established and supported to ensure local community stakeholders, including traditional authorities and other stakeholder groups own the EVD response process and play a lead role in the post Ebola response.
4. Further interventions are necessary to eradicate stigma against survivors and families affected.
5. Gaps⁴ were identified in the operations of the various actors involved in the coordination and governance of interventions geared towards the fight to eradicate the EVD. Further probing and analysis of these gaps would be required and base on the findings, specific support would be provided on a case by case bases.

⁴ For example, Financial support, training and IT supports