



REPORT

How a virus shattered the development of a whole country

The social impact of the Ebola crisis in Liberia - with particular consideration of food security

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Preface

For years and all over the world, Bread for the World (Brot für die Welt) and its partner organisations have campaigned for an improvement in the health situation and for equal access to appropriate, high-quality healthcare. When the West African countries Liberia, Sierra Leone and Guinea, were affected by the worst Ebola epidemic ever in 2014, Bread for the World's partners also took action, raising awareness and providing basic healthcare. They continue to do this today because the crisis has had a long-term impact. People's health continues to suffer from the consequences of Ebola, but the epidemic's impact on their lives was by no means limited to health.

This report examines the impact of Ebola on nutrition in Liberia and highlights the long-term, initially unknown, consequences, those affected have to cope with. It is based on research and discussions with those affected, as well as with development aid workers, that were conducted in Liberia. The report shows how urgent it is to support the fight against poverty and hunger in West Africa.

The first cases of Ebola emerged in West Africa at the end of 2013, but it was several months before the scale of the hitherto biggest Ebola epidemic became clear. It was almost a year later that the World Health Organisation (WHO) declared the outbreak of Ebola a global health emergency - only then did international aid and development cooperation attain such an extent that had rarely been seen before. A few isolated cases in the US and Europe made it clear that anyone could be affected by Ebola and that the virus would not stop at national borders.

After some initial hesitation on the part of the international community, it was possible to put an end to the Ebola epidemic through decisive action and the courageous involvement of local communities. The partner organisations of Bread for the World in Liberia, Sierra Leone and Guinea were able to adopt a particular role because they had already worked directly with people in these countries and enjoyed their confidence. They trained thousands of volunteers to raise awareness about Ebola and how to avoid getting infected, as well as to isolate anyone affected and provide medical help. Thanks to their competence, governments and the international community considered our partner organisations valuable allies in the containment of Ebola.

In January 2016, the WHO declared West Africa "free from Ebola" even though there have been some isolated cases of new infections since and the devastating consequences will have a long-term impact. Even before Ebola broke out, the countries most affected already

numbered among the world's least developed countries. Large parts of the population suffered from poverty, hunger and poor healthcare. The countries' health systems were in a poor condition even before the crisis. After two years of epidemic and many deaths, including among health workers, they are in a worse state than ever.

Food supplies have decreased since 2014 because Ebola brought farming, processing and sales to a standstill. To prevent the disease from spreading, governments banned weekly markets and restricted travel. Farmers and their families were not able to sell their goods. Thus, key sources of income were lost and the already difficult living conditions got worse. The food insecurity that arose is extremely harmful for the health of the population. Malnutrition is rising and West African development efforts are under threat.

Bread for the World and its partner organisations want to support West African countries to deal with the impact of Ebola both now and in the future, by strengthening community-based healthcare systems and providing support to agriculture which is an important source of income. It is extremely important to be better prepared.

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Chapter 1

A virus becomes an epidemic



Reuben Shellu (second from the right) survived Ebola but lost all his belongings, which were decontaminated.

place. This publication focusses on the Ebola epidemic in Liberia and its impact.

Liberia, which became the country with the highest number of Ebola casualties, registered its first cases in March 2014. After an initial denial of the dangers posed by the epidemic, there was an escalation of the situation in June. The government introduced drastic measures to bring the aggressive virus under control. It declared a state of emergency in August, which had severe consequences for the population: schools and government agencies were closed down, public gatherings were banned, strict regulations on how to deal with people who were infected were introduced. Frequently families, districts and even whole towns where there had been cases of Ebola were quarantined.

Some of the restrictions were lifted in November. Weekly markets were permitted again and quarantines were stopped. By the beginning of 2015, there were fewer and fewer reports of new infections. In the summer, the WHO declared Liberia “Ebola-free” after there had not been a new case for 42 days - twice the incubation time for the disease. Two further infections, which have since become known, make clear that this status is uncertain and that the long-term development of the disease is unknown. Nevertheless, the Ebola epidemic in West Africa was officially declared over on 14th January 2016.

Liberia, Sierra Leone and Guinea - these three West African countries were particularly affected by the 2014 outbreak of the infectious disease Ebola. In these countries alone, 11,316 people died of Ebola. Over 28,000 were infected although they survived. On 8th August 2014, the WHO declared that the outbreak met the conditions of a Public Health Emergency of International Concern (PHEIC).

Ebola Virus Disease, formerly known as Ebola haemorrhagic fever, is highly contagious. Just a small amount of saliva can transmit the disease, which is fatal in 50 to 90 percent of cases. There currently exist no vaccines or cure for Ebola. However, certain symptoms can be relieved and antibiotics can treat certain complications that arise from the disease.

Liberia, Sierra Leone and Guinea were affected particularly badly by the Ebola epidemic because - apart from other factors - their health systems were weak as a result of more than ten years of civil war. The infrastructure needed for dealing with a health crisis of this scale was not in

Chapter 2

Epidemic policy becomes development policy

A lot has been published about the health aspects of the epidemic, not least because of its significant potential for spreading well beyond West Africa. However, the social impact and the consequences for a country's development have received less attention. Because such an epidemic represents a dramatic event for an entire society that can take place at any time anywhere in the world - especially in developing countries - it is important to examine the total social impact of the epidemic.

Ebola posed a major setback for development in Liberia, Sierra Leone and Guinea, which number among the world's ten poorest. With a GDP per capita of \$805, Liberia is ranked 177th out of 185 countries in the UN's Human Development Index from 2014, which measures the standard of living in countries according to indicators such as wealth, education, health, equality or gender equality.

In 2014, Liberia was going through a phase of economic recovery after a civil war that raged for 14 years and almost ruined the country. Between 1987 and 1995, its GDP had fallen by about 90 percent. In 2005, when a peace treaty was signed, the average income was a quarter of what it had been in 1987. Many bridges and public facilities had been damaged, there was hardly any public electricity supply and healthcare and education were in a very poor state of affairs. In comparison to the pre-war period, agricultural productivity, from which the majority of the population lives, had fallen by 75 percent.

On top of poverty, income distribution in Liberia is the least equal in the whole of Africa. Only 4.8 percent of the population can be classified as "middle class" - most of the population is either rich or poor (Boley 2013). Some 60 percent of workers try to survive from productive agriculture, others live from the "fruits of the forest", as charcoal burners, gatherers, hunters, small fishermen (inland and maritime) or as street vendors. Only 15 percent of Liberians are employed, with most doing casual work in rubber or palm oil plantations or iron mines owned by international corporations.

The pyramid-like social structure goes back to when Liberia was a colony, settled in the 19th century mostly by free-born and formerly enslaved African Americans, who came to be known as Americo Liberians. After the Republic of Liberia declared independence in 1847, local populations were often suppressed.

In the 20th century, Liberia experienced a phase of political instability which culminated in a civil war that lasted years. It ended in 2005 with a peace treaty and the creation of a government that seemed relatively stable. By



There was great hope for an economic recovery after 14 years of civil war in Liberia. The Ebola epidemic was a major setback.

2014, Liberia was on track to reach sixth place in the global ranking of fastest growing economies with an expected growth rate of 5.9 percent. However, Ebola struck and Liberia remained extremely poor. Before the crisis, 460,000 people - some 14 percent of the population - were affected by malnutrition; they could not feed themselves well and adequately. Some 64 percent of the population lived below the poverty line of \$1.25 a day, did not have access to clean drinking water or sanitation. Ebola was able to spread more aggressively because of poverty and the shortcomings in society, and the epidemic also worsened the situation and helped to further destroy the economy.

Chapter 3

The epidemic becomes a social crisis



Health workers at Elwa Hospital in Monrovia use infrared thermometers to monitor outpatients.

To evaluate the impact of Ebola on society, it is important to differentiate between the consequences directly linked to the disease, and the indirect results of a change of behaviour because of Ebola.

The direct social costs were caused by the destructive nature of the virus itself: Many people died, others became severely ill with tuberculosis, malaria or HIV/Aids because all diseases other than Ebola were neglected. The measures introduced to combat the crisis triggered by Ebola used up many resources: in both financial and human terms. The health system was subjected to extra costs to provide medical care and introduce preventative and hygienic measures and the crisis also took a severe psychological toll. Many did not go to work because of grieving and trauma so there was less productivity. These costs alone had a major impact on the population, the state and the economy and would not have been surmountable without foreign aid. On top of this, problems arose in families, communities and among the wider population because people were afraid of infection. People started to avoid each other as much as possible.

The indirect consequences of Ebola that arose from the social changes were also drastic. These include government measures, such as restrictions on freedom to travel and the movement of goods, the closure of weekly markets, the shutting down of national borders, curfews, bans on public gatherings and restricted public services, which had major consequences for all aspects of economic life. The supply of food and daily goods, as well as their prices, were affected, as were work and the population's income, communications and flow of information. Food became scarce and expensive because the markets no longer functioned as places where it could be distributed. Although the availability of food improved from January 2015 and markets regained momentum, the food security situation remained tight because income rose much more slowly.

On top of that, business activity slowed down: companies and development organisations reduced their activities during the epidemic, planned investment projects were postponed, experts left the country, farmers neglected their fields because there were not enough workers, resources or sales opportunities, fishermen stopped going out to fish. Almost all casual workers lost their jobs and anyone whose profession meant that they came into close contact with others, e.g. hairdressers, taxi drivers, traders, domestic workers, travelling salespeople or street vendors, lost customers. International airlines cancelled most of their flights to Liberia.

Chapter 4

The crisis becomes a hunger problem



There was less and less food during the Ebola epidemic in Liberia so more people faced malnutrition and hunger. However, Foya Borma Hospital and others needed all their resources to deal with Ebola patients.

In 2015, the number of people in Liberia suffering from food insecurity rose by 170,000 to about 630,000. According to the Ministry of Agriculture, this represented 16 percent of the population (Ministry of Agriculture 2015, 6). According to a wide-ranging World Bank survey, nine out of ten households reported that food security in the family had become a serious problem since the Ebola crisis, even those which had not been affected by poverty before (World Bank Group et al. 2015).

The income of many people decreased considerably or ceased entirely to exist during this period; according to a study commissioned by the Liberian government, in February/March 2015 a third of the population had 35 percent less income compared to the previous year (see Republic of Liberia 2015, 8). At the same time, the prices for food at the few remaining markets went up as they did for other goods that became important in the wake of Ebola, such as rubber gloves, buckets, chlorinated water or disin-

fectant which were vital for purposes of hygiene and warding off infection. People's freedom of movement was strictly restricted by government measures and there was a nationwide night curfew. Many traditional ways of finding food, such as in the wild, were no longer possible. Eating and selling game, which was a source of Ebola, were banned. For poor populations in the cities and the country, the cheap meat provides an important source of protein that is not easy to replace.

Chapter 5

Survival becomes a coping strategy



Annie Sumo survived Ebola but her husband did not. It is now even harder to feed their five children.

As the virus spread, people had to resort to increasingly drastic emergency measures to survive: They ate less, just one meal a day, or ate portions that were even smaller than normally, used up their reserves (e.g. seeds for the next sowing season), switched to cheaper, less popular foods (e.g. from rice to cassava) or even made do without certain foods, such as vegetables, fruit, fish or meat, often eating monotonous, calorie-rich foods. Some people went out to beg, women in particular made do without food so that their children would have more. People had to take out loans to pay for food or sold household goods or equipment to satisfy their basic needs.

The World Food Program (World Food Program 2015) periodically conducts surveys about the use of food-related coping strategies in crisis situations for its Coping Strategy Index. Five of the above-mentioned emergency measures are included; their frequency and development are also observed. The higher the value, the more difficult the food situation in a household is considered to be.

While in 2012, the average value for the test group in Liberia was 3.5 in the index, it rose to 8.6 at the beginning of 2015. The survey divided households into four groups of affected people and found the following results: 60 percent of the test group said that they did not use coping strategies, eleven percent talked of a crisis situation and 18 percent of an emergency situation.

However, there were considerable regional differences in the index values. This is not surprising because there are areas in Liberia where there were few cases of Ebola if at all. The impact there was only indirect, for example because of shockwaves on the markets (general price increases, flow of goods from and to areas where was a surplus or shortage) the closure of facilities and panic reactions. However, it must be said that the index for 2015 was higher for all regions than it was in 2012, two years before the Ebola crisis broke out.

Some of the measures taken to overcome the crisis had a very damaging long-term impact, even if families were able to feed themselves in the short term. For example, children not going to school, farmers using up seeds for the next planting season or selling tools such as shovels, sickles, hoes or pangas (a knife that resembles an axe) to buy food. Most Liberian families do not own much. It posed a risk to sell important tools because 70 percent of the active population lives from agriculture. How can people produce food if they no longer have seeds or tools? When the survey was conducted, only 17 percent of households had access to seeds while only between ten and 27 percent of the farmers still owned equipment needed for agricultural activity.

Chapter 6

Ebola has an impact on the whole country's food situation



The Ebola outbreak most affected Liberia's "breadbasket".

The Ebola crisis also had devastating consequences for food security in Liberia because incomes are so low that even in normal times over half of people's income goes on food. In 2012, Liberians spent an average of 53 percent of their income on food, in some areas expenditure on food was 70 percent. Setbacks in income or increased prices can therefore do a lot of damage to adequate and healthy nutrition.

This is exactly what happened during the Ebola epidemic: food prices at Red Light, the biggest market in the Liberian capital Monrovia, exploded after a state of emergency was declared in July 2014. During the first two weeks of August, the price of cassava rose by 150 percent, of palm oil by 53 percent and the price of gari (dried cassava that is a major component of the widespread dish Fufu) doubled. The price of fresh peppers, one of the main vegetables, rose by 133 percent and the price of plantains rose by 66 percent (Kowonu 2014). In other parts of the country, prices did not rise quite as high but by 30 to 75 percent on average (Mercy Corps 2014).

After the crisis, prices decreased again but because of inflation, food still costs about eight percent more than before the epidemic. The price of rice has even risen more.

The time of the epidemic also played a major role in rising food prices. The height of the crisis coincided with the period of the year when most of the work is usually conducted in the fields, when the seedbeds are prepared and rice is planted. Moreover, Liberia's rice stores - Lofa, Bomi and Nimba - lie on the border with Guinea and were the areas most affected by Ebola. They are where the disease was first detected when it crossed the border from Guinea.

In Liberia's southern districts, where seeds are sown one or two months earlier, harvest losses were less considerable. However, there are currently no reliable figures for nationwide harvest losses in 2014/2015. The FAO estimates that there was a drop of 15 to 25 percent in domestic market supply (FAO/WFP 2015), while the Liberian government speaks of 15 percent (Ministry of Agriculture et al. 2015).

Chapter 7

Why the Ebola epidemic has such an influence on agriculture

The devastating impact of Ebola on Liberia's agriculture cannot only be attributed to the fact that the beginning of the crisis coincided with the sowing period. Another important factor was that the possibilities for selling goods vanished. Although food in the cities became increasingly scarce and expensive, as Ebola spread, the price that farmers could fetch fell as hardly any traders came to their villages to buy the harvest. Demand fell. The few traders there were faced higher transport costs because of the numerous road blocks. Transport costs on the domestic market are estimated to have risen by 40 to 45 percent on the domestic market (ACG/Welthungerhilfe 2014). Furthermore, it took so much longer to transport goods that they were no longer fresh on arrival.

Ebola also caused a shortage of labourers in agriculture. There were no more migrant workers and "kuu systems", a traditional form of mutual cooperation in many ethnic groups in Liberia, collapsed during the crisis. People were less willing to help their neighbours because of fear of contagion.

Moreover, supplies of fertilisers, commercial seeds and further means of production came to a standstill. Although only a few farmers in Liberia buy in such products as fertilisers, these are the ones who supply the markets in the cities. In a survey conducted by the Ministry of Agriculture, 99 percent of households that usually buy such products complained that there was a shortage of mineral fertilisers and pesticides during the Ebola crisis and 58 percent said they had a shortage of seeds (Ministry of Agriculture/LISGIS et al. 2014). Even if these goods had been available during the crisis, most farmers would not have been able to afford them since it was almost impossible to get a loan, either with informal lenders or official banks.

Another reason that the virus had such a destructive impact on Liberia's agriculture is that the country is strongly dependent on imports of food and fodder. Only 20 to 40 percent of food consumed in Liberia is produced there (see Ministry of Agriculture/LISGIS et al. 2014). But in 2014, the country's importing capacity decreased considerably: important actors in the country's economic development lost confidence and the currency's value fell by 15 percent between March 2014 and August 2015, leading to a loss of purchasing power on the world markets. Moreover, the global market prices (www.indexmundi.com/de/rohstoffpreise) for Liberia's most important exports fell even more from mid-2014 to mid-2015: by 40 percent for iron ore, by 23 percent for rubber and by 28 percent for palm oil.

Fortunately, the global market price for rice, Liberia's most important import, fell by around 15 percent. Moreover, the international aid for the Ebola-hit country brought in foreign currencies.

Chapter 8

Why women are particularly affected by the social impact of Ebola



Women were particularly susceptible to infection because of the jobs they often do. Washing hands was one way of preventing disease.

Because of discriminatory economic and social structures, women in many countries of the world are denied an equal share in education, work, healthcare, and other resources. So women are often among the weaker, marginalised groups of a society and often most affected by economic collapse or health crises such as the Ebola epidemic. There are currently no reliable figures comparing the incidence of Ebola among men and women. Julia Duncan-Cassel, Liberian Minister of Gender and Development, told the Washington Post that 75 percent of those who had become ill were women and girls. For its part, in “Gender Alert” February 2015, the Inter-Agency Standing Committee (IASC) said that 49 percent of those who had fallen ill and died because of Ebola were women (IASC 2014). In that case, more men than women would have been directly affected.

Because of the jobs that women in Liberia tend to have they are sometimes more prone to infection than men. Particularly those working in the services sector, selling goods on the street for instance, working as carers, health workers, cleaners or educators who tend to be

women. Women are also traditionally responsible for conducting funeral ceremonies. They also have more contact with health establishments before, during and after childbirth and these are dangerous hotbeds of the virus.

Women were also more affected than men by Ebola from an economic point of view. A state study found that more women than men had lost their jobs: 60 percent of recently jobless people were women, while 40 percent were men (Ministry of Agriculture/LISGIS et al. 2015). Poultry farming which is typically done by women collapsed entirely because of shortages of both feed and chicks from the Ivory Coast (Kotilainen 2014).

Women in Liberia depend particularly on the 700 Village Savings and Loan Associations (VSLAs) which have 21,000 members who have been trained in business methods. Some 12,300 more such associations are currently in the foundation phase. Around 90 percent of the members are women and the groups are very important for their economic independence and feelings of self worth. But the VSLAs also faced major hardship during the crisis. Members were not able to meet for their weekly meetings, nor pay off their loans. It remains to be seen whether they will be able to function again normally (Langlay 2014).

Chapter 9

The virus becomes a problem of economic policy

Before the epidemic, Liberia's economic policy was based on the expectation that foreign investment would channel into the country's agriculture, forestry, mining sector and subsequent value chains. Before Ebola broke out in 2014, Liberia had witnessed the highest rate of foreign direct investment compared to GDP in the whole world (African Governance Initiative 2011). The government's hope that foreign investment would have an impact on the country's economic development was not fulfilled, although 40 percent of the country's territory was handed over to foreign companies via concession agreements (according to unofficial sources, see Ford 2012). Foreign investors became less willing to exploit the country's natural resources during the Ebola crisis; moreover, the falling prices of Liberia's most important raw material exports had a very negative impact on the world market. Liberia does not yet process raw materials itself and remains very dependent on world market prices.

The steel giant ArcelorMittal put its planned investments on ice because of the Ebola crisis. A Chinese metallurgical group's plans to build a metal mine were cancelled. Rural conflicts over plans by Simo Darby, Golden

Veroleum and EPO (Equatorial Palm Oil) to expand palm oil cultivation escalated during the crisis. The biggest rubber plantation in the world, which is operated by Firestone, was very badly hit and most workers lost their jobs.

Increasingly over recent years, the Liberian government has understood that development cannot rest alone on the export of natural resources. A "transformation" of the economy is necessary (CASS Lib 2007). Decision-makers in Liberia understand this as the transformation of an economy based on extraction to one focussed on labour-intensive sectors such as construction, agriculture, fisheries and services. Currently, the government is also concentrating on expanding the domestic market for goods produced by smaller agricultural companies (Republic of Liberia 2015). It is also exerting more pressure on corporations that have signed concession agreements to take part in "outgrower schemes" and involve small farmers in production and supply, according to the new Minister of Agriculture Moses Zinnah (Zinnah 2015). This gradual transformation towards more labour-intensive areas was accelerated by the Ebola crisis.



The government wants to build up the domestic market, and the fisheries sector for example because Ebola paralysed Liberia's economy and frightened off investors in major projects.

Chapter 10

Community-based health-related activities play a decisive role

Even though Liberia's weak health infrastructure was boosted by massive international aid, the central hospitals and the measures introduced by the government would not have been able to fight the Ebola virus alone. Actually, the central health stations were often hotbeds of the virus that people avoided as much as possible. In the end, the epidemic was stopped because of Liberia's local populations and community-based health strategies. Local partners of Brot für die Welt such as the Christian Health Association of Liberia and the Civil Peace Service Network Mano River Region, which are known and have networks in the region, were able to mobilise hundreds of people to raise awareness about infection and the development of the virus and to campaign for stronger hygiene measures. Every day, hundreds of volunteers went from house to house and spoke with the population. Community-based health workers looked after patients in their homes and when necessary they organised the transport to nearby health facilities.

The Liberian government seemed to be surprised by the high degree of mobilisation at local level, by people's ability to self-organise and apply preventive measures. When the real danger posed by the virus became evident, many communities did not wait for government officials to act but took their own initiatives in their villages. Churches and parishes, NGOs, associations and the private sector became active. Tamba Boima, the Director of Community Health Services at the Liberian Ministry of Health said: "It's true: as a government, we have learned our lesson. Ebola has changed a lot in health policy. Measures to contain and prevent the disease are now being implemented at community level. We hope that the local population has the willpower and skills to cope with this new responsibility. However, it would be inappropriate to play local and centralized services against each other. Everybody was scared and was uncertain as to how to deal with the virus" (Boima 2014).

Bread for the World's partner organisations during the Ebola crisis in Liberia

At the time of the Ebola epidemic, Bread for the World and Diakonie Katastrophenhilfe in Liberia particularly supported the Liberian partner organisation Christian Health Association of Liberia (CHAL). CHAL is a long-term partner of Bread for the World and was involved in fighting Ebola in the districts of Bong, Nimba, Lofa, Montserrado, Grand Bassa, Rivercess, Sinoe, River Gee, Maryland, Grand Kru, Bomi and Grand Gedeh.

The aim of CHAL's measures was to interrupt the infection chain of Ebola as early as possible. This meant that the transport of patients or those suspected of having Ebola had to be reduced to an absolute minimum. Therefore, at community level, adequate, expert care had to be secured in people's homes, local health stations had to be equipped appropriately and staff had to be trained in how to diagnose Ebola early on and how to care for those affected by the virus. The CHAL project was supported on the ground by the Deutsches Institut für Ärztliche Mission (DIFÄM). A focus was placed particularly on two activities that would reach the population:

- 1) The training of over 608 volunteers from the communities to raise awareness regarding Ebola; 309 were nominated and trained as "contact tracers" (three per community), who regularly visited households in their communities. They received training in how to recognise suspected cases of Ebola, how to deal with patients, and how to transfer them to health establishments;
- 2) Implementation of debates and events in about 100 communities to raise awareness about Ebola, how infection occurs and preventive measures.

The Liberian Church Council (LCC) and its partner organisation Programme for Christian-Muslim Relationship in Africa (PROCMURA) as well as Bread for the World's partner The New African Research and Development Agency (NARDA) and the Lutheran Church of Liberia's Trauma Healing and Reconciliation Program (LCL-THRP) were given 350,000 euros as support. The focus here lay on community-based health awareness-raising which reached about 1.2 million people nationwide.



During the epidemic, Bread for the World's partner organisation Christian Health Association in Liberia trained numerous community health workers who raised awareness about Ebola and the most important ways of preventing infection.

The Bread for the World partner network Civil Peace Service Network Mano River Region played a significant role in fighting Ebola in Liberia. It was created in May 2008 by the Protestant Development Service and its partner organisations from Liberia and Sierra Leone to support peace-promoting projects in the former war zones. During the epidemic, the network got involved in Ebola awareness-raising campaigns to avert a state of social paralysis and isolation that threatened to take hold. The network's activities ranged

from church community work to communal sensitivity campaigns and adult education to participation in radio programmes.

Apart from supporting the measures of its partner organisations in bringing immediate relief in the wake of the Ebola epidemic, over the next two years Bread for the World will give CHAL 850,000 euros to help build and strengthen sustainable health structures, although the focus will lie in prevention and resilience.

Chapter 11

Ebola became a global matter concern

After some initial hesitation, after August 2014 the United Nations deployed a lot of funds and staff to fight Ebola. The Liberian government seemed to be at a loss. President Ellen Johnson Sirleaf admitted in public that she felt helpless, Moses Zinnah said that the government almost collapsed in panic (Zinnah 2014). Thereafter, UN organisations dominated the aid efforts. At national level, Emergency Operation Centres were created under the auspices of the ministry of health. Later, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) took over at national level, especially with regard to the attribution of funds and the management of the Central Emergency Response Fund, which was supposed to pool donations from international and state donors (UN Secretary-General 2014).

In 2014, the Liberian government's budget of \$401 million shrunk by 100 million compared to 2013 because of the export setbacks in iron ore and rubber. The immediate measures against Ebola cost the state \$76 million, which would not have been able to function if the international community had not raised \$156.6 million for the health budget (Republic of Liberia 2015, 21).

The World Food Programme distributed food because of the acute emergency situation in areas that were quarantined for instance or to families where there were members with Ebola. In a government poll conducted in 90 districts in 2015, 70 percent of respondents said that they had received free food at least once in the past six months (see Republic of Liberia et al. 2015). Still, there was not enough food to meet the need. To provide food for 290,000 people whose food situation became insecure because of the Ebola epidemic and for the 460,000 people already suffering from malnutrition, it would have been necessary for Liberia to import 445,000 more tons of crops, according to World Food Programme estimates. Neither the resources nor logistics existed to support such a huge aid effort (World Food Program 2015).

In September 2014, the World Health Organisation and UN-OCHA drew up a comprehensive Ebola aid plan for Liberia, Sierra Leone and Guinea. They estimated that financial aid of \$987.8 million was needed, \$476.4 million for Liberia alone (WHO/OCHA 2015 or detailed Africa Renewal 2014). To implement the plan, an international donors' conference was called and pledges were made. For Liberia, the major part, 72 percent of the funds, were intended for the health sector, ten percent for food security, nine percent for economic revival programmes and 2.2 percent for social mobilisation/awareness-raising.

In December 2014, the UN Special Envoy on Ebola David Nabarro announced that the donor community had responded unusually generously. But there is a big difference between agreeing to donate and actually donating. In August 2015, only some of the money pledged had actually been paid.

On 20th January 2015, the World Bank reported that it had been easier to contain the epidemic than originally expected. The estimated \$1.6 billion losses in GDP in three countries because of the epidemic were also lower than expected. This made no difference to the willingness to donate. The United Nations announced that the fundraising efforts had been successful and the goal of almost one billion dollar had been attained. The Liberian government was confident that the \$1.6 billion in development aid promised for its development plans before the Ebola crisis will be made available despite the Ebola funds for its plans to restructure the economy (Republic of Liberia 2015, 7).

Although the crisis has been overcome in Liberia, Ebola has not yet been eradicated. There could be another outbreak and a new health crisis. African states are aware of this so on 2nd and 3rd July 2014, African health ministers met at a summit to discuss future strategies for preventing an epidemic in Africa ("Accra Response Strategy").

Chapter 12

Will dealing with the epidemic be “business as usual”?

Public life in Liberia may have returned to normal, but the crisis did not only leave its mark on the economy and agriculture but also on the population. Many people remain traumatised by the epidemic. There are very few professional psychotherapists and psychiatrists in Liberia. The few psychologists who offer trauma therapy are paid for by the Lutheran Church of Liberia.

The grieving process after losing relatives remains a big challenge. The fact that many were forced to forego the traditional funeral rights usually so important in Liberian culture is an issue. Mass cremations, which would have been unthinkable before, took place to prevent infection.

Moreover, society was affected in the sense that in many places the crisis triggered a lack of solidarity - there

was too much fear of infection. On the other hand, some communities also witnessed more solidarity and new forms of collective self-help and community-based health-work emerged.

The Liberian state has acknowledged that the involvement of local communities was a crucial factor in putting a stop to Ebola. One can hope that this recognition will have an impact beyond the health crisis and that from now on civil society, with its wide-ranging experience and understanding of local needs will be incorporated in long-term political processes and strategy planning as well as implementation.

Stories from the villages of Liberia

In autumn 2015, students from the William R. Tolbert Jr. College of Agriculture and Forestry (WRTCFAF) at

the University of Liberia asked people in their home villages about their experiences during the Ebola crisis.

Ebola and the story of the “Untouchables”

By Numanee Zergbo and Kames Kpanakau

Lofa County was one of the regions in Liberia that was worst hit by Ebola. However, amazingly after the virus broke out in March 2014, no infections were registered in the two cities, Salayea and Zolowo Town. They were nicknamed “The Untouchables” after the population and various groups mobilised their efforts and introduced measures to successfully fight the disease.

The people of Salayea and Zolowo consistently followed all the precautionary measures recommended by the Liberian Ministry of Health, which included the regular washing of hands, a ban on the hunting and eating of game, a ban on the washing of corpses, the avoidance of public gatherings, restrictions on travel. All cases of Ebola had to be reported to the district Ebola task force.

However, this was not enough for the inhabitants of Salayea. The commissioner, the mayor and the district heads, as well as youth and women’s groups, all became part of the fight to prevent the spread of Ebola. Right from the start, the inhabitants called on

everybody to educate themselves about the virus. At first, there were rumours that Ebola had not broken out at all. So the commissioner set up a district task force and involved all the important people and groups of the town. The task force invited NGOs to teach them important practices, including the preparation of chlorinated water for washing hands, public latrines and other public places. A mandate was issued instructing that all visitors should be registered and monitored during the 21 days of incubation time. If they came from Guinea or other highly affected areas, they were not allowed in but sent back. The road linking the town to the border with Guinea was closed. The task force set up a watch team to guard the town and set up checkpoints at various entrances. Health workers were assigned to the checkpoints where there were also stations for washing hands and monitoring people’s temperature. Those whose temperature was too high were not allowed to enter the town. While most of the health facilities in the county closed down, Salayea’s health centre remained open, but it only treated locals, no visitors.

The youths took over responsibility for keeping the town clean. Every morning, they raised awareness about the importance of cleanliness, speaking the local dialect. Every Saturday, they cleaned the town thoroughly. They helped people who had problems preparing chlorinated water because it was difficult to measure out the chemicals, such as the elderly, the disabled and the blind.

No case of Ebola was registered in Salayea, but there were some suspected cases. One family was quarantined after losing a relative to the disease in Monrovia. The daughter of the family had visited him just two days before he died. The task force questioned the family members and then decided to put it under quarantine for the town's safety. Health workers from the government clinic monitored the family members' temperature every morning and night. The women's club brought them food and water, while youths gathered firewood for them. So although they were quarantined, they were treated well

Ganta: An example of the impact of Ebola on church life

By Fredda Gono and Daanue Zwuogbae

The Ebola epidemic in Liberia left perpetual scars on the country's churches. Some were even forced to close. The churches were at the front of fight against Ebola; survival was paramount. Ganta, Liberia's second-largest city, was severely affected by Ebola and illustrates what the virus meant for church life. Most of the victims of Ebola in Ganta, where over 100 died, were Christians. Many became infected at the funerals of the first victims. Some families believed that poison was involved. The pastors were largely not scared, continuing to visit patients and pray for them. Some came down with the virus themselves and lost their lives; others survived.

Ebola became the main theme of sermons and was approached from different perspectives. Many pastors used the internet to find out more about the disease so that they could raise awareness among their congregations. Others listened to the radio and attended workshops organised by Christian communities and NGOs, where information leaflets were distributed. Some pastors created their own educational material.

and lovingly. No signs of Ebola appeared during the 21 days of quarantine.

The General Chief of Zolowo Town, some 15 minutes' drive from Salayea, also made sure that the Ministry of Health's mandate was followed strictly. Moreover, no visitors were allowed into the town. After a person was suspected of having died of Ebola, a 42-day self-quarantine was imposed. During this period, cars and motorbikes were not allowed to enter the town and the general market did not take place on Saturdays. The youths set up checkpoints to take the temperature of people going to work in Salayea or on their farms. The major road that links Lofa to Belle National Forest and runs through Zolowo was shut during the epidemic.

Despite the crisis, farming activities did not stop in either town. Both mayors played an important role in the task force and because there was high community participation and a spirit of togetherness, the towns were largely unscathed by the Ebola epidemic.

Some congregation members believed that Ebola was a demonic attack on the Church of God. One pastor who had survived said that Ebola was not a physical illness but a spiritual disease. He said that he had prayed intensively when he was given medication at the Ebola Treatment Unit. After a rapid recovery, he opened a prayer centre at the ETU and claimed that he had thus helped to save a lot of people.

At services, everyone was encouraged to wear long sleeves or clothes that covered the whole body. Buckets of chlorinated water were placed at the entrance of each church so people could wash their hands. Seating was also rearranged - instead of eight people per bench, there were only four - to limit physical contact. Additional chairs were bought. Because the churches were too small to accommodate everybody now, some pastors offered two or three services per day. Others rented or built new halls.

Despite the restrictions on large gatherings, large numbers continued to go to church. Congregations doubled in size, from 200 to 400.

The churches knew that they had to act against Ebola. The Christian community was the first to organise an Ebola task force and called on Christians to donate material for the fight. In collaboration with the local authorities, the Christian community task force even quarantined some people. This caused resentment and some of those who were placed under quarantine did not return to church after the 21-day incubation period.

Parishioners became afraid of each other. Many church activities were stopped. Shaking hands for ex-

ample, a tradition and a sign of peace in churches, was replaced by waving. There was no more hugging. Baptism, the first of the Seven Holy Sacraments, did not take place in many churches during this time, nor was the Holy Eucharist administered. However, the Catholic Church continued to administer sacramental bread so long as the priest and parishioner had both washed their hands with chlorinated water. Mrs Keamue, a member of the Catholic Church, gave an example of sitting next to an older man in whose neighbourhood there was a suspected case of Ebola. He was asked to leave the church. She also went home and bathed herself in chlorinated water. Even though the parishioners later visited him to apologise, he did not forgive them.

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