'Worse than the war':
An Ethnographic Study of the Impact of the Ebola Crisis on Life, Sex, Teenage Pregnancy, and a Community-driven Intervention in Rural Sierra Leone[1]

Columbia Group for Children in Adversity
on behalf of the
Inter-Agency Learning Initiative on Community-Based Child Protection Mechanisms
and Child Protection systems

Suggested citation:
Kostelny, K., Lamin, D., Manyeh, M., Ondoro, K., Stark, L., Lilley, S., & Wessells, M. (2016). *'Worse than the war': An ethnographic study of the impact of the Ebola crisis on life, sex, teenage pregnancy, and a community-driven intervention in rural Sierra Leone*. London: Save the Children.

[1] This research was made possible by generous support from the ESRC/DfID Poverty Alleviation Fund.

Acknowledgements

ACRONYMS

CDC	Center for Disease Control
CWC	Child Welfare Committee
DFID	Department for International Development
ESRC	Economic and Social Research Council
EVD	Ebola Virus Disease
FGM	Female Genital Mutilation
MSWGCA	Ministry of Social Welfare, Gender, and Children's Affairs
NGO	Non-governmental Organization
SEA	Sexual Exploitation and Abuse
STD	Sexually Transmitted Disease
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

Table of Contents

EXECUTIVE SUMMARY

The Ebola virus disease (EVD) epidemic and crisis of 2014-2016 dealt a devastating blow to the citizens of Guinea, Liberia, and Sierra Leone, the full impact of which is still being unearthed. In Sierra Leone, the disastrous consequences to health were only one dimension of the catastrophic impact of the Ebola crisis, which in many respects turned the world upside down for children and adults. The purpose of this research is to illuminate both the wider impacts of the Ebola crisis on people's lived experiences, with an emphasis on children, and its more specific effects on issues related to teenage pregnancy and its prevention.

The research was conducted as part of an effort to learn how the Ebola crisis had affected and interacted with a community-driven intervention to reduce teenage pregnancy. The intervention, which had been developed and conducted by two clusters of three communities each in Moyamba and Bombali Districts, respectively, included elements such as: dramas created and performed by teenage girls and boys on consequences of pregnancy followed by discussions; parent-child discussions on puberty, sex, and pregnancy; creation of and transmission by teenagers of youth oriented messages about preventing teenage pregnancy; ongoing community dialogues and reflection about teenage pregnancy; and support from health workers and authorities. Midline data collected in 2014 using mixed methods and comparisons with control clusters that had not received the intervention showed promising effects on reducing teenage pregnancy.

Unfortunately, the Ebola crisis erupted in Sierra Leone in August, 2014, making it impossible to collect the endline data that would have enabled the documentation and analysis of the full effects of the community driven intervention. Reports from the field indicated that the Ebola crisis had interrupted the intervention, and had introduced a host of confounding variables and threats to children, including increases in teenage pregnancy. Realizing that it would be impossible to interpret the endline survey data in a meaningful way, the research team decided to conduct post-Ebola ethnography that would examine how the Ebola crisis had affected children's well-being, teenage pregnancy and related issues, and the community driven intervention.

Method

Conducted during November – December, 2015, the research used a method of rapid ethnography in which trained Sierra Leonean researchers, who spoke the local languages and were familiar with the context, lived and worked in rural villages. In each district, two of the intervention villages and two of the control villages were randomly selected for participation, making a total of eight participating villages. For each District, a team of 4-5 researchers worked in four villages, and were to spend a period of 5-7 working days in each village. Backstopping the researchers in the villages were more experienced Team Leaders from Sierra Leone, and also international researchers from the Columbia Group.

The participants, who included people from different socio-economic strata, consisted of 621 people who took part in 63 group discussions, and an additional 255 people participated in the

in-depth and key informant interviews. Group discussions and in-depth, individual interviews were planned in a manner that learned systematically from ten subgroups: girls (11-13 years), teenage girls (14-19 years), young women (20-25 years), women (26-49 years), elder women (50 years and over), boys (11-13 years), teenage boys (14-19 years), young men (typically not married, 20-25 years), men (26-49 years), and elder men (50 years and over). Group discussions were conducted separately with different subgroups for purposes of enabling the participants to speak more openly and also to contrast the views of different subgroups.

The interviews and group discussions were conducted in a flexible, open ended manner that sought to elicit the participants' views and to capture their exact words. The researchers deliberately avoided using the language of international child protection. Initially, the researchers asked broad, open ended questions and then followed up with probing questions to learn in greater depth about participants' views.

The research was conducted in a manner designed to ensure that the benefits to participants outweighed any costs or unintended harm, and that the research process embodied the ethical principles of humanity, impartiality, neutrality, beneficence, nonmaleficence, and the best interests of the child. Columbia University reviewed the proposed research and granted IRB approval. The researchers, who were bound by Save the Children's Child Safeguarding Policy, talked with people in a respectful, empathic manner when querying people about the impact of the Ebola crisis and difficult life conditions. To avoid causing unintended harm, the researchers asked not about specific cases or participants' own situation but about all the children in the area. Informed consent was obtained through careful procedures that did not involve coercion. Children’s assent was also obtained together with the consent of their parents. To protect confidentiality, the records contain no names or personal identifiers. Throughout, care was taken not to raise expectations that the participants or their family or community would receive material benefits such as money as a result of their participation.

The data were analyzed systematically using a grounded methodology. Key categories, themes, and patterns were identified inductively, through holistic reading and examined through processes of triangulation. These categories, themes, and patterns were checked through discussion among the Columbia Group researchers, with revisions made as necessary.

Limitations of this research include its short time frame and operational limits on the monitoring of the quality of the data. A further limitation was that respondents sometimes had difficulty recalling events within specified time frames. The research has limited generalizability since the areas studied did not comprise a representative national sample.

Key Findings

The key findings are presented in three sections on general effects of the Ebola crisis, effects on teenage pregnancy and related issues, and effects on the community driven intervention.

General Effects

During the Ebola crisis, the rhythms of daily life were ruptured, as people lost their livelihoods, social relationships were torn apart, and an atmosphere of fear and mistrust permeated daily life. Although Ebola did not reach any of the villages in the study, children, teens, parents and caregivers were nonetheless profoundly affected by the changes brought about during the Ebola crisis.

The Ebola crisis had devastating effects on people's social interactions and movements. In response to Center for Disease Control (CDC) guidelines for national infection control, the Paramount Chiefs imposed two by-laws that forbade movement in and out of villages and restricted people from gathering within their own villages, respectively. Together, these by-laws not only worsened poverty but also decreased sharply the participation in social and cultural activities such as religious events, burial rituals, and entertainment. Fearful of touching each other, people reported that they no longer slept near each other, and some married couples avoided having sex. People became so fearful of each other that they no longer 'ate off the same plate' with each other. The combined effects of this social isolation and fear were sufficiently crippling that some participants described the Ebola crisis as having been worse than the armed conflict in Sierra Leone had been.

Because people could not work and children could neither play nor go to school, people said they felt as if they were living in a cage. The inability to gather and travel outside one's village had devastating economic consequences. Because people could not travel to their usual places of business, including the weekly market where they sold their produce and goods, people were unable to earn money to buy food or other necessities. As a result, there was ‘plenty hunger.’ Also, there was no possibility of financial help from relatives who lived in the larger towns, which in normal times had been a steady source of support. Further, husbands and wives who had been in separate places when the by-laws went into effect were unable to reunite during the Ebola crisis, as many roads were closed, and transportation was not widely available.

Fear and suspicion of the health posts and hospitals were widespread. People believed that they could be misdiagnosed as having Ebola and killed, or that they would not be treated well and would not receive the medicine they needed. In some villages, people feared that at health facilities they would be injected with the Ebola virus either deliberately or unintentionally through the use of contaminated needles and syringes that had been used previously with Ebola victims. Also, people feared that if their blood was drawn, they would die immediately. People also feared misdiagnosis, as the usual symptoms of diarrhea, fever, and vomiting of some of the frequent illness such as malaria or cholera were the same as Ebola symptoms. They feared that once they had been diagnosed as having Ebola, they would be taken to a holding center where certain death by Ebola awaited. As a consequence, many people did not go to the health post or take their children there.

People said they had avoided health posts since they feared that they would not be treated well or at all, because the intense focus on Ebola had excluded the treatment of other conditions. Also, people feared that the diminished supply of medicines would impede proper treatment of one's ailments. These fears likely had some basis in reality. For example, during the Ebola crisis, many expectant mothers, including teenagers, received no prenatal care, and even if they had gone to the hospital to deliver their babies, they received no assistance. In addition, by-laws

restricted the previously common practice of using traditional medicine. In essence, the Ebola crisis shut down people's use of either the Western or the traditional parts of the health system. The net result of people not taking their sick young children to the hospitals was that children died from malnutrition, malaria, and other 'common' illnesses. Because mothers were not assisted during delivery at hospitals, some children died during birth, or shortly thereafter due to delivery complications.

In addition to the health issues mentioned above, the Ebola crisis had a profound, negative impact on children's well-being. Children's well-being suffered due to their inability to engage in normal activities such as playing, farming, being with other children, or going to school. Overall, children were described as unhappy, discouraged, lonely, and despondent. Because schools were closed, school-age children missed interacting with their age-mates and engaging with them through play, sports, storytelling, and doing chores together. Children particularly missed the special gatherings on holidays with friends and people from other villages. Teenagers, too, suffered due to their inability to socialize and engage in important cultural activities, including attending church or mosque, participating in sporting events, and going to dances and entertainment activities that had been integral parts of their lives.

Further, some children, especially adolescents, were perceived to have become disobedient because their parents could not supply food or meet other basic needs. Some young children reportedly received more beatings, not only for disobedience, but also because they were crying from hunger. Teenage girls refused to heed their parents' advice not to get involved in sexual activities. Teenage boys became more disobedient and defiant, smoking cannabis and gambling.

A significant source of distress for children was that schools were closed for nearly a full school year. Diverse community members, including children, said that as a result, children became '*idle*' since they had no structured activities to occupy their time. Also, participants reported that children had forgotten what they had learned and had become '*fools*.' Held back, they were unable to take their entrance exams for secondary school, causing some children to lose interest and drop out of school altogether. Further, some children descended on a pathway that led through pregnancy, poverty, or loss of hope to permanently dropping out of school. Many children felt that their future had been destroyed because they had been held back in school, or that they would never go back to school. For girls, this was especially true if they had gotten pregnant.

The Ebola crisis had a severe impact on youth both socially and economically. Girls who normally had participated in the *bondo* (secret) society activities were unable to do so during the Ebola crisis owing to the ban on gathering. This deprived them not only of opportunities to socialize with peers but also of mentoring from elder women and meaningful cultural activities. The inability of teenage boys and young men to do the traditional collaborative farming made it difficult to meet their own and their families' needs.

Highly distressful for people of all ages was the inability to participate in traditional burial rituals, which were seen as important for the identity and well-being of the living. There was a strong cultural tradition of washing the body, paying last respects, and accompanying the deceased and their family to the burial. Particularly distressful was the burial during the Ebola

crisis by protected workers (strangers), who placed the dead bodies in plastic bags and took them to an unknown burial site. Sometimes the burial team did not come for several days, leaving the body to decompose while relatives were helpless to do anything.

Effects on Sexual Behavior, Teenage Pregnancy, and Sexual Exploitation and Abuse (SEA)

The descent of the country into deeper poverty, coupled with the psychological impact of the Ebola crisis, children's idleness, and the disruption of organized routines of social behavior, led to significant increases in sexual behavior among teenagers, including transactional sex and even sexual exploitation by Ebola workers. As a result, teenage pregnancy rates reportedly increased.

The new poverty was a driver for transactional sex. A particularly heinous example was that in one village, Ebola workers who flashed their money lured girls with promises of marriage into having sex with them. Typically, these 'Ebola marriages' resulted in single girls having babies with no fathers. In all the villages, sexual exploitation was evident as girls who wanted food, basic necessities, or even ‘little things’ such as body oil, turned to those who could provide such things or the money to obtain them. People reported that, prior to the Ebola crisis, girls had been able to earn money and take care of their needs by selling things in the market. Key informants reported that most parents, who benefitted from it, 'closed their eyes' to their girl’s transactional sex, which often led to pregnancy.

The Ebola crisis also upset the unwritten social contract wherein parents provide for their children, and, in return, the children are obligated to obey and respect parents. Because parents were unable to feed their daughters, teenage girls stopped heeding their parents’ advice to avoid ‘boyfriend biznes’ (sex with peers). Despite the ban on gatherings, young people found ways to sneak out and have sex. Also teenagers' idleness and being out of school led many teenage girls to get involved in either sex with boyfriends or transactional sex with men (‘man bizness’). Further, some children experienced diminished expectations for the future that contributed to a desire to become pregnant and a decreased use of contraceptives. Other girls, wanting to have as much fun as possible since they believed they would eventually die from Ebola, became pregnant. The increase in teenage pregnancies also led to increases in early marriage.

Interaction of the Ebola Crisis with the Community Driven Intervention

The Ebola crisis significantly disrupted many of the community intervention activities such as peer education workshops, group discussions on puberty and pregnancy prevention, village meetings for teens and parents on the prevention of pregnancy, and community dramas Also, people were less likely to go to the health posts for contraceptives because of their mistrust and fear of the health structures. During the Ebola crisis, the two community facilitators, who encouraged the organization of the intervention activities, were prohibited from visiting the villages. Although there were some limited activities in the intervention villages in Bombali, the overall pattern was one of significant disruption. In Moyamba, too, there were very limited intervention activities, as people feared that the coordinator was an Ebola worker, whom people generally avoided.

Throughout the Ebola crisis, contraceptives were available at the health posts most of the time and also through Marie Stopes, an international NGO of Sierra Leonean origin. However, the preferred types of contraceptives (implants) were not always available, and sometimes the supplies ran out. Also, people feared that any items from the health post might give them Ebola.

Nevertheless, several skills and lessons from the intervention carried over to the efforts to fight Ebola. In Moyamba, even though peer education gatherings were not allowed, one intervention focal point continued to encourage girls to stay in school and not become pregnant when he saw them in the village. He not only continued to advise children to avoid pregnancy and stay in school, but also made home monitoring visits and advised the teen girls and boys regarding Ebola during the village education broadcasts and meetings at the *baray* (community meeting) every evening. Similarly, in Bombali, washing hands had been taught as part of the life skills training, and that skill transferred readily and was important in the Ebola response. In both Bombali and Moyamba, the community focal points, task force members, and peer educators continued to advise teens, emphasizing that the practices they had learned during the intervention also applied to the prevention of Ebola. Encouragingly, some intervention task force members and youth readily volunteered to be part of the Ebola response, helping out at the hand washing stations, conducting home visits, and volunteering at the health post.

As the Ebola crisis disrupted the intervention, it also introduced numerous confounding variables, particularly the increased poverty and the closure of schools, that had not been taken into account in the design of the action research. Also, with teenage pregnancy increasing, NGOs such as BRAC and Marie Stopes entered villages without attention to the research design and began working to reduce teenage pregnancy. The presence of these confounding variables frustrate efforts to interpret the effects of any remnants of the community driven intervention during the period of the Ebola crisis and afterwards.

Recommendations

Four key recommendations grow out of this post-Ebola ethnographic research.

1. Strengthen the training and monitoring of emergency workers in regard to child protection and the prevention of sexual exploitation and abuse.

The occurrence of sexual exploitation and abuse by Ebola workers in one village indicates the necessity of making child protection an integral part of the selection and training of emergency workers in all sectors. Beyond signing a Code of Conduct, workers should receive training that stimulates empathy and highlights the adverse effects of sexual exploitation on girls, children, and families. In addition, steps must be taken to monitor workers' behavior in the field and end the impunity for violations.

2. Improve the alignment between community practices and those recommended by Westernized health systems.

The Ebola crisis highlighted not only the severe weaknesses in the health systems in Sierra Leone but also the gap between community practices and those recommended or required by the

formal health system, which embraces Western science, values, and modalities of disease diagnosis, treatment, and prevention. As part of the post-Ebola recovery and the longer term efforts to improve the health system and the child protection system, it is essential to improve the alignment between the formal systems and the nonformal aspects of the systems that local people, particularly in rural areas, prefer to use. This work should embody principles of respect and reconciliation and should include constructive dialogue and collaboration. Particularly valuable would be the identification of alternate burial practices that simultaneously respect local values and protect public health.

3. Build emergency preparedness and response and disaster risk reduction into community driven interventions.

The fact that intervention was overwhelmed by the Ebola crisis indicates that community action in a specific domain by itself does not prepare the community to respond to large scale disasters and crises. Because the latter are recurrent features of life in Sierra Leone, it will be important in the future to build into all community interventions elements that increase the likelihood of (a) the transfer of elements and processes of the intervention into a crisis period, and (b) the sustainability of the intervention process. All interventions should have well defined elements related to helping the community prepare for and respond to emergencies, and enhance the sustainability of the intervention process during and following the crisis.

4. Re-prioritize the prevention of teenage pregnancy in Sierra Leone, building social protection into prevention efforts.

This research, like other research projects indicates that the Ebola crisis produced a sharp increase in the rates of sexual exploitation and teenage pregnancy. A high priority, then, is to launch concerted efforts on a national scale to reduce teenage pregnancy. Since increased poverty during the Ebola crisis was a key driver of sexual exploitation and teenage pregnancy, prevention efforts should include work on social protection and other means of enabling effective livelihoods and reducing the burdens of increased poverty.

INTRODUCTION

The Ebola virus disease (EVD) epidemic and crisis of 2014-2016 dealt a devastating blow to the citizens of Guinea, Liberia, and Sierra Leone, the full impact of which is still being unearthed. Rapid pathogen spread, coupled with weak health systems and mismanaged responses to the crisis, resulted in 28,616 confirmed cases, 11,310 confirmed deaths due to Ebola,[2] and a suspected large number of other preventable deaths due to other diseases during the Ebola crisis. In Sierra Leone, the Ebola crisis uncovered the severe inadequacy of its health systems, particularly in rural areas. A legacy of the Ebola crisis is a current public health emergency in Sierra Leone.[3]

In Sierra Leone, the disastrous consequences to health were only one dimension of the catastrophic impact of the Ebola crisis, which in many respects turned the world upside down for children and adults. In many respects, the Ebola crisis profoundly altered the nature and quality of human interactions, people's sense of hope, relations between rural communities and the health system, and the fabric of children's lives. The Ebola crisis sharply increased the food insecurity and chronic poverty that had already inflicted large tolls of suffering on children, families, and communities. These and other human dimensions of the Ebola crisis should not be overlooked. The findings illuminated much about how teenage pregnancy changed during the Ebola crisis, yet they also have implications far beyond issues of pregnancy.

The purpose of this report is to illuminate both the wider impacts of the Ebola crisis on people's lived experiences, with an emphasis on children, and its more specific effects on issues related to teenage pregnancy and its prevention. As discussed below, the research was conducted as part of an effort to learn how the Ebola crisis had affected and interacted with a community-driven intervention to reduce teenage pregnancy. Based on rapid ethnographic research conducted in two districts of Sierra Leone in November-December, 2015, the report is divided into four sections. The first provides an overview of the background and purpose of the research, the primary aim of which was to reduce teenage pregnancy. Second is a description of the methodology used in the present study and its limitations. Third, the report presents key findings on the broad, general effects of the Ebola crisis, its specific effects on sexual behavior and teenage pregnancy, and its impact on the community-driven intervention. The fourth section discusses the implications of the findings. Although this report alone cannot give a complete picture of the felt impact of the Ebola crisis, it aims to complement the extensive work done on the health impact and to appreciate the magnitude of the human impact. Recognizing that the crisis also provides new opportunities, it makes suggestions regarding comprehensive processes of recovery and transformation in the aftermath of the Ebola crisis.

Background on the Multi-Phase Action Research

Globally, the dominant approaches used by NGOs to establish or support community-based child protection mechanisms are characterized by relatively low levels of community ownership.[4] This is problematic since community ownership is one of the primary determinants

[2] CDC (2016).
[3] Elston (2015).
[4] Wessells (2009).

of the effectiveness and sustainability of interventions. In addition, top-down efforts at strengthening child protection systems have suffered from low sustainability, limited use, and also from pushback from local communities. At the same time, the child protection sector has had a weak evidence base. Too often, program evaluations have focused on the number of Child Welfare Committees (CWCs) established, the numbers of trainings conducted for CWC members, or the number of cases of violations against children reported to CWCs, among others. Seldom has there been sufficient focus on actual outcomes for children.

To help address these problems, a group of NGOs, UN agencies, and donors formed in 2010 the Interagency Learning Initiative on Community-Based Child Protection Mechanisms and Child Protection Systems. Save the Children coordinates its global Reference Group, and the Columbia Group for Children in Adversity serves as the technical arm of the Interagency Learning Initiative. In both Sierra Leone and Kenya, the Interagency Learning Initiative has sought to develop and test the effectiveness of community-owned and driven work on child protection. Within Sierra Leone, the work was undertaken in close collaboration with UNICEF, the Ministry of Social Welfare Gender and Children's Affairs (MSWGCA), the national Child Protection Committee, and key NGOs such as Save the Children, Plan International, World Vision, and Goal, among others. Together, these agencies helped to select the sites for the research, settling on two similar chiefdoms in each of two districts--Bombali (predominantly Temne speaking) in the north and Moyamba (predominantly Mende speaking) in the south. Within each chiefdom was a cluster of three villages which were the actual sites.

Research Design

The research has consisted of three phases, the first of which was ethnographic learning in 2011 which trained Sierra Leonean researchers who knew the local languages, lived in rural communities, and learned in a nonjudgmental manner about who are children, what are the harms to children (other than poverty and health problems), what happens when those harms occur, and what supports children's well-being. Led by Dora King (Lead National Researcher) and David Lamin of UNICEF, this phase built significant trust with local people and enabled learning about both the challenges and the strengths of local people in regard to their children. People identified the top four harms to children as being out of school, teenage pregnancy out of wedlock, heavy work, and maltreatment of children not living with their biological parents. Overwhelmingly, they did not use the CWCs or other formal mechanisms in addressing these problems but preferred to use their traditional family and chiefdom mechanisms for addressing them.[5] In fact, there seemed to be a severe disconnect between the nonformal aspects and the formal aspects of the child protection system. This pattern fit that observed in other research as well.[6] The ethnographic findings were shared with each cluster of communities, who validated the findings and reflected on their own on what they should do to address the problems. In important respects, these reflections set the stage for the next phase--the action research phase.

In the second phase (2012), the research team used a free listing methodology to learn about how local adults and teenagers (13-18 years of age) understand children's well-being.[7] They

[5] Wessells (2011); Wessells et al., (2012).
[6] Behnam (2011); Child Frontiers (2010).
[7] Stark et al. (2012).

consistently identified aspects such as participation in education, contributing to one's family, respect for elders, and obedience as key signs that children are doing well. These outcome areas, together with those derived from the ethnographic research, were used to define key outcome areas regarding children's risks and well-being. Subsequently these outcome areas were used to define specific indicators and to construct a survey that measured children's risks and well-being outcomes. In this manner, local views regarding important outcomes for children were incorporated into systematic measures. The survey that was developed also reflected a balance of outcomes for children that were based on international child rights standards.

In the third phase (2013 - 2015), the research used a quasi-experimental design in which clusters of communities were assigned on a random basis to an intervention condition or to a comparison condition.[8] To enable community ownership of work to support vulnerable children, the approach taken was that of participatory action research. In participatory action research approaches, local groups of people collectively identify a problem of concern and then mobilize themselves to plan, implement, and evaluate an intervention to address the problem. This approach generates high levels of community ownership since it is the community that defines the problem, manages or runs the intervention, and holds the power and makes key decisions. The idea was to have communities choose a harm to children and then implement a self-designed intervention to address it. To promote bottom-up system strengthening, the communities were to choose and collaborate with formal (government) actors in the child protection system. Living within each intervention cluster was a trained facilitator who was highly process focused and who enabled inclusive participation, slow dialogue and group problem solving, and decision making by the communities, without excessive guidance by their chiefs. The plan was to collect baseline, mid-line, and endline data by means of the aforementioned survey, and to collect qualitative data as well.

Both clusters of intervention communities chose teenage pregnancy as the problem to be addressed. This was not surprising since the ethnographic research had identified teenage pregnancy as one of the top four harms to children. Also, the conditions surrounding teenage pregnancy were intolerable. In Sierra Leone, nearly one-third of the teenage pregnancies were the result of sexual abuse and exploitation.[9] Since many families were unable to feed another person, teenage pregnancies and births frequently led girl mothers to turn to sex work as a means of survival. Throughout Sierra Leone, the problem of teenage pregnancy is of such great magnitude that in 2013, the President declared a state of emergency and asked everyone to help address it.

The Intervention and Its Preliminary Effects

In both districts, the intervention cluster chose to address teenage pregnancy through a mixture of family planning, sexual and reproductive health education, and life skills. These were enabled in part through trainings provided by Marie Stopes and Restless Development in Bombali and by Restless Development in Moyamba. High levels of ownership were achieved by virtue of the fact that the communities themselves created an inclusive planning process, defined

[8] For both ethical and practical reasons, the action research is currently being extended to the former comparison communities, with support from the Oak Foundation.
[9] Coinco (2011).

the problem to address, chose how to address it, and implemented the intervention. Collaboration with the government was achieved by virtue of the District Ministry of Health providing contraceptives, training health post staff on how to use implants, and having health workers educate on issues of puberty, sexuality, pregnancy, and pregnancy prevention. As described elsewhere,[10] key to the intervention was community action, including: dramas created and performed by teenage girls and boys on consequences of pregnancy followed by discussions; parent-child discussions on puberty, sex, and pregnancy; creation of and transmission by teenagers of youth oriented messages about preventing teenage pregnancy; ongoing community dialogues and reflection about teenage pregnancy; and support from health workers and authorities.

With the intervention having begun in March-April, 2013, the mid-line effects of the intervention were assessed in 2014 using the quantitative survey[11] and qualitative findings from key informant interviews and a community self-assessment.[12] As shown in the box on the following page, the results at this stage were promising and featured high levels of community ownership and diverse signs of the intervention effects in addressing teenage pregnancy. However, the results are preliminary in that more time was needed to see fully the effects of the intervention. Also, descriptions and qualitative data were not triangulated fully with the quantitative data. It was hoped that the subsequent endline measures would allow full triangulation and thorough analysis of the results, including systematic comparisons with the control clusters.

Unfortunately, the Ebola crisis erupted in Sierra Leone in August, 2014. This made it impossible to collect the endline survey data as had been planned at the end of that year and that would have enabled the documentation and analysis of the full effects of the community driven intervention. Further, as the Ebola crisis continued, reports from the field indicated that the Ebola crisis had interrupted the intervention, and had introduced a host of confounding variables and threats to children, including increases in teenage pregnancy.[13] Without knowing more about the status and characteristics of the intervention, what the confounding variables were, and how conditions that affect teenage pregnancy had changed, the Columbia Group realized that it would be impossible to interpret the endline survey data in a meaningful way.
pregnancy and issues associated with it had changed. With the approval of the donor (ESRC/DFID), the selected methodology was rapid ethnography, which had proven useful in the early phase of the research described above. Broadly, the rapid ethnography sought to address three key questions:

1. What new confounding variables had arisen that could have increased or decreased teenage pregnancy?
2. How did the Ebola crisis affect and interact with the community-driven intervention?
3. How was children's well-being affected by the Ebola crisis?

[10] Wessells et al., (2014); Wessells (2015)
[11] Stark et al., 2014.
[12] Wessells et al. (2014).
[13] IMC (2014).

Promising Findings

The preliminary results included positive outcomes related to child protection, the community process, and system strengthening.

Community ownership. High levels of community ownership were evident in how many people volunteered their time and work, without material compensation, and regularly referred to the intervention as 'ours,' stating that NGOs and the government support them but do not lead the intervention.

Nonformal-formal linkage and collaboration. The intervention process significantly improved communities' collaboration and linkage with the local health posts. In contrast to previous low use of health posts, many teenagers and/or their parents visited the health posts regularly for contraceptives or advice. Also, villages frequently invited nurses and other health staff to visit in order to educate villagers about puberty, sex, and preventing teenage pregnancy.

Contraception. The District Medical Officers fulfilled their promise to supply the contraceptives and train the health staff. Relative to the comparison condition, teenagers in the intervention communities reported increased intent to use condoms regularly and increased willingness to ask their partner to use a condom. These can be precursors of wider changes in behavior and social norms related to sex.

Life skills. Teenage girls reported that because of the intervention, they said 'No' more frequently to unwanted sex. Both girls and boys said that they had learned how to discuss and negotiate with their partners in regard to sex, and also how to plan their sexual activities in light of wider, life goals. In addition, boys said openly that they had a responsibility to prevent teenage pregnancy. This responsibility taking contrasted sharply with the boys' previous behavior.

Teenage pregnancy. Participant observations and interviews with health post staff, monitors, teenagers, and adults indicated a significant decrease in teenage pregnancies. In the intervention communities in both districts, participants reported that in an average school year (September-June) before the intervention had begun, there were five or six teenage pregnancies. In contrast, in the 2013-2014 school year, many fewer teenage pregnancies had occurred. During that period, half the communities reported no new teenage pregnancies, and the other half reported only one new teenage pregnancy. Grandmothers, who are respected community figures, assured that it is impossible to hide pregnancies in the villages.

Spinoffs. Participants said that school dropouts had decreased. Also, some villages had spontaneously begun to discuss the problem of early marriage. Having learned more about the adverse effects of teenage pregnancy, villagers had begun to question the appropriateness of any teenage pregnancy and also of early marriage.

For these reasons, a decision was taken to change the methodology in a manner that enabled grounded learning about the actual situation in the communities, how the intervention had been affected, what new threats and potentially confounding variables had arisen, and how teenage

As shown below, the research shed light not only on these questions but also on the broader effects of the Ebola crisis on life in rural areas of Sierra Leone.

METHODOLOGY

The study used a method of rapid ethnography during November – December, 2015. The method was similar to what had been used at the initial stage of the research, before communities had chosen a child protection issue and an intervention to address teenage pregnancy. The methodology stressed the importance of listening to children and community members about children's lived experiences.

Participants

A total of 876 community members participated in the rapid ethnography. A total of 621 people took part in 63 focus group discussions, while 255 people participated in the in-depth and key informant interviews. Criterion sampling was used to obtain participants of different ages, genders, and socio-economic status.

Group discussions and in-depth, individual interviews were planned in a manner that learned systematically from ten subgroups:

- Girls: Age 11-13
- Teenage girls: Age 14-19
- Young women: Age 20-25
- Women: Age 26-49
- Elder women: Age 50 and over
- Boys: Age 11-13
- Teenage boys: Age 14-19
- Young men (typically not married): Age 20-25 years
- Men: Age 26-49
- Elder men: Age 50 and over

In all activities, deliberate effort was made to learn from these different subgroups. Because bias might have occurred through mixing members of different subgroups (e.g., by mixing women and men, or teenagers and adults), group discussions were conducted separately with different subgroups. This approach enabled participants to speak more openly, and it made it possible to contrast the views of different subgroups. Due to the lack of precision regarding participants' ages and also due to constraints in the field, some subgroups were combined for data analysis. These included: girls/teenage girls; boys/teenage boys; young women/women; and young men/men.

Sites

At the beginning of the wider research study, within each district of Bombali and Moyamba, two chiefdoms had been selected and randomly assigned to either the intervention or control

condition. Within each chiefdom, three villages had been selected for the research. For this phase, two villages from each of the four chiefdoms were randomly selected for participation in the research (see Table 1). The village names are masked to protect confidentiality.

Table 1. Research sites in Bombali and Moyamba District

Bombali District		**Moyamba District**	
Chiefdom		***Chiefdom***	
Kombura (Intervention)	*Upper Banta (Comparison)*	*Magbiama N'dohahum (Intervention)*	*Liebiesaygahun (Comparison)*
Village A	Village A	Village A	Village A
Village B	Village B	Village B	Village B

Research Team and Organization

The research team included both international and national researchers.The international researchers were from the Columbia Group for Children in Adversity, which developed and oversaw the technical aspects of the research. Mike Wessells and Lindsay Stark were co-principal investigators, responsible for developing the ethnographic research design and methodologies. Kathleen Kostelny co-facilitated the training, analyzed the data, and prepared this report. Ken Ondoro co-facilitated the training and mentored and monitored the national team during the first part of data collection. The national researchers included two five-person teams. David Lamin and Paul Mackavore were Team Leader and assistant team leader, respectively, for Moyamba, while Marie Manyeh and Phillip Songo were Team Leader and assistant team leader, respectively, in Bombali, and were responsible for overseeing data collection. The national team included equal numbers of male and female researchers, which made it possible to match the gender of the researcher and the participants in most cases.

Procedure

The research, conducted during November – December 2015, used group discussions, in-depth interviews, and key informant interviews which were conducted in the local languages of Krio, Temne and Mende. Participant observations were also carried out. Consistent with the quasi-experimental design, the ethnography was conducted in both the intervention villages and the comparison villages. For each District, a team of 4-5 researchers worked in four villages, and were to spend a period of 5-7 working days in each village.

To prepare for the research and train the national researchers, a week-long workshop was conducted by the international researchers and the team leaders. The training was highly participatory and included role plays followed by reflection and discussion. The training covered the purpose of the research, research ethics, researcher roles and responsibilities, asking effective probing questions, note taking and preparing transcripts, and the storage of data.

Research Tools

The research tools are summarized below (see Table 2). Steps were taken to reduce possible negative impact by not asking about the participants own experiences or those of their children, but about children, teens, and people in general in their community.

Table 2. Research Tools

Method	Description
Group Discussions (n=63 FGDs; n=621 participants)	Group discussions were researcher facilitated discussions with approximately 7-12 participants over a period of approximately 60 minutes. The discussion participants came from a pre-defined sub-group such as teenage girls, teenage boys, women, and men.
In-depth interviews (n=230)	The field researchers conducted interviews of approximately 45-60 minutes duration in the local languages with children, youth and adult participants. The open-ended interviews aimed to probe the questions outlined above, yet were conducted in a contextual, flexible manner that took into account the participant's age, gender, their situation and social position, and their interests and willingness to discuss Ebola related questions.
Key Informant Interviews (n=25)	In depth interviews that were approximately 60-90 minute in length, were conducted with key local stakeholders such as health post nurses, chiefs, and focal points for the intervention.
Participant Observations	Researchers observed children in the context of family, peers, work, and community life, and prepared written records.

Research Ethics

The research recognized and actively sought to address the ethical complexities and dilemmas associated with research on children.[14] Columbia University reviewed the proposed research and granted IRB approval. The research was conducted in a manner designed to ensure that the benefits to participants outweighed any costs or unintended harm, and that the research process embodied the ethical principles of humanity, impartiality, neutrality, beneficence, nonmaleficence, and the best interests of the child. All the researchers were bound by the Save the Children Child Safeguarding Policy, which defined key principles, harmful actions that must be avoided, and processes for reporting violations and responding to them in an appropriate manner. Ethical considerations also included how to talk in a respectful and empathic manner when querying people about the impact of the Ebola crisis and difficult life conditions.
To avoid causing unintended harm, participants were asked not about specific cases or their own situation, but about all the children in the area. Informed consent was obtained through careful procedures that did not involve coercion. Children's assent was also obtained together with the consent of their parents. The participants were free to end their involvement in an activity at any time. To protect confidentiality, the records contain no names or personal identifiers.

[14] Alderson & Morrow (2011); Allden et al. (2009); Boyden (2004); Graham et al. (2013); Hart &Tyrer (2006); Morrow (2009); Schenk & Williamson (2005).

Throughout, care was taken not to raise expectations that the participants or their family or community would receive material benefits such as money as a result of their participation.

Data Analysis

The data was analyzed systematically using a grounded methodology. Key categories, themes, and patterns were identified inductively, through holistic reading and examined through processes of triangulation. These categories, themes, and patterns were checked through discussion among the Columbia Group researchers, with revisions made as necessary.

Limitations

The short time frame of this research (1 week in each site) limited the depth of what was learned by comparison with the thick descriptions provided by multi-year ethnography. Due to challenges in the field, the system of monitoring and checking the quality of data lacked robustness. The retrospective method and challenge of recalling accurately within specified time frames was a further limitation. Also, the research has limited generalizability since the areas studied did not comprise a representative national sample.

KEY FINDINGS

This section is organized in three parts. The first considers the broad effects of the EVD crisis on life in the rural villages. Having established this broad context of change, the second section focuses on the changes related to sexual behavior, teenage pregnancy, and associated topics such as sexual exploitation and abuse (SEA). The third section presents the findings related to the community driven intervention.

1. General Effects on Life

The broad effects of the Ebola crisis on life in Sierra Leone are best seen against the background of the importance of social relations, and religious and cultural practices that define ordinary life in rural Sierra Leone villages in times not affected by Ebola or war.

Sierra Leoneans are a remarkably resilient people who exhibit and draw upon a wide variety of family and community strengths. Life in villages is characterized by a system of mutual reciprocities and interdependence in which one gets by through helping and in turn being helped by others. A high priority is attached to group identity, which may be defined along lines of kinship, village, religion, and other dimensions. In this system, social relationships have a high priority, and to be well means to have good family and community relations, to be respected and respectful of others, to interact in ways that conform to social norms and cultural and religious practices. Relationships are the basis of family, are prominent in religious practices, and are at the heart of community life, wherein people see themselves as sharing responsibility to develop and support the community, adhere to its customs and laws, and respect the authority vested in the Paramount Chief and also in lower Chiefs. Relationships are particularly important in regard to family and children. Multiple generations typically live in the same household and share work

and child rearing responsibilities. Children are valued not only for work but also for continuing the family line, boosting status, and bringing hope for the future.

The web of human relationships in Sierra Leone is embedded within a complex, variegated system of beliefs and practices that are frequently described as religious and cultural but that defy simply categorizations. Approximately 70% of Sierra Leoneans are Muslim, and nearly 30% are Christians. Both Muslims and Christians are remarkably tolerant and supportive of each other's faith, and many celebrate the holidays of the other in addition to their own. Islamic and Christian practices are intermixed with indigenous, animistic practices, demonstrating Sierra Leoneans' rich ability to blend different cultural and religious systems. Culturally, there are traditions and rites that impact relationships and individual status in profound ways. When girls reach puberty, they are initiated into the Bondo society--a secret society where they are mentored in the skills of being a woman, and also circumcised--which gives them the status of women and signifies that they are 'ready' for marriage and child bearing. Boys, too, undergo their own initiation rites of passage (entering the Poro) and are typically seen as becoming men by the age of 15-16 years.

Physical contact--touching in culturally scripted ways--plays an important role in maintaining this web of relationships. People greet each other through words, smiles, and also through handshakes and touching, which in many ways symbolizes inter-relationship, mutual respect, and shared dignity. Supportive touching of children is an important means through with parents bond with their children and comfort and support them emotionally. Children touch each other frequently during play and normal activities. At marriages, supportive touching is an expected and important means of expressing support for new relationships and cementing the bonds between families. The role of touch is highly conspicuous in regard to death, bereavement, and burial. Muslims in Sierra Leoneans ritually wash the body of deceased loved ones and see this as a necessary demonstration of respect and also as fulfilling a spiritual obligation to the deceased and to the ancestors.

The mixing of Western, internationalized practices and indigenous beliefs and practices is visible within the health system. Most communities either have or are located within several miles of a health post where nurses and, occasionally, doctors practice mostly Western health care. Many Sierra Leoneans also look to traditional herbalists and healers in addressing health problems that are seen as having spiritual causes. In negotiating these dual systems, many villagers attach primacy to their traditional healers and view Western health care as alien. In the best of times, Western health care is viewed with a mixture of respect, hesitancy, and even suspicion.

Amidst these and many other strengths, life in Sierra Leonean villages in stable times is challenged by ongoing poverty, diverse health problems, food insecurity, difficulty getting jobs, and short life expectations. Before the Ebola crisis, Sierra Leone rated among one of the lowest countries in the world on combined health and development indicators. In 2015, Sierra Leone was ranked among the lowest of all countries (181 of 188) on the global Human Development Index.[15]When the EVD crisis hit, the impact fell hard on relationships, cultural practices, and relations with the Western health care system.

[15] UNDP (2015).

Everything was just upside down (Man, Bombali, Intervention Village B)

During the Ebola crisis the rhythms of daily life were ruptured, as people lost their livelihoods, social relationships were torn apart, and an atmosphere of fear and mistrust permeated daily life. Although Ebola did not reach any of the villages in the study, children, teens, parents and caregivers were nonetheless profoundly affected by the changes brought about during the Ebola crisis.

> *Ebola did not reach here but the breeze touch us in this community.…by that I mean Ebola did not kill anybody in this community but it affected us greatly.* (Elderly woman, Bombali, Intervention Village A)

For some, these changes were worse than the decade long civil war that they had endured.

> *My child, let me tell you the truth -- the war was far better than Ebola....During the war we had all what you need like food, movement, medication. But during Ebola, nobody travels. Food became (like a) diamond -- very hard to get. Even if your family died or became sick, you (were) not allowed to go see that person. ... Business all stopped and the money is gone.* (Woman, Bombali,Intervention Village A)

> *Ebola was more fearful than the rebel war. Before Ebola you could leave your child with your neighbor, but during the Ebla you can't dare to touch anybody and believe anyone to give your child to.* (Man, Bombali,Intervention Village A)

Loss of Income and Livelihoods

In response to Center for Disease Control (CDC) guidelines for national infection control, the Paramount Chiefs imposed two by-laws that impacted livelihoods and income streams, resulting in increased poverty and inability to meet basic needs. The first by-law forbade movement in and out of villages, while the second by-law restricted people from gathering within their own villages. Together, these by-laws not only worsened poverty but also decreased sharply the participation in social and cultural activities such as religious events, burial rituals, and entertainment. As will be discussed in section two of the findings, the increasing poverty contributed to corresponding increases in transactional sex and teenage pregnancy.

Restriction of Movement

Daily routines were severely disrupted by the Ebola crisis. As people could not work and children could neither play nor go to school, people felt as if they were living in a cage.

We were like a slave in a cage (Woman, Bombali, Intervention Village A)

One of the most profound changes was the restriction of movement of people going outside their village or having 'outsider'" come into their village. The outsiders included those who did not live in the village as well as residents who had been living outside the village when the Ebola crisis struck, and included fathers, mothers, wives, husbands, and children. This restriction had devastating consequences for everyone living in the villages. Because people could not travel to their usual places of business – including the *luma* -- the weekly market where they sold their produce and goods – people were unable to earn any money to buy food or other basic necessities. As a result, there was 'plenty hunger.' This not only impacted adults, but also teen girls who engaged in petty trading at the market to sell produce or small items to get their needs met.

In addition, the financial help from relatives who lived in the larger towns also vanished, as relatives could not enter the village, nor could anyone leave the village to go to their relatives. For some, relatives' financial help had been a steady source of support, while for most others, it had been a source of support during an emergency or difficult times. During this crisis, however, relatives' financial support was completely cut off. Not only were one's relatives suffering financially, but there was no possibility of physical travel, which was the only possible means of bringing resources to these small communities that had otherwise never been connected with the national and global electronic funds transfer systems.

Furthermore, the physical separations curtailed the emotional support that would normally have been provided by and for husbands and wives, children, and extended family. If husbands and wives were separated from each other when the by-laws went into effect, most were unable to reunite during the Ebola crisis. Many roads were closed, and transportation was extremely difficult to come by.

> *Our boyfriends who stay away from this village stop visiting us….Again I became pregnant during this Ebola and I gave birth as a young lactating mother and school girl. And my child's father stay in Freetown. I want him to send for me and the baby. He said, 'Road closed!' So I keep suffering and regretted everything, even love.* (Teenage girl, Bombali, Intervention Village A)

> *During Ebola, when our brothers and sisters come to visit, we will not let them enter this community. They stop us not to visit our relatives outside this community.* (Young man, Moyamba, Intervention Village A)

> *Our children staying out of this town do not come to visit us and we also do not go out of this town. It really 'pwel we heart'* [pain us].

Fear and Suspicion of Health Posts and Hospitals

During the Ebola Crisis, people lost trust in health posts and hospitals and feared that they would contract Ebola in health facilities. Also, local people believed that they could be misdiagnosed as having Ebola and killed, or that they would not be treated well and would not receive the medicine they needed.

> *We were not going to the hospital because people were saying the nurses have the Ebola, and the treatment they give you will transfer the Ebola to you. We also heard that some people with malaria went to hospitals and were told they have Ebola and killed*. (Teen girl, Moyamba, Comparison Village B)

These fears and suspicions were also coupled with the difficulty of traveling out of the village, leaving parents feeling trapped and unable to support children who experienced health problems.

> *Children were not taken to the hospital due to fear that they might inject them to die. They suffered so much because there was no medicine for the children, because their parents could not take them out of the community, and the message they were getting about the hospital.* (Boy, Bombali, Intervention Village A)

Most people in the villages were fearful and suspicious of the health posts. In one intervention village in Bombali, however, the community had a good relationship with the nurse, and people reportedly did visit the health post, though they still feared going to the hospital.

> *We had good relationship in the health centers. All the workers do work with the responsibility assigned to them*. (Woman, Bombali, Intervention Village B)

Yet in the other villages, where misinformation and rumors had spread, people harbored suspicions that the actions of health staff would kill them. People feared that they would be injected with the Ebola virus either deliberately or unintentionally through the use of contaminated needles and syringes that had been used previously with Ebola victims. Also, people feared that if their blood was drawn, they would die immediately. As a consequence, many people did not go to the health post or take their children there.

> *We were not going to the hospital because we were afraid they will inject us with the Ebola syringe and die.* (Woman, Moyamba, Intervention Village A)

> *Parents were afraid to take their children to hospital when they fall sick because of the Ebola.* (Teen girl, Moyamba, Comparison Village A)

> *Children could not go to the hospital for fear of being killed with injection, or their blood being drawn. All of the news brought fear on the children*. (Man,Bombali, Intervention Village A)

> *Some parents did not take babies due to the fear that the doctors will give their babies Ebola injection that get them affected by the virus.*(Young man, Bombali, Comparison Village B)

People also feared misdiagnosis, as the usual symptoms of diarrhea, fever, and vomiting of some of the frequent illness such as malaria or cholera were the same as Ebola symptoms. They feared that once they had been diagnosed as having Ebola, one would be taken to a holding center where certain death by Ebola awaited.

> *Because they did not want to get the sick and they told us if your body is warm or your head is aching, the nurses will say you have Ebola and give you injection. That injection will kill you and you will be buried with none of your family present.* (Teen Boy, Moyamba, Comparison Village A)

> *Before, one could vomit with blood and you go to the hospital and they will treat you perfect and give you many medicines. But during Ebola when someone have simple headache, they said is Ebola...So we were afraid to go to the hospital.* (Young woman,Bombali, Intervention Village A)

> *During Ebola, even if you have headache, we were afraid to go to the health enter because they will soon tag you Ebola patient*. (Young woman, Bombali Comparison Village B)

> *The signs and symptoms they explained to us about Ebola were rash, warm body, vomiting and diarrhea -- and those are common among the under five children. So when our children get any one of those signs, we were afraid to take them to the clinic, so most of them died.* (Teenage girl, Bombali, Intervention Village A)

> *Everybody became fearful of going to the hospital because any small fever they said is Ebola.* (Young man, Bombali, Intervention Village B)

The avoidance of health posts was fueled also by people's belief that they would not be treated well or at all because the intense focus on Ebola excluded the treatment of other conditions. People also feared that the diminished supply of medicines would impede proper treatment of one's ailments.

> *The nurses were not treating us well...They said because of the Ebola they are not touching any sick person. They themselves are protecting their own lives.* (Woman,Bombali. Intervention Village A)

> *…if we manage to take them there, the nurse will not give them the full dosage required.* (Teenage girl,Bombali, Intervention Village A)

During the Ebola crisis, many expectant mothers, including teenagers, received no prenatal care. Even if they went to the hospital to deliver their babies, they received no assistance. As a result, complications that arose during delivery were not attended to, and some babies died.

> *Before Ebola when you become pregnant, you go to the hospital, they treat you...But during Ebola they stopped and everything was associated with Ebola.* (Young woman,Bombali, Intervention Village A)

> *When I got pregnant, I decided to go to the hospital for regular checkup, but the nurse keep saying to all of us pregnant women that 'This is Ebola. Don't see us or touch us!' When it is time for me to give birth, I again went to the hospital...The nurse and other workers took me in the labor room and closed the door and*

> *nobody was allowed to enter. They said to me, 'Help yourself, this is Ebola, no touching'...I keep shouting 'Tell God help me!' and I delivered safely. The nurse managed to move my baby's umbilical cord safely and I shouted 'I have given birth!' Then they opened* [the door] *to let me go home. When I went home I meet three days lockdown with no food to eat. That is how I was affected as a new mother.* (Teen girl,Bombali, Intervention Village A)

Other factors that limited the use of health posts included people's belief that they would have to pay for services that had been free before the Ebola crisis. Also, transportation was limited as motorbikes typically used for getting around were not readily available, and people could no longer afford transportation in the difficult economic climate.

> *The distance from the village to the health center is very long, and by then there were no okada or vehicle to take you to the health center just for the nurses to say we have no medicine at the center.* (Woman, Bombali, Intervention Village A)

Preventable Deaths

As profound fears kept people from taking their sick young children to the hospitals, children died from malnutrition, malaria, and other 'common' illnesses.

> *Many children died in our hands.* (Young woman, Moyamba, Intervention Village A)

> *…because of wrong information, we avoided the hospital for some time* (Woman, Bombali, Intervention Village B)

> *Some children even died because they did not get the right treatment.* (Teen girl, Moyamba, Comparison Village A)

> *Children were dying during Ebola, because their parents were afraid to take them to hospital. Most of them were malnourished.* (Man, Bombali, Comparison Village A)

> *Well some of them* [young children] *died because their parents were afraid to take them to hospitals when they got ill.…that was due to the wrong informations that were spreading around the village that if anybody happens to fall* [sick] *by then and goes to the hospital, he/she will immediately be considered as an Ebola victim by the doctors or nurses.*

Because mothers were not assisted during delivery at hospitals, children died during birth, or shortly thereafter due to delivery complications. At least one teen mother reportedly died during delivery due to lack of assistance.

> *The pregnant women were delivering on their own. Some children were having complication during delivery because nurses were not helping, and died after a few days or months.* (Young woman, Bombali, Intervention Village A)

Disuse of Traditional Treatments

Since there were by-laws against going to traditional healers and using traditional medicine, other types of sicknesses were not treated in the customary way.

> *Some sickness are associated traditional medicine, but there were laws against traditional treatment. People were dying as a results of that.* (Teenage girl, Bombali, Intervention Village A)

In essence, the Ebola crisis shut down people's use of either the Western or the traditional parts of the health system.

Death of Relatives from Ebola

Although no one in the villages died from Ebola, people did in fact lose relatives who lived in other towns and villages. Significant distress arose not only because of the loss of their loved ones but also because of their inability to attend to them while sick. They were especially distraught that they could not conduct the proper burial rituals and that a respectful burial was not accorded to their loved ones. The practice of Ebola workers wrapping the body in a plastic bag was enormously disrespectful to people. Distress arose also from the fact that the deceased were buried in locations that were unknown or inaccessible to their relatives, neighbors and friends.

> *Before, when your father or mother died, we go and stay with our bereaved family until forty days. But during Ebola when you see the way the burial team handle your dead, you will want to kill them, but no chance and power to do that. We only die slowly with the pain inside. You may want to revenge but no way.*(Teen girl, Bombali, Comparison Village B)

Fear and Suspicion of Friends and Relatives

The Ebola crisis inflicted on people enormous fear, sorrow, and emotional pain. Understandably, people had powerful fears of contracting Ebola. Although the legal prohibition against touching intended to protect people from contracting Ebola, it had the unfortunate side effect of making people suspicious and fearful of people with whom they had formerly enjoyed good relations. Children and adolescents became fearful of each other – everyone was a suspect -- and even families became suspicious of each other. Unbridled fear led to changes in living arrangements and the routines of life – people no longer slept together or ate together "off the same plate" as they once had. Even married couples avoided sexual activities.

> *We were affected greatly with fear of the Ebola sickness. Everybody was a suspect, even your own family members.* (Man, Bombali, Comparison Village A)

> *The whole community was in a state of panic, stress, dilemma and fear. Everyone was afraid of each other. Like families and friends, and boyfriends and girlfriends were all afraid of each other.* (Teen boy, Bombali, Intervention Village B)

> *Before the Ebola we used to shake hands, hug each other, and all the likes. But all of a sudden we heard of Ebola. Within another moment we started information that we shouldn't touch each other. We shouldn't touch the dead body. We shouldn't touch sick people and all the likes. So we were paranoid in every way. So Ebola then automatically turned us to enemies against each other, because it is only your enemy that will pass you by without you noticing him, neither wishing or wanting to touch him.*(Young man, Bombali, Intervention Village A)

Hunger and Malnutrition

Hunger was a source of distress and malnutrition, and it was both pervasive and omnipresent.

> *Hunger was their new friend, always with them.* (Young man, Bombali, Intervention Village A)

'*Plenty hunge*r' was a phrase that was frequently used to describe how children were affected by the Ebola crisis. Particularly affected were young children under 5 years of age, who reportedly cried continuously from hunger and were more likely to become malnourished. Some children who might have survived under normal circumstances, which allowed for medical treatment, died as they were not taken to the health post or hospital.

> *Because there was no farming going on, so we had no crops to harvest, which made hunger the order of the day. It was indeed painful for those children.* (Man, Bombali , Intervention Village B)

> *Those little children suffered a lot due to hunger. Many children of that age got sick. Some died….* (Teen girl, Bombali, Intervention Village B)

> *At times when your baby is crying* [from hunger] *we go far away, because I feel sorry for her. And some died as a result.* (Woman, Bombali, Intervention Village A)

Breast fed children were reported to be malnourished because their mothers did not have good breast milk that contained the '*good nutrients*' from '*good food*'.

> *The lactating mothers were suffering from hunger. Not enough food to eat. If there is enough and good food, the children too will have good breast feeding and also good breast milk will come out of our breast. But that was not the case so some died as a result of that.* (Woman, Bombali, Intervention Village A)

> *It was quite impossible during the Ebola to have enough food to eat in the morning, to eat in the afternoon and to eat in the evening…and that was if there is*

> *any food at all for the day. It was quite sorrowful for these little children, and that was how most of them got seriously ill and malnourished*. (Key informant interview, Bombali, Intervention Village B)

Decreased Child Well-being

Children's well-being was affected negatively by many factors, including teenage pregnancy, which is the focus of the following section. Changes related to lack of play and socializing weighed heavily on children, while children's disobedience concerned parents.

Restricted play and socializing. A major source of psychosocial distress for children was their inability to engage in normal activities. Because they could not play, farm, be with other children, or go to school, children were described as unhappy, discouraged, lonely, and despondent.

> *Well before Ebola we used to play under the moonlight happily and also go to school regularly. But during Ebola all was stopped. We were kept indoors like wild animals locked up in cage*. (Teen boy, Bombali,Intervention Village A)

> *We were so lonely….we were not playing with each other at home and even in the community*. (Teen boy, Bombali, Intervention Village B)

> *We were not walking. We were not going to friends we were not greeting each other. We were not going to school. We were hungry. Our parents were not selling. We were not happy because we were not doing what we were doing before. We were not going to thefarm. We were not eating together. We were not selling for our parents.*(Young girl, Bombali, Intervention Village A)

The lack of socializing and play hit children particularly hard. Because of the by-law prohibiting gathering, children were deprived of opportunities to benefit from positive peer, family, and community interactions. Not being able to play or engage in social activities affected both boys and girls, young and old and made them feel imprisoned.

> *It placed us under a house arrest*. (Teen boy, Intervention Village B)

Restricted from moving throughout the village and unable to play their customary games with other, young children were deprived of the play that is widely regarded as a pillar of children's healthy social and emotional development. Young children were described as being tormented and sick from not being able to play.

> *Child, I could say if you want to punish them, tell them to sit a minute. So then they say no movement, it affected them so much. They were restricted not to not go out and play.* (Woman, Bombali, Intervention Village A)

> *My sister who is four is a waka bot* [plays and walk around a lot]. *She cried every day when she was refused to go to neighbors for play* (Teen Girl, Bombali, Comparison Village B)

> *The children were held in isolation for quite a long while. Their movements were highly restricted by parents. They had no freedom of movement as they used to before the Ebola period*. (Young man, Bombali, Intervention Village B)

> *Children were restricted to play. Children are like a dog. If you keep them tight, they become sick. So that affected them greatly.* (Woman, Bombali, Intervention Village A)

School-age children also missed interacting with their age-mates at school and engaging with them through play, sports, storytelling, and doing chores together. Especially missed also were the special gatherings at holidays with friends and people from other villages.

> *We used to play with each other. We used to go to the farm to plant and to find food. We were selling to get lunch when am going to school. At night we used to tell stories outside the house with our friends. We were fetching water for our parents before Ebola, but during Ebola we were not allowed to do that*. (Young girl, Bombali, Intervention Village B)

Teens also felt the brunt of not being able to socialize and engage in important cultural activities with peers and community, including attending church or mosque, participating in sporting events, and going to the customary dances and entertainment that were an integral part of their lives.

> *This town was like a graveyard*. (Teen Boy Bombali, Comparison Village A)

> *Ebola seized our freedom…let me say we had activities like football that we could no longer play during the Ebola, so it seized our freedom.* (Teen Boy, Moyamba, Comparison Village A)

During holiday seasons in normal times, youth typically 'made the town lively', organizing dancing events, football competitions between villages, and other social activities to which people from other towns and villages and even cities such as Makeni and Freetown were invited. During the Ebola crisis, however, all entertainment ceased

> *Well, before the Ebola, children used to have school, sports, school shows and concerts. Even we the youths used to organize several social activities like dance shows, football matches between village to village. And we also stopped going to churches and mosques. All that was stopped during the Ebola. We were just locked up in fear and frustration, and hunger and starvation* (Young man, Bombali, Intervention Village A)

> *When it was Christmas our parents will organize football match and also bring musical set and they will invite people from other villages to enjoy together. But last year we were unable to do that because of Ebola.* (Boy, Moyamba, Comparison Village A)

> *When we were just sitting in one place we were tormented all the time. When we go to our friends to play, their parents were driving us* (away). (Young girl, Bombali, Intervention Village A)

Social relationships were weakened or destroyed because of fear, restrictions on movement and gathering, and competition for scarce resources.

> *We used to live like brothers and sisters. Now look, we are enemies*. (Man, Bombali, Intervention Village A)

According to the earlier outcomes research on children's well-being, obedience to parents had been one of the top-ranked indicators of children's well-being. However, some children, especially adolescents, were now perceived to have become disobedient because their parents could not supply them food and other basic needs.

> *There used to be a very big change and difference ...before the Ebola, because they used to be obedient. They also used to be under control*. (Key Informant, Bombali, Intervention Village A)

> *Children were no longer listening to their parents because they were not providing their basic needs*. (Woman, Bombali, Intervention Village B)

> *If the children are hungry and you have nothing to give to them, they always want to challenge you because you are unable to meet their needs.* (Man, Bombali, Intervention Village B)

Teen girls refused to heed their parents' advice not to get involved in sexual activities and not to get pregnant.

> *We advised them to take medicines not to get pregnant but most of them refused to listen to us. We also told them not to go out at night.*

Teen boys were also reported to have become more disobedient and defiant, smoking cannabis and gambling.

> *Lots of things changed, like the way the children started behaving towards parents - they become defiant and children especially teenagers, started acting like hoodlums*. (Young man, Bombali, Intervention Village A)

Unfortunately, some young children received more beatings, not only for disobedience, but also because they were crying from hunger.

> *They were always crying on our parents, and they beat them*. (Young woman, Bombali, Intervention Village A)

> *Some were even beaten by their mother when they continuously cried for food and the mother has no food and were not allowed to go out to look for food somewhere else*. (Woman, Bombali, Intervention Village A)

Loss of Education

Children's loss of access to education had a profound psychosocial impact. For nearly a full school year, children were unable to attend school. According to diverse community members, including children, the most serious consequence was that children became '*idle*' since they had no structured activities to occupy their time.

> *This Ebola made us to stop going to school.* (Teen Girl, Moyamba, Comparison Village A)

> *We sit from morning til night doing nothing.* (Teen girl, Moyamba, Comparison Village B)

As discussed in the following section, idleness was related to an increase in sexual activity.

Numerous cognitive harms related to schools being closed emerged: children forgot what they had learned and became '*fools*'. Held back, they were unable to take their entrance exams for secondary school; also, some children lost interest in learning and dropped out of school altogether. Harms to their social development also were evident as children could not socialize with their peer groups and benefit from positive peer integration, nor could they benefit from the advice and guidance of teachers.

> *When they said no school, we were discouraged. It brings us backwardness*. (Teen girl, Bombali, Comparison Village A)

> *We were not studying. We forgot most of the things we were taught. We were not playing football as we used to play before in school. We were not happy when we were not going to school*. (Young boy, Bombali, Intervention Village B)

Although radios had been brought in to the villages with the intent to have children continue their lessons via educational radio programs. Unfortunately, that did not happen since people did not know how to operate the radios, or children lack interest and thus did not engage in this type of learning.

> *They were even supplied radio, but we the parents don't know how to go about it, so it was like a furniture in their hands*. (Woman, Bombali, Intervention Village A)

The loss of education was viewed as an enormous harm to children's well-being. Also, most children suffered from having lost valuable knowledge and being held behind.

> *Our education was set backward.* (Teen boy, Bombali, Intervention Village B)

> *When there was no school, some* [children]*got stupid because we were not learning. Some have got backward. They don't even know how to spell some words they were spelling before*. (Teen boy, Bombali, Intervention Village B)

While losing almost a year of education was discouraging for most children, others descended on a pathway that led through pregnancy, poverty, or loss of hope to permanently dropping out of school. Many children felt that their future had been destroyed because they had been held back in school, or that they would never go back to school. For girls, this was especially true if they had gotten pregnant.

> *It destroyed education because I was preparing to sit to be BECE exam, but when they said 'no school' I became pregnant and my education became affected*. (Teenage girl, Bombali, Intervention village A)

> *The most painful effect of the Ebola is the bad thing it caused on our children and young ones. Schools were closed, they were idle, their ages have gone up but they are still at the same level in school. My junior brother has impregnated two girls during this period. The burden is now upon me. Our youngest sister - a very small girl - is also pregnant. There is no business going on. I used to do business but not anymore*. (Teen Girl, Moyamba, Comparison Village A)

Most people believed that boys were not as affected girls since boys would be able to return to school. Other people, however, pointed out that boys were also affected as they would have to drop out of school to support the girl and her baby.

> *As for boys, they were not affected. In fact, they have started going to school*. (Woman, Bombali,Intervention Village B)

> (Girls were more affected)*because they were impregnated by the boys and the boys continue living their normal lives whiles the girls become dropouts and suffer to raise their children*.(Teen girl, Moyamba, Comparison Village A)

Restrictions on Gathering

Severe restrictions on gathering affected all aspects of daily life including school, religious services, playing and working.

> *We were just locked up in fear and frustration, and hunger and starvation*. (Young man, Bombali, Intervention Village A)

> *The time there was no Ebola, we used to walk around freely. But the time that Ebola came, we were not walking around again. Also we should not gather one place, even school we should not go there.* (Girl, Moyamba, Comparison Village A)

As with the by law restricting travel outside one's village, the restriction on gathering impacted those who relied on collective farming for their livelihood, as well as youth who relied on income from organizing social and entertainment activities. This further contributed to teen girls not having their basic needs met since parents and brothers could not contribute to their families' sustenance.

Before the Ebola crisis, community members, including the youth, had often farmed together. This collaborative farming enabled people to harvest the crops more easily, thus providing a good yield for the owner of the land as well as income and food for those who had helped. To meet their own needs as well as to help their families, many teens had depended on the money or food they had obtained from collective work on their neighbors' farms.

> *Before Ebola we used to farm in group. All the youth this village will go to one person's bush to brush the bush for farming or plough the large portion of land. In that way we can produce plenty food. But during Ebola, it all cut off.* (Woman, Bombali, Intervention Village A)

Youth had also organized dances and social events, which had also produced an income for them. The fact that this was forbidden during the Ebola crisis had severe economic impact.

> *In this community, we have calendar of activities for our social life. But when Ebola enter this country, the Paramount Chief put by-laws, which disturbed greatly our activities. Before Ebola our social activities earn us money and the money was used to support our families.* (Man, Bombali, Intervention Village A)

Cessation of Cultural Activities and Ceremonies

In addition, people were deprived from participating in their cultural activities and ceremonies, including naming rituals, burial rituals, and religious gatherings at churches and mosques. Youth were not able to attend sporting activities, dances, and other social events. Girls who normally had participated in the *bondo* [secret] society activities were unable to do so during the Ebola crisis owing to the ban on gathering. This deprived them not only of opportunities to socialize with peers but also of mentoring from elder women and meaningful cultural activities. This limitation on participation in the bondo had the side effect of preventing traditional circumcision activities (FGM). Although international child rights and protection workers would likely have regarded the reduction of FGM as a positive outcome, the cessation of these activities caused distress to teen girls.

> *The elderly women were not allowed to do their bondo and other initiations. They normally have their bondo society where they can initiate young girls and most teenagers, and during those period, those who are member of the society were free to go in to their society bush to eat, dance, and have a lot of fun. But all these things were not allowed during Ebola*. (Teenage girl, Intervention Village A)

Highly distressful for people of all ages was the inability to participate in traditional burial rituals, which were seen as important for the identity and well-being of the living. There was a

strong cultural tradition of washing the body,paying last respects, and accompanying the deceased and their family to the burial. If the deceased person was a relative, it was also customary to spend a period of 40 days with the deceased person's family. Particularly distressful was the manner in which the person was buried. During the Ebola crisis, dead bodies were placed in a plastic bag by carefully protected workers (strangers) and taken away to an unknown burial site. Sometimes the burial team did not come for several days, leaving the body to decompose while relatives sat helplessly, unable to perform the practices that were seen as necessary for respecting the dead.

> *The one that pained us more was the way they were burying our relatives. They were put in plastic bags even when it was not Ebola that killed them.* (Boy, Moyamba, Intervention Village A)

> *Our relatives die, they say we should not wash them or even be at the berin* [funeral]. *We should also not make berin Sarah* [burial rite].

2. Effects on Sexual Behavior, Teenage Pregnancy, and Sexual Exploitation and Abuse (SEA)

The descent of the country into deeper poverty, coupled with the psychological impact of the Ebola crisis, children's idleness, and the disruption of organized routines of social behavior, led to significant increases in sexual behavior among teenagers, including transactional sex and even sexual exploitation by Ebola workers. As a result, teenage pregnancy rates reportedly increased. These interacting factors as well as the consequences are evident in the excerpt below from a women's focus group.

E2: *Some girls have got pregnant and are no longer interested in education.*
E3*: Some girls have got into early marriages.*
E4: *Some have babies with no father.*
E5: *Some teenage girls lost their babies during delivering in the hospital. The nurse never attended to them during the period of labor. They delivered on their own and the babies ended up with complications. They said the teenagers got pregnant by strangers like the burial team and they can't tell whether they are infected with the Ebola or not.*
E6: *The teenagers were not going to school and during their sitting down period they were so idling with nothing in their hands like money to take care of their basic needs. They allowed strangers to have sex with them for money and by that time they were also not on their contraceptives and they got pregnant.*
E8:[Before Ebola] *some girls were doing business so that they can be taking care of their basic needs since we the parents can't afford everything for them. They were not allowed to do all that during the Ebola and there were no other source of getting money to take care of those little things they need, except they were forced to have affairs with those burial team people for money to buy Vaseline, slippers, soap and they got pregnant. Now they have children with no father to take care of their children.*
E7:*Some were just disobedient...We the parents advised them over and over to forget about all these needs until the Ebola (is over), but they never listened to us.* (Women, Bombali, Intervention Village A)

Loss of Livelihoods and Income Leading to Sexual Exploitation

The new poverty was a driver for transactional sex.

> *We were not allowed to do our businesses. We were not meeting our needs like food to eat, soap to wash or even to launder, no cream to rub. Men have sex with us and gave us money*. (Teen girl, Bombali, Intervention Village A)

Sexual exploitation was evident as girls who wanted food, basic necessities, or even 'little things' such as Vaseline and body oil, turned to those who could provide such things or the money to obtain them. Prior to the Ebola crisis, people reported that girls had been able to earn money to take care of their needs by selling things in the market. There was a clear link between this economic activity and not being 'tampered' with.

> *Before Ebola, they can sell banana, cake, butter to have money…They don't allow anybody to tamper with them*. (Key informant interview, Bombali)

> *Because we were not selling our little market, like the butter, groundnut, we were not able to provide food or to buy when we were hungry. Our parents were also not providing food because there were no market, no business, no money. When we were selling before the Ebola period, we use part of the profit to buy food and eat, but all were affected during Ebola. Some men in this village were even using girls for food* [exchanging food for sex]*when their parents were not providing them*. (Teen girl, Bombali, Intervention Village B)

Because of the dire economic situation, girls were expected to obtain for themselves items such as food, soap, or more expensive items such as nice clothes or a mobile phone. They were also expected to contribute to the family and help out their parents.

> *…their needs were varied. Some needed mobile phones…some wanted nice clothes ,and shoes whilst some wanted money to take care of their parents as there was, and there is still, poverty in this community.* (Teen boy, Bombali, Comparison Village A)

Although it was not explicitly stated by community members, key informants reported that most parents 'closed their eyes' to their girl's transactional sex because they benefitted from it. When girls brought home money, food, or other goods, the parents did not ask where it had come from.

> *Most parents close their eyes as long as girls bring home money and material things.* (Key Informant, Bombali)

As a result of this transactional sex, girls became pregnant.

> *Because we were hungry, the big girls got pregnant during Ebola.* (Young girl, Bombali, Intervention Village A)

> *Some were even pregnant because they were pregnant by those who were giving them money or food to eat.* (Woman, Bombali, Intervention Village B)

However, for some teen girls in one of the villages, transactional sex, which they had engaged with boyfriends and other men in prior to the Ebola crisis, decreased as a result of Ebola. In particular, the prohibition on dances severely impaired the girls' ability to go to places where they would dance, have sex, and then get money to pay for their sustenance and even their school fees.

> *For us teenagers, we like enjoyments. When they stopped all social activities like dancing we were affected and discouraged. Some girls see doing thing as a way of business* [civilized way girl prostitute]. *Some had boyfriend, whom we don't want our parent to know about, so where there is dancing we invite them. When they come after the dancing show they give us money for sustenance. Some go there without having boyfriend, but in the process the girl happens to have one which might end up serious relationship. Some of them will end up paying our school fees. When Ebola came and stopped all those activities, we were affected.* (Teen girl, Bombali, Intervention Village B)

Teenage Girls Not Heeding Parental Advice to Avoid Sex

Poverty was also seen as having caused children to disobey their parents, who could no longer meet their children's basic needs. According to local norms, the social contract between parents and children requires that parents provide for their children, and, in return, the children are obligated to obey and respect parents. The Ebola crisis weakened this unwritten contract.

> *You the parent cannot control your girl child if you cannot feed her*. (Woman, Bombali, Comparison Village A)

> *We were very stubborn because then I say I want something, they will not give me any. They send me, I will not go there*. (Young girl, Bombali, Intervention Village B)

Without parents meeting their children's needs, teenage girls stopped heeding their parents' advice to avoid boyfriend business. In spite of by-laws that prohibited gatherings, young people nevertheless found ways to rendezvous, including girls sneaking out when parents were asleep or on patrol at the village border.

> *Our girl children went out of control, so (a) few of them got pregnant*. (Man, Bombali, Intervention Village A)

> *They used to be under tight restriction and always advised to avoid body contact, but teenagers rebelled*. (Key Informant, Bombali, Intervention Village A)

> *My younger sister will wait til I'm asleep then she'll sneak out of the house. Other kids were doing the same thing…*(Young women, Moyamba, Comparison Village A)

Idleness of Teenage Girls

Most people, including teenage girls, saw idleness from not being in school as the primary reason why girls engaged in sexual activity and became pregnant. To capture this idea, people often invoked the popular proverb 'An idle mind is the devil's workshop.'

> *They got pregnant because they were not going to school. They were just seated home idly doing nothing, and we all know that an idle mind is the devil's workshop.* (Young man, Bombali, Intervention Village B)

Various explanations were offered in regard to the harmful effects of idleness. One held that when teen girls were busy with school during the day and studies at night, they had no time to engage in sexual activity. Another held that when their minds were focused on their school activities, girls did not have time to think about sexual encounters. But, when teen girls were idle, they got involved in 'boyfriend bizness' -- sexual activity with boys who were their peers.

> *Because of the shutdown of school, they were just home idle, so that gave them the chance to go about their boyfriend bizness*. (Teen boy, Bombali, Comparison Village B)

> *They were not going to school, so most of the school girls got pregnant and that affected them even up til now... The parents were discouraged to see their children like that.* (Teenage girl, Bombali, Intervention Village A)

> *Well it's the school bizness. Girls cannot control their hearts. Because there was no school as soon as morning comes they will go 'bia'* [visit lovers]. *They will be on that till some become pregnant. We, the guys, we don't get pregnant*. (Teen boy, Moyamba, Intervention Village A)

> *This Ebola has destroyed the future of our children. There are so many pregnant girls around this town as a result of idleness. You will confirm with your eyes if you are spend some time here.* (Young woman, Moyamba, Comparison Village A)

Coupled with the pressure to obtain food and other items, idleness was also seen as a driver for transactional sex – often referred to as 'man bizness'. This created a one-two punch in which idleness simultaneously spurred sexual activity with girls' age mates and also transactional sex, mostly with the big men who had some money or goods to exchange.

> *Before Ebola they were going to school so most of them did not have time for 'man bizness' but during the Ebola they were unable to go to school. They were just sitting in this village and the families of especially the girls were unable to*

> *take care of their needs. At night the parents go to bed and the girls go out do 'man bizness' and get 'belleh'* [belly - pregnant]. *This would not have happened if they were going to school*. (Teen boy, Moyamba, Comparison Village A)

> *You know when a girl child has been fully matured, and she has that feeling for sex, being idle makes them go out to look for men*. (Man, Bombali, Intervention Village B)

> *Other girls, even when their parents are around, they will be all over the town at night running after boys…Some of them just like 'man bizness'. Others because the boys give them money and their parents don't give them.*(Teen girl, Moyamba, Comparison Village A)

Shift in Beliefs and Expectations about the Future

As the Ebola crisis wore on, children also experienced diminished expectations for the future that contributed to a desire to become pregnant and a decreased use of contraceptives.

> *Some girls, or even everybody,was thinking that Ebola is not going to end.. so some were saying 'why do I need to sit. Let me get pregnant.'* (Teen girl, Bombali, Intervention Village A)

Some girls believed that they would die from Ebola, creating a desire to become pregnant in order to leave a legacy.

> *Because they were not going to school. They said Ebola is not going to end, so they are not wasting time. Let them get pregnant. Some said Ebola is a killer disease, so let them leave a legacy who will be representing them when they would have died.* (Young woman, Bombali, Intervention Village A)

Other girls wanted to have as much fun as possible and do whatever they wanted since they believed they would eventually die from Ebola. In one village, it was reported that girls even entered boys rooms uninvited, pursuing the boys for sex.

After schools had been closed for some months, some teen girls believed that schools would either never open again or would not remain closed for a very long time. Without the opportunity to attend school, some girls deliberately became pregnant as their focus shifted from wanting to complete schooling and 'be somebody' by having a baby. Believing that schools would reopen but not in the near future, some girls thought that they would have time to become pregnant, take care of the baby while breastfeeding, then return to school when the child was older and could be left in the care of family or neighbors.

> *Some* [teen girls] *were saying Ebola is not going to end, and even if it ends, it is not going to be soon, so they are going to have children. And by the time Ebola ends they have already given birth to their babies and they can be able to attend school. .* (Woman, Bombali, Intervention Village A)

Before the Ebola crisis hit, girls had a goal for the future, and this motivated them to avoid becoming pregnant.

> *We were going to school and at school there was competition amongst the girls. Everybody wanted to become somebody in the country. But when the Ebola came, some of us decided to give birth with the thought that when the Ebola ends, we will go back to school.* (Teen girl, Moyamba, Comparison Village B)

Some girls appeared to have been influenced by having seen others having babies. Wanting to imitate their behavior, they deliberately had their implants removed and stopped using other forms of contraception.

> *I heard that they were giving them PPA so they will not be pregnant. But some girls here, when they see their companions having pregnancies, they too will say they want to become pregnant. So some stop going to the hospital*. (Young man, Moyamba, Intervention Village B)

> *Those who have implant go and remove it secretly. As a result they got pregnant.*(Woman, Bombali, Intervention Village B)

Sexual Exploitation by the Ebola Burial Team

In one of the villages, one of the biggest changes that affected teen girls' sexual activity and pregnancy was the sexual exploitation by the Ebola burial team.

> *The burial team for Ebola that was sent also cause the pregnancy rate to increase because they had money, and they gave us, and have sex with us as they like it.* (Teenage girl, Bombali, Intervention Village A)

Flashing the money that they were paid, they attracted the girls by buying them food and giving them money. In return, the girls gave them sex.

Numerous participants commented that girls were particularly vulnerable to exploitation because of their lack of food and their idleness.

> *The secondary school children, most of them got pregnant during this Ebola. ..when they were going to school they were not interested in any man affairs. The other thing that affected the teenagers was poverty because the men that came to work during Ebola were giving us money and we give sex in return.....* (Teenage girl, Bombali, Intervention Village A)

> [Before Ebola] *some girls were doing business so that they can be taking care of their basic needs since we the parents can't afford everything for them. They were not allowed to do all that during the Ebola and there were no other source of getting money to take care of those little things they need, except they were forced*

> *to have affairs with those burial team people for money to buy vaseline, slippers, soap, and they got pregnant. Now they have children with no father to take care of their children*. (Woman, Bombali, Intervention Village A)

Some girls viewed their sexual activities with the burial workers as an exchange of goods, and continued to use their contraceptives. They attributed their use of contraceptives to having been sensitized about contraception during the intervention.

> *For some of us who were sensitized, we prevented.* (Teenage girl, Bombali, Intervention Village A)

Often, however, girls did not use contraceptives and became pregnant. This situation was augmented by the false promises men made that they wanted to marry the girls. Some men even provided a brideprice to the parents, who were happy to receive even a small amount (5,000 Leones or $1) amidst difficult economic times. Some parents willingly accepted a bride price from the Ebola workers whether or not their daughters consented. In return, the Ebola workers were free to have sex with the girls, even though the girls may not have been in agreement with this decision.

> *The other reason* [girls became pregnant] *was also poverty.*
>
> *..During the Ebola things were not easy for us. Because they said no stranger should visit, so people who used to send things or money stop coming. But the Ebola workers were coming in this village. When they are around they fall in love and will say to us 'I love you for real, not for foolishness.' and they could say 'I want to go and meet your parents.' And because of poverty, whatever they give our parents, it is considered marriage. So you the girl is now supposed to stay with the man. He will be using you anyhow*. (Teenage girl, Bombali, Intervention Village A)
>
> *Some got pregnant because of food. The burial team was coming in the village with food and other things and they used that to have sex affairs with them. They were giving them food as well as money to get sex with them and at the end they impregnated them and went back from where they were coming from.* (Woman, Bombali, Intervention Village A)

Many of the girls wanted to marry the Ebola workers and believed their declarations of love and marriage. Because of this, they stopped taking their contraceptives since being pregnant while married was not only acceptable, but expected.

> *Another thing, we were not preventing ourselves. As for me, before Ebola, I use to take injection to prevent me, but during Ebola I stop taking the injection. That's why I got pregnant ...Some came from Freetown and say they love us and we enter the room for sex. We don't know if they have sick or not....*(Teenage girl, Bombali, Intervention Village A)

Sadly, none of the burial team stayed on to marry the girls after their assignment in the village had been completed. People in the village referred to these as 'Ebola marriages' that resulted in 'babies without fathers.'

> *Most teenage girls gave themselves in marriage. We used to call them Ebola marriage and indeed we were saying the truth because theburial team has gone and we are all here.* (Teenage girl, Bombali, Intervention Village A)

> *After they make the appointment for the man, when he is ready to travel* [finish the job and leave the village] *he will not even say goodbye to you. Or if they say goodbye they will say 'I will call you' and that's the end.* (Teenage girl, Bombali, Intervention Village A)

> *We have grandchildren without fathers*. (Woman, Bombali, Intervention Village A)

One result of teen girls having children was that they plan not to return to school.

> *Most of these girls are now taking care of their children and they have no intention of going back to school*. (Woman, Bombali, Intervention Village A)

Reduced Punishment of Perpetrators

Even aside from the intervention, one of the customary practices that communities used to prevent teenage pregnancy was to punish the perpetrators. As had been observed during the initial ethnography at the beginning of the action research, families frequently used compromise to deal with cases of teenage pregnancy out of wedlock. Typically, the parents of the pregnant girl demanded to know who had impregnated her, and went to the boy's family and demanded that he take responsibility. The families usually arranged a marriage that included compromises such as working for the girl's family for a period of time. If, however, a compromise was not agreed, the case was brought to the Chief, who usually fined the family of the boy.

> *Yes, like us we have laws in this town, but the parents compromise issues. Sometimes the boys will go and cut 'banga'* [palm nut] *for them, some even work on their farm. If we don't see any compromise, the person that gives the 'bele'* [pregnancy] *will pay a fine of 50,000* [$100]*or taken to Moyamba to face the law*.

Unfortunately, some leaders, such as a Chief who saw that the perpetrator was his nephew, used the changed Ebola context as an excuse for evading the imposition of punishment.

> *Most parents begged the men to answer to the pregnancy but the community as a whole did nothing about it. But one of my aunts, whose child became pregnant, wanted to report the matter to the police, but was advised by the chief not to go to the police because it was Ebola period. But the boy who impregnated my aunt's child was the Chief's nephew. So the Chief said after the Ebola they will deal with*

> *the matter and up till now they are on it.*(Teen girl, Moyamba, Intervention Village A)

Impunity also seemed to have applied to the Ebola burial team that had exploited and impregnated girls. Neither Chiefs nor community members took actions against such perpetrators. It is not known whether this inaction occurred because the workers had paid a brideprice for the girl, making the girls their 'wives' in local eyes. Also, it may have been difficult to find and prosecute them in the chaotic Ebola context.

Yet in some cases, customary practices did continue into the Ebola period. In at least one case, a 'big man' attempted to marry a young girl but was prohibited from doing so, with the case going all the way to the Paramount Chief.

> *They were talking to their children to be careful of what they do. There was one case reported to me that even reached the Paramount Chief. One big man wanted to 'put money'* [pay the bride price] *for teenage girl and we put a stop to it. So the caregiver took the matter to the Paramount Chief who gave the verdict that the marriage should not go through. So the father of the child who was not staying in this village was called to come remove his child from the caregiver and he did.* (Key informant interview, Bombali)

Increase in Teenage Pregnancies

As a result of the changes precipitated by the Ebola crisis, teenage pregnancies in all villages were reported to have increased. Although the data were impressionistic and variable, the increases seemed to have been greater in the comparison villages than in the intervention villages. People in the intervention villages also reported that prior to the Ebola crisis, pregnancy rates had decreased due to the intervention.

> *Before Ebola pregnancy rate was not high. Nurse give us medicine, injection, and Captain Ban. If we do not go to the health center, they go to our school, but during Ebola they stop.* (Teenage girl, Bombali, Intervention Village A)

> [Before Ebola, the pregnancy rate was not high] ..*because the girls were sensitized about the use of condoms, pills, injections and the use of captain band. But during Ebola, due to poverty and lack of continuous sensitization, they forget about it*. (Woman, Bombali, Intervention Village A)

It was not possible to obtain exact counts of how many girls had become pregnant in each village during the Ebola crisis. Numerical estimates varied widely, and some people counted girls who had become pregnant and then married, whereas others did not. Also, some parents tried to hide their daughter's pregnancy. Teenage girls themselves seemed to have the most precise information, often counting silently on their fingers the number of girls they knew who had become pregnant.

> *Teenagers not going to school so most of the school girls got pregnant. Most teenage girls gave themselves in marriage.*(Teen girl, Bombali, Intervention Village A)

> *During Ebola, pregnancy cases increased…because they were not going to school and those who did not take the implanted medicine which was introduced in 2012/2013 became pregnant during this Ebola period.* (Key informant interview, Bombali, Intervention Village B)

> *We only had two cases of teenage pregnancy that I am aware of the whole community since the beginning to the end of Ebola and that was due to their own faults because they were highly sensitized by us the peer educators.*(Peer educator, Bombali, Intervention Village B)

> *There was changes in teenage pregnancies during the Ebola crisis because three teenager's girls got pregnant during the Ebola crisis. Some parents when they*[girls]*get pregnant they hide it from the community because they don't want people in the community to know*. (Man, Bombali, Comparison Village A)

In Moyamba, people in one intervention villages reported 4-5 pregnancies, while in the second intervention village they reported 10 pregnancies. Even one of the peer educators became pregnant because she was not using contraceptives as she believed she could not get pregnant since her menses had not yet started.

> [I was not preventing] *because I never thought I would get pregnant. People told me I won't get pregnant because I was not seeing my period and all my age mates were seeing theirs*. (Peer educator, Moyamba, Intervention Village B)

In the comparison villages, people in one village reported that there were about 15 pregnancies in one village and between 15 and 20 pregnancies in the other village.

> *During Ebola teenage pregnancy is too much as you can see for yourself. Any girl you see in this village is either she is breast feeding or a pregnant girl. Almost every girl is pregnant in this village*. (Young woman, Moyamba, Comparison Village A)

> *Before Ebola girls were getting pregnant, but it was not many. But during the Ebola, almost all of the girls that are mature got pregnant. Even me, I got pregnant because we were not going to school.* (Teen girl, Moyamba, Comparison Village B).

It also appears that pregnancies may have increased because in some villages in Bombali (intervention and comparison), the traditional herbs used by teenage girls to prevent pregnancy, as well as the traditional methods used for abortions by traditional healers were prohibited.

> *Some elderly women had traditional medicine for abortion. They used to sell it to some teenagers… Now during Ebola they were banned from all of that*. (Teen girl, Bombali, Comparison Village B)

> *There was also traditional herb that prevent us from becoming pregnant and also some when they get pregnant they commit abortion, but Ebola say no to all that.*(Teen girl, Bombali, Intervention Village A)

Moreover, in the absence of intervention activities, communities in the intervention communities, as well as the comparison communities, used the traditional method of preventing pregnancy of tying a rope around a girl's waist.

Increase in Early Marriages

When a girl became pregnant, her parents typically tried to arrange a marriage with the boy or man who had impregnated her. This was sometimes difficult since the boy or man would deny that he was the one responsible. Overall, though, more teenage girls became pregnant, and more were also married.

> *Well most of them got pregnant during this Ebola. Because of the Ebola many girls get married early*. (Young woman, Moyamba, Intervention Village B)

> *Another harm of Ebola to children is this early marriage because before Ebola our children were going to school but during this Ebola most of them got pregnant and we have no option than to send them to the men who got them pregnant which was not planned. We were not planning for them to be married at an early age*. (Young woman, Moyamba, Comparison Village A)

3. Interaction of the Ebola Crisis with the Community Driven Intervention

The picture that emerged was of an intervention that had mostly been disrupted and overwhelmed by the magnitude and intensity of the Ebola crisis. As discussed below, only a few aspects of the intervention process carried over into the Ebola crisis. Making matters worse, the changing situation brought forward a host of confounding variables that would have made it difficult to interpret the effects of the intervention if the intervention had endured through the crisis period.

Disruption of Intervention Activities

Peer education workshops, village meetings for teens and parents on pregnancy and staying in school, and community dramas could not be continued during the Ebola crisis because of the bans on people coming into the village and on gathering within the village. School activities related to peer education and supplying contraceptives ceased as schools were closed. Also, people were less likely to go to the health posts for contraceptives because of their mistrust and fear of the health structures. As one teen girl described:

> [Before Ebola]*we were going to school. We were not idling after school. Some of us had our little business to have money and to take care of our needs, especially food. Our movements were not restricted. We were able to go to the hospital for*

> *contraceptives of any kind you want. We were having peer group education where we teach ourselves on what to do to not get pregnant, what are the problems involved in early pregnancy, what you undergo when you drop out of school. We were acting plays*. (Teenage girl, Bombali, Intervention Village A)

However, almost all the intervention activities ceased, or were severely restricted, during the Ebola crisis. Some attributed the intervention stopping directly with teen girls getting pregnant.

> *The program was very good for our children. They help to prevent teenage pregnancy. But since they stop coming, that caused the three pregnancies in the community. ...their usual visit stop and their continuous training and workshop stopped. ... The children had a healthy competition among themselves with a common slogan for the girls that 'we should not do it'* [have sex at all]. (Man, Bombali, Intervention Village A*)*

The disruption of intervention activities meant that girls who had recently entered puberty were not engaged in the peer support and sexual and reproductive health activities that their predecessors had been involved in. Such girls were seen as being sexually active.

> *The girl children who have started projecting breasts got involved in sex.* (Woman, Bombali, Intervention Village B)

Peer Education and Support Activities. During the Ebola crisis, the two community facilitators, who encouraged the organization of the intervention activities, were prohibited from visiting the villages due to the ban on movement and security instructions from the Principal Investigator. Moreover, because no gatherings were allowed, the local coordinators and peer educators had little or no ability to conduct peer support meetings, workshops, sensitization discussions, and community dramas. Even before the ban on gathering had been enacted, some parents forbade their children to participate in the intervention activities.

> *Some parents even stop their children from group discussions on teenage pregnancy before the by-law were passed because they were afraid of contact*. (KII, Moyamba)

Most activities in Bombali ceased entirely. An exception was intervention village A in Bombali, where the peer educators and Chief reported some small, though restricted, intervention activity.

> *We continued to carry out the activities with no body contact*.....[but] *there were changes in our effort to prevent teenage pregnancy....by-laws were very strong and we could not do as much as we used to do before the Ebola*..(Peer educator leader, Bombali, Intervention Village A)

> *The peer educators were doing their best because we allowed them to do or give the advice they should to their peer group.* (Chief, Bombali, Intervention Village A)

However, the teen girls and teen boys, as well as others in the community perceived that meetings with teens about the intervention did not occur because of the ban on meetings. These included workshops in the community, school based activities, and meetings at churches and mosques.

> *Peer educators not able to continue their activities because no public gatherings. Since we were not allowed to hold public gatherings like prayer in the mosque, we had no way to discuss about teenage pregnancy, so our effort before Ebola change during the Ebola crisis....Since everybody was afraid of the sickness, so they(peer educators) were not that active at all. Even the youth who are the peer educators they too were afraid of the by-laws set by the paramount chief.* (Iman, Bombali, Intervention Village A).

> *They* [community facilitators] *used to teach us a lot, especially the children like the teenagers and all other children. Due to what they used to teach these children,* [it] *minimized problems like teenage pregnancy and all other ways that put their futures at stake. However when the Ebola issue came up, the whole program stopped and we never saw them come to the community.* (Young man, Bombali, Intervention Village A)

> *They were not able to have their peer education group where they teach themselves about dropping out of school, what to do to avoid unwanted pregnancy. (*Woman, Bombali, Intervention Village A)

In intervention village B in Bombali, people also confirmed that the community meetings, dramas, and education activities ceased during 'Ebola time'.

In Moyamba, too, there were very limited intervention activities. Although the facilitator was unable to travel, the coordinator in Moyamba did have a motorbike and could engage in limited travel. Yet his work was hampered because people harbored fears and suspicions that he was an Ebola worker, and Ebola workers in general were feared.

> *Even when I was able to go it was difficult reaching people. They were afraid to come close to me, and because I was using an 'NGO bike' they thought I was involved in the Ebola work.* (Key informant interview, Moyamba)

The disruptive effects of the Ebola crisis were also visible in regard to school based activities such as teen support groups, and the distribution of contraceptives by nurses. The closure of the schools abruptly ended these intervention activities.

> *... but didn't continue prevention activities* [drama]*during Ebola because during Ebola they said no gathering and touching and we do these things in school and there was no school.* (Teenage girl, Bombali, Intervention Village A)

Contraceptive Use. The pattern of disruption of activities and supports for the prevention of teenage pregnancy was evident as well in regard to teenagers' decreased use of contraceptives. Throughout the Ebola crisis, contraceptives were available at the health posts most of the time and also through Marie Stopes, an international NGO of Sierra Leonean origin. However, the preferred types of contraceptives were not always available, and sometimes the supplies ran out.

> *The nurse was giving out treatment to those who go to the health post by giving them condoms and injection.* (Task Force Member, Bombali, Intervention Village B)

In general, though, the Ebola crisis caused a sharp reduction in the use of contraceptives by teenagers, particularly girls. This reduction generated frustration and stress among the nurses at health posts.

> *Last July (during the Ebola crisis), we talked to them and gave them the pills 'by fos'* [by force] *but lots of them were not drinking the pills and there was nothing we could do about that…Teenage pregnancy is a stress for us. The boys came in to collect condoms but the girls did not use preventives. They are our headaches*. (Nurse, Moyamba)

Multiple factors contributed to the reduced use of contraceptives. One was intense fear of the health posts and agencies such as Marie Stopes, fueled in part by rumors that the contraceptives, the nurses, or the medicines at the health posts would give the girls Ebola.

> *Some were using the contraceptives others were afraid. They'll hide them or throw them away. Because people were thinking that Ebola was brought and transferred to them through some of these medications*. (Key informant, Moyamba, Intervention Village A)

> *Before Ebola they were giving PPA medicine but during the Ebola we heard that there is a medicine that they are giving to kill someone, so many of the girls were afraid to go to the clinic for PPA*. (Young man, Moyamba, Intervention Village B)

> *Marie Stopes came here to give our sisters prevention, but most of them refused to take the medicine. They said the nurses want to give them Ebola.* (Teen Boy, Moyamba, Intervention Village A)

In addition, contraceptive supplies were not always available at the health posts. Also, some girls from numerous villages complained that they did not have their preferred means of contraception, or that the contraceptive device did not fit them well. In some villages it was the PPA that was no longer available, whereas in other villages it was the implants (Captain Band) that were not available.

> *The nurses here before Ebola gave condoms, PPA and captain band to our children but during Ebola it stopped. The nurses said they don't have medicines again*. (Teen Boy, Moyamba, Intervention Village B)

> *Because everybody concentrated on Ebola supply stopped coming so there was shortage*. (Young man, Moyamba, Intervention Village B)

In village B in Moyamba, the intervention focal point persuaded the health post to use contraceptives from their 'own supplies' when the designated contraceptives for the project ran out. He also advised the girls to take the contraceptives that were available, even if they were not their preferred contraceptive.

> [They] *used to supply the PPA which they administered to the girls. But when it got finished I talked to them because I'm also working there as a volunteer. They gave the girls the medicines from their own supplies. Sometimes they ran out of supply especially the tablet because it was what most of the girls used. But as soon as they received supply they'll give it out to the girls.* (Intervention Focal Point, Moyamba, Intervention Village B)

> *Well they normally told me that the injection and even the tablet 'nor fit dem'* [is not good for them] *especially the little girls but I talked to them and they are managing the pills for now since the implants are not available here*. (Key informant interview, Moyamba, Intervention Village B)

However, as discussed earlier, some girls intentionally stopped using contraceptives because they wanted to become pregnant.

> *Yes, they* [the health post staff] *gave the girls medicines. They gave them P.P.A, Injection, Captain band but most of them were not going for the medicine again because they wanted the pregnancy*. (Key informant interview, Moyamba, Intervention Village B)

> *Yes they were talking to us to advise us. Some of us took the preventions like me it was the captain band. But I remove it did not fit me…Many girls stop the prevention, they said it did not fit them*...[The facilitator] *was calling us to advise us, but some us were not listening. It will enter the one ear and go out of the other one.*(Young woman, Moyamba Intervention Village B)

Not all girls, however, sought to become pregnant. In intervention village A in Bombali, one girl reported that though some girls had stopped taking contraceptives because they thought they were going to marry the Ebola workers, other girls had heeded the intervention sensitization about the need to use contraceptives and 'played the game very smart' by continuing to take their contraceptives.

> *The rest of them played the game very smart and continued by following the sensitizations given to them by these two people* [facilitators] *I have mentioned, during the Ebola period.* (Teen girl, Bombali, Intervention Village A)

Lack of money also contributed to the reduced use of contraceptives by girls, who were faced with a choice between spending money on food or contraceptives. In addition, girls found it difficult and expensive to get transportation to the health post.

> *We were also not preventing ourselves because the little money we had we use it for food instead of contraceptives.* (Teenage girl, Bombali, Intervention Village A)

> *They were not able to go to the hospital for their preventives. They were not using them.*(Woman, Bombali, Intervention Village B)

Aspects of the Intervention that Carried over to Help with Ebola Crisis

Several skills and lessons from the intervention carried over to the efforts to fight Ebola. The particular skills that were carried over varied across the villages. These included the peer education, the practice of frequent hand washing, the use of condoms, advice giving by task force members, and house to house monitoring visits. Furthermore, youth who had mobilized for the intervention readily volunteered to help with the Ebola response, manning the checkpoints at the village borders and at the hand washing stations.

Peer education.In intervention village B in Moyamba, even though peer education gatherings were not allowed, the intervention focal point continued to encourage girls to stay in school and not become pregnant when he saw them in the village. When the village held meetings to disseminate information about the Ebola crisis, he continued to advise children to avoid pregnancy and stay in school.

> *Well we no longer held workshops, but we met with the children and advised them. In fact the last time during the Ebola crisis we met down there. We sat in a circle -- nobody was touching anybody. We had a focus group with* [the focal point] *and talked to people correctly about issues pertaining to children*. (Key informant Interview, Moyamba)

When the Ebola crisis became 'less serious', the peer educators organized a drama depicting the risks of pregnancy and the virtues of staying in school.

> *When the Ebola was not that serious anymore and people began to relax, the peer educators acted a drama. The councilor* [of the ward], *who was present for the drama promised to award scholarship to six of the girls and two boys because he was impressed with their performance.*(Key informant, Moyamba, Intervention Village A)

However, although the politician was impressed, the scholarships did not materialize, supposedly due to the difficulties of conducting any kind of business during 'Ebola time'.

The same intervention focal point mentioned above reported that he had continued to advise the teen girls and boys regarding Ebola during the village education broadcasts and meetings at

the *baray* (community meeting) every evening. He also continued home monitoring visits, and advised girls who had started their menses to begin using contraception. Similarly, he met briefly with teenage boys during a *baray* meeting where he advised them and distributed condoms.

In the other intervention village in Moyamba (Village A), too, the focal point continued to advise on avoiding teenage pregnancy, though on a smaller scale.

> *She was advising us about teenage pregnancy and teaching us*.
> *Yes, she was she even advise us to be careful about Ebola, we should obey the laws to go to the clinic to join PPA.*(Teenage girl, Moyamba, Intervention Village B)

Hand washing. In one of the intervention communities in Bombali, washing hands had been one of the life skills that had been taught as part of the life skills training. That skill transferred readily and turned out to be of considerable importance in the Ebola response.

> *The intervention taught them the washing of hands with soap after using thetoilet and before eating any food. So when Ebola break out, they ask us to wash hands with soap, which we learnt before the Ebola. So the intervention help us greatly during the Ebola*. (Man, Bombali, Intervention Village A)

> *They taught the children to wash hands before eating and when coming from the toilet and some few things about cleanness. And because we were already taught that, when the Ebola sensitization came to us, it was not difficult to all get used to the washing of hands with soap for both the children and us*. (Teen girl, Bombali, Intervention Village B)

> *They also taught them to wash their hands with soap and clean water before eating and after coming from the toilet, so we used these skills in responding to Ebola. We really thank God for (facilitators) as we made sure we were not only listening to them, but we also practiced their teaching.* (Young man,Bombali, Intervention Village A)

> *They were the first people who taught us to wash our hands ...so when we got to know that those were the main preventive measures against the Ebola, we did not find it difficult adapting to the process as we have been taught that long ago by* [the facilitators]. (Teen boy, Bombali, Intervention Village A)

Condom Use. In addition to the hand washing skill that continued as part of the Ebola response, condom distribution continued as well in Intervention Village A in Bombali. Because youth, especially teen boys, knew about using condoms to prevent sexually transmitted diseases from the intervention, they easily transferred this knowledge of using condoms as part of the Ebola prevention activities.

> *And we were also taught how to prevent pregnancy and sexually transmitted diseases as well* [during the intervention]*and thathelped our community alot*

> *because those were some of the preventive measures given for Ebola. So it was not difficult to adapt to those laws which helped us prevent Ebola.* (Teen boy, Bombali, Intervention Village A)

> *We used the skills learnt by* [the community facilitators] *to respond to Ebola. Because when they were here, they taught us how to take care ourselves, not only on teenage pregnancy, but also from some other sexually transmitted diseases.* (Young man, Bombali, Intervention Village A)

> *The washing of hands and the use of condom was completely used during the Ebola in fear not to contact Ebola.*(Teen-age boy, Bombali, Intervention Village A)

In Moyamba, the intervention focal point continued to use their skills of advising teens and home monitoring. The focal point also used the connection he had made at the health post to insure that contraceptives were available for the teens.

Advising teenagers. In both Bombali and Moyamba, the community focal points, task force members, and peer educators continued to advise teens through various venues, including at the village *baray* meetings and one on one meetings when walking through the village. In Intervention Village A in Bombali, the peer educators and task force members used the meetings for the dissemination of information about Ebola, emphasizing to teens that the practices they had learned during the intervention also applied to the prevention of Ebola. Because they already had relationships with teenagers, they were able to reinforce the intervention message while simultaneously bringing in the Ebola prevention messages.

> *We used to gather the children from ages like 13 years upwards, but we made sure they were somehow how a little bit far apart from each other. These gathering were organized to sensitize them. We used to tell them that* [the facilitator] *told us that all the preventive measure we were taught from those workshops they held before Ebola, are almost the same preventive measures we were using to prevent Ebola. We used to tell them that if only we go by those preventive measures, our community will be Ebolafree, and held those meetings several times during the Ebola*. (Peer educator, Bombali, Intervention Village A)

Volunteering to support the Ebola response. Some intervention task force members and youth readily volunteered to be part of the Ebola response, helping out at the hand washing stations, conducting home visits, and volunteering at the health post.

> *The task force was very active in setting things within the community and they continue the same during the time of Ebola…They were there to see the community protected. They were watching people's movement in the community. They were seeking out strangers in the village. They make sure no stranger enters in the village. We should not go to neighbors for any reason.* (Teen Girl, Bombali, Intervention Village B)

Conducting home visits was also an important role that carried over. In both districts, youth who had been involved in home visits for the intervention also volunteered to conduct home visits as part of the Ebola response. The skills they had learned and the relationships they had built during the intervention phase transferred readily and successfully to the Ebola response. In Moyamba, the intervention focal point, who had conducted home monitoring visits as part of the intervention, continued making home visits as part of his Ebola task force role. During these home visits for purposes of monitoring Ebola, he also incorporated aspects of the intervention, by, for example, checking to see whether girls were taking their contraceptives.

Confounding Variables

The Ebola related changes described above – the loss of livelihoods, idleness from being out of school, children not heeding parents' advice, the shift in future orientation, and widespread sexual exploitation – were strong drivers of increased sexual behavior and increased numbers of teenage pregnancy. Because these factors affected all the villages in the action research but were neither part of the initial design nor controllable, they count as significant confounding variables. Additional confounding variables arose through the work of other NGOs--BRAC and Marie Stopes--which provided necessary supports but had not been included in the design of the action research.

In the intervention villages in Moyamba, BRAC entered and conducted activities to reduce pregnancy.

> *Yes, even BRAC came and advise us and share condoms.* (Young women, Moyamba, Intervention Village B)

> *Even BRAC opened their office at the school. They were talking to the girls.* (Key informant, Moyamba)

BRAC also offered incentives to teenage boys to start a small business instead of 'tampering' with girls.

> *The nurses were sharing condoms, I even saw BRAC giving them money encouraging them not to tamper with girls -- they should use the money to do some business. The nurses were even calling the girls but I was not going there so I don't know what they were doing there.* (Man, Moyamba, Intervention Village B)

Also in Moyamba, Marie Stopes conducted activities in some of the comparison communities in Moyamba.

> *Marie Stopes came with Captain Band.* (Moyamba, Comparison Village B)

In Bombali, too, girls in Village B reported that they had obtained contraceptives from health posts in other towns and implants from Marie Stopes.

We use condom, implant, injection. If you have chance you go to Matoto. The implant was provided by Marie Stopes. (Teen Girl, Bombali, Comparison Village B)

RECOMMENDATIONS

Although the community driven action to prevent child protection focused on the reduction of teenage pregnancy, the findings of this ethnographic research have implications that extend well beyond teenage pregnancy. These are discussed below in the context of four main recommendations.

1. Strengthen the training and monitoring of emergency workers in regard to child protection and the prevention of sexual exploitation and abuse.

The Ebola crisis imposed a very heavy burden of suffering on people in Sierra Leone. Although most Ebola workers treated people with respect, this research indicates that some Ebola workers used their money and positions of relative power to sexually exploit teenage girls. This exploitation is a highly objectionable violation of the primary humanitarian ethical principle, Do No Harm. The sexual exploitation, together with the false promises, new pregnancies, and increased pressures to feed another person that frequently went along with it, only helped to undermine the well-being of teenage girls and their families. This situation has the potential to recur, as Sierra Leone regularly faces new crises, and the lure of abusing one's position of power and privilege will remain high for paid workers in a highly impoverished environment.

An essential step is to make child protection an integral part of the selection and training of emergency workers in all sectors. An essential first step is to have each emergency worker receive a brief training on child protection and sign an appropriate Code of Conduct as a condition of employment. Beyond outlining boundaries and rules, the training should also stimulate empathy and highlight the adverse effects of sexual exploitation on girls, children, and families. In addition, there must be no impunity for violations. Steps should be taken to insure adequate monitoring of the workers' behavior at field level and to enable effective reporting of and action against those who violate the Code of Conduct.

2. Improve the alignment between community practices and those recommended by Westernized health systems.

The Ebola crisis highlighted not only the severe weaknesses in the health systems in Sierra Leone but also the gap between community practices and those recommended or required by the formal health system, which embraces Western science, values, and modalities of disease diagnosis, treatment, and prevention. This gap was evident in local practices such as the Islamic practice of washing the dead by hand, which increased the spread of the Ebola virus. During the Ebola crisis, efforts to save lives necessitated a top-down approach addressing this gap. For example, the Government of Sierra Leone mandated that all corpses in Sierra Leone were to be buried in body bags under sterile conditions. However, such top-down approaches produce low

levels of community ownership and enable low levels of public willingness to use the formal systems.[16]

As part of the post-Ebola recovery and the longer term efforts to improve the health system and the child protection system, it is essential to improve the alignment between the formal systems and the nonformal aspects of the systems that local people, particularly in rural areas, prefer to use. Now that the crisis period has passed, efforts to improve this alignment should be guided by principles of respect and reconciliation. Rather than demonizing or denigrating local practices, it will be helpful to enable constructive dialogues between Imams and other community leaders with formal stakeholders in formal health and child protection systems. Such dialogues should seek to identify ways of reconciling local practices with those of formal health and child protection systems by, for example, alternative burial practices. A core principle of reconciliation should be that of cooperation. The possibilities of nonformal-formal collaboration were visible in this action research, in which communities chose and addressed child protection issues through collaboration with the formal health system. Such collaborative processes at the district level should be augmented by similar collaborative dialogues and steps at the national level to develop appropriate divisions of labor between, and also social changes in, the formal and nonformal aspects the health and child protection systems.

3. Build emergency preparedness and response and disaster risk reduction into community driven interventions.

The community driven approach that was featured in this action research focused primarily on the prevention of teenage pregnancy. The fact that the intervention was overwhelmed by the Ebola crisis indicates that community action in a specific domain by itself does not prepare the community to respond to large scale disasters and crises. Because the latter are recurrent features of life in Sierra Leone, it will be important in the future to build into all community interventions elements that increase the likelihood of (a) the transfer of elements and processes of the intervention into the crisis period, and (b) the sustainability of the intervention process. In practice, this means that all interventions, including community driven ones, should have well defined elements related to helping the community prepare for and respond to emergencies that arise, and enhance the sustainability of the intervention process during and following the crisis.

4. Re-prioritize the prevention of teenage pregnancy in Sierra Leone, building social protection into prevention efforts.

The evidence from this research shows unequivocally that the Ebola crisis unleashed a multitude of factors that together led to a significant escalation in the rates of teenage pregnancy in the project areas. Broadly these factors included sharp increases in risk factors (e.g., increased sexual exploitation, increased poverty, idleness of children, etc.), reduced protective factors (e.g., no access to education), and disruption of the intervention. These findings converge with those of other research projects[17] that indicate that the Ebola crisis produced a sharp increase in the rates of sexual exploitation and teenage pregnancy.

[16] Wessells et al. (2012).
[17] Save the Children, Plan International, World Vision, & UNICEF (2015); UNDP (2015).

A high priority, then, is to launch concerted efforts on a national scale to reduce teenage pregnancy. Since the findings of this study and others indicate that increased poverty during the Ebola crisis was a key driver of sexual exploitation and teenage pregnancy, prevention efforts should include work on social protection and other means of enabling effective livelihoods and reducing the burdens of increased poverty.

References

Alderson, P., & Morrow, V. (2011).The ethics of research with children and young people. London: Sage.

Allden, K., Jones, L., Weissbecker, I., Wessells, M., Bolton, P., Betancourt, T., Hijazi, Z., Galappati, A., Yamout, R., Patel, P. Sumathipala, A. (2009). Mental health and psychosocial support in crisis and conflict: Report of the Mental Health Working Group—Humanitarian Action Summit. *Prehospital and Disaster Medicine, vol. 24* (supplement 2).

Behnam, N. (2011). *Awkward engagement: Friction, translation and human rights education in post-conflict Sierra Leone.* Unpublished doctoral dissertation. Philadelphia: University of Pennsylvania.

Boyden, J. (2004). Anthropology under fire: Ethics, researchers and children in war. In J. Boyden & J. de Berry (Eds.), *Children and youth on the front line* (pp. 237-258). New York: Berghahn.

CDC(2016). *2014 Ebola outbreak in West Africa - Case counts* (updated April 13, 2016). Downloaded July 27, 2016 from www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts_html.

Child Frontiers (2010). *Mapping and analysis of the child protection system in Sierra Leone. UNICEF, Save the Children, Plan International*. Downloaded 23 May, 2013 fromhttps://childfrontiers.box.net/shared/n5z0rscmpj1euy2r718

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative research*. Thousand Oaks, CA: Sage.

Child Frontiers (2010). *Mapping and assessing child protection systems in West and Central Africa: A five-country analysis paper*. Bangkok: Author.

Coinco, E. (2010). *A glimpse into the world of teenage pregnancy in Sierra Leone. Freetown.* UNICEF Sierra Leone.

Denney, L., Gordon, R. & Ibrahim, A. *Teenage pregnancy after Ebola in Sierra Leone: Mapping responses, gaps and ongoing challenges. Working Paper 39.* London: Secure Livelihoods Research Consortium, Overseas Development Institute.

Elston, J., Moosa, A., Moses, F., Walker, N. Dotta, N. (2015). *Journal of Public Health* (Advance Access published October 27, 2015).

Graham, A., Powell, M., Taylor, N., Anderson, D. & Fitzgerald, R. (2013). *Ethical research involving children*. Florence: UNICEF Office of Research-Innocenti.

Hart, J., &Tyrer, B. (2006). *Research with children living in situations of armed conflict: Concepts, ethics and methods*. Refugee Studies Centre Working Paper No. 30. Oxford University: Queen Elizabeth House.

IMC (2014). *Assessment of mental health and psychosocial support (mhpss) needs and resources in the context of Ebola.* Lunsar, Port Loko District, Sierra Leone: IMC Sierra Leone.

Morrow, V. (2009).*The ethics of social research with children and families in Young Lives: Practical experiences*. Oxford: Young Lives Research Project.

Schenk, K., & Williamson, J. (2005). *Ethical approaches to gathering information from children and adolescents in international settings: Guidelines and resources*. Washington, DC: Population Council.

Stark, L., Wessells, M., King, D., Lamin, D. & Lilley, S. (2012). *A grounded approach to the definition of population-based, child protection and well-being outcome areas*. London: Interagency Learning Initiative on Community-Based Child Protection Mechanisms and Child Protection Systems.

Stark, L., Macfarlane, M., King, D., Lamin, D., Lilley, S., & Wessells, M. (2014). *A community-driven approach to reducing teenage pregnancy in Sierra Leone: Midline evaluation brief*. London: Save the Children.

Save the Children, Plan International, World Vision, UNICEF (2015). *Children's Ebola recovery assessment: Sierra Leone*. Freetown: Author.

UNDP (2015). *Human Development Report 2015*. New York: Author.

UNDP (2015). *Assessing sexual and gender based violence during the Ebola crisis in Sierra Leone*. Freetown: Author.

UNICEF (2013). *Female genital mutilation/cutting: A statistical overview and exploration of the dynamics of change*. New York: Author.

Wessells, M. (2009). *What are we learning about protecting children in the community? An inter-agency review of the evidence on community-based child protection mechanisms in humanitarian and development settings*. London: Save the Children.

Wessells, M. G. (2011). *An ethnographic study of community-based child protection mechanisms and their linkage with the national child protection system of Sierra Leone.* New York: Columbia Group for Children in Adversity.

Wessells, M., Lamin, D., King, D., Kostelny, K., Stark, L., & Lilley, S. (2012). The disconnect between community-based child protection mechanisms and the formal child protection system in rural Sierra Leone: Challenges to building an effective national child protection

system. *Vulnerable Children and Youth Studies, 7(31),* 211-227.

Wessells, M., Manyeh, M., & Lamin, D. (2014). *Preliminary results of the community-driven intervention to reduce teenage pregnancy in two districts of Sierra Leone: Findings from participatory review workshops with children and adults*. London: Save the Children.