2 April 2015

Ebola Outbreak

Monthly Overview March

	Not required	Low	Moderate	Significant	Urgent
Need for international assistance				X	
	Insignificant	**Minor**	**Moderate**	**Significant**	**Major**
Expected impact				X	

Crisis Overview

- **Evolution of the spread of the disease:** The total cumulative number of reported cases across the region has reached 25,178 including 10,445 deaths (Guinea, Liberia and Sierra Leone each reported over 29 March). The rate of infection has fallen to around under 100 new cases a week.
- With the **health** system focused on Ebola treatment, there is limited capacity to address non-Ebola healthcare in the three countries.
- **Food security:** Currently 1,235,000 people are in need of immediate assistance to protect livelihoods and prevent malnutrition (IPC Phase 3).

Number of reported Ebola cases (29 March)

	No. of cases	No. of deaths
Liberia	9,712	4,332
Sierra Leone	11,974	3,799
Guinea	3,492	2,314
Total	**25,178**	**10,445**

Source: WHO 31/03/2015

Key Findings

Anticipated scope and scale

- Livelihoods have been affected by the crisis and opportunities are expected to decrease further. Poor households and families affected by the loss of a member are facing food insecurity.
- The already weak health systems have been overwhelmed by the crisis, leading to an increase of non-Ebola related mortality. The weakened monitoring system, together with a lack of diagnosis and treatments, could potentially lead to an increase in preventable morbidity and mortality.
- Chronic health problems, maternal health and interruption in immunisation programmes are other worrying outcomes caused by constraints of health systems and populations' lack of trust in health systems.
- Despite schools opening in Liberia and Guinea, and partially in Sierra Leone, the already low literacy rates are expected to drop further and school dropout rates increase, particularly among girls and women.

Priorities for humanitarian intervention

- Assistance is needed to address the disruption of health services, food supply and decreased livelihood opportunities.
- Children, especially girls, women and survivors of Ebola are vulnerable to protection issues.
- Data collection is still needed to identify Ebola-induced problems and their extent.
- Responders should consider the approaching rainy season, and the negative impact on accessing vulnerable areas.

Humanitarian constraints and response gaps

- Community resistance and lack of trust in the health systems, as well as security incidents.
- Time constraints for the containment of the virus due to the expected onset of the rainy season in April/May, affecting accessibility and logistics.

Regional

Key Developments

Spread of the disease: Guinea, Liberia and Sierra Leone remain the most affected countries by the crisis, with 24,957 reported Ebola cases, including 10,350 deaths, each country reported over 22-25 March (WHO, 27/03/2015). 79 confirmed new cases were reported in the week to 22 March, the lowest weekly total in 2015. Among them, 45 confirmed new cases were reported from Guinea. After four consecutive weeks without any new cases being reported, one was reported from Liberia on 20 March. Sierra Leone reported 33 confirmed new cases in the week to 22 March. As of 25 March, at least 853 healthcare workers have been infected by Ebola, of whom 494 died (WHO, 25/03/2015).

Borders: Transmission is currently confined to a narrow geographic corridor. The population is highly mobile, with a great deal of movement throughout surrounding districts and countries, increasing the risk of transmission (WHO, 18/03/2015). Guinea has announced increased vigilance and surveillance of border communities, particularly at 53 border crossing points between Guinea and Sierra Leone, of which only three are official crossing points (UNMEER, 27/03/2015).

Neighbouring countries: The poverty impact of EVD on non-EVD affected countries is high, especially in Mali, Senegal, Côte d'Ivoire and Niger. Stigmatization has reduced international trade and foreign investments between these countries and their main trading and investment partners. The closure of borders from neighbouring countries to Guinea, Liberia and Sierra Leone triggered some loss of jobs and livelihoods. For the other West African countries, the loss in the GDP growth varies from 0.1 to 4 percentage points. The loss of GDP for the whole region is expected to be at least US$ 3.6 billion on average per year (UNDG, 11/03/2015).

Crisis Impact

Health

Measles: Measles outbreaks have been declared in the three countries. Pre-Ebola routine vaccination campaigns had limited success and have been deprioritized during the Ebola crisis. Areas of active Ebola transmission have not been covered by mass vaccination campaigns, increasing the risk of transmission, especially in Sierra Leone. The lack of trust in the health system is also hampering the response (ACAPS, 03/2015). Researchers from National Institutes of Health and four universities warned that the interruption of health services, such as childhood immunizations, could create secondary epidemics of preventable diseases that would exceed Ebola's impact. At the start of the Ebola crisis, there were 778,000 unvaccinated children in the three countries. The number of children between nine months and five years old who are not vaccinated against measles increases by an average of approximately 20,000 every month health care is disrupted, assuming a 75% reduction in national vaccination rates. After six months the number of unvaccinated children will be between 862,000, and 1,290,000. After a year it will be between 914,000 and 1,289,000. At 18 months, it will be between 934,000 and 1,409,000. The size of a regional measles outbreak is then expected to increase from 127,000 to 227,000 cases after 18 months, resulting in 2,000 to 16,000 additional deaths (Science Magazine, 13/03/2015; international media, 18/03/2015).

Malnutrition: Surveillance and treatment of malnutrition have been almost entirely put on hold during the Ebola outbreak. Resuming activities will be problematic as available basic health services are still limited and as communities have lost confidence in the health system. The lack of screening and treatment could contribute to a mid or long term increase in Global Acute Malnutrition (GAM) rates (Cadre Harmonise, 01/03/2015).

Food Security

The Ebola outbreak began during the planting season and intensified throughout the countries during the typical crop maintenance and harvesting periods. Ebola-related fears as well as official restrictions on movements led to labour shortages throughout the growing season, with the most severe impacts on crop maintenance activities. EVD caused also a reduced usage of labour-associated agricultural inputs, reducing incomes and food availability at household level for many families. Stocks are expected to be lower than usual in some areas that were significantly impacted by Ebola or related fears. However, with increased awareness on Ebola over time, agricultural activities resumed in most areas and allowed households to replenish some of their food stocks for the coming May/June 2015 lean season (Cadre Harmonise, 01/03/2015).

Food availability: The lean season, which typically starts in June, is expected to be harder than usual, households in all areas have suffered economic losses over the past months and, in areas most affected by the disease, food stocks are lower due to the recent poor harvest.

Currently 1,235,000 people are in need of immediate assistance to protect livelihoods and prevent malnutrition (IPC Phase 3), and 3.9 million people are at a Stressed level (IPC Phase 2). Projections increase to 2,215,000 in Crisis (IPC Phase 3) at peak of lean season, and 4.65 million in Stress level (IPC Phase 2) (Cadre Harmonise, 01/03/2015). Population are resorting to coping strategies, such as reducing from two to one meal per day (ACF, 23/03/2015).

Food production: Rice production was impacted by Ebola. Overall production was 10% lower this year, a shortage of 130,000 metric tonnes (ACF, 23/03/2015).

Livelihoods

Markets, trade and the overall economy are expected to begin recovering, with the lifting of quarantines in Liberia and partial reopening of main crossing points on borders between the three countries and the neighbouring countries (Cadre Harmonise, 01/03/2015).

Protection

Children have been vulnerable during the outbreak, with a rise of abuse being reported in Sierra Leone and suspected in the other two countries (international media, 14/03/2015). At least, 16,024 children have lost one or both parents to Ebola in the three countries (UNICEF, 18/03/2015; UNICEF, 18/03/2015; UNICEF, 18/03/2015).

Education

Schools have re-opened in Guinea and Liberia for a few weeks. Junior schools reopened on 24 March in Sierra Leone, with other schools planned to reopen on 14 April.

Humanitarian Access

Rainy season: According to the WHO, halting the spread of Ebola in West Africa will depend on mobilising funds and aid workers before the rainy season begins in April-May. The rains will wash away roads, complicating logistics for aid delivery and the movement of healthcare workers, especially to remote areas, and lead to an increase in other diseases, such as cholera (Reuters 23/01/2015, CIDRAP 18/02/2015).

Responding actors are not equipped for the extensive rains, creating an additional risk for the Ebola response. The health systems are not prepared to deal with any health emergency that might occur during the rainy season, on top of EVD. Health and education will be even more impacted as accessibility to basic services decreases dramatically. WASH services at household level are also of great concern (ACAPS, 03/2015).

Information Gaps

Health: Information needs to be obtained on - access to and availability of health services, the coverage of preventive measure programmes (such as malaria) and vaccinations, the availability and affordability of medicine and treatments and the level of stigmatisation of health infrastructure and staff.

The need for and availability of medicine and medical supplies for non-Ebola illnesses has to be monitored, as does the presence and adequate training of medical staff at health centres. The continuation of training in healthcare, after the end of the emergency, has to be investigated. Incidence of infectious diseases and mortality, unrelated to Ebola, has to be recorded and monitored. Psychological assistance needs should be assessed.

Food security: Information needs to be collected on the status and supply of local markets, food prices and the purchasing power of households as a consequence of the crisis.

Nutrition: Acute malnutrition needs to be monitored and the effects on the nutrition situation from the Ebola crisis established.

Livelihoods: Surveys are required to determine the income situation of households and how they may have been affected by EDV. The number of people unemployed, who have lost their small businesses, trade, work, or informal occupation due to the crisis, needs to be assessed. Affordability and availability of seeds to farmers need further investigation.

Protection: The acceptance of survivors and orphaned children in communities needs to be monitored. The sexual exploitation of children, extent of child labour, rate of teenage pregnancies and early marriages as a consequence of Ebola need to be assessed. The situation of women with regards to maintaining their livelihoods and with regard to gender-based violence caused by the crisis needs to be investigated.

Education: The attendance rate of girls and boys, reasons for non-attendance and drop-outs and information on the stigmatisation of children from families with Ebola cases needs further inquiry. The availability of safe and functional learning spaces and the WASH situation in schools needs to be assessed.

WASH: Access to safe drinking water is of concern and needs further investigation. Information on the safe waste disposal in emergency treatment units (ETUs) needs to be established. The availability, accessibility and use of hygiene items need assessment.

Lessons learned

Quarantine

EVD Outbreak, 2014–2015 - Liberia & Sierra Leone

- Community-led self-imposed quarantine is more effective than those at a district or individual level. This has been crucial in minimising violations of quarantine, tracing of contacts and discovering of new cases, including corpses (ACAPS, 19/03/2015).
- The ability of responders to react to the requirements of the quarantined community, and to reliably bring provisions (e.g. food, water, cash, information), is a vital. It ensures continued cooperation, limits human suffering and deters violations of quarantine. The supply of skilled practitioners, who can provide the necessary expertise and resources to remove bodies safely and train contact tracers, has been important (ACAPS, 19/03/2015).
- Effective communication of the benefits of quarantine and its role in stopping the outbreak a community level is essential. The shift from denial to acceptance of the existence or causes of Ebola has been a major factor in communities imposing and cooperating with quarantines. Two major factors in the behavioural shift have been social mobilisation efforts and the evident impact of the outbreak (ACAPS, 19/03/2015).
- Dissemination of information has been vital to combating stigmatisation and denial. Several independent sources indicate that, as more of the population witnessed the impact of Ebola first-hand or had relatives who became infected, the denial of its existence and resistance to the international response decreased. It has been suggested that it was this fact, more than any external effort, that increased community engagement and behavioural change (ACAPS, 19/03/2015).
- Coercion has come to be viewed as counterproductive. After the negative repercussion and failures of West Point in Liberia, and the other large-scale forced quarantines predominantly orchestrated by the military in August, the Liberian Government and responders moved away from mass quarantine. Some INGOs have argued that the use of force breaks down the trust required for social mobilisation and community engagement. There are strong indications that this perception shift has not occurred in Sierra Leone, least of all among local frontline workers, and that it is necessary to begin the community-led approach (ACAPS, 19/03/2015).

Social Awareness

EVD Outbreak, 2013–2015

- Demystifying quarantine is the key to a successfully conveyed message. The local community had previously considered quarantine as a death sentence. Quarantine needs to be described as liveable, even desirable, and a situation where basic necessities like food, water and medicine are provided for free. It is necessary to ensure the safety of the patients' family members and the rest of the society (Ebola Anthropology platform, 10/01/2015)
- Ebola treatment centres need to be recognisable far away from living quarters to give the non-infected assurances of their own safety. Treatment centres for non-Ebola illnesses also need to be set up away from Ebola treatment centres, or cleared separated and identified, to reassure the population (Ebola Anthropology platform, 10/01/2015).
- The easy availability of medication, coupled with the perceived safe non-Ebola hospital atmosphere, restored some of the people's belief in the hospital system (Ebola Anthropology platform, 10/01/2015).
- It is considered vital to work with, engage, and empower local communities in order to convey messages and information. Local actors and organisations know the culture, traditions and language of the areas in which they work, and often have strong relationships with community members themselves, and with local, trusted leadership (ALNAP 19/02/2015). Results from a study regarding community perspectives about Ebola in the Liberian Bong, Lofa and Montserrado counties showed that community leaders, the chief or religious leaders, often were the first people to be contacted by community members with Ebola related questions. Good leaders and leadership were perceived to include delivery of strong communication messages about prevention and new cases, and enforcement of preventive measures (USAID 01/2015).

Stigmatisation

EVD Outbreak, 2013–2015

- Organisations and institutions often contribute to stigmatising processes through 'institutional bias' or attribution of medical or beneficiary labels. An organisation wishing to address stigma should therefore first consider ways in which its own policies favour or discredit certain practices or groups, then consider the impact of other formal and informal institutions that are active in its target population (Ebola Anthropology Platform, 11/12/2014).

- Lessons can be drawn from ex-combatant reintegration programmes after the civil war in Sierra Leone. For example, punch-cards given to ex-combatants that showed their engagement with reintegration programmes became a highly valued symbol of their reintegration into society and of their break with their previous military life. A similar system could be implemented for example with households under quarantine, to recognise and acknowledge adherence to transmission control procedures and symbolise the end of the 'risk' posed to others (Ebola Anthropology Platform, 11/12/2014).

Coordination and responsibilities

EVD Outbreak, 2013–2015

From a review of the current Ebola crisis, an Oxfam report has identified the need for clear leadership on policy and technical issues; for effective standing operational capacity to monitor and prepare for outbreaks; and for surge capacity to lead and resource an emergency response. An architecture is necessary for coordinated response programmes and that the role and responsibilities of the various responders in the setup needs to be clear (OXFAM 01/2015, The Lancet 10/02/2015).

Recovery

EVD Outbreak, 2013–2015

- "Ebola money" has both positive and negative connotations. Reducing potential conflicts associated with cash distributions should be prioritised. Payment for Ebola-related work must be transparent and rapid in terms of scale and location of disbursements. Payment for labour mobilisation should be made through existing and legitimate networks of the "patron-client" system, such as markets, women's unions, women's cooperatives, youth or students unions, church groups, drivers and motorcycle unions. It would be advisable to acknowledge efforts already made with small symbolic amounts of cash or goods prior to formal payment to create goodwill among local chiefs (Ebola Anthropology Platform, 15/11/2014).
- Cash payments are currently focusing on Ebola response workers, but the response should also secure other means of lessening the impact on affected vulnerable populations, through social protection mechanisms or local food distributions, for instance (Ebola Anthropology Platform, 15/11/2014).

Liberia

Key Developments

Number of cases: As of 20 March, 9,593 cumulative Ebola cases had been reported, including 4,296 deaths (WHO, 23/03/2015). 372 health workers have been infected, 180 of whom have died (UNICEF, 11/03/2015).

Spread of the disease: On 20 March, Montserrado county confirmed a new Ebola case, the first case since 22 February (AFP, 20/03/2015). The case did not originate from a known chain of transmission and there are reports that it may have been sexually transmitted (Al Jazeera, 28/03/2015). All other counties have passed the 21 day incubation period. (Government, 13/03/2015). There are currently no Ebola cases in Liberia, following the latest's death (Al Jazeera, 28/03/2015).

For more information on the Sexual transmission of Ebola *see Annex 1.*

Borders: Despite borders with Sierra Leone and Guinea still being officially closed, many thousands of people are now crossing daily through official and unofficial crossing-points. Some people cross while seeking health care, which is worrisome for triage and screening (IMS, 07/03/2015).

Crisis Impact

Health

Pertussis (whooping cough): As of March 2015, there were 240 suspected cases of whooping cough reported in Barrobo and Karluay districts in Maryland county (UNICEF, 25/02/2015).

Measles: Measles vaccinations have dropped dramatically as a consequence of the EVD outbreak. As of March, suspected and confirmed measles cases have been reported in Grand Bassa, Sinoe, Lofa, and Montserrado. More than 180 suspected measles have been reported in Monrovia in the past weeks (MSF, 23/03/2015). The patients in Grand Bassa were being hosted in the empty Buchanan ETU, which is against protocol (PI, 20/03/2015). The next round of measles vaccinations has been delayed until 8–14 May, to allow social mobilisation campaigns more time to combat rumours that confuse routine vaccination with the Ebola vaccine trials, and led many to prevent their children from being vaccinated (UNICEF, 11/03/2015).

Mental Health: There is only one psychiatrist in Liberia, and there are no psychologists. 143 mental health clinicians are meant to be attached to wellness units, but these are yet to be established. There are no long-term treatment facilities for mental health in Liberia. There is one facility with approximately 80 beds for short-term patients (PI, 21/03/2015).

Nutrition: The Ministry of Health and UNICEF work plan proposes to increase the number of Integrated Management of Acute Malnutrition (IMAM) sites from 93 to 127 facilities nationwide (Nutrition Cluster, 24/03/2015). Relative to trends observed from 1992–2012, malnutrition prevalence is estimated to increase by 2.8–5.3% between 2014 and 2016 (UN Development Group, 11/03/2015). GAM was 6% before the EVD crisis (PI, 24/03/2015).

Surveillance: Routine disease surveillance remains sporadic; data is limited and outbreaks of disease such as measles and pertussis have been reported (UNMEER, 22/02/2015).

Food Security

190,000 people are facing Crisis (IPC Phase 3) food insecurity, and 1.23 million Stressed (Phase 2). These figures are projected to increase to 720,000 and 1.5 million, respectively, in June – August 2015 (Cadre Harmonise, 03/2015).

Food Utilisation: The highest uptake of negative coping strategies were among females in the northern and western counties of Lofa, Bomi, Gbarpolu and Grand Cape Mount. Female headed households were more likely to adopt negative coping strategies (WFP, 28/02/2015).

Livelihoods

Income: Wage rates trends in Liberia have been mixed. Wages rose in Western Liberia and Bong, but they dropped in Margibi and the south-east. Wage rates in Lofa County still stand at around $L200, which is 20% below the national average (WFP, 28/02/2015).

Poverty: The number of people living in poverty is predicted to increase by 5.5-17.6% during 2014-2015, from the previously pre-Ebola level of people living in poverty, 63.47% (UN Development Group, 13/03/2015).

Employment and Revenue: Nearly 20% of Liberians who had stopped working since the Ebola crisis have returned to work in February. Nearly 85% of participants in a World Bank survey reported having used negative coping strategies since the beginning of the outbreak, including selling of assets, selling or slaughtering of livestock, borrowing money, sending children to live with relatives or spending savings (WB, 24/02/2015).

Protection

Refugees: There are hopes that the repatriation of Ivoirian refugees will restart as early as 6 or 7 April. The first batch would be about 600. IPC protocols are being drafted to ensure returning Ivoirians are not an EVD risk (PI, 25/03/2015).

Quarantine: Whole communities are no longer quarantined. Responders are now attempting to negotiate the terms of quarantine on an individual basis with each new contact. Concerns are still being raised over reported incidents of forced or unsafe quarantine by the Government, or threats from the local community (PI, 14/03/2015). This is exemplified by the case of a group of young males allegedly coerced into an ETU scheduled for decommission after one died under suspicious circumstances in Monrovia (PI, 20/02/2015).

Stigmatisation: Although social mobilisation has improved knowledge of the outbreak, a recent Oxfam protection assessment involving 800 respondents, including community and religious leaders, generally said that quarantine brings shame and stigma on people (Oxfam, 04/03/2015).

Education

A lack of awareness about safe school reopening, through the implementation of protocols, remains a challenge. There are persisting concerns that reopened schools will not be safe for children, hence parents' resistance to sending their children to school (UNICEF, 04/03/2015).

Attendance: Low attendance in schools in Nimba county is attributed to confusion over the official reopening date and persistent fear of Ebola among the population (UNMEER, 02/03/2015).

WASH

WASH infrastructure: Safe sources of water have been scarce in quarantined areas (Water Missions International, 03/09/2014). These problems were exacerbated by Liberia's dysfunctional transportation and seasonally inaccessible roads.

WASH in schools: The majority of schools have not yet implemented safety measures due to lack of water supply and limited space for the construction of isolation centres (UNMEER, 22/02/2015). Between 31% and 43% of schools assessed did not have functional latrines, according to separate Education Cluster and Ministry of Education assessments, and schools that did average one latrine per 123 students. Only 60% of the schools had safe drinking water within 500m, 40% of schools had soap and water

for hand washing, and 39% had functional hand-washing facilities (Education Cluster, 17/03/2015). Approximately 2800 schools need improved access to water (PI, 26/03/2015).

Humanitarian Access

Resistance to the Ebola Response

Resistance to the Ebola response continues. A funeral home in Monrovia was reported to be refusing to allow mouth swabs of the bodies in its care during March (PI, 20/03/2015)

There are reports of people suspected to have measles fleeing to avoid specimen collection and testing (UNMEER, 27/03/2015).

Response Capacities

International response: The US military officially ended its mission to build treatment facilities to combat the Ebola outbreak in Liberia, and is transitioning into a civilian operation (Reuters, 26/02/2015).

In March, the OCHA team which will eventually take over from UNMEER began arriving in Liberia. It is currently supporting UNMEER and other clusters activities (PI, 29/03/2015).

The Government of Liberia has increased restrictions on access to data relating to the health sector and prohibited unauthorized research (PI, 29/03/2015).

Sierra Leone

Key Developments

Number of cases: As of 21 March, 11,829 cumulative Ebola cases have been reported in Sierra Leone, including 3,742 deaths (WHO, 23/03/2015).

Spread of the disease: In March, new confirmed case numbers decreased from 81 at the start of the month (WHO, 04/03/2015) to 33 on the 22 March (WHO, 22/03/2015). The most intense transmission still occurs in the west: The Western Area - Freetown, Kambia, Port Loko and Western Rural, as well as in Bombali (WHO, 11/03/2015).

Political Context: Sierra Leone's president has dismissed his deputy for seeking asylum in a foreign embassy, according to a statement from the president's office (Al Jazeera, 18/03/2015). A recent audit on the management of the Ebola funds reported that a third of the USD 18 million of treasury and public donations to the Ebola response in Sierra Leone is “unaccounted for” (IRIN, 30/03/2015).

Burials: 15 unsafe burials took place from 16-19 February, most in Bombali and Freetown, indicating a challenge in community engagement (WHO, 25/02/2015).

Movement restrictions: The Government implemented a three day nationwide stay-at-home, over 27–29 March. The purpose was to find hidden Ebola cases, remind people how to protect themselves from EVD and control further transmission (international media, 18/03/2015; 19/03/2015). Several security incidents occurred. One was reported in the Kaffu Bullom chiefdom of Port Loko where a group of health workers came under attack, and another incident where resident and security forces clashed because of food package distributions in Freetown.

Vaccine Trials: Clinical trials for an Ebola vaccine started in Sierra Leone on 11 March (Reuters, 11/03/2015).

Containment: The outbreak in Aberdeen has led to outbreaks in other districts, notably Bombali and Port Loko and resulted in entire villages being quarantined (IFRC, 06/03/2015; WHO, 04/03/2015). On 27 February, 31 new cases were reported close to the town of Makeni. A community of 500 people has been put on lockdown. The cases are thought to be linked to a man who escaped quarantine in Freetown (international media, 27/02/2015). The President announced additional measures to control the spread of EVD. No public transportation carrying goods is allowed in the city after 18.00 and boats are not allowed to operate at night. The number of passengers is restricted on all means of public transportation and checkpoints will be mounted again (Government, 02/03/2015).

Crisis Impact

Health

A consultation was conducted on the most basic needs of the population affected by EVD in Sierra Leone, on February 2015. Almost three in four informants (over 70% of all respondents) believe that the health status and conditions of the population has worsened since the outbreak because of fear of infection, lack of trust in health facilities and deficit of health workers (ACAPS, ENAP survey, 02/04/2015).

Services: Overall, visits to primary health facilities decreased by a third in June–December 2014 compared to the same period in 2013. Most districts show an initial drop at the onset of the Ebola outbreak in June, and a further decline as the epidemic reached its peak in November–December. The decline in health service utilisation is not uniform across key health services. Malaria and diarrhoea services are the most affected. In December 2014 suspected malaria cases decreased by half compared to December 2013, and only 20% were receiving treatment. In the same period, treatment of diarrhoea decreased by about 60%. Key health service utilisation has been most affected in Kenema, Port Loko, and Kailahun districts (ACAPS, 25/03/2015).

Maternal Health: By December 2014 little more than half of pregnant women were coming to a primary health facilities for at least one antenatal class compared to 93% between 2008 and 2012 (ACAPS, 25/03/2015).

Vaccination: In September 2014 half of children under 12 months did not receive the recommended vaccinations, compared to about 70% coverage before the outbreak. Vaccination rates have remained low until the end of the year (ACAPS, 25/03/2015).

Nutrition: It is predicted that the prevalence of undernourishment during 2014–2016 could increase by 1.30–1.39%, compared to observed trends from 1992 to 2012 (UNDG, 11/03/2015).

Measles: At the end of February there were 864 suspected measles cases reported over six districts, Bo, Bombali, Koinadugu, Port Loko, Tonkolili and Western Area. There is an urgent need for precautionary measures to prevent further spread of the disease (PI, 06/03/2015).

Food Security

The vast majority, (93%) of informants, described the food situation as worse when compared to the situation in February 2014 before the Ebola crisis. Availability and access to food decreased as a result of the disruption in planting and harvest cycles and movement restriction worsened the food security situation across the country (ACAPS, ENAP survey, 02/04/2015).

Between February and March 2015, 770,000 people (10% of the population) are in Crisis (IPC Phase 3). 1.32 million are in IPC Phase 2. This is projected to increase to 1.1 million in Phase 3 and 1.69 million in Phase 2 in the June–August lean season (Cadre Harmonisé, 01/03/2015).

Food Utilisation: The highest level uptake of negative coping strategies (e.g. borrowing money or selling assets) is in the districts of Bombali, Koinandugu and Tonkolili in the north (WFP, 28/02/2015).

Livelihoods

The vast majority (95%) of informants consulted during the month of February 2015 described the livelihoods situation as worse, when compared to the situation in February 2014. Loss of income opportunities and death of caregivers were the main reasons (ACAPS, ENAP survey, 02/04/2015).

Income: At the beginning of March, wage rates declined more prominently in Port Loko (-17%) and Kambia (-19%) as the rice harvest ended and casual labour opportunities declined. High staple food prices and low wages are hampering food access in northern Sierra Leone (WFP, 28/02/2015).

Quarantined Households: Due to pre-existing high levels of poverty and food insecurity, households that experienced the quarantine have been impacted more seriously. This is partly because they have experienced a higher reduction in income. Therefore some are already facing critical levels of food insecurity, just two months after the main harvest. Concerns are now being raised about the ability of the quarantined to recover and prepare for the planting season, as the lean season (August) approaches (Oxfam SL, 17/3/2015)

Protection

Child Protection: More than 2,000 cases of sexual abuse against children were recorded in 2014 – a record high. Many more cases have likely gone unreported (Ebola Deeply, 14/03/2015). A recent study reveals a total of 12,023 Ebola orphans across the country, the majority of them in Port Loko with 3,410 cases. The study highlights that orphans are not a homogenous group and that if their different aid needs are not immediately addressed, the number of children relying on the street for survival could increase (Street Child, 27/01/2015).

Quarantine: 1,845 households, approximately 10,886 individuals, were under quarantine in Sierra Leone as of March 8 (NERC, 08/03/2015).

Stigmatisation: Discrimination and stigma have resulted in abuse and mistreatment, especially of women. Many survivors fear returning to their community of have been chased away. 47% of respondents indicated that stigma and discrimination exists in their communities, while 50% of them did not rate this as a problem and 3% did not express an opinion. The main issues reported were social and family exclusion (ACAPS, ENAP survey, 02/04/2015).

Gender-based violence: Female survivors have reported being afraid of experiencing gender-based violence because of EVD (Ministry of Social Welfare, Oxfam, UN Women, 27/02/2015).

Education

On 24 March Junior Secondary Schools reopened, after months of closure. The remaining schools are expected to be open on 14 April. All of the respondents said the educational situation has worsened since the outbreak, (100%) of the consultation in February 2015 across all districts (ACAPS, ENAP survey, 02/04/2015).

WASH

WASH in Schools: According to a recent School Wash Assessment, more than half of all schools do not have sufficient access to water throughout the year. Half of the schools practice hygiene convenience with soap and water (UNICEF, 11/03/2015).

WASH in Slums: Issues relating to food and water distribution, livelihoods, and WASH facilities are more challenging in urban slum areas. Frequently, there are no improved latrines. Where there are improved latrines, they are often shared between the quarantined and non-quarantined (Ground Truth, 16/03/2015). The capacity to improve conditions is hampered by a lack of space or the high water table, which increases the likelihood of groundwater becoming contaminated (PI, 03/03/2015). All of these conditions are exacerbated during the rainy season.

Humanitarian Access

Resistance: The residents of slum areas are more likely to have poor relations with the existing government and authority figures than in other areas (PI, 03/03/2015). This fuels denial, the hiding of corpses, and escape attempts from quarantine (PI, 5/2/2015).

Access: The supply of food, water, and adequate sanitation facilities to quarantined areas has become challenging (UNMEER, 04/03/2015). Due to poor coordination and road access in rural areas, HHhouseholds frequently do not receive food packages within 24 hours of being placed in quarantine (UNMEER, 01/02/2015) and there have been incidences of HHs waiting 48 hours (NERC, 08/03/2015). In recent weeks in the Western Area the delivery of first packages has improved, though the delivery of supplies for the remainder of quarantine remain and issue (Ground Truth, 16/03/2015).

Response Capacities

Around 9 to 10 OCHA staff are being deployed in Sierra Leone to support UNMEER and the transition of its tasks (PI, 10/3/2015).

Quarantine Coordination: The different ways organisations deliver food aid has created confusion among quarantine community members (WAERC Quarantine Meeting, 02/03/2015). There also complaints of food being spoiled or out-of-date.

Stay-at-home: A three day nationwide stay-at-home was conducted from March 27 to 1800 GMT March 29. Approximately 26,000 volunteers went door-to-door to check for sick people and raise awareness about the disease (AFP, 29/03/2015; Reuters, 29/03/2015).

Guinea

Key Developments

Number of cases: As of 25 March, 3,466 cumulative Ebola cases, including 2,276 deaths, have been reported in Guinea (WHO, 27/03/2015).

Spread of the disease: 95 confirmed cases were reported in the week to 15 March, the highest new caseload since early January 2015. Almost half of the cases were reported in Forecariah prefecture, a quarter in and around Conakry, and another quarter in Coyah. Other areas of active transmission included Kindia, Boffa, and Dubreka (WHO, 18/03/2015). Three doctors working at a hospital in Conakry tested positive for EVD in the week to 15 March (USAID, 18/03/2015). A total of 45 confirmed cases were reported in the week to 22 March. Transmission is confined to an area around and including the capital Conakry, with the nearby prefectures of Coyah and Forecariah being the only other prefectures to report cases in the week to 22 March. Macenta has not reported a confirmed case for over 21 days (WHO, 25/03/2015). However, case searching efforts continue in both Macenta and N'zérékoré prefectures (UNMEER, 27/03/2015). The sudden increase could be a sign that access to hidden patients is improving, rather than a surge in new infections (international media, 20/03/2015). Response indicators have shown some improvement compared with recent weeks, though many cases are still arising from unknown chains of transmission. In the week to 15 March, fewer than half of confirmed EVD cases (38%) arose among known contacts: an increase compared with 28% the previous week (WHO, 25/03/2015).

Political Context: Opposition suspended its participation in parliament and the electoral commission and has called for anti-Conde demonstrations on the first week of April, over disagreement on the schedule of the next presidential and local elections (local media, 19/03/2015; international media, 24/03/2015).

Containment measures: Authorities have indicated that Forécariah will also follow a stay-at-home period from 27-29 March, to reinforce the efforts of Sierra Leonean authorities (UNMEER, 26/03/2015). Increase militarized surveillance at the border was also planned, as rumours of a large influx of people fleeing Sierra Leone and crossing into Guinea was reported (UNMEER, 27/03/2015; AFP, 28/03/2015). On 28 March, a 45-day "health emergency" and quarantine measures in Forecariah, Coyah, Dubreka, Boffa and Kindia prefectures were declared by the President. Emergency measures will be enforced for 45 days (international media, 28/03/2015).

Resistance: Community resistance continues to impede the response. Few incidents of resistance were reported in Lola, Conakry, Faranah and Boffa prefectures. Resistance took place in different ways: body management teams were impeded by the communities to bury safely, attacks targeted volunteers following disinfection of the houses, stones were thrown at healthcare workers and vehicles set on fire (UNMEER, 09/03/2015; IFRC, 06/03/2015; UNMEER, 02/03/2015; USAID, 04/03/2015; WHO, 02/03/2015). In the week to 15 March, 18 unsafe burials were reported and more than half of Ebola deaths occurred in the community (WHO, 18/03/2015).

Trial: In early March WHO and Guinea MoH, together with partners, launched a Phase III clinical trial early to test the VSV-EBOV vaccine for efficacy and effectiveness in preventing Ebola. The trial takes place in Maritime Guinea, where most cases are currently being reported (WHO, 05/03/2015).

Crisis Impact

Health

Measles: In response to measles outbreaks in Gaoual, Koundara and Boke prefecture, a six-day immunisation campaign was held in Gaoual. It targeted 59,555 children between six months and ten years (UNICEF, 25/02/2015). Sixty-nine cases of measles were reported in the Kankan prefecture (UNICEF, 18/03/2015).

Malnutrition: The prevalence of undernourishment during 2014–2016 could increase by 0.49%, to 1.72%, relative to trends between 1992 and 2012 (UNDG, 11/03/2015).

Food Security

275,000 people are estimated to be in Crisis (IPC Phase 3), in addition to 1.35 million in Stressed (IPC Phase 2). These figures are projected to increase to 395,000 and 1.5 million, respectively, during the lean season, June – August 2015 (Cadre Harmonise, 03/2015).

Livelihoods

Poverty is predicted to rise from 2.25% in 2014 to 7.9% in 2015, because of the Ebola crisis (UN Development Group, 11/03/2015).

Protection

Child protection: The total number of children who have lost one or both parents due to Ebola reached 4,742. 20% of these children have lost both parents and they are being cared for by members of their extended families. The majority of affected children are boys aged 6-12 years. According to more than 1,000 home-visits by UNICEF and partners, families are now looking after an additional three to four children, in addition to the four or five of their own children. Families have expanded by about 75 %, worsening their situation of poverty (UNICEF, 18/03/2015).

Women: The Ebola epidemic in West Africa reportedly exacerbated violence against women and decreased access to reproductive healthcare in the region. Data indicates that there would have been a 4.5 % increase in cases of gender-based violence since the epidemic (International media, 19/03/2015).

Survivors: There are reports of recovered patients not being accepted into their communities, despite awareness-raising in the community (USAID, 18/03/2015).

Humanitarian Access

The larger size and population of Guinea, compared to Liberia and Sierra Leone, makes the response more difficult (Washington Post, 13/03/2015). Difficulty reaching children in remote areas is hampering a measles vaccination campaign in Gaoual and Koundara prefectures (UNICEF, 11/03/2015).

Response Capacities

- The high number of confirmed Ebola deaths in the community suggests that the need for early isolation and treatment is not being met (IFRC, 06/03/2015). During the 45 days of the "health emergency", all burials in the affected areas will be done by the Red Cross or security forces, and all dead bodies will be systematically tested in the five regions (international media, 29/03/2015).
- Former EVD patients have been identified as a vulnerable social group due to stigmatization by their communities. The Guinean authorities and EVD Response partners have started providing them with food and monetary assistance in order to improve their living conditions (UNMEER, 17/03/2015).
- Guinea continued to respond to the measles outbreak. Initial vaccination campaigns planned for six days in Gaoual and Koundara were prolonged because of difficulties in reaching children in remote areas. The aim is to vaccinate 95% of the total number of targeted children (UNICEF, 11/03/2015).

Annex 1. Transmission of the Ebola Virus

Sexual transmission of the Ebola

- It is possible that the Ebola virus can be transmitted sexually, but this has yet to be verified or documented (WHO, 09/02/2015).
- There is evidence that seminal fluids of convalescent men can shed the Ebola virus for at least 82 days after onset of symptoms. There is limited evidence suggesting that live Ebola virus can persist in urine for 26 days following symptom onset (WHO, 09/02/2015).
- The evidence of detected Ebola virus in vaginal secretions is weak: traces of Ebola virus was detected in vaginal secretions of a woman on the 33rd day after her symptom onset. Whether these traces found in vaginal secretions represent live virus, and if so how long it would remain in vaginal secretions, is not known.

Transmission of the Virus (WHO, 06/10/2014)

- The Ebola virus is transmitted among humans through close and direct physical contact with infected bodily fluids, the most infectious being blood, faeces, and vomit.
- The Ebola virus has also been detected in breast milk, urine, and semen.
- Saliva and tears may also carry some risk. However, the studies implicating these additional bodily fluids were extremely limited in sample size and the science is inconclusive. In studies of saliva, the virus was found most frequently in patients at a severe stage of illness. The whole live virus has never been isolated from sweat, though traces of Ebola virus were detected in the sweat of one recovering patient on the 40th day after his symptom onset (WHO, 09/02/2015).
- The Ebola virus can also be transmitted indirectly, by contact with previously contaminated surfaces and objects. The risk of transmission from these surfaces is low and can be reduced even further by appropriate cleaning and disinfection procedures.

Key Characteristics

Pre-crisis Indicators

Key Indicators	Guinea	Liberia	Sierra Leone
Total population	11.45 million (WB 2012)	4.19 million (WB 2012)	5.98 million (WB 2012)
Outbreak start date	23 March 2014	29 March 2014	25 May 2014
Age distribution	42.9% under the age of 14 (HEWS 25/09/2012)	43.49% under the age of 14 (HEWS 25/09/2012)	43% under the age of 14 (HEWS 25/09/2012).
Nutrition	35.8% of under-5s underweight, 16.3% stunting, 5.6% wasting (WHO 2012)	20.4% of under-5s underweight, 39.4% stunting, 7.8% wasting (WHO 2007)	21.1% of under-5s underweight, 44.9% stunting, 7.6% wasting (WHO 2010)
Infant mortality rate (per 1,000 live births)	65 (UNDP 2014)	56 (UNDP 2014)	117 (UNDP 2014)
U5MR per 1,000	101 (World Bank 2012)	75 (UNDP 2014)	182 (UNDP 2014)
2014 HDI rank	179 (0.392) (UNDP 2014)	175 (0.412) (UNDP 2014)	183 (0.374) (UNDP 2014)
People below the poverty line (%)	58% (UNFDA 2010)	64% (UNFDA 2008)	70% (UNFDA 2012)
Health expenditure, total (% of GDP)	6% (World Bank 2012)	16% (World Bank 2012)	15% (World Bank 2012)
Maternal mortality rate (per 100,000 live births)	980 (UNICEF 2012)	990 (UNICEF 2012)	1,100 (WB 2013)
Immunisation, measles (% of children aged 12–23 months)	58 (World Bank 2012)	80 (World Bank 2012)	80 (World Bank 2012)
Incidence of malaria (per 100,000 people)	38,333 (WHO 2012)	27,793 (WHO 2012)	19,027 (WHO 2012)
Average births attended by skilled health personnel (%)	45 (WHO 2006)	61 (WHO 2006)	61 (WHO 2006)
Physicians per 10,000 people	1 (World Bank 2010)	0.1 (WHO 2006)	0.2 (WHO 2006)
Nurses and midwives per 10,000 people	0.4 (World Bank 2010)	2.7 (WHO 2006)	1.7 (WHO 2006)
Main causes of death in children under 5 (%)	Malaria: 27% Acute respiratory infections: 13% (WHO 2012)	Malaria: 21% Acute respiratory infections: 14% (WHO 2012)	Acute respiratory infections: 17% Diarrhoea: 14% Malaria: 14% (WHO 2012)