G.O.S.L
Moyamba DERC
Psychosocial Pillar

EVD Survivors' assessment report
Moyamba District
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EVD Survivors' Comprehensive Assessment

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Moyamba District, Sierra Leone

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DERC (District Ebola Response Coordination) – Psychosocial Pillar, Moyamba.

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Médicos del Mundo/Doctors of the World in collaboration with Solidarités International.

Authors:
Lourdes Carrasco Colom and Marie Grasmuck

Involved Partners:

DERC PSS Pillar members with technical support from: Action Contre la Faim, Moyamba's Women's Network, Children's Forum Network, Mustard Seed, Plan SL, World Vision, Disability Right Movement SL, Defence for Children International, Children Of The Nation, Fountain Of Peace Radio, Youth And Children Advocacy Network, One Family People, FORUT SL (For Development and Solidarity SL), Forum for African Women Educationalist, CHATS.

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And finally, a special acknowledgement is deserved to all interviewers and social workers involved in the field assessment that have made possible this report and recommendations:
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They have worked very hard in the field, visiting and interviewing all survivors, showing high levels of strength and commitment, in a limited amount of time, with difficult road conditions and long distances.

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List of acronyms

ACF	Action Contre la Faim
CFN	Children's Forum Network
COTN	Children of the Nation
DCI	Defence for Children International
DERC	District Ebola Response Center
DRIM SL	Disability Right Movement Sierra Leone
EVD	Ebola Virus Disease
FAWE	Forum for African Women Educationalist
FOP	Fountain of Peace Radio
FORUT S/L	For Development and Solidarity Sierra Leone.
IGA	Income Generating Activities
DoTW	Doctors of the World
MdM	Medicos del Mundo
MODWON	Women's Network
MoHS	Ministry of Health and Sanitation
MSWGCA	Ministry of Social Welfare, Gender and Children Affairs
NERC	National Ebola Response Center
NFI	Non Food Items
OFP	One Family People
PSS	Psychosocial Support
SI	Solidarites International
WASH	Water, Sanitation and Hygiene
WFP	World Food Program
WOCAN	Women and Children Advocacy Network
WV	World Vision
YACAN	Youth and Children Advocacy Network

Definitions

Discrimination: Unfair treatment of a person, racial group or minority, based on prejudice.

Household: Consists of all members of one family who may be related by blood, marriage, or adoption, including other persons, who normally live together in one house or in a premises and take their meals from the same kitchen and share the same budget. A household can also consist of one member. This group of persons looks at one person who they regard as the head of the household.

Rejection: To refuse to accept someone, avoiding him/her. The noun rejection can refer to the actual act of rejecting something or to the feeling one has after being rejected. In other words, you might have feelings of *rejection* after experiencing the *rejection* of others.

Resilience: An individual's capacity to recover from, adapt and remain strong in the face of adversities

To stigmatize: To put some mark of disgrace, shame or dishonour upon someone. Locally described as "pointing fingers at someone"

Vulnerability: Susceptibility to be harmed physically or emotionally. It results from an interaction between the resources available to individuals and communities and the life challenges they face. Vulnerability results from developmental problems, personal incapacities, disadvantaged social status, inadequacy of interpersonal networks and supports, degraded neighborhoods and environments.

Risk: When people are vulnerable and face threats outlined above (crisis situations, crisis environments, poverty), they are at risk. The longer of more frequently they encounter such threats, the higher level of risk.

Executive Summary

The District of Moyamba celebrated its 42 days without confirmed EVD case milestone on April, 27th 2015, after registering a total of 208 EVD cases. The District is now home to 85 survivors anda better knowledge their situation was deemed essential by the DERC and its partners, under the growing concerns of post EVD complications, to learn from experience how to better manage the medical and psychosocial support of the survivors, and to plan for specific activities when needed.

During the months of March and April 2015 MdM and SI in coordination with the DERC and its PSS partners conducted a comprehensive assessment of EVD survivors in Moyamba district, with the objective of assessing their general situation several weeks and months after their discharge, including a follow up on their psychological wellbeing, medical complications and community reintegration, social, and general living conditions. The main focus of the assessment is to inform, guide and streamline understanding and responses to EVD complications' concerns in a realistic and feasible way. As these findings aim to inform humanitarian partners, government and donors, the report is intended for:

- Internal dissemination by partners
- External dissemination to DFID and partners' donors.
- External dissemination to the DERC and Psychosocial Pillar in Moyamba.
- External dissemination to NERC, DHMT and the MoHS at national level in Sierra Leone.
- External dissemination to the humanitarian community involved in the Ebola Response intervention.

The survey was commissioned by the DERC PSS Pillar with MdM as main lead partner for organisation and data analysis. Terms of reference were agreed between partners before implementing the data collection activity and included the review of the questionnaire drafted by the DERC PSS Pillar and MdM/SI. The DERC Coordinator of Moyamba District formally validated the ToRs and its annexes. All the interviewers received the same training by MdM on the same day.

It was decided that semi structured interviews was the most relevant and efficient method to collect information on PSS and medical conditions of the survivors. The timeframe and the fact that it involved numerous partners did not allow for mixed methods to be implemented and it was deemed more important to allow sufficient time for individual discussions than for extensive questionnaires on parallel concerns. The survey consisted in a comprehensive questionnaire designed by a group of professionals with different backgrounds. The questionnaire included:

- Personal data and general information (including authorised facility where they were treated)
- Psychosocial information (psychological distress questionnaire, discharge, community reintegration, social wellbeing and stigmatization)
- Medical complications questionnaire
- Living conditions and access to basic needs (Livelihoods and Water and sanitation)

The field assessment covered 87% of the total EVD survivors in Moyamba district, 74 survivors out of 85 identified and located Moyamba EVD survivors (12% remaining having been relocated to new geographical areas and therefore not reached).

The evaluation was subject to several limitations, out of which:

- The numerous number of partners associated to data collection, while a proof of comprehensive coordination by the DERC PSS pillar, made it challenging to ensure that data collection was harmonised. All the field workers received training on the questionnaire and were given the associated guideline, although the adjustments that were needed in the understanding of the questions and in how to collect the answers were not implemented at all times. In addition to that, data entry was not performed by the interviewers themselves but by the two referents from MdM and SI, to ensure continuity in the data entry and minimize dissemination of questionnaires, therefore mistakes or misunderstandings could have been derived from this shift in responsibilities, although the training on the questionnaire and the debriefing times should have limited this margin of error, a secondary data review could be necessary if a deeper analysis of the assessment wants to be done.

- The survey did not enter into discussions with families of EVD survivors of with the communities they come from. It was decided that the survey should focus on individuals only but that the interviewers could ask further questions to third parties if they found it relevant to do so.

- The survey was intended to be mostly a qualitative one. As such, a consequent part of the questionnaire leaves room for expression and interpretation. It was also asked to the interviewers not to insist on questions that were unanswered. Consequently, some quantitative data has been drawn

from the questionnaire but are also impeded by theses constraints. Both qualitative and quantitative results presented in this report should be read with this specific limitation in mind.

- Geographic distribution of survivors challenged local partners' mobility to reach all of them.

Most important findings and conclusions:

Although survivors had generally positive feelings upon discharge and felt dignified and respected when accompanied to their communities from the authorized facilities, several weeks and months after, EVD personal complications and broader EVD social and economic impact in their lives and communities, are becoming a challenge for numerous survivors and their families to meet basic needs and overcome the traumatic experience lived.
EVD outbreak impact does not finish with the end of the disease-spreading out and with Ebola zero cases. EVD medical, social and economic impacts are important and not to be neglected. Medical, psychological and socioeconomic assistance is highly needed and social services and post EVD assistance programs should be planned within a wider reintegration, recovery and resilience perspective and for a long-term period.

Psychosocial: 48% of survivors in Moyamba district present signs and symptoms of distress, several weeks and months after discharge, putting them at risk of experiencing different levels of mental health disorders.
Even if stigma and rejection attitudes have been improving throughout the district, 28% of survivors in specific chiefdoms like Fakunya, Kori, Lower Banta and Kaiyamba still experience rejection and stigma in their communities several weeks and months after discharge.
81% declare to have hope for the future if they find the way to resume their life through support for education, vocational training and livelihoods.

Livelihoods: Two thirds of the adult women and one half of the adult men who survived EVD lost the livelihood activity they were engaged in before contracting the EVD. The main reasons are loss of capital and medical complications that prevent them to resume their livelihood.
Only 35% of the survivors are presently engaged in a livelihood activity. Out of those who are head of household, the majority are without livelihood activity. Women seem to be more affected, as 69% of women heads of household have no livelihood activity to provide for their family.

Medical: 96% of survivors present at least one or two medical complications. The most common ones are headaches, tiredness, joint and eye problems and loss of hair. It is important to note that only free medical treatment is available for eye problems, while for the rest, no free medical assistance is provided in the whole district and survivors pay for painkillers whenever possible. Medical complications and lack of reliable information are a source of stress for survivors who do not understand their medical condition and do not have the resources to get medical diagnosis.

Concluding, EVD has an important impact not only on survivors, but on their whole families due to numerous family losses in each household, loss of capital and livelihoods and in addition a number of medical complications that become a challenge to overcome the situation.
Quantitative results reveal that women seem to be more affected by psychological distress and livelihoods loss. Qualitative results and survivors' statements explain that in addition to having suffered EVD and loss of family members, the loss of livelihoods, medical complications, lack of autonomy and incapacity to provide for their families have a direct consequence on psychological stability of survivors making them more prompt to choose negative coping mechanisms that can put them at risk of a wide range of protection issues.

EVD impact can be comparable to a conflict impact in communities due to number of human losses, family and social bonds breakup, social and economic impact due to movement's restriction and reduction of trading, etc. EVD survivors and deceased patients' families need, as in any conflict and post conflict setting, a coordinated, integrated and systematic humanitarian assistance to reinforce their resilience capacity to overcome the impact of the disease in their lives.

It is important to stress the priority of an integrated approach of intervention including the most urgent needs of assistance: medical referral, psychosocial assistance and livelihoods support, all of them in short and long term interventions.

The main recommendations to improve the current situation of the survivors and improve the discharge process and follow up of future survivors are:

- More information about EVD medical complications and limitations for survivors need to be shared, as it has been noticed that medical status and complications have started to become a stressful factor for survivors after their discharge.
- Humanitarian assistance should strongly consider livelihood support activities and design integrated programs of livelihood and psychosocial support for EVD survivors and their families, providing basic needs coverage (food and NFI), vocational training and IGA.
- While survivors without current livelihood activity need funding support to start or resume an activity, any livelihood assistance provided should take into account the current health status of the survivors and medical referral should be prioritized or implemented in parallel with any livelihood activity
- Psychosocial support programs with family and community approach (family and peer groups seem to be one of the main positive coping mechanisms for survivors, a psychosocial support program designed in group, family and peer support may be a good option)
- Individual and group psychological support for those who are likely to have mental disorders in order to identify symptoms or to prevent the mental health disorders to develop.
- Reinforce awareness raising campaigns in the main chiefdoms with prevalent stigma and rejection for EVD survivors: Fakunya, Kaiyamba, Kori.
- Design spaces of dialogue and information campaigns to clarify with survivors the different assistance that they can access and under which criteria and which pathways, information about medical complications and to understand and address challenges for survivors, families and communities (focus group discussions, radio programs, etc.)
- Clarify and harmonize messages and advices for survivors at national level designed by a medical/psychosocial/social mob, task force of experts.
- To coordinate medical referral and follow up for all survivors presenting any medical complications.

Context and background

As of today, the District of Moyamba counts 208 confirmed EVD cases. Out of those 85 were recorded as survivors. Under the growing concerns of post EVD complications (medical, social and psychological), the psychosocial pillar of the DERC Moyamba requested for a research to guide and streamline understanding and responses to such concerns in a realistic and feasible way.

As planned in the EVD response structure, EVD patients and families receive PSS counselling during their treatment, and once recovered, the patients are accompanied back in their village of origin by the PSS teams. There, the teams emphasize on the need for survivors' community reintegration, dangers of stigmatization and the 90 days safe sex/abstinence rule.

As of now, the survivors have been followed up by the PSS Pillar, through community outreach, but no structured and comprehensive survey has been implemented to address their concerns in a systematic way. A better knowledge of the situation of the survivors was deemed helpful for the DERC and its partners to learn from experience how to better manage the medical and psychosocial support of the survivors, and to plan appropriate activities if deemed necessary. Some parts were also included to help the partners reflect on past activities and improve current existing support.

The objectives of the survey were as follows:

- Assess in general the situation of the survivors several weeks after their discharge
- Have a specific follow up of their psychosocial well-being
- Have a specific follow up of their medical condition
- Assess in general their living conditions in terms of community reintegration (including access to water and sanitation and livelihood)
- Highlight the need for further technical assessment or activities

This assessment initially targeted 84 of the 85 EVD survivors that have been discharged in Moyamba District by an authorized facility. The survey was mainly focused on their psychosocial situation and medical condition. It only rapidly collected information on their livelihood and water and sanitation situation, with the objectives of triggering in depth technical assessment if deemed necessary. This survey is meant to be qualitative above quantitative, but some numbers have been drawn from the questionnaire when possible and relevant.

All the medical data has been transferred to medical teams at the ETC of Moyamba in order to take action on urgent referral and medical follow up of the survivors. Other punctual referrals have been flagged to the DERC PSS Pillar or internally within partners.

Timeframe and location

This assessment has concerned the 85 survivors in Moyamba district of Sierra Leone, who had been discharged from different authorized facilities.
As specified in the methodology section and in the graphic below, EVD survivors in Moyamba have been found and visited in 8 chiefdoms out of the 14 chiefdoms of the district:

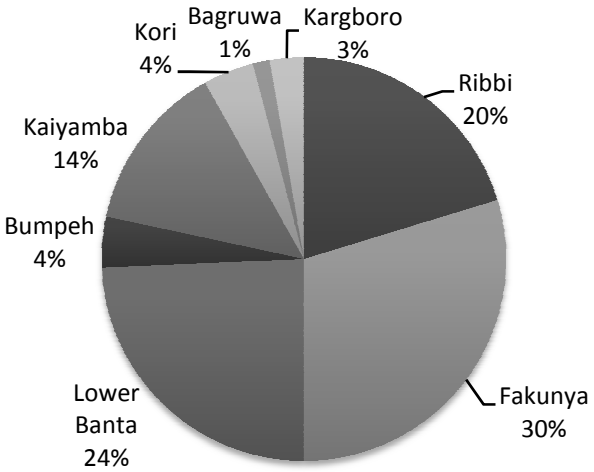


Figure 1- EVD Survivors geographical distribution in Moyamba District

The different stages of the assessment have been conducted in a period of two months. The first month (March-April 2015) being dedicated to draft the documents (ToR, questionnaire, guidelines, consent script form, survivors mapping and surveys geographic distribution) and formulate an agreement with DERC and the different members involved in the PSS Pillar.
Field data collection by the 15 agencies involved was conducted in two weeks, from April 9th until April 23rd, after one-day training on how to administer the questionnaire.
A general debriefing with all interviewers and a presentation of first findings and recommendations was conducted on the April 24th
Data entry by the two MdM and SI staff was finalized in one week, from the April 28th until May 6th
Analysis and reporting have been conducted in one week from the 7th until the 14th of May, the first draft having been submitted internally on the 15th of May for revision and comments.
The final version of the assessment report was submitted on May 29th 2015, two months after the inception of the assessment.

It is important to note that, in the case of replicating this assessment for other districts of the country, less time would be needed for the documents drafting and preparation and a recommendation would be to dedicate more time and resources for the field data collection process, having the time to debrief after each interview and to amend questions in basis of field recommendations.

Methodology

Informed consent: Each survivor was presented with a consent script (annex 4) that was read and explained to them. It was signed in two copies, one of them being left with the survivor. It contained the number to call in case of questions or complaints. No such call has been recorded at the time of writing. Out of the 74 survivors interviewed between the 10th and 27th of April 2015, all of them agreed with the consent form and the use of their personal data for referral purposes only.

Involvement of stakeholders: The survey was commissioned by the DERC PSS Pillar with MdM as main lead partner for organisation and data analysis. Terms of reference (annex 2) were agreed between partners before implementing the data collection activity and included the review of the questionnaire drafted by the DERC PSS Pillar and MdM/SI. The DERC Coordinator of Moyamba District formally validated the ToRs and its annexes. All the interviewers received the same training by MdM on the same day. Interviewers were debriefed during the data collection exercise and a feedback presentation was made by MdM after the data collection exercise.
The data entry and data analysis was conducted by MdM/SI and compiled in a draft of the present report. The draft was presented during a one-day validation workshop with all partners, in order to ensure all information and views expressed on the field were properly represented in the report. This report has been agreed on by the DERC Coordinator of Moyamba District.

Data collection: It was decided that semi structured interviews was the most relevant and efficient method to collect information on PSS and medical conditions of the survivors. The timeframe and the fact that it involved numerous partners did not allow for mixed methods to be implemented and it was deemed more important to allow sufficient time for individual discussions than for extensive questionnaires on parallel concerns. A questionnaire was discussed between partners and the DERC PSS Pillar and agreed on (annex 3). The interviews have been conducted by psychosocial and community workers contracted by the different partners. They all received the same training on field data collection and were given the associated guideline at the end.

Sampling frame: Given the small size of the population to be surveyed, the partners intended to interview all of them[1]taking into account an imposed convenience sampling implicated by the possibility that some individuals could refuse to be interviewed or that some individuals would not be found. Out of the updated 85persons that are recorded as survivors[2], the partners interviewed a total of 74 persons (87% of the total number of survivors), mainly because some people were not found or found to be relocated in another area.

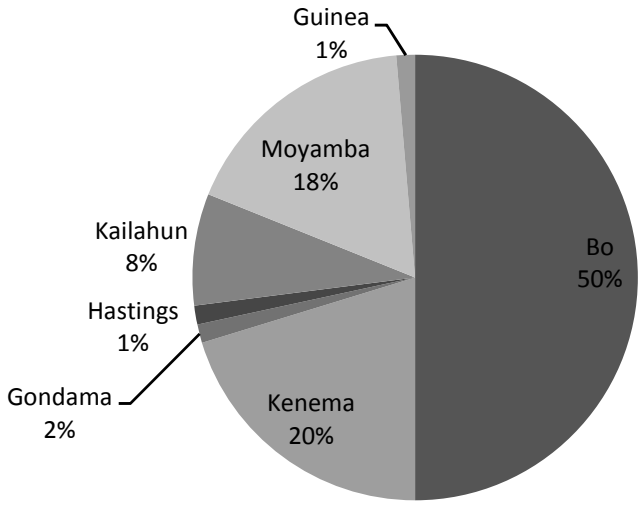


Figure 2 - Place of discharge of the interviewed survivors

The table below summarizes the number of persons interviewed per chiefdoms and the few specific cases that were encountered during data collection:

[2] 85 survivors initially recorded and 2 survivors found during data collection that were not initially recorded on the list

Chiefdom	Recorded	Interviewed	Not found	Relocated	Place of relocation	Deceased	Not recorded	Not EVD Survivor
Ribbi	16	15	0	1	Freetown	0	1	0
Fakunya	24	22	0	1	Timdale	1	1	0
Kaiyamba	12	10	1	1	Freetown	0	0	0
Lower Banta	22	18	0	2	Freetown	0	0	2
Kori	7	3	2	2	?	0	0	0
Bumpeh	3	3	0	0		0	0	0
Bagruwa	1	1	0	0		0	0	0
Kargboro	2	2	0	0		0	0	0
TOTAL	87	74	2	6		1	2	2

Figure 3- Number of persons interviewed per chiefdom and specific cases encountered

Extrapolation of the results: Considering that it was not possible to determine attributes of the surveyed population beforehand, this assessment can be representative only of the persons it surveyed and generalisation to all the survivors of Moyamba district is not possible. At national level, the partners did not dispose of enough comparative attributes to be able to assess possible extrapolation of Moyamba district's results to other districts. Although, the questionnaire could replicated with a smaller sampling frame in other districts in order to determine if that extrapolation is possible.

Rights and gender approaches: Rights and gender approaches were taken into account all along the study. First of all, it is important to stress that the study was commissioned by the PSS Pillar of Moyamba DERC and therefore, concerned only partners who are viewed qualified for such a task. The interviewers were also selected on these criteria by the different partners and they were all trained by the psychologist of Medicos del Mundo on how to conduct the interview and what attitude to adopt in case of challenges or urgent referral to be done. According to their age, interviews of children were conducted in presence of one of their parent or tutor, or directly with the parent or tutor. For the analysis that necessitated a gender or age approach, the results were disaggregated accordingly and are presented in each section as such.

Data protection: Individual personal data has been shared with some partners we had to refer cases to after the interview and providing that the interviewee agreed to it by signing the consent script. Referral information was given to the strict minimum necessary for the structure to be able to understand the object of the referral and to have the information needed to contact the concerned person.
The database not anonymized is protected and hasn't been shared outside of the two MdM/SI staffs that were charged with data entry and data analysis. A back up of this database can be found with the referent psychologist at Medicos Del Mundo headquarters in Madrid. The database was anonymized in order to be shared as raw data with some third parties analysts.

Results presentation: For each section, the report presents the number of respondents that are concerned by the analysis and precise the challenges encountered during the data entry and data analysis stage, if any. Unless notified, the number of respondents taken into account for analysis is 74.

Staff debriefing: Due to the sensitive information gathered in the assessment and the difficult situation that survivors have been going through since they were discharged, it have been deemed necessary to conduct regular debriefings with the interviewers after each day of field data collection. This has not been systematic for all partners involved in this assessment due to the limited time available; therefore a general debriefing was conducted with all partners at the end of the two weeks of field data collection. The objectives of the final debriefing were to leave a space for interviewers to express their feelings during and after administering the questionnaires, to gather from all interviewers the main difficulties encountered during the field data collection and to collect all interviewers' preliminary findings and recommendations regarding EVD survivors' situation and assistance.
A recommendation for future assessments of this nature, as stated above, would be to dedicate more time for the field data collection, allowing planning systematic debriefings with all interviewers, reviewing data and challenges after each day of interviews.

Dissemination: This report is intended for broad dissemination within the humanitarian community and its different forums of coordination and information. It is not subject to any restriction but should be properly cited if referred to.

Limitations and challenges

The survey was subject to several limitations. The ones presented hereafter are both the limitations that were expected and the ones that were highlighted during the field data collection and the analysis of the results.

- The survey did not enter into discussions with families of EVD survivors or with the communities they come from. It was decided that the survey should focus on individuals only but that the interviewers could ask further questions to third parties if they found it relevant to do so.

- While on the field, in some areas, it was particularly challenging to find a private space to discuss with the survivor. Consequently, the interviews didn't reach the level of confidentiality expected and some answers were clearly flawed because of this, as expressed during the debriefing of interviewers.

- The numerous partners associated to data collection, while a proof of comprehensive coordination by the DERC PSS pillar, made it challenging to ensure that data collection was harmonised. All the field workers received training on the questionnaire and were given the associated guideline, although the adjustments that were needed in the understanding of the questions and in how to collect the answers were not implemented at all times. The total number of answers taken into account for analysis is highlighted for each section.

- The data entry was not performed by the interviewers themselves but by the two referents from MdM and SI, to ensure continuity in the data entry and minimize dissemination of questionnaires. It is important to note that mistakes or misunderstandings could have been derived from this shift in responsibilities, although the training on the questionnaire and the debriefing times should have limited this margin of error.

- The interview was conducted by psychosocial and community workers, not by medical workers. They were trained on each part of the questionnaire including the medical part. Any medical condition that needed further investigation has been referred to and handled by a trained medical staff.

- While it seemed a better decision for each partner to cover questionnaires of their area of assistance or from some persons they already knew (e.g. the PSS team of the ETC of Moyamba interviewed the survivors that were discharged in Moyamba ETC), it could also add some bias to the interview. Although, it was decided that pre-existing contacts superseded the limitation of bias in this specific survey, where a lot of PSS related questions were asked.

- The survey was intended to be mostly a qualitative one. As such, a consequent part of the questionnaire leaves room for expression and interpretation. It was also asked to the interviewers not to insist on questions that were unanswered. Consequently, some quantitative data has been drawn from the questionnaire but are also impeded by theses constraints. Both qualitative and quantitative results presented in this report should be read with this specific limitation in mind.

- Geographic distribution of survivors throughout the district became a challenge for partners' mobility to reach all survivors.

- Even though the preliminary training for all interviewers was done with the aim of conceptual challenges limitation, local tribal languages became a challenge for some psychological concepts and questions.

Demographics and social characteristics of the surveyed population

Methodology Note: The demographics questions were not detailed ones, as the focus of the questionnaire was individual situations. Hence, it was not possible to clearly identify household situations and sex and age disaggregation of the households of the survivor. The global numbers related to households in this present report should be seen as theoretical ones subjected to possible misunderstanding by the interviewee or the interviewer, as numerous inconsistencies were found during the data cleaning process. No results could be extracted regarding the highest educational level of the respondents, as the question was generally unanswered.

A total of 74 survivors were interviewed or interviewed with or through a tutor for this study, the sex and age disaggregation being as follows:

Age/Sex	Male		Female		Total	
	Count	% of total interviewed	Count	% of total interviewed	Count	% of total interviewed
0 - 5	1	1%	0	0%	1	1%
6 -12	9	12%	3	4%	12	16%
13 - 17	4	5%	5	7%	9	12%
18 - 49	14	19%	31	42%	45	61%
50 - 59	1	1%	3	4%	4	5%
60+	1	1%	2	3%	3	4%
Total	30	41%	44	59%	74	100%

Figure 4- Age and sex disaggregation of the survivors interviewed

Women constitute 60% of the sample of interviewed. The majority of the survivors are adults, 30% being children, including one survivor under 5 years old. A typical household of a survivor[3] in Moyamba District is constituted of 9 to 8 members, 4 of which being males and 5 of which being females. They have on average[4] 4 children, including one under 5 years old. In total, at least 595 individuals[5] are indirectly linked to this survey as being survivors or being part of a survivors' household, a quarter of them being children. 58% of the adults[6] interviewed are head of household, out of which 31% are female head of household. In other terms, almost half (44%) of the female adult survivors interviewed are the head of household, while almost all (88%) of the adult men survivors interviewed are the head of household. No survivor children were recorded as being the head of household.

Half of the adult survivors interviewed are married, while 32% of them are widowers. We notice that those numbers vary consequently according to gender. 80% of men are married for only 40% of the women and 7% of men are widowers, against 43% of the women. Out of all the women who provided their marital status, one third of them are both widowers and head of household, which households comprises on average 7 to 8 members, 5 of them being children. No children were recorded as being married, widower or divorced.

[3] For this demographics section, 53 respondents were taken into account on number of children, and 57 on household size and sex disaggregation taken into account. Given the inconsistencies deleted during data cleaning, those numbers have to be considered with caution.
[4] The calculation of the median gives fairly similar numbers
[5] 66 respondents gave a number on the size of their household. It seems that some of those respondents did not count themselves or their spouse as part of the household size when asked. Hence the expected number of individuals indirectly linked to this survey as being survivors or being part of a survivors' household should be greater than 595 individuals.
[6] 18 to 60 + years old included

	Male[7]		Female[8]		Total	
	18-60+ incl.	%	18-60+ incl.	%	18-60+ incl.	%
Single	2	13%	5	14%	7	14%
Married	12	80%	14	40%	26	52%
Widow	1	7%	15	43%	16	32%
Divorced	0	0%	1	3%	1	2%

Figure 5 - Marital status of adult respondents

Regarding the main occupation[9], all children were referred to as students. Most of the adults (40%) declared themselves as being traders, petty traders, businessmen or businesswomen, and a third of them as farmers. The complete table can be found in annex1.

	Male		Female		Total	
	18 - 60+ incl.	%	18 - 60+ incl.	%	18 - 60+ incl.	%
Farmer	6	13%	8	17%	14	29%
Trader/Business	2	4%	17	35%	19	40%
Total	8	17%	25	52%	33	69%

Figure 6- Main occupation of adult survivors[10]

Muslims constitute74% of the interviewed and Christians constitute 26%, out of 73 respondents. The majority of the interviewees identified themselves to the Mende Tribe (55%) or to the Temne tribe (31%). The complete table on tribe can be found in annex 1.

Recommendations

- Ensure sex and age disaggregation and questions on household size are well understood by interviewee and interviewer
- Ensure questions on educational level of respondents are understood.

[7] Out of 15 respondents
[8] Out of 35 respondents
[9] Understood as usual daily work and qualification, not as current livelihood activity
[10] Out of 48 respondents

Findings

Psychosocial

- ### Discharge

Methodology note: The initial part of the psychosocial questionnaire was designed to understand how the discharge was done and if an appropriate accompaniment was conducted upon discharge. Respondents were asked if they had been accompanied or not, by whom and how did they value the fact of being accompanied.

Results of the impact of being accompanied show that this action has been very positive for the psychosocial status of survivors; 90% of survivors accompanied declare having felt happy to come back and being discharged from the ETC; 40% of them (those accompanied by ETC staff) specified the fact of being accompanied as a key factor for their reintegration, dignity, respect and acceptance.

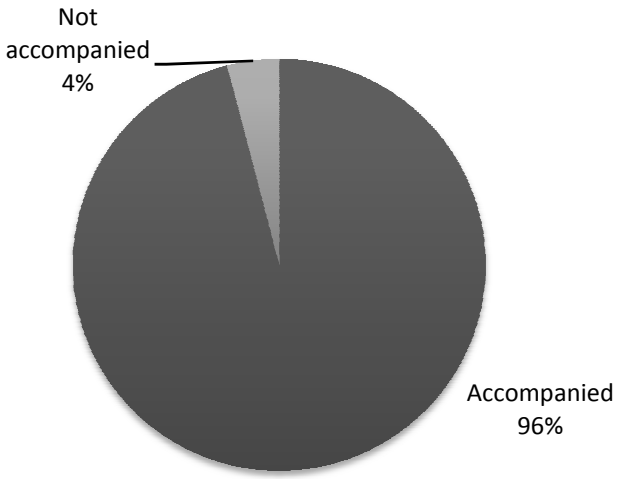


Figure 7 - Accompaniment at discharge

96% of the survivors have been accompanied to their villages of origin upon discharge from the different treatment facilities; only a 4% of the survivors in Moyamba district were not accompanied.
42% of the survivors declare having been accompanied by the ETC medical or psychosocial staff; 24% declared having been accompanied by MSGWCA staff; 15% have stated that the DHMT health workers accompanied them to their villages; 9% have been accompanied by NGOs not related to the treatment facilities (World Vision, ACF and Action Aid) and finally 10% didn't identify who accompanied them or do not remember it.
Only 4% of the survivors stated bad feelings upon discharge for different reasons: 1 survivor declared to be sad and not feel good because the health team that accompanied him didn't sensitize the community so the accompaniment was not as useful as it could have been. 2 other survivors explained that they felt bad anyways because they had been the only survivors of the group that was admitted in the ETC at the same time as them, and 1 survivor stated that the accompaniment was not useful, as he was accompanied by a driver, without any medical or psychosocial team.
It seems that accompaniment works better when the ETC or MSGWA staff are the ones doing it, in particular if there is specific psychosocial team at the treatment facility. The survivor and the family are already familiar with them, and the accompaniment has more positive impact and avoids confusion.

Recommendations

- Accompaniment has a positive impact on survivors' dignity, respect and confidence and should be systematized
- When possible, plan for the ETC staff to accompany the survivor back in his community

- It is always necessary that a PSS or health technical staff accompany the survivor, and talk to neighbours and community to ensure his/her condition is well understood to facilitate the reintegration
- Discharging a survivor has to continue to be taken as a good opportunity for psychosocial teams or health workers to sensitize the community

• Main impact of EVD on survivors' life

Methodology note: this is a qualitative stand-alone open-ended question for survivors to express what has been the main impact of EVD in their life. Two survivors didn't answer it and two children were too young to reply. Its open-ended nature leaves the space for survivors to say whatever are for them the main challenges and impact related to EVD.

42% of the survivors that replied to the question have expressed that the loss of job, loss of capital, loss of the main breadwinner in the family and in general loss of livelihood, has been the main impact of EVD in their life, the main challenge and source of unhappiness or stress.
47% mentioned the loss of family members as the main impact and source of unhappiness or stress. It is important to note that 100% of these survivors have mentioned multiple losses in the family (both parents, more than two children, husbands, wives, etc.)
15% mentioned psychological feelings and status as the main impact and challenge after surviving EVD. These feelings being: discouragement, bad feelings, abnormal behavior (4 year old boy), unhappiness and trauma.
9% mentioned their medical complications and current health status as the main challenge and impact of EVD.
Only two survivors gave positive answers for EVD impact: one mentioned that he found a job in an EVD observation facility and the second one stated that after having survived to EVD, everything is possible.

Regarding children in particular:
50% of them expressed that the loss of family members was the main impact of EVD in their lives.
23% mentioned the schools closure as the main impact, not having been able to go to school after their discharge.
And 10% mentioned the loss of family livelihood as a main impact and challenge after EVD (parents having lost their jobs or their capital, parents having passed away and therefore the child has to work)

• Introduction to feelings

Methodology note: This is a qualitative initial part to open the questionnaire to psychological issues. Survivors were asked to answer to one closed question (bad, weak, moderate, good or very good) to open a discussion on general feelings. The main limitation and challenge in this section regards the common understanding of feelings and mental health, as a lot of respondents chose the answer "good" only because they state they are not "crazy", while in the next parts of the questionnaire, good would not be the word that defines their situation in the best way.

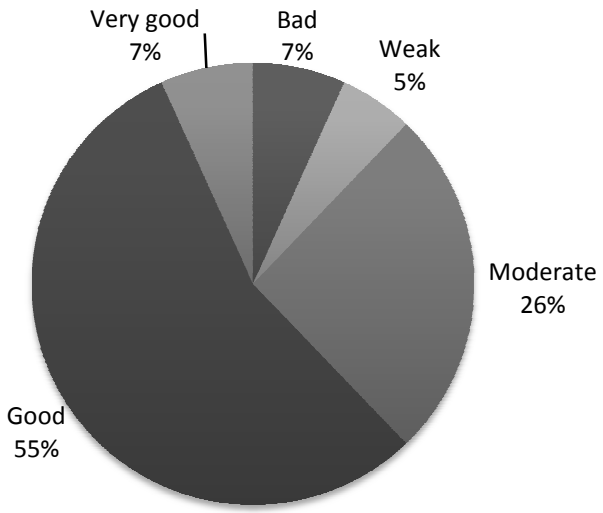


Figure 8 - General feelings

It is important to note the reasons explained by survivors:

- In the cases where bad, weak and moderate feelings were declared, the reasons for negative feelings were concentrated in medical complications and limitations after survival (20% of responders) and loss of family members (10%). Medical status and complications have started to become a stressful factor for survivors after their discharge.
- In cases were positive answers were given, the reasons were focused on non-mental health problems (not being "crazy" – 33%), the fact of having survived to EVD (14%), the fact of having received NFI and cash assistance (1 person) and the community acceptance (1 person).

Recommendations:

- Mental Health and psychosocial support needs to be contextualized and adapted to bias and beliefs. A community approach is recommended to work on psychosocial and mental health issues and to clarify that mental health and feelings are not always related to craziness. Mental health interventions recommended are support groups and individual sessions regarding two main issues:
- Multiple and complicated losses
- Positive mental health status and feelings
- More information about EVD medical complications and limitations for survivors need to be shared, as it has been noticed that medical status and complications have started to become a stressful factor for survivors after their discharge.

• Psychological distress, coping mechanisms and protective factors

Methodology note: This section concerns only psychological status of the survivor, through two groups of questions:
The first part and group of questions is the standard "Kessler Psychological Distress Scale"[11], provided by WHO for the survivors' psychological assessment. This is a 10-item questionnaire intended to yield a global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent four-week period.
The second part is a group of opened questions to get more information about the person and his/her specific coping mechanisms and protective factors that could be enhanced through a psychosocial intervention.

The scoring and interpretation of Kessler Scale reveals that 48% of the survivors interviewed who answered the psychological questionnaire[12] present some signs and symptoms of distress.

[11] Kessler, R.C., Andrews, G., Colpe, .et al (2002) Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychological Medicine, 32, 959-956.
[12] 73 survivors answered completely the Kessler scale questionnaire

As presented in the graphic below and the table, 27% of survivors interviewed are likely to have a mild mental disorder; 10% are likely to have a moderate mental disorder and 11% are likely to present a severe mental disorder[13].

Score	Interpretation	Count	%
Under 20	Likely to be well	38	52%
20 - 24 points	Likely to have a mild mental disorder	20	27%
25 29 points	Likely to have moderate mental disorder	7	10%
More than 30 points	Likely to have a severe mental disorder	8	11%
	Total	**73**	**100%**

Figure 9 - Kessler scale scoring

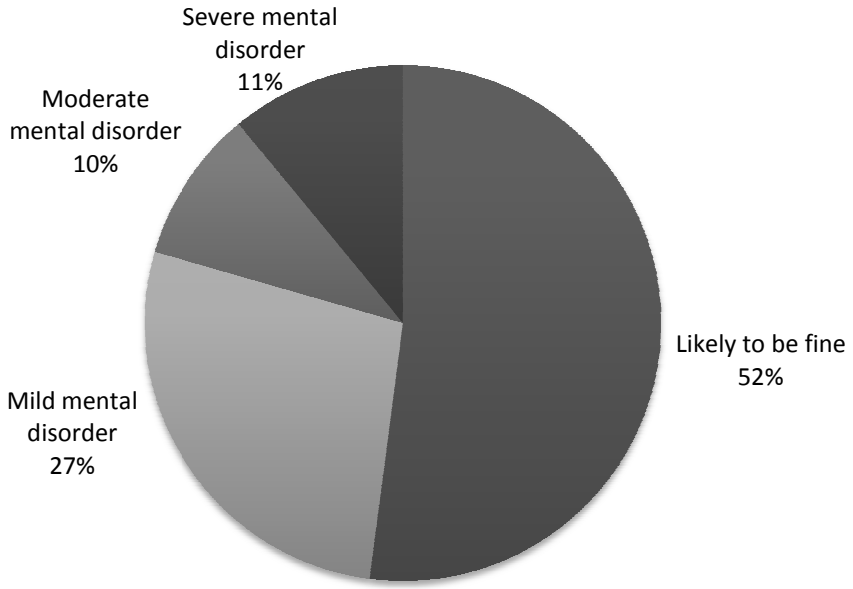


Figure 10 - Psychological distress

The table below presents a disaggregation by gender regarding the psychological impact of EVD, even though the prevalence of women in all categories may be explained by the superior number of women survivors in general.

[13]Kessler R. Professor of Health Care Policy, Harvard Medical School, Boston, USA.

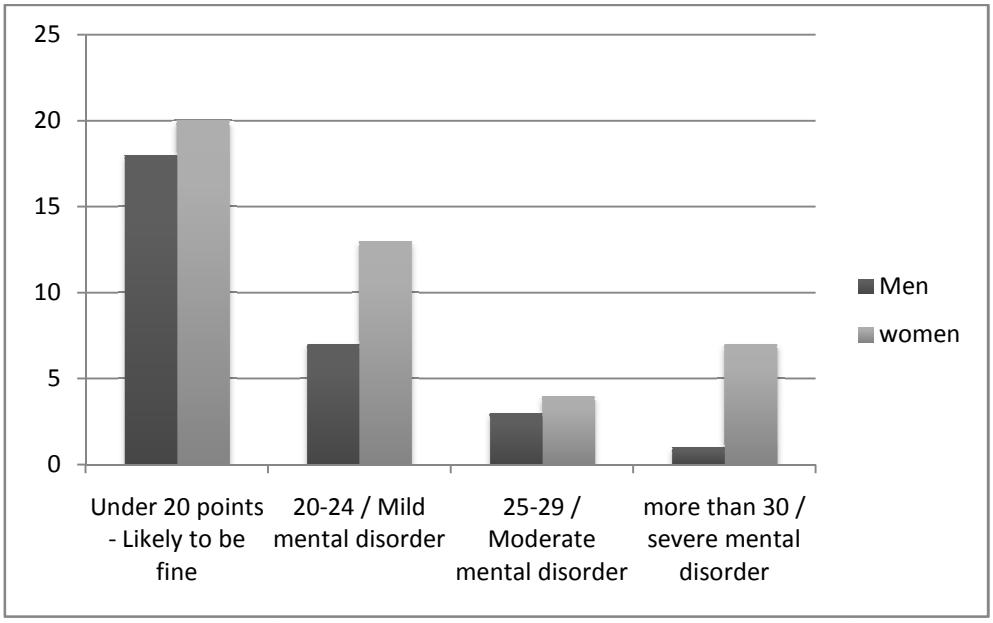


Figure 11 - Psychological distress by gender

Regarding the different feelings in the questionnaire (nervous, restless, depressed, tired, hopeless, sad) the most common ones are those referring to hopelessness, tiredness, sadness and depression rather that nervousness or restlessness.

It is important to note that results do not mean that people are already suffering from mental health disorders, but that they are more likely to experience them.

For the second group of opened questions, some challenges were encountered, as protective factors and coping mechanisms (thoughts and actions to overcome bad feelings) where difficult to understand for almost all survivors. Even though some conclusions can be drawn:

- 46% of survivors interviewed[14] declared interaction with family and friends, as their best way to overcome bad feelings and thoughts, and 18% stated that thinking about living relatives was their best positive thought.
- 14% declared that faith, hope in God and praying was their solution to overcome bad feelings;
- 31% (all children from 6 to 20) play with friends as their first coping mechanism;
- Finally 7% declared that sleeping and resting is the only way to overcome bad thoughts.

Regarding opened questions about the future, 16% of the respondents[15] declared to have a negative vision of their future, being worried about their current situation, while 81% have some hope in their future to be better, nevertheless this hope is completely linked to getting support for education and/or livelihood activities in order to restart their life, support their family and overcome the current situation.
Taking the most repeated feelings mentioned in the previous section and comments made by survivors in this opened questions, it appears clear the link between hopelessness and depression with the lack of autonomy the survivors have found once they were discharged from the ETC. The only way to look into a brighter future as they state, is to find support to run again livelihood activities to feed their family and allow children to go to school.

As stated by Maslow[16](pyramid below) five stages can be divided into basic (or deficiency) needs (e.g. physiological, safety, love, and esteem) and growth needs (self-actualization).
The deficiency or basic needs are said to motivate people when they are unmet. Also, the need to fulfil such needs will become stronger the longer the duration they are denied. Maslow's theory suggests that the most basic level of needs must be met before the individual will strongly desire (or focus motivation upon) the secondary or higher level needs. One must satisfy lower level basic needs before progressing on to meet higher level growth needs. Once these needs have been reasonably satisfied, one may be able to reach the highest level called self-actualization.

[14]70 survivors answered completely this section
[15]Only 69 aswered completely this question
[16]Maslow's theory (1943, 1954) *Hierarchy of needs*

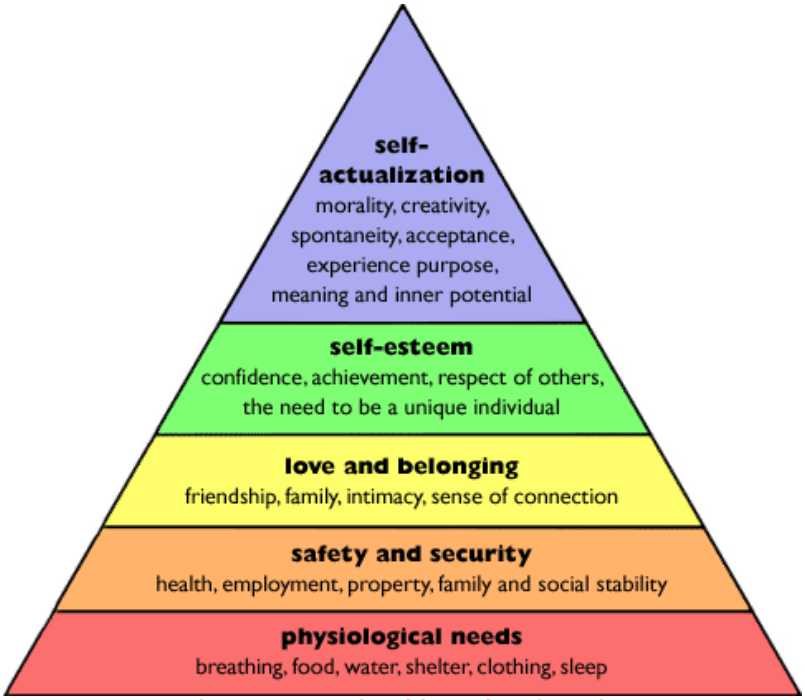


Figure 12 - Maslow hierarchy of needs

Recommendations:

- Design and implement integrated programs of livelihood and psychosocial support for EVD survivors and their families, providing basic needs coverage (food and NFI), vocational training and IGA, everything accompanied by a psychosocial support program.
- Design a psychosocial support program with family and community approach: as family and peer groups seem to be one of the main positive coping mechanisms for survivors, a psychosocial support program designed in group, family and peer support may be a good option
- Individual and group psychological support for those who are likely to have mental disorders in order to identify symptoms or to prevent the mental health disorders to develop.

• Stigma

Methodology note: this part of the psychosocial questionnaire was designed to quantify how many survivors have been suffering stigmatization, rejection or fear in their community reintegration process, and to understand through some qualitative and opened questions, some examples of rejection and stigma that they have suffered to better inform strategies to address this kind of situations.
The main limitation was the survivors understanding of both concepts of stigma and rejection, even if those concepts and the questionnaire had been tested before and concepts seemed to be very clear even in local language, definition and examples given by responders are not really different.

Surprisingly, only 28% of the total of survivors assessed (74) declared having been stigmatized and rejected by their community upon their arrival. Some examples given where:

- The community isolated me and my family
- Nobody was approaching our house when we came back
- Nobody wanted to buy anything from me
- Everyone feared to be infected near my family
- People was saying that I brought EVD to the community and the district
- Nobody come close to me and they isolate me
- All neighbours moved away from our compound
- People fear me in church
- People talked about us very badly
- People point fingers at me
- Some people wish I have died
- People humiliated me
- They rejected me in a shop so I couldn’t even buy rice

- People stopped visiting our house

And 8% of survivors interviewed declared having faced security concerns since they came back to their community:

- One security officer attacked me not to use the public street
- People said we must leave this community
- Fear of being attacked by community people

It is important to note that survivors stated during the survey that stigmatization and rejection were normal upon their arrival to the community but that after a few months it has been reduced.
Finally, the assessment has revealed that stigma; rejection and community reintegration of EVD survivors differ among chiefdoms.
All survivors having suffered stigma, rejection and fear come from five chiefdoms: Fakunya, Kaiyamba, Kori, Ribbi and Bagruwa. 71% of all survivors having stated rejection and stigma are from Fakunya, 14% from Kaiyamba and only one from Ribbi and one from Bagruwa.

Recommendations:

- To reinforce awareness raising campaigns in the three main chiefdoms with prevalent stigma and rejection for EVD survivors: Fakunya, Kaiyamba and Kori.
- Review and compare social mobilization and psychosocial work implemented in other chiefdoms where stigma seems to have been reduced
- Design community based psychosocial interventions and focus group discussions to better understand and address challenges for survivors, families and communities.

Livelihood

Methodology Note: This part of the questionnaire was designed only to get a minimum of information about the current possibility of survivors to provide for themselves and the identified challenges in order to do so, but was not intended as giving a comprehensive outlook into occupation specificities. Similarly, one question was asked regarding the changes in market prices and was designed to get a general idea of the changes in price at chiefdom and district level, not to enable a methodology-proof view of market prices fluctuations or market chains disruption.

• Past and current livelihood activity

Two thirds of the adult women and one half of the adult men who survived EVD lost the livelihood activity they were engaged in before contracting the EVD. Before the EVD outbreak, the totality of women had a livelihood activity against 88% of men, but after the disease, less women than men have a livelihood activity. The main livelihood activities are unchanged and revolve around trading, petty trading and farming. We note that 2 survivors are now working in an EVD related facility.

For those who haven't been engaged in a livelihood activity[17] after contracting the EVD, they mainly cite the lack of funds or more generally of resources and sometimes insist on the fact that the capital they previously had has been lost. 7 of them explained that their physical conditions and/or their poor health status weren't allowing them to resume or start a livelihood activity. 4 persons simply said that they had no livelihood activity due to the EVD but it is unclear what consequences they are referring to, while 1 clearly mentioned stigmatization as the reason for not having a livelihood activity. 1 person mentioned that the poor health of one family member did not allow him/her to engage into livelihood activity, and 1 other mentioned that the loss of a family member made it difficult for him/her to do it. 1 survivor mentioned helping its relatives in their own livelihood activity. The detailed table of livelihood activities before and after the survivors contracted the EVD is in annex 1.

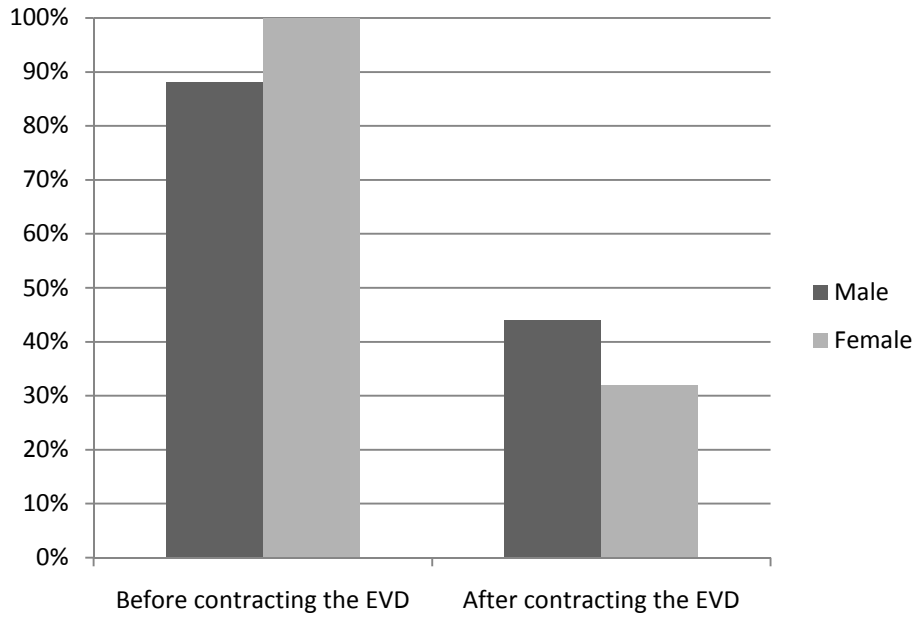


Figure 13 - Percentage by gender engaged in a livelihood activity before and after contracting the EVD

At present, only 32% of the survivors are engaged in a livelihood activity. Out of those who are head of household, the majority are without livelihood activity. Women seem to be more affected as 74% of women have no livelihood activity at present to provide for their household, against 56% of men.

[17] 32 respondents

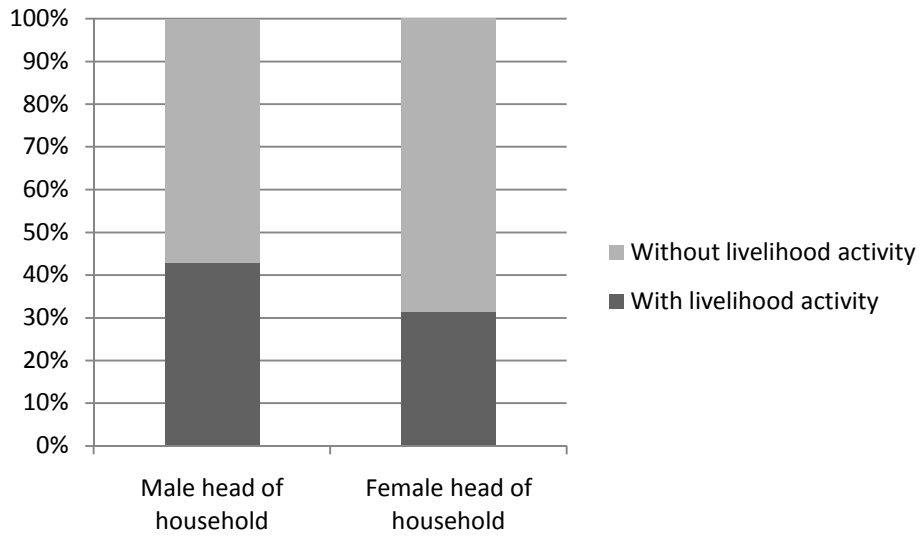


Figure 14 - Percentage of head of household with and without livelihood activities at present

Before contracting the EVD, 2 children declared being engaged in a livelihood activity, both being 17 years old and engaged into garden work and carpentry. All children were enrolled in school at the time of the survey.

83% of the respondents[18] said they noticed a change in the market prices since the start of the EVD outbreak. While it was impossible to draw rigorous representative data out of the examples that were cited, it is still good to note that the average increase in prices for all cited items is 36%, and that the most cited examples were rice, palm oil, pepper, food stuff in general and clothes or related (including fabric or sewing). The detailed table of the examples that were cited by the interviewees can be found in annex 1.

Recommendations

- Humanitarian assistance should strongly consider livelihood support activities for survivors
- While survivors without current livelihood activity need funding support to start or resume an activity, any livelihood assistance provided should take into account the current health status of the survivors and medical referral should be prioritized or implemented in parallel with any livelihood activity

[18] 69 respondents

Water and sanitation

Methodology Note: This assessment did not intend to focus on the situation of the survivors in water and sanitation, but it was deemed interesting to add a few water and sanitation questions in case it highlighted some concerns and in case it could be linked to the medical questionnaire. While the study did not link the water and sanitation section with the livelihoods section of the questionnaire, it is a shortfall that should be addressed if the study is replicated. It is good to remind at this stage that the study is representative only of the survivors interviewed and cannot be extrapolated to the community they live in.

The respondents could select several water sources, without precision on which one was the primary one. Most of the survivors (42%) currently get their drinking water from a hand dug well, operated with a bucket. The second most cited source of water is the stream/creek (24%). Close to a half of the survivors[19] explained that they were treating their water, but some broad differences can be noticed according to which sources of water they use.
More than half (57%) of the persons collecting water at a borehole will treat it afterwards, and as much as 79% treat the water coming from a hand dug well, while 94% of the persons drinking water coming from a stream/creek declare not treating this water (The complete table can be found in annex 1). Chlorine is the only declared mean of treatment for the drinking water. While we cannot draw chiefdom specific results for each of them, we can note that all the respondents from Ribbi declared not treating their water[20] and that half of them take their water from a stream/crick. For Lower Banta, out of 18 respondents, 7 do not treat their water and out of those 7, 6 take their water from a stream/crick.

Drinking water source	Count	%
Borehole	7	8%
Network/ water tower/ water tank	0	0%
Hand dug well - bucket	35	42%
Hand dug well - pump	10	12%
River	1	1%
Stream / creek	20	24%
Purchase	5	6%
Other	3	4%
NA	2	2%
Total	83	100%

Figure 15 - Drinking water sources

82 % of the survivors declared using a collective or familial latrines, 12% said they had no specific latrine to use. Out of those 82%, 33 use a collective latrine and 67% use a family latrine. 77% of the survivors declare that all of the family members are using a mosquito net, and 15% say that a part of the family is using it. Only 7% of the survivors said they do not have any mosquito net.

Recommendations:

- Further assess drinking and raw water needs in Moyamba District, both for health, hygiene and livelihood purposes
- If an assessment is launched, Ribbi and Lower Banta could be considered in priority

[19] 73 respondents
[20] 15 respondents for Ribbi Chiefdom, one did not answer.

Medical

Methodology note: The questionnaire has been conceived by the medical team in the ETC Moyamba and validated by WHO and DERC-DHMT.
The questionnaire is divided into six sections: eye problems, neurological problems, headache, joint problems, general symptoms, abdominal symptoms and other symptoms.
Survivors were expected to answer Yes/No to each symptom, and if yes, since when they were experiencing them and if any treatment started.
This questionnaire is designed to provide information about typical medical complications for EVD survivors, to understand if they have already been offered any treatment and to identify and refer those who need immediate medical attention.

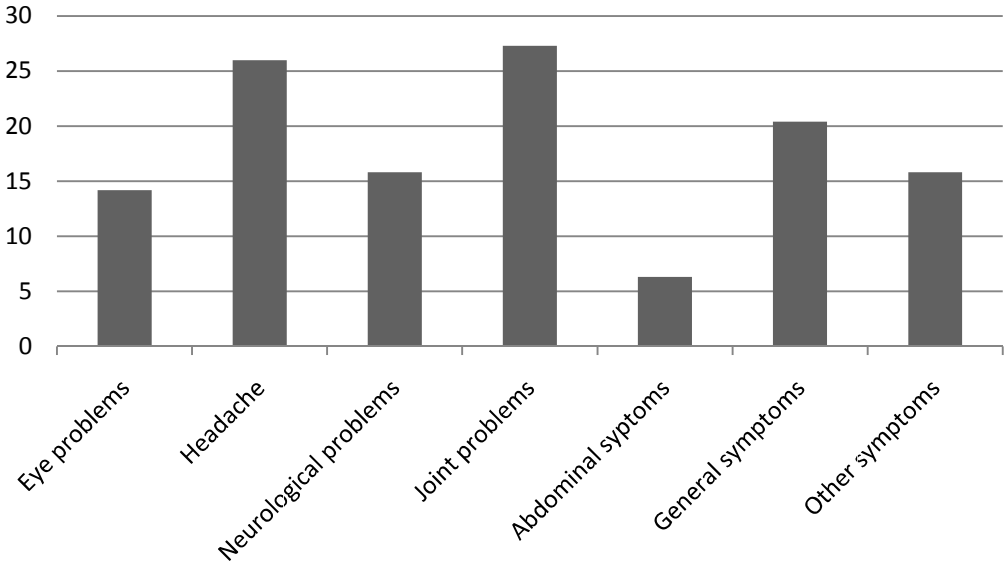
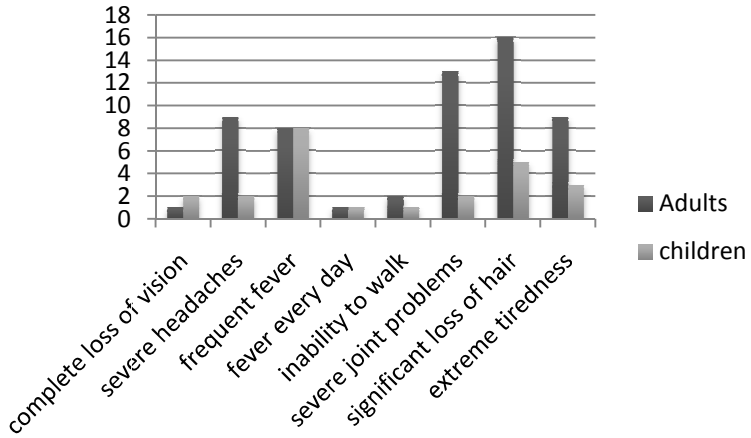


Figure 16 - Average of medical categories complications

96% of all survivors interviewed[21] present at least one or two medical complications. Only 3 survivors declared not to have any symptom out of the medical questionnaire.
Analysing the average medical complications, eye problems, joint discomfort and general symptoms as tiredness and loss of hair are the main medical problems suffered by EVD survivors several months after their discharge.
In the tables below, the information breakdown about all symptoms in the questionnaire for each category is available including differences among women and men and adults and children survivors.

- ## Severe medical complications



[21] 73 survivors answered the medical questionnaire

Symptoms		Male adult	Male minor	Total male	Female adult	Female minor	Total female	Total adult	total minor	Total survivor #	total survivor %
Eye problems	Itching	6	4	10	24	3	27	30	7	37	51%
	Ocular redness	5	4	9	6	1	7	11	5	16	22%
	Eyelids inflammation	3	1	4	10	1	11	13	2	15	21%
	Ocular redness with blurred vision	2	1	3	10	3	13	12	4	16	22%
	Complete loss of vision (one or both eyes)	0	1	1	1	1	2	1	2	3	4%
Headache	Mild headache	9	4	13	24	5	29	33	9	42	58%
	Frequent headache	5	3	8	15	2	17	20	5	25	34%
	Severe headache hindering daily activities	2	1	3	7	1	8	9	2	11	15%
Neurological	Paraesthesia	3	3	6	11	4	15	14	7	21	29%
	Loss of strength in some arm	7	4	11	13	0	13	20	4	24	33%
	Significant loss of strength in arms	3	0	3	6	0	6	9	0	9	12%
	Loss of strength in one leg	3	3	6	14	2	16	17	5	22	30%
	Inability to walk	0	0	0	2	1	3	2	1	3	4%
Joint problems	Joint discomfort	3	1	4	33	3	36	36	4	40	55%
	Severe joint pain requiring painkillers	5	1	6	20	1	21	25	2	27	37%
	Severe pain in one or more joints with inflammatory signs that have limited my daily life	5	1	6	8	1	9	13	2	15	21%
General symptoms	Weight loss	6	3	9	18	1	19	24	4	28	38%
	Significant weight loss for over 5 Kg	1	2	3	4	1	5	5	3	8	11%
	Eating less than before	7	5	12	16	0	16	23	5	28	38%
	Feeling tired	13	5	18	26	5	31	39	10	49	67%
	Feeling so tired not able to leave home	3	2	5	6	1	7	9	3	12	16%
	Fever of more than 38º some days	3	6	9	5	2	7	8	8	16	22%
	Fever of more than 38º every day	1	1	2	0	0	0	1	1	2	3%
Abdominal	Abdominal pain some days	3	2	5	10	2	12	13	4	17	23%
	Abdominal pain almost every day with vomiting	0	1	1	0	0	0	0	1	1	1%
	Continuous abdominal pain impossible to eat	0	1	1	0	0	0	0	1	1	1%
Other symptoms	Loss of hair	1	1	2	26	7	33	27	8	35	48%
	Significant loss of hair, changing appearance	0	1	1	16	4	20	16	5	21	29%
	Skin spots	2	1	3	8	1	9	10	2	12	16%
	Skin problems with itching	4	3	7	11	2	13	15	5	20	27%
	Submandibular swelling	1	0	1	1	1	2	2	1	3	4%
	testicular pain	2	0	2	0	0	0	2	0	2	3%
	testicular pain and inflammation	2	0	2	0	0	0	2	0	2	3%

- **Eye problems**

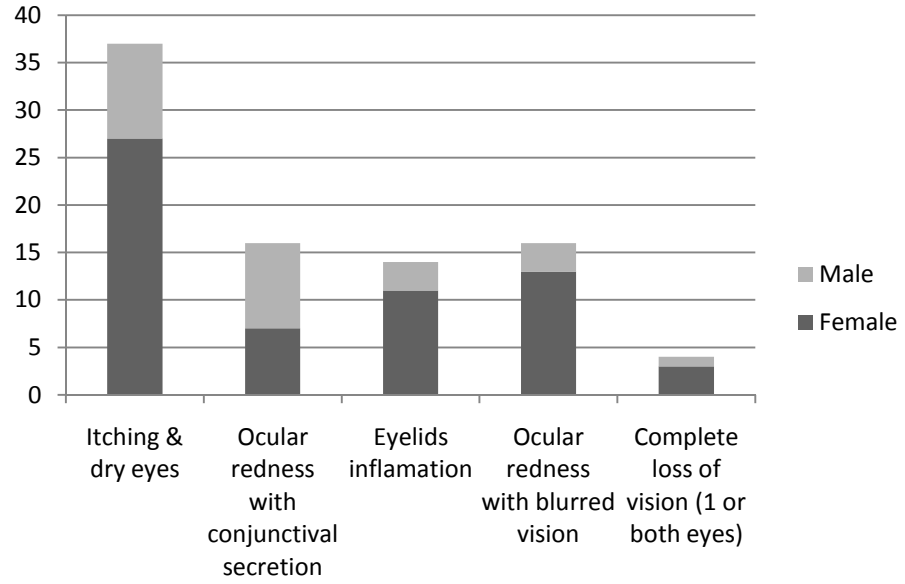


Figure 17 - Eye problems

Itching and dry eyes is the most common medical complication for this category, being present for 51% of the survivors who answered to medical questions[22]. Women representing 73% of cases.
3 female reported complete loss of vision of one or both eyes, needing urgent medical attention (one 15 years old girl)

- **Headaches**

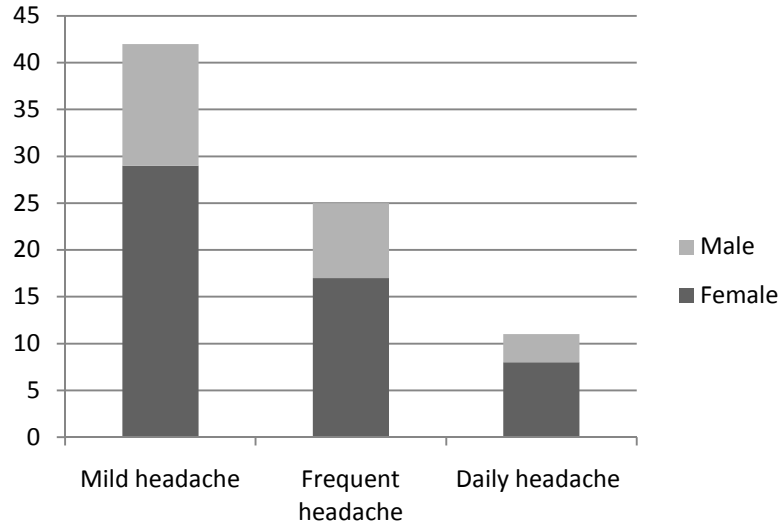


Figure 18 – Headaches

57% of EVD survivors present sporadic headaches and 15% of survivors experience severe headaches hindering daily activities.
No medical assistance has been provided for this kind of problems, and survivors stated to be paying for painkillers whenever possible.

[22]73 survivors answered the medical questionnaire

- **Neurological problems**

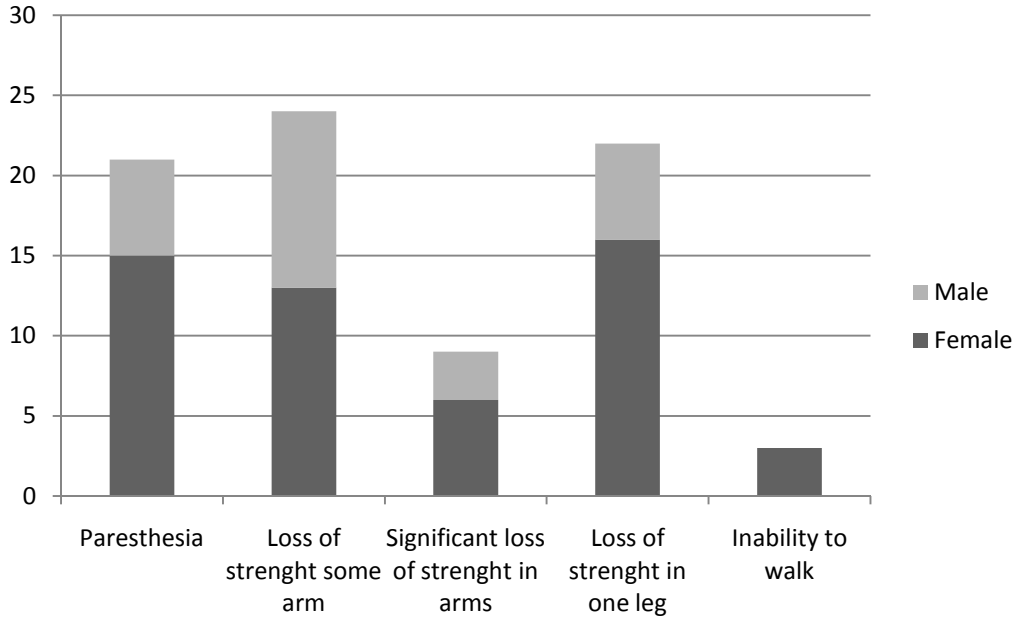


Figure 19 - Neurological problems

33% of survivors present loss of strength in some arm and 30% in some leg.
29% declare to be experiencing paraesthesia.
3 survivors stated severe loss of strength in legs causing inability to walk and 9 present severe loss of strength in the arms hindering their daily activities
No significant differences among gender to report.

- **Joint discomfort**

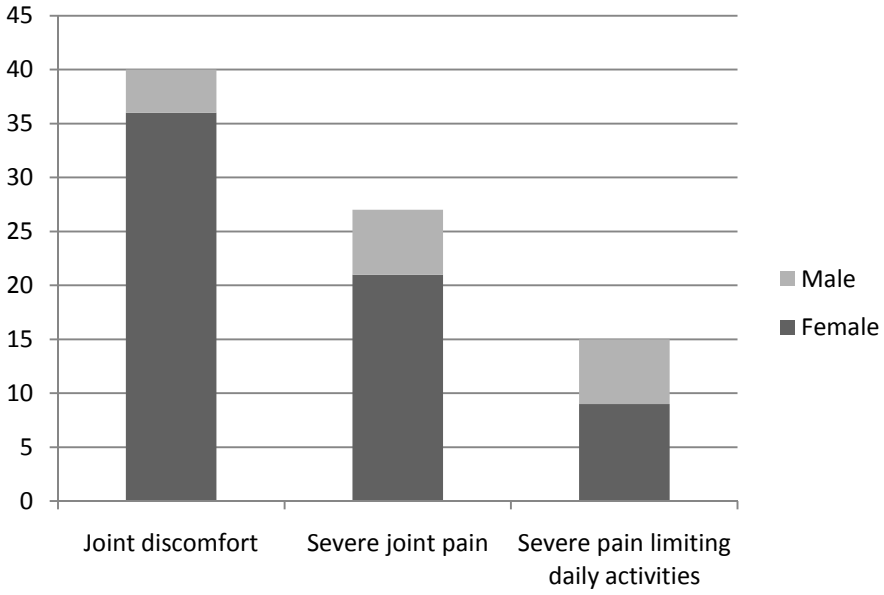


Figure 20 - Joint discomfort

55% of survivors present some joint discomfort after several months upon discharge, women representing 90% of cases.
37% experience severe joint pain, and 20% have severe pain limiting daily activities.
Any survivor has received medical assistance for this kind of problems and those who can, buy painkillers for it.

- **General symptoms**

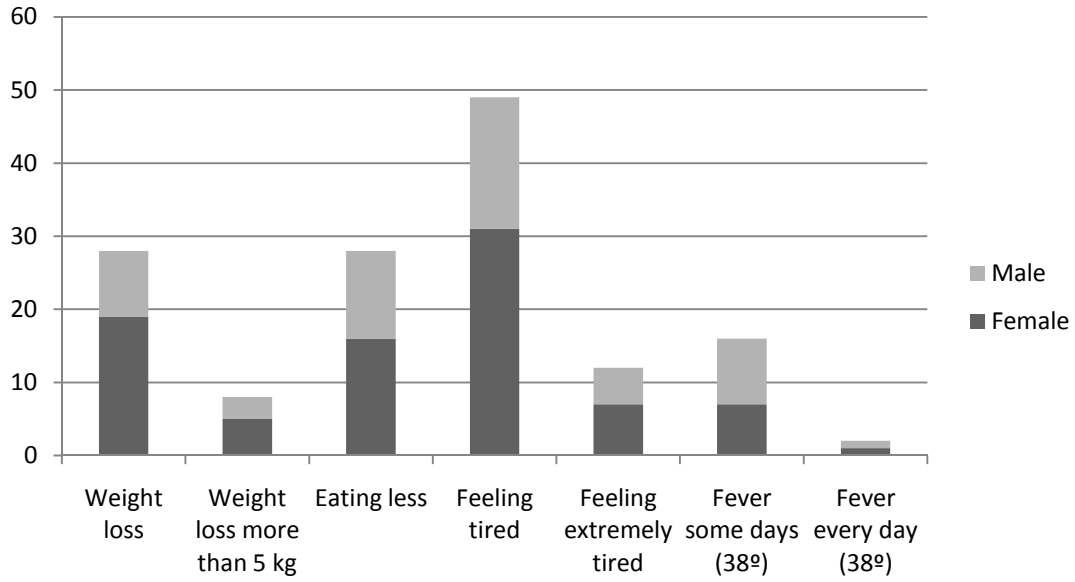


Figure 21 - General symptoms

Tiredness is a common symptom, reaching 67% of survivors.
Weight loss and eating less have been declared by 38% of survivors
No significant difference among men and women.

- **Abdominal symptoms**

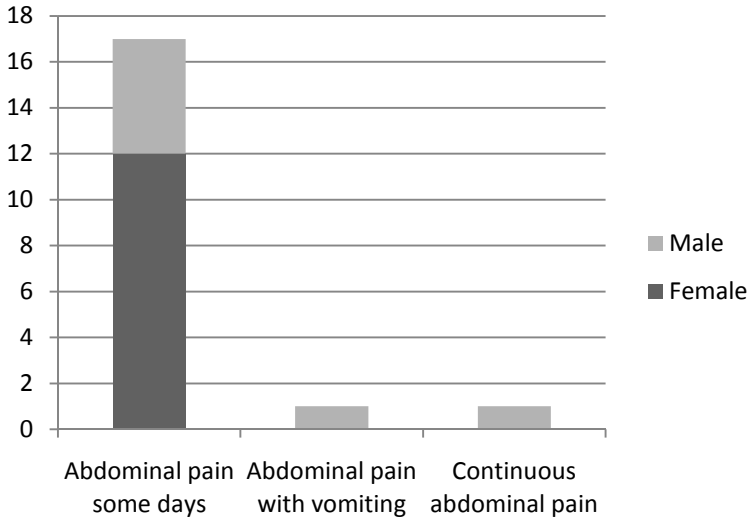


Figure 22 - Abdominal symptoms

Abdominal pain is less prevalent as medical complication; nevertheless 23% of survivors present some abdominal pain, women representing 60% of the cases.

- **Other symptoms**

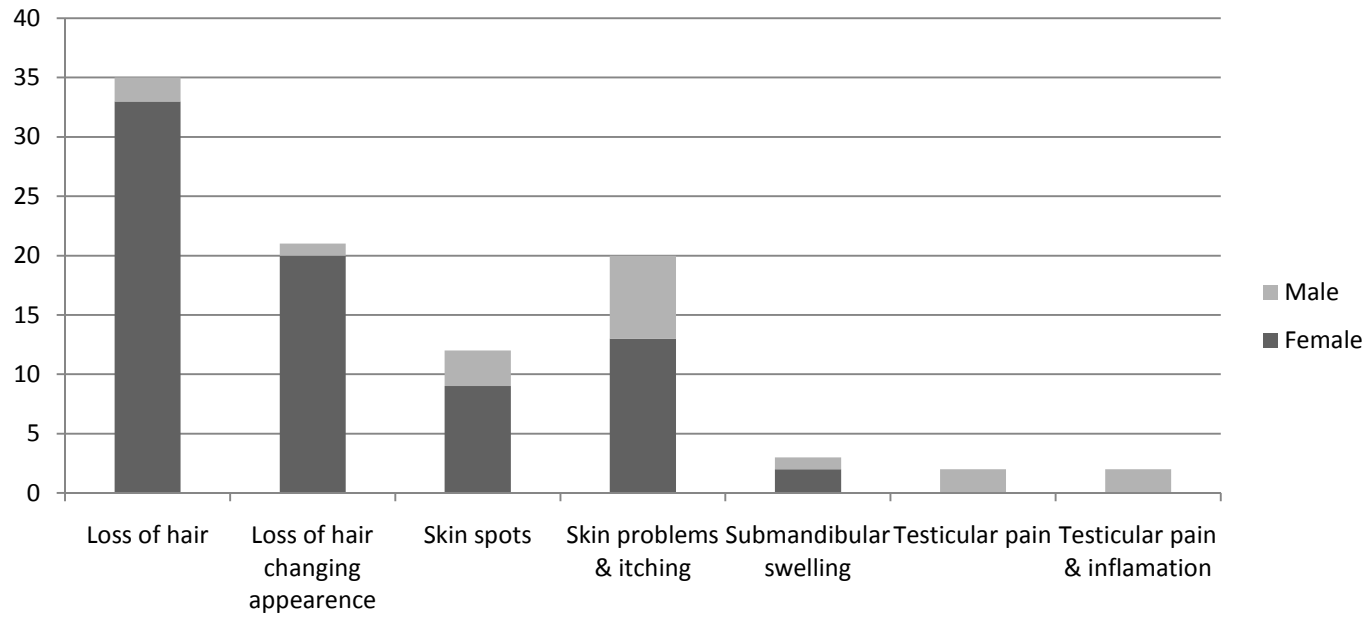


Figure 23 - Other symptoms

48% of survivors have been experiencing loss of hair, and 28% significant loss of hair changing appearance. Women represent 95% of survivors experiencing this medical complication.
27% present skin problems and itching.
Only 3 survivors have declared to be experiencing submandibular swelling and 2 men experiencing testicular pain and inflammation.

Recommendations:

- To inform the Ministry of Health and social welfare and collaborate with them to design a follow up plan for all EVD survivors.
- A medical team to identify the most urgent cases to be referred immediately.
- To coordinate medical referral and follow up for all survivors presenting any medical complications.
- Design information campaigns about typical medical complications and recommendations for treatment.
- Create spaces for discussion about medical complications and solutions (radio programs, focus groups, medical visits…).

Comments

The survivors were welcomed to comment at any time during the interview and under some specific sectors. Another comment section was added at the end of the questionnaire. Section relevant comments have been included in the different section of this report. The comments that did not clearly fit any section are summarized below, although some can be seen as redundant.

- Some survivors thanked “the helpers” for their assistance
- Some survivors explained that they are paying for their treatment or that they have to buy the drugs
- Cross border survivors do not benefit of the same services as Sierra Leone’s survivors
- There were numerous requests for livelihood, food and education support
- There were some request for PSS support
- There were several requests for Medical assistance
- Some emphasized that their position as head of family was very difficult without the physical or material or financial means of earning a living for their family
- Some explained that the community was willing to support them but as they were also in a difficult situation, they could not support much
- Children emphasized that their education was important and that they were willing to continue it
- Some emphasized the poor shelter situation they were in

Recommendations

- Ensure follow up of the different referrals
- The priority sectors for assistance to survivors are: Medical, PSS, education and livelihood.
- Clarify and disseminate wildly referral pathways that exists in Moyamba District
- Consider the possibility of integrating survivors from other affected countries to be eligible for assistance

Conclusion

Both the survivors and their families are still enduring the consequences from the EVD today. The majority of them lost loved ones, capital and livelihood, in addition to the numerous medical complications they are suffering from. Their lack of autonomy in providing for themselves and their families considerably affects their psychological stability and their ability, making them more prompt to choose negative coping mechanisms.

With a number of human losses, family and social bonds break ups, movement restrictions and the economic decay it implies, the impact of the EVD in the communities can be comparable to the one of an armed conflict. While this study concentrated on survivors, the need for humanitarian assistance is strong and the response should be integrated and inclusive of all EVD affected households. Immediate and urgent action should also be taken regarding the medical condition of the survivor and the coverage of their basic needs, while planning for the medium and longer term.

EVD outbreak impact does not finish with the end of the disease-spreading out and with Ebola zero cases. EVD medical, social and economic impacts are important and not to be neglected. Medical, psychological and socioeconomic assistance is highly needed and social services and post EVD assistance programs should be planned within a wider reintegration, recovery and resilience perspective and for a long-term period.

Most vulnerable groups

Being an EVD survivor constitute already vulnerability, due to the number of social, psychological and medical consequences and complications of EVD upon survival. The fact of having suffered from EVD, being stigmatized, having loss all means of livelihood to provide for family members or to continue suffering from medical complications, are vulnerabilities that can easily put survivors and their families at risk of a wide range of protection issues, through negative coping mechanisms, in particular for the most vulnerable, who may have less resilience and positive coping mechanisms. Social position, age, gender, family bonds, etc. are factors that can contribute to enhance vulnerabilities and risks, helping to identify the most vulnerable groups:

Orphans without appropriate family care: When they have lost their parents due to the outbreak and after discharge they do not have the appropriate family care and therefore they are not provided with basic needs such as food, medical assistance and schooling. These children are exposed to a number of risk factors that may bring them to negative coping mechanisms to provide for themselves (forced labour, economic or sexual exploitation…)

Widows, heads of household, without livelihood support: Women having lost their husbands and breadwinners due to the outbreak and once discharged, who cannot replace or undertake the husband's livelihood activity to sustain the family due to lack of capital, medical complications or any other family tasks. Women in these situations are exposed to negative coping mechanisms which may put themselves and their children at risk

Widowers, heads of household, in charge of children and without livelihood support: Men having lost their wife during the outbreak and once discharged, they have difficulties to restart their livelihood activity due to lack of capital or medical complications. Socially, men are not considered as a vulnerable group and therefore they are prompt to receive less support and assistance. But there are some examples of men without means of livelihood to provide for the family and with the added challenge of taking care of all children alone. Natural frustration can be a trigger of alcohol abuse, domestic violence and/or abandonment. In these cases, the vulnerability of the head of the household is a contributing factor for children's risk.

Children (girls in particular) of low-income families without any educational support: Children survivors that are not provided with the appropriate basic needs as food, medical assistance and education. After having lived such a traumatic event as having been in an Ebola Treatment Centre, having survived and having lost family members and friends, children need to get back to the sense of normality as soon as possible. But without an appropriate care and provision of basic needs, their psychological state of mind can be worsened. Food, medical care and schooling should be a priority of assistance for any child having suffered of EVD

Recommendations

- The priority sectors for assistance to survivors are: Medical, PSS, education and livelihood.
- Clarify with survivors the different assistance that they can access and under which criteria and which pathways
- Consider the possibility of integrating survivors from other affected countries to be eligible for assistance
- Clarify and harmonize messages and advices for survivors at national level designed by a medical/psychosocial/social mob, task force of experts, including medical information and referral system or assistance available for EVD survivors.
- The Ministry of Welfare accompaniment protocols have had a very positive impact on survivors' dignity, respect and confidence and should be continued and systematized.
- Design information campaigns and spaces for discussion (radio programs, focus groups, medical visits…) about typical medical complications and recommendations for treatment.
- Distinguish EVD awareness messages for the community from survivors' specific messages
- To reinforce awareness raising campaigns in the two main chiefdoms with prevalent stigma and rejection for EVD survivors: Fakunya, Kaiyamba and Kori.
- Review and compare social mobilization and psychosocial work implemented in other chiefdoms where stigma seems to have been reduced
- Ministry of Health and Ministry of Social Welfare should design a follow up plan for all EVD survivors and free medical treatment.
- As a general recommendation, government institutions and coordination platforms should ensure that all partners and international community work in a coordinated and holistic manner, avoiding overlapping, increasing coverage and maximizing efforts.
- Partners and international community are strongly advised to support the Ministries involved capacity (Social Welfare and Health).
- Mental Health and psychosocial support needs to be contextualized and adapted to bias and beliefs.
- Design a psychosocial support program with family and community approach as family and peer groups seem to be one of the main positive coping mechanisms for survivors.
- Design and implement integrated and individualized programs of livelihood and psychosocial support for EVD survivors and their families. Programs should include basic needs coverage (food and NFI), vocational training, access to formal and non-formal education and IGA.
- While survivors without current livelihood activity need funding support to start or resume an activity, any livelihood assistance provided should take into account the current health status of the survivors and medical referral should be prioritized or implemented in parallel with any livelihood activity
- A medical team to identify the most urgent cases to be referred immediately and coordinate medical referral and follow up for all survivors.
- Assess drinking and raw water needs further in Moyamba District, both for health, hygiene and livelihood purposes. If an assessment is launched, Ribbi and Lower Banta could be considered in priority

- EVD response humanitarian community should plan a systematic M&E approach for all interventions.

- As a general recommendation, the EVD response humanitarian community has to ensure a proper coordination to avoid overlapping, and human rights based approach for any assessment or intervention program with survivors and affected families.

General Recommendations

- Replicate and cross-check similar assessments in different districts to better address post EVD complications

- International community should work in coordination and with an holistic approach

- Build national and local capacity through long term programs

- Ensure programs reach the most vulnerable groups and EVD affected families and communities, not only survivors individually.

Methodological recommendations for partners interested in replicating the assessment

- Ensure sex and age disaggregation and questions on household size are well understood by interviewee and interviewer

- Ensure questions on educational level of respondents are understood.

Implementing Partners' presentation

Medicos del Mundo / Doctors of the World

Mèdicos del Mundo/ Doctor of the World is an international, humanitarian and voluntary association which Works for the universal right to health through health assistance, reporting, testimonies, and political and social action, with excluded or vulnerable populations or victims of crises. Since its inception, Mèdicos del Mundo has been part of the Humanitarian Movement; therefore, the organization shares and promotes the Movement's principles and code of conduct, such as the protection of, access to and care of victims; denunciation of injustices; universality, impartiality, independence, consent, participation, testimony and priority, depending on needs. We are committed to the defence and strengthening of the public health systems. Health care is not a good that should be governed by market laws. Public health systems are the best guarantors of universal, fair and quality health care. We work for the empowerment of people. A core strategy of our interventions is training and the exchange of knowledge with the social groups we collaborate with, and we link our health-related action to the promotion of development in the middle and the long term, given the close connection between health and development.
Mèdicos del Mundo began activities in Sierra Leone in 2003 in the district of Port Loko. Since 2006 we have focused our efforts in the district of Koinadugu in partnership with the DHMT in strengthening of primary health care services and provision of sexual and reproductive health services. When the Ebola outbreak was declared in July 2014 Medicos del Mundo started talks with Doctors of the World and DFID and sent a team to Sierra Leone in late August to assess the feasibility of running the treatment centre. Following discussions with our colleagues from Doctors of the World and talks with partners Solidarites International and IHP (Norway), we agreed to manage the centre in Moyamba

Solidarites International

Solidarites International is an NGO whose mission is to provide humanitarian aid to populations affected by conflict or natural disaster by meeting their vital needs: drinking water, food and shelter. We also work alongside vulnerable populations to help strengthen their resilience. Solidarites International is particularly committed to fighting water-related diseases, the leading cause of death in the world today. Our teams of humanitarian workers are recognized for their expertise, not only in terms of water and sanitation, but also in food security and reconstruction, which are equally essential. Solidarites International follows Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief, is a full member of the ALNAP network, and has an advisory role at the Global Wash Cluster in Geneva. In 2013, Solidarites International was able to provide humanitarian relief to over 5.8 million people affected by conflict or natural disaster for a budget of 70 million euros, 93% of which was directly allocated to our missions and humanitarian action.

Solidarites International has been working in Sierra Leone since November 2014 to help stop the progression of Ebola. Solidarites International works in partnership with Medicos del Mundo in the Ebola Treatment Centre of Moyamba District and is responsible for the WASH and IPC management within the centre. In parallel with the decrease of confirmed cases in the district of Moyamba, Solidarites International developed outreach activities to ensure a smooth transition between the EVD outbreak crisis and the early recovery stage: decontamination of holding centers, assessment, disinfection, hygiene kits distribution and training on IEC material in a 100 schools in the district., as well as small repairs and maintenance to ensure minimal access to water there. Solidarites International also implements a WASH in Community Health Centres (CHC) project in the District of Bonthe, where it will conduct WASH rehabilitation and construction in 13 CHCs.

Annexes

ANNEX 1 - Additional results tables

	Male		Female		Total	
	18 - 60+ incl.	%	18 - 60+ incl.	%	18 - 60+ incl.	%
CHA	1	2%	0	0%	1	2%
Cook	0	0%	1	2%	1	2%
Driver	2	4%	0	0%	2	4%
ETC	0	0%	1	2%	1	2%
Farmer	6	13%	8	17%	14	29%
Gardener	1	2%	0	0%	1	2%
Housewife	0	0%	4	8%	4	8%
Mason	1	2%	0	0%	1	2%
Midwife	0	0%	1	2%	1	2%
Student	1	2%	1	2%	2	4%
Trader/Business	2	4%	17	35%	19	40%
Trader/Farmer	1	2%	0	0%	1	2%
Total	15	31%	33	69%	48	100%

Figure 24 - Main occupation of adult survivors[23]

	Fullah	Krio	Limba	Loko	Mende	Sherbo	Temne/ Madingo	Temne/ Mende	Temne	Total
Count	4	1	1	1	41	1	1	1	23	74
%	5%	1%	1%	1%	55%	1%	1%	1%	31%	100%

Figure 25 - Tribes the survivors identified themselves to

	Male		Female		Total	
	Count	%	Count	%	Count	%
Yes	14	88%	36	100%	50	96%
No	2	13%	0	0%	2	4%
Total	16	100%	36	100%	52	100%

Figure 26 - Adult survivors engaged in a livelihood activity before they contracted the EVD

	5.2 Are you engaged in any form of livelihood activity presently?					
	Male		Female		Total	
	Count	%	Count	%	Count	%
Yes	7	44%	9	26%	16	32%
No	9	56%	25	74%	34	68%
Total	16	100%	34	100%	50	100%

Figure 27 - Adult engaged in a livelihood activity at present

Activity before contracting EVD	Male		Female		Total	
	Count	%	Count	%	Count	%
Trading/business	4	29%	24	67%	28	56%

[23] Out of 48 respondents

Farming	5	36%	8	22%	13	26%
Business and farming	0	0%	2	6%	2	4%
Tailoring	0	0%	1	3%	1	2%
Midwife	0	0%	1	3%	1	2%
Construction	1	7%	0	0%	1	2%
Gardening	1	7%	0	0%	1	2%
Driving	2	14%	0	0%	2	4%
Activities related to agriculture	1	7%	0	0%	1	2%
TOTAL	14	100%	36	100%	50	100%

Figure 28 - Type of livelihood activity survivors were engaged in before contracting the EVD

Activity after contracting EVD	Male		Female		Total	
	Count	%	Count	%	Count	%
Trading/business	1	14%	4	44%	5	31%
Farming	2	29%	2	22%	4	25%
Driving	1	14%	0	0%	1	6%
Activities related to agriculture	1	14%	0	0%	1	6%
ETC	1	14%	1	11%	2	13%
OICC	1	14%	1	11%	2	13%
Trading and bread maker	0	0%	1	11%	1	6%
TOTAL	7	100%	9	100%	16	100%

Figure 29 - Type of livelihood activity survivors were engaged in before contracting the EVD

tem	Unit	Former Price Le	Current Price Le	Increase Le	Increase %
Battery	pot	6,000	9,000	3,000	33%
Rice	Bag	120,000	140,000	20,000	14%
Rice	Bag	125,000	140,000	15,000	11%
Rice	Bag	120,000	150,000	30,000	20%
Rice	Bag	100,000	150,000	50,000	33%
Rice	Cup	700	1,000	300	30%
Rice	Cup	800	1,000	200	20%
Rice	Cup	600	1,000	400	40%
Rice	Cup	700	900	200	22%
Rice	Cup	500	1,000	500	50%
Palm Oil		150,000	200,000	50,000	25%
Palm Oil		600	1,500	900	60%
Palm Oil	Pint	1,500	2,000	500	25%
Palm Oil		1,000	1,500	500	33%
Palm Oil		600	1,200	600	50%
Palm Oil		600	1,500	900	60%
Palm Oil	Cup	1,500	2,500	1,000	40%
Palm Oil		2,000	2,500	500	20%
Palm Oil		1,000	2,500	1,500	60%
Palm Oil		1,200	1,500	300	20%
Sardines		4,000	5,000	1,000	20%
Pepper	Cup	200	500	300	60%
Pepper		1,000	1,500	500	33%
Pepper	Cup	1,000	2,000	1,000	50%
Mango	6u/4u	1,000	5,000	4,000	80%
Groundnut	Cup	1,000	1,500	500	33%
Groundnut	Cup	700	1,500	800	53%
Groundnut	Cup	1,000	2,500	1,500	60%
Energy Drink	Can	4,000	5,000	1,000	20%
Plastic for oil		2,000	3,000	1,000	33%
Flour		1,500	2,000	500	25%
Syrup		25,000	40,000	15,000	38%
Poplin Uniform	Yard	3,000	4,500	1,500	33%
Tobacco	Gross	8,000	17,000	9,000	53%
Fish		2,000	5,000	3,000	60%
School uniform sewing	1 set	25,000	50,000	25,000	50%
Drinking water	Bundle	2,000	4,500	2,500	56%
Cement	Bag	38,000	45,000	7,000	16%
Lappa		10,000	15,000	5,000	33%
Sugar		1,500	2,000	500	25%
Salt	Cup	500	1,000	500	50%
Salt		1,500	2,000	500	25%
Maggie	Packet	8,000	10,000	2,000	20%

Maggie	Cube	50	100	50	50%
Maggie		3,000	3,500	500	14%
Roofing zinc	Bolle	250,000	350,000	100,000	29%
Garri	Cup	250	500	250	50%
80 pages book		800	1,000	200	20%

Figure 30 - Illustrative examples of rise in food prices, as presented by the interviewee

	Water Treatment						
Water source	**Yes**	**%**	**No**	**%**	**NA**	**%**	**TOTAL**
Borehole	4	57%	3	43%	0	0%	7
Hand dug well - bucket	26	79%	6	18%	1	3%	33
Hand dug well - pump	5	50%	3	30%	2	20%	10
River	0	0%	1	100%	0	0%	1
Stream / crick	0	0%	16	94%	1	6%	17
Purchase	0	0%	0	0%	2	100%	2
Other	0	0%	0	0%	2	100%	2
NA	0	0%	0	0%	1	100%	1
Total	35	48%	29	40%	9	12%	73

Figure 31 - Water treatment per water source

ANNEX 2 - Terms of Reference

TERMS OF REFERENCE
EVD survivors´ assessment

Title of the assessment:	EVD Survivor comprehensive assessment
Location of the assessment:	Moyamba District, Sierra Leone
Commissioning body:	DERC PSS Pillar
Involved Partners:	DERC PSS Pillar members with technical support from Medicos del Mundo, Solidarités International
Expected start date:	15/04/2015
Expected end date:	30/04/2015

Document drafted by Lourdes Carrasco, Medicos del Mundo and Marie Grasmuck, Solidarités International

A. Background

As of today, the District of Moyamba counts 208 confirmed EVD cases, out of those 85 survived. Under the growing concerns of post EVD complications (medical, social and psychological), the Psychosocial Pillar wants to launch a research to guide and streamline such concerns in a realistic and feasible way.
As planned in the EVD response structure, EVD patients and families received PSS counseling during their treatment, and once recovered, the patients were accompanied back in their village of origin by the PSS teams. There, the teams emphasize on the need for survivors community reintegration, dangers of stigmatization and the 90 days safe sex/abstinence rule. Upon discharge, survivors are being provided with relief packages that included food from WFP, NFIs and cash from MSWGCA/UNICEF and Cash from ACF.
As of now, the survivors have been followed up by the PSS Pillar through community outreach, but no structured and comprehensive questionnaires have been implemented to address their concerns in a systematic way. As, the District of Moyamba is not free of EVD cases yet, a better knowledge of the situation of the survivors will be helpful for the DERC and its partners to learn from experience how to better manage the medical and psychosocial support and to plan appropriate activities if deemed necessary.

B. Objectives of the assessment

The objectives of the EVD survivors' assessment are as follows:
- Assess in general the situation of the survivors several weeks after their discharge
- Have a specific follow up of their psychosocial well-being
- Have a specific follow up of their medical condition
- Assess in general their living conditions in terms of community reintegration (including access to water and sanitation and livelihoods)
- Highlight the need for further technical assessment or activities

C. Scope of the assessment

This assessment will concern 84 of the 85 EVD survivors that have been discharged in Moyamba District by an authorized facility and the family of the only death survivor.
The assessment will be mainly focused on their psychosocial situation and medical conditions. It will only rapidly assess their livelihoods and wash situation, with the objectives of triggering in depth technical assessment if deemed necessary. The assessment is meant to be qualitative above quantitative, but some numbers will be drawn from the questionnaire when possible and relevant.

Limitations:

- This assessment will not enter into discussions with families of EVD survivors or with the communities they come from. The partners may decide to also assess them.
- The interview will be conducted by psychosocial and community workers, not by medical workers. They will be trained on each part of the questionnaire including the medical part. Any medical condition that would need further investigation will be referred to and should be handled by a trained medical staff.

D. Deliverable and dissemination

The interviews will be analysed by the interviewers and their manager (MSWGCA/MDM/UNICEF/PLAN), who will gather results and analysis in a single report. The report will be submitted for reviews and questions to the partners within a limited timeframe.

The resulting agreed final report will:

- Clearly express results of the assessment and its findings, be factual and straightforward and avoid any unnecessary use of broad concepts and sentences;
- Express successes and challenges in a constructive way;
- Provide realistic and pragmatic recommendations to any EVD response partners, according to what will be identified in the report.

The final report will be disseminated as follows:

- Communicated to the DERC Coordination and DERC pillars' mailing list through the DERC Pillars' representatives, including to the NERC representatives;
- A PowerPoint presentation to the DERC PSS Pillar;
- A PowerPoint presentation to the DERC Coordination meeting;
- A possible presentation in the Freetown NERC PSS Pillar if requested;
- Internal dissemination by all partners within their organisation according to their own will

E. Timeframe and resources

Date	Topic	Partner responsible to follow up	Comment
March 2015	Submission of ToR to DERC PSS	MDM/SI	The questionnaire will be included as part of the ToR
March 2015	Agreement on ToR by DERC PSS	MDM/SI	Includes questionnaire
March 2015	Submission of ToR to DERC Coordinator for agreement	DERC PSS	See with the DERC Coordinator if NERC also has to approve or if we can move forward while keeping them informed
13/04/2015	Training of the interviewers	MDM/SI	
15/04/2015	Start of field data collection		
21/04/2015	End of field data collection		
22-24/04/2015	Data entry		
24-28/04/2015	Analysis and reporting	MDM/SI	
28/04/2015	Submission to DERC PSS	MDM/SI	
05/05/2015	Workshop & agreement by DERC PSS on final version	MDM/SI	
07/05/2015	Agreement by DERC Coordinator on final version	DERC PSS	
09/05/2015	Email dissemination	DERC	And internally by partners NGO
TBD	Presentations		

Concerning the field data collection, as agreed within the Moyamba PSS Pillar, the interviews will be split as specified in the survivors mapping attached.

The partners will discretionary contribute their own resources to undertake the interviews

F. Methodology

The survivors will have to be found and will have to agree to the interview through a consent form that will be given to them.

The methodology for this assessment will be semi structured interviews that will follow the questionnaire annexed to this ToR. The interviews will be conducted by psychosocial and community workerscontracted by the different partners. They will all receive the same training on field data collection.
To complete the analysis and the information gathering process, the lead reporting agency will conduct a workshop with the DERC PSS partners to present the draft report and ensure all information and views expressed on the field are represented in the report.

ANNEX 3 - Questionnaire

EVD Survivors' ComprehensiveAssessment

1. Preliminary Information

1.1 Date or the interview:		**1.2.Name of the interviewer:**	
1.3 Name of the organization			
1.4The consent script is read and the person agrees to be interviewed:			□ YES □ NO
1.5The person agrees to be contacted by the interviewer's organization if necessary:			□ YES □ NO

2. Personal Data

2.1 Name of the survivor:			
2.2. Age:		**2.3 Sex:**	□ Male □ Female
2.4 Occupation:		**2.5 Education Level:**	
2.6 Contact Address:			
2.7 Town/Village Name:		**2.8 Chiefdom Name:**	
2.9 Contact Number:		**2.10 Marital Status:**	
2.11 Total no of children:		**2.12 No of children under 5:**	
2.13 Household Size:		**2.14 Number of males and females**	..... Males ..... Females
2.15 Are you the head of household?	□ YES □ NO	**2.15.1 If not, who is the head/caregiver?**	
2.17 Religion:		**2.18 Tribe:**	

3. General Information

3.1 In which ETC did you stay and were discharged from?	
3.2 Do you have a certificate?	□ YES □ NO□ NA
3.2.1 If no, what happened to it?	
3.2.2 If yes, have you already used it/ shown it to some people to prove that you are a survivor or that you are now EVD free?	

4. Psychosocial

4.1 Were you accompanied in the village after your discharge?	□ YES □ NO□ NA
4.1.1 If yes, <u>Who</u> accompanied you to your village after discharge?:	
4.2 How do you value the fact to have been accompanied?	

4.3 How are you feeling (mental health condition) since you came back home?	□Bad □weak □moderate □ good □very good
4.3.1 Please explain the answer chosen. Why?	

4.4 These questions concern how you have been feeling over the past 30 days. Tick a box below each question that best represents how you have been…)

How much of the time	None of the time	A little of the time	Some of the time	Most of the time	All of t he time
	1	**2**	**3**	**4**	**5**
4.4.1. During the last 30 days, did you feel with energy?					
4.4.2. During the last 30 days, did you feel tired out for no good reason?					
4.4.3. During the last 30 days, have you felt calm?					
4.4.4. During the last 30 days, did you feel nervous?					
4.4.5. During the last 30 days, did you feel so nervous that nothing could calm you down?					
4.4.6.During the last 30 days, have you felt happy/cheerful/Joy?					
4.4.7. During the last 30 days, did you feel hopeless?					
4.4.8. During the last 30 days, did you felt restless or fidgety?					
4.4.9. During the last 30 days, did you feel so restless you could not sit still?					
4.4.10. During the last 30 days, did you feel depressed?					
4.4.11. During the last 30 days, did you feel that everything was an effort?					
4.4.12. During the last 30 days, did you feel so sad that nothing could cheer you up?					
4.4.13. During the last 30 days, did you feel worthless?					

4.5. In case you have had bad feelings/thoughts what help you to overcome them?	
4.5.1What thoughts helped you to feel better?	
4.5.2What actions helped you to feel better?	
4.5.3What has done your family that helped you?	
4.5.4What has done the community to help you?	
4.5.5What do you think about your future?	

4.5.6What would you like to do from now on?	

4.6Have you lost any family member during the Ebola crisis?	□ YES □ NO□ NA
4.6.1 If yes, was it as a result of Ebola?	□ YES □ NO□ NA
4.7 How is the community interacting with you since you came back?	
4.8Are you allowed to participate in community's activities since you came back?	□ YES □ NO□ NA
4.8.1 If no, why?	
4.9Have you been subjected to any kind of stigma because of the EVD?	□ YES □ NO□ NA
4.9.1 If yes, how?	
4.10Have you been subjected to any kind of rejections because of the EVD?	□ YES □ NO□ NA
4.10.1 If yes, how?	
4.11Have you had to face any security concern since you came back, because of the EVD?	□ YES □ NO□ NA
4.11.1 If yes, explain	

5. Livelihood and access to school

5.1 Were you engaged in any form of livelihood activity before you were sick?	□ YES □ NO □ NA
5.1.1 If yes, what was it?	
5.1.2 If not, why?	
5.2 Are you engaged in any form of livelihood activity presently?	□ YES □ NO □ NA
5.2.1 If yes, what is it?	
5.2.2 If no, why?	
5.3 Are your children going to school, if any? / Are you going to school (in case is a child)	□ YES □ NO □ NA
5.3.1 If yes, how many are there? /what about your siblings?	
5.3.2 If yes, which school?	
5.3.3 If no, why?	
5.4 Generally, what has been the main impact of the EVD in your daily life?	

5.4.1 Any improvements?	
5.4.2 Any challenges?	

5.5 Have you noticed any changes in the prices in the market?	□ YES □ NO□ NA
5.5.1 If yes, please give us some examples	
5.5.1.1 Example 1.	
5.5.1.2 Example 2.	
5.5.1.3 Example 3.	

6. Access to water and sanitation

8.1 Which is your drinking water source?	□ Borehole			□ Network/ water tower/ water tank
	□ Hand dug well – bucket			□ Hand dug well – pump
	□ River			□ Stream/crick
	□ Purchase			□ Other:
8.2 Do you treat your water?	□ YES □ NO□ NA			
8.2.1 If yes, how?	□ Chlorine	□ Boiling	□ Filtering	□ Other:
8.3 Do you use a latrine?	□ YES □ NO□ NA			
8.3.1 If yes:	□ Family□ Collective			
8.4 Do you have a mosquito net?	□ YES □ NO□ YES but not for everybody □ NA			

7. Medical questionnaire

Symptoms		Yes	No	Date of onset of symptoms	Treatment started
9.1 Eye problems	9.1.1 Itching and dry eyes				
	9.1.2 Ocular redness (red eyes) with conjunctival secretion				
	9.1.3 Inflammation of the eyelids				
	9.1.4 Ocular redness with blurred vision				
	9.1.5 Complete loss of vision in one or both eyes				
9.2 Headache	9.2.1 Sporadic headache, mild headache				
	9.2.2 Frequent headache that requires painkillers				
	9.2.3 Daily headache that hinders the activities of daily living.				
9.3 Neurological problems	9.3.1 Paresthesia or tingling in hands or feet				
	9.3.2 Loss of strength in some arm				
	9.3.3 Significant loss of strength in any arm falling objects				
	9.3.4 Loss of strength in one leg				
	9.3.5 Loss of strength in both legs with inability to walk				
9.4 Joint problems	9.4.1 I have had some joint discomfort				
	9.4.2 I had severe pain in any joint requiring painkillers				
	9.4.3 I had severe pain in one or more joints with inflammatory signs that have limited my daily life.				
9.5 General symptoms	9.5.1 Weight loss				
	9.5.2 Significant weight loss for over 5 Kg				
	9.5.3 I eat less than before				
	9.5.4 I eat very few during the last months				
	9.5.5 Some days I find myself tired				
	9.5.6 Many days I'm so tired I cannot leave home				
	9.5.7 Some days I have a fever of more than 38° (serious fever)				
	9.5.8 I have daily fever over 38 degrees sometimes with chills and important sweating				
9.6 Abdominal symptoms	9.6.1 I have abdominal pain some days				
	9.6.2 I have abdominal pain almost daily sometimes with vomiting				
	9.6.3 have a continuous abdominal pain that does not let me eat				
9.7 Other symptoms	9.7.1 I lost hair				
	9.7.2 I lost a lot of hair and my appearance has changed				
	9.7.3 I had spots on the skin				
	9.7.4 I have many skin problems with itching				
	9.7.5 I had swelling in the submandibular area				
	9.7.6 I had testicular pain				
	9.7.7 I had testicular pain and inflammation				

8. End of the interview

10.1 Is there anything else you would like to share with us?	□ YES □ NO
10.1.1 Answer	

9. Comments from the interviewer

11.1 Comments about the interview: *Here to record specific things about the interview. It will stay attach to the questionnaire.*

11.2 Feedback form: This form you will detach from the questionnaire. It is anonymous and you will give it to the manager before the debriefing so he can talk about it during the debriefing.

11.2.1 Have you encountered problems today that you wish to share anonymously?

11.2.2 Do you have suggestions for improvements? (of the survey, of the organization, of the activities in general…)

ANNEX 4 - Consent Script

ASSESSMENT CONSENT SCRIPT

Dear Sir/Madam,
Our names are …

We are from the **Child Protection Gender and Psychosocial Pillar** from the District Ebola Response Committee.

We are here today because you are a survivor of the Ebola Virus Disease (EVD). We would like to ask you some questions related to your well-being and living conditions since you were discharged. This information will help us understand your needs, how we can support you and if we can support you. It is important you understand that the support will not be automatic.

The personal information and individual data (name, contact number etc.) you give us is confidential and will not be communicated to any authority or structures, local, national or international, it could however be utilized internally to contact you if we wish to follow up on the situation and if you agree to. The rest of the information you communicate to us on the questionnaire will be anonymised before use.

You can also choose not to participate in this questionnaire at all or participate but refuse to answer some questions.
You can stop the interview at any time.

Please remember than humanitarian assistance is free of any kind of charge. If that is not the case, please send your complaint to the contact below. You can do so anonymously if you wish. The psychosocial pillar will investigate your claim while protecting your identity against harm.

If you have questions later or would like to complain regarding this interview, you can contact our office:
Name:
Position:
Number:
This document is for you to keep.

May I proceed with the interview?
□ YES □ NO

Are you willing to share the personal data you provide to be used internally by the NGO that conducted the interview?
□ YES □ NO

Date (DD/MM/YYYY): _____

Location: _____

Full Name and signature of the field worker:

_____

Full Name and signature of the interviewee:

_____