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The Socio-economic Impact of the Ebola Virus Disease on the Youths in Sierra Leone. A case study of Marampa Chiefdom, Port Loko District, North-West Region

Alusine Kamara
Ernest Bai Koroma University of Science and Technology, Port Loko Campus, Faculty of Social Science
Email address: alkamara(at)ebkustedu.sl

Abstract— *This paper attempts to examine the Socio-economic impact of the Ebola virus disease on the youths. The study was descriptive in nature as it targeted some youths in Marampa chiefdom, Port Loko district. A structured questionnaire was administered to Youths, health workers and other stake holders in the chiefdom. However a small fraction of One hundred and twenty (120) people was used as a sample size. Tables and pie charts were used and they were accompanied by thorough discussion of findings.The findings of the study reveal that the Ebola epidemic seriously affected the Youths in Marampa chiefdom. The Socio-economic sectors that were seriously affected include Mining, agriculture, education, games and sports, trade and mobility. This greatly militated against their development strides in their different communities. The study also brings out the role played by the Government and Non-governmental Organizations (NGO's) in uplifting the Socio-economic status of the youths in the chiefdom. The study recommended that, in order to effectively control future outbreaks of Ebola, there should be the need for government and other agencies to improve the health sector through education and sensitization of people on health related matters and a rapid response to future Ebola outbreaks.*

Keywords— *Epidemic, Ebola, outbreak, youths, Socio-economic, disease, virus.*

I. INTRODUCTION

Sierra Leone is located on the West Coast of Africa, between 7 and 10 degrees North and Longitudes 10 and 13 degrees west. The Republic of Guinea is to the North and North east, Liberia is to the East and South east, and the Atlantic Ocean is on the West and South of the country. The country has a total area of 71,740 km^2(source: statistics Sierra Leone Website) and occupies into a land area of 71,620 km^2.

From an approximate 70 miles coastal belt of low-lying land, the country rises to a mountain plateau near the eastern frontier rising 4000 to 6000 it with a rich timber forest region. The western area, on which the capital and main commercial center of Freetown stands, is 24 miles long and 10 miles wide. According to the 2015 census result, the population of the country is 7,075,641.

The history of Sierra Leone began when the land became inhabited by the indigenous African people at least 2,500 years ago. Sierra Leone was founded by a Portuguese Sailor named Pedro de Sintra who came up with the name "Sierra Lyoa" meaning lion mountain since the coastal regions looked like the shape of a lion.

In 1787, British philanthropists founded the "Province of Freedom" for freed slaves which later became Freetown, a British crown colony and the principal base for the suppression of the slave trade. In 1896, a British protectorate was proclaimed over the hinterland of the country.

Sierra Leone became an independent nation on 27th April 1961. A military coup overthrew the civilian government in 1967, which was in turn replaced by civilian rule a year later. The country declared itself a Republic on 19th April 1971.

A coup attempt early in 1971 led to the then prime minister, Siaka Stevens calling in troops from neighboring Guinea's army which remained for two years. A one party state was introduced by Stevens in 1978 under the All People Congress Party.

In 1992, soldiers led by Valentine Strasser overthrew Stevens' successor, Joseph Saidu Momoh, calling for a return to a multi-party system. Democratic elections were organized in 1996 which ushered President Ahmed Tejan Kabba of the Sierra Leone Peoples Party. This preceded a decade long civil war organized by Corporal Foday Sankoh in 1991. President Kabba was later succeeded by President Ernest Bai Koroma in 2007 under the ticket of the All Peoples Congress Party.

The economy of Sierra Leone is largely under developed and over dependent on mineral exploitation. Successive governments and the population as a whole have always believed that "diamonds, Iron-ore and gold" are sufficient generators of foreign currency earnings and lure spring board for investment.

As a result, large scale agriculture of commodity products, industrial development and sustainable investments have been neglected by successive governments.

Two thirds of the population of Sierra Leone is directly involved in subsistence agriculture. Agriculture accounted for 58% National Gross Domestic Product (GDP) in 2015 (source African Development Bank Report 2015).

Since independence, the government of Sierra Leone has encouraged foreign investment although the business climate suffers from uncertainty and a shortage of foreign exchange because of civil conflicts and the Ebola epidemic. Investors are

protected by an agreement that allows for arbitration under the 1965 World Bank Convention.

The Sierra Leone governance system is divided into three branches - the legislative, executive and the judiciary. The government is headed by a president who is both head of state and head of government and of a multi-party system. Executive power is exercised by the president and legislative power is vested by the parliament of Sierra Leone. There is a High Court, an Appeals court and a supreme court controlled by the Judiciary. The House of Representatives has 124 members of which 112 representatives are elected members of parliaments (MPS) and the 12 are paramount chiefs representing their various districts.

Sierra Leone is home to seventeen ethnic groups, each with its own language. Membership of an ethnic group often overlaps with a shared religious identity. The largest ethnic group is the Temne, (about 35%) closely followed by the Mendes, at (about 31%) (2015 census report).

Sierra Leone's health system over the years has been rated very poorly. Globally, infant and maternal mortality rates, according to a recent BBC report, remain among the highest. Most deaths within the country are attributed to nutritional deficiencies, lack of access to clean water, pneumonia, diarrhea diseases, and malaria, Tuberculosis, HIV/AIDS and quite recently Ebola.

The Ebola virus is one of the world's most deadly diseases. It is a highly infectious virus with no cure and it carries with it a mortality rate of up to 90% killing almost all who catch it and spread terror among infected communities. The virus first appeared in 1976 in two simultaneous outbreaks, one in Zaire (now Democratic Republic of Congo) and the other in Sudan. The former occurred in a village near the Ebola River from which the disease took its name.

The Ebola incidence in West Africa was one of the largest and most complex outbreaks since the virus was first discovered in 1976. In effect, there have been more cases and deaths in this outbreak than previous cases combined. It has spread between countries starting in Guinea and spreading across Sierra Leone, Liberia, Nigeria, and the United States of America.

In Sierra Leone, the Ebola outbreak began slowly and silently, gradually building up to a burst of cases in late May and early June 2014. A retrospective investigation by World Health Education (WHO) revealed that, the country's first case was a female traditional healer who was a guest at home of the index case in meliandou, Guinea. When the host family became ill, she travelled back home in Sokoma, Kailahun District and died there shortly after her return. However, that death was neither investigated nor reported at the time. The funeral sparked a chain reaction of more cases, more deaths and more funerals which spread the virus in almost all parts of the country. Peoples' early attitude towards the virus was a strong factor that contributed to the spread of the disease.

Initially, there was a denial syndrome among most of the people. Some claimed that it was a witch plane craft that had crashed in certain areas especially in the study area-Marampa chiefdom. There were also strong beliefs among other people that, some nurses at the Mabessseneh Hospital Lunsar had stolen some money from a Fula patient admitted at the Hospital. The Fula man in a way of seeking revenge for such a calamity had decided to swear all those nurses that were involved in the theft case. This was an accepted belief by most people as the virus initially killed lots of nurses in the chiefdom.

People were also careless in fighting the virus. The medical precautionary measures implemented by health agencies were neglected which contributed to the death of many people in the country. There was also lack of knowledge about the virus and the method of control. People had little or no knowledge of the virus including the health ministry in the country. It was therefore a difficult task to prevent and control this deadly virus outbreak.

The rapid spread of the disease in the country could be attributed to different factors. In the first instance, public health campaigns started too late and didn't reach enough people. Ishmeal Alfred Charles, who was working on the Ebola frontline in Freetown, said there was little awareness about Ebola until late July 2014, about four months after the first suspected cases emerged in the country. The virus was taken into seriousness when Dr. Shiek Umar Khan, Sierra Leone only expert on hemorrhagic fever, by then died after contacting Ebola at his clinic in Kenema on 30th July, 2014.

Additionally, most of the public health messaging about Ebola was concentrated on mainstream media including TV and radio, so it was mainly reaching the middle and upper classes of the country.

Moreover, health campaigning and raising health literacy was not also easy in places where people can't read especially in the rural areas of Sierra Leone.

Another cause of the rapid spread of the virus was traditional West African funeral practices that involved close contact with infectious corpses. The problem of conducting burials in a safe and dignified manner made it difficult to reduce the transmission of the disease. This was also coupled with hand greetings.

On other times, other schools of thought believed that hot water and salt could stop the Ebola. Others suggested faith healing or hot chocolate, coffee and raw onions will stamp out the virus. All these were myths that contributed to the spread of the virus.

Poverty and international indifference also contributed to the spread of the virus, especially in Sierra Leone, Liberia and Guinea which are among the poorest countries in the world and have only recently emerged from years of armed conflicts that destroyed the health care systems. Before the Ebola outbreak, Sierra Leone had a weak health system and little money to spend on health care. There were few ambulances and other health care equipment to fight such a dangerous virus.

Besides this, there was limited capacity for travelling. People became congested in vehicles and the body contact also resulted in the rapid spread of the virus.

However, with all these challenges faced in combating the virus, government and its partners strongly came in to control it. The authorities in Sierra Leone declared a public health emergency in July 2014 and instituted a strict set of measures including the suspension of markets and movement restricted bya 7:00 PM curfew.

Persons suspected to have the disease were reported to the nearest health unit without delay. A free line "117" was created to be used for any suspected case of Ebola.

Traditional healers were banned from all traditional treatment. All burials, hand shaking and social gatherings were banned. The use of veronica buckets for frequent hand washing was also instituted. Legal actions and fines were imposed on defaulters.

However, foreign medical intervention played a great role in controlling the virus especially the support of World Health Organization (WHO). A lot of foreign doctors, ambulances, and drugs preventive equipment and donor funds were poured in the country to control the virus, including the setting up of different treatment centers in almost all the districts in the country.

On the whole, according to WHO Ebola situation report released on the 30th March 2016, it was revealed that Sierra Leone had 14,124 Ebola positive cases. Out of this number, 3,956 people died from the virus.

The virus also had an impact on the economy of the country. Mining companies were forced to close down, thus creating a negative impact on the revenue government is earning from these mining companies. Most youths lost jobs in these mining companies.

The agricultural sector also came to a standstill. As a result of market restrictions, the availability of cash crops in the rural economy diminished with a consequent impact on the purchasing power.

The educational sector was also brought to its knees as schools and other higher institutions were closed down for a long period. This saw a high influx of drop outs especially among girls who became pregnant.

Freedom of movement and association were restricted, thus depriving people of their fundamental human rights. Traditional practices like hand shaking, attending funerals were also curtailed.

However, during the course of the epidemic, some youths gained employment as Aid-workers in Ebola health facilities. More health facilities were created, there were lots of ambulances and foreign medical workers.

Most of the above scenario is national but the need to apply a local understanding of the impact of Ebola to specific communities is ever growing, hence the need for the proposed study.

Problem Statement

The Ebola epidemic which struck Sierra Leone in May 2014 came as a surprise to most Sierra Leoneans. There was little or lack of knowledge on the part of government on how to tackle the virus quickly to disallow spread in the whole country.

There were poor health infrastructure in the country before the epidemic which also ignited the flame of the virus. It was therefore a difficult task to control the virus which spread in all the regions in Sierra Leone including Marampa chiefdom, the study area.

This adversely affected people in Sierra Leone and Marampa chiefdom in particular. Youths lost their jobs to mining companies which were shut down. The country's economy dwindled and the educational sector collapsed. Some youths in the chiefdom lost their relatives to the Ebola epidemic and those who survived the virus are still counting on the psychological impacts they experienced.

Although the government and non-governmental organizations (NGOs) have played and are still playing an active role to improve on the socio-economic status of these youths, the researcher is of the strong opinion that there is yet still much to be done to improve on these affected youths. It is against this background that the researcher has focused on examining the socio-economic impacts of the Ebola virus disease on the youths in Marampa chiefdom, Port Loko distract.

Coupled with this, the Ebola epidemic was a new epidemic in Sierra Leone, hence the national and international response was very challenging.

Besides, not much was known about the comprehensive impact of the virus at national not alone local level like the study area, hence the need for the study.

Aim and Objectives

The research aims at investigating the socio-economic impacts of the Ebola virus disease on the youths in Sierra Leone with a special focus in the Marampa chiefdom, Port Loko District.

The specific objectives of this research are to:

1. Identify respondent's profile
2. Identify the major origin and cause of the Ebola virus
3. Determine the spread of the virus nationwide with special reference to the study area
4. Identify measures taken by government and other stakeholders in the chiefdom to contain the disease
5. Identify the challenges faced in the control of Ebola nationwide
6. Identify the role played by the government and non-governmental organizations (NGOs) in uplifting the socio-economic status of the youths especially those affected with the virus in the study area.
7. Identify the socio-economic impacts of the epidemic on youths in the study area.
8. Identify lessons learnt in the Ebola epidemic in Sierra Leone
9. Elucidate suggestions from respondents which are likely to control the Ebola virus and make recommendations to the government and NGOs on the way forward in helping youths with post Ebola programmes to prevent the disease in the future.

II. METHODOLOGY

Introduction

The last chapter focuses on the available literature review for this study. This chapter addresses the study area, the research design, the sample size for the study, the data collection instruments and the methods that would be used to analyses the data.

Research Design

In order to find out the socio-economic impacts of Ebola on the youths in Marampa chiefdom, the researcher has decided to design his work in such a way as to be able to accomplish the objectives.

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The chapter deals with the methods and the procedures used in the study which include:

- Determination of the total population
- Sampling procedures
- Research instruments used / data collection
- Data analysis

The Research design to be chosen will be the survey methods. It will be suitable because, it will enable the researcher to focus on a large sample size ranging from youths who have been affected by the Ebola virus, health workers, Aid agencies and other stake holders in the chiefdom.

Questionnaires and interviews would be used to obtain the bulk of information for this research work.

Sample Size

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Marampa chiefdom is a large chiefdom that was seriously hit during the Ebola epidemic but because of time and constraints, samples would be drawn from certain localities in the chiefdom. This will help the researcher to have easier access to the sources of information from the youths, health workers, Aid Agencies and other stakeholders in these communities.

A small fraction of these population will be used as a sample size. This will include 58 government workers drawn from teachers, Health Workers, Police, Bank Workers etc., 10 Non Governmental Organization Workers, and 52 people from local communities ranging from youths, business people, students, traditional authorities etc.

On the whole, 120 people will be used as sample size for this research work.

The sampling technique to be used in selecting the above sample size will be based on randomized sample technique where in respondents will be selected randomly in their different localities.

Methods of Data Collection

The questionnaires would be hand delivered to the various categories of people highlighted earlier. A time frame of one week would be given to them to write down their responses which will be collected by the researcher.

Interviews would also be conducted on certain personalities after making an appointment with them. Heads of various institutions like the Hospitals, Clinics, International medical corpes (IMC), Schools etc. will also be approached with enough notice to get official documents about the Ebola epidemic.

Data Analysis

The information collected would be analyzed using both quantitative and qualitative analysis. Tables and figures that would be used will be followed by interpretation and thorough discussion of findings. Besides this, the researcher will also embark on Pie charts as a means of central tendency to be able to analyses the data.

Summary

This chapter of the research work has examined the study area, the sampling procedures, the Data Collection methods and the procedure in which the data will be analyzed in the next chapter.

III. Result and Data Discussion

Profile of Respondents

TABLE 1. Shows Gender of Respondents

Institutions	Male	Percentage %	Female	Percentage %	Total
AID Agencies	6	60	4	40	10
Health Workers	5	50	5	50	10
Youths	46	58	34	42	80
Community People	28	56	22	44	50
Total	85	-	65	-	150
Percentage	57	-	43	-	-

Source- Researcher, 2017.

As shown in the figure above, 85 of the respondents were males, which is 57% and 65, were females, which is 43%. This implies that more males than females were given the questionnaires to be responded to.

TABLE 2. Shows Ages of Respondents

Age Range	Number of Respondents	Percentages
15-30 years	42	28
31-46 years	58	39
47-62years	30	20
63 above	20	13
Total	**150**	**100**

Source – Researcher, 2017.

The table above clearly shows the age range of the respondents. It could be deduced from the table that majority of the respondents are between the age group 15-46years which is 67% of those who were respondents. This implies that most of those who were targeted were youths whose inputs towards this work is of great importance because they were the focus of the study.

Origin and Major Causes of the Ebola Virus

From the interviews, focus group discussions and questionnaires, the researcher was able to obtain the above information on the origin and major causes of the Ebola virus in the country with Marampa chiefdom as a focus.

Majority of the respondents believed that, Ebola was externally transmitted into Sierra Leone through Guinea. It was

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believed that the country's first case occurred on 25th may 2014 when a female traditional healer, was a quest at the home of the index case in meliandou, Guinea. When the host family became ill, she travelled back home in Sokoma, Kailahun district and died shortly after her return.

The funeral sparked more deaths and more funerals spread the virus in almost all parts of the country. The respondents also brought out the following points as the major causes of the Ebola Virus in the country:

a) Contact with those infected with the virus
b) Eating of raw bush meat such as bats and monkeys
c) Cultural beliefs and behavioral practices of the people e.g. burials, attending funeral practices, hand shaking etc.
d) Poor public health infrastructures and lack of drugs to cure the virus
e) Poor road network to transport suspected cases to Ebola treatment Centres.
f) Public health messages that showed negative impacts to cure the virus.
g) Inadequate knowledge on how to fight against the virus as the epidemic represents the first time the virus was discovered in Sierra Leone.

Awareness About the Spread of Ebola in the Study Area

TABLE 3. Shows The Area in the Chiefdom Where the Ebola Virus First Hit.

Area Where the Ebola Virus First Hit in the Chiefdom	Number of Respondents	Percentages
Labour compound Lunsar	55	37
Mabessenehhospital Lunsar	90	60
Komrabai Village	05	03
Total	**150**	**100**

Source – Researcher, 2017.

From the table above, it could be clearly identified that 55 respondents which is 37% of the responses given testified that labour compound in Lunsar was the first place where the virus first hit. Those who believed that the epidemic started at the Mabesseneh hospital in Lunsar were 90 in number, which are 60% and those who confirmed that it started in Komrabai Village; some miles away from Lunsar were five in number, which is 3%.

The researcher was however able to interview technical personnels from the Mabesseneh hospital who proved that the epidemic started at the hospital from a Fula patient who was admitted there. Most nurses and doctors who treated him became infected and died from the virus.

However, sources gathered from different people also reveal that, there were stories that, those nurses who initially died must have stolen a huge sum of money that was in the possession of the Fula and this resulted to their deaths. Others testified that it was a witch plane craft that got an accident that caused the death of many people. All these were not true as the deaths of all these people were later proved to be as a result of Ebola virus.

Other information that the researcher obtained was that, the most common means of spreading the virus from one place to another was through transportation or movement of people from one place to another, visiting Ebola affected homes, moving Ebola patients from one place to another, attending funerals etc. The most common means of spreading the virus from one person to another was by touching the sick, hand shaking with infected persons, touching Ebola Corpses, sleeping in the same bed with an Ebola victim etc.

TABLE 4. Shows Assistance Given by Government to Health Facilitators to Control the Virus and Extent to Which These Assistance Help to Contain the Virus.

Assistance Given by Government to Health Facilitators	No Extent	Some Extent	Great Extent	Very Great Extent	Total
Provision of ambulances	12	28	60	50	150
Increase in drugs supply	10	45	52	43	150
Providing personal protective equipment (PPE)	-	30	55	65	150
Financial benefits	5	18	42	85	150
Supplying veronica buckets and chlorine	-	8	62	80	150
Training of health personnel's	12	44	58	36	150
Sensitization on the Ebola virus and its treatment	-	23	56	71	150
Frequency	39	196	385	430	1050
Percentage	**4**	**19**	**36**	**41**	**100**

Sources – Researcher 2017.

The table above indicates the assistance given by the government to health facilitators to control the Ebola virus and the extent to which these assistance help to contain the virus. On the whole, it could be noticed that government played a great role to contain the virus. For instance, in the provision of ambulances, about 110 respondents which is 73% confirm "great" and Very great extent" to which government assistance help to contain the virus.

Government also play a great role in supplying drugs and 95 of the respondents which is 63% also attest "a great" and "very great extent" in containing the virus. The provision of personal protective equipment (PPE), financial benefits to health workers, supplying of veronica buckets and chlorine, training of health personnels and sensitization of health practitioners on the Ebola preventive measures were to a "great and very great extent" done by the government to contain the virus.

TABLE 5. Cultural Practices That Hindered the Control of the Ebola Virus in the Country and the Extent to Which These Practices Hindered the Control of Ebola.

Cultural Practices That Hindered the Control of Ebola Virus	No Extent	Some Extent	Great Extent	Very Great Extent	Total
Caring for the sick	8	22	45	75	150
Washing of dead bodies	-	35	65	50	150
Secret burials	4	26	58	62	150
Hand shaking	6	40	50	54	150
Secret societies	25	56	44	25	150
Attending funerals	12	43	55	40	150
Frequency	55	222	317	306	900
Percentage	**6**	**25**	**35**	**34**	**100**

Sources – research 2017.

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Table 5 clearly shows the cultural practices that hindered the control of Ebola virus in the country and the extent to which these practices hindered the control of the virus. From the table, 75 respondents which is 50% to a very great extent" confirms that, caring for the sick hindered the control of Ebola nationwide. Other cultural practices that hindered the control of Ebola virus include washing of dead bodies, secret burials, hands shaking, secret societies, and attending funerals.

On the whole, those who attested to all these responses by saying "no extent" made up 6% "some extent" 25%, "Great extent"-35% and "very great extent"-34%.

TABLE 6. Strategies Adopted by the Government and NGOS In Combating Ebola and Extent to Which These Strategies Helped in Controlling Ebola.

Strategies Adopted by the Government and NGOS to Combat Ebola	No Extent	Some Extent	Great Extent	Very Great Extent	Total
WHO provided ambulances and drugs	-	30	65	55	150
Health Alert sensitized people on dangers of Ebola	10	46	47	47	150
International Medical Corps created treatment Centre	-	20	62	68	150
Street child, Red Cross, GOAL, Partners in Health etc. adopted preventive measures	5	43	52	50	150
Health ministry played a leading role in the fight against Ebola	-	30	55	65	150
Frequency	15	169	281	285	750
Percentage	**2**	**23**	**37**	**38**	**100**

Source Research 2017

The table above shows the strategies adopted by the government and NGO to combat Ebola in the Marampa chiefdom and the extent to which such strategies helped in controlling Ebola.

World Health organization, which is an agency of the U.N.O, played a major role by providing ambulances and drugs. Majority of the respondents to a "great extent" and "very great extent" (120 respondents) attested to this.

Other organizations that also played a major role in combating the virus were Health Alert, International Medical Corps, Street child, ENGIM, Partners in Health, Goal, Red Cross etc. These organizations to a "great extent" adopted preventive measures by supplying food, water, cooking oil, drugs to most communities in the chiefdom. They also sensitized people on the use of safe measures.

The percentage of those who said "No extent" was 2%, "some extent" was 23% "Great extent" was 37% and "Very great extent" was 38%. This implies that about 75% of the respondents believe to a great and very great extent to the strategies highlighted that they helped to contain the virus.

In addition to this, government through the health ministry played a leading role in the fight against the virus. For instance, a treatment Centre was set up in a village called Rogbalan, very close to Lunsar. The International medical corps (I M C) set this up. The working conditions of Health workers in the front where improved to motivate them.

A curfew or state of emergency was declared by the president on different occasions to enhance the control of the virus. Chiefdom authorities implemented by-laws and those who were defaulters were fined.

Okada riders were restricted to operate from 7 a.m. to 7 p.m. daily.

All nightclubs, cinemas, and video centers ceased their operations. All mushroom hospitals and clinics also ceased to operate. The Sierra Leone Police and military force also organized regular patrols to prevent rampant movement of people from one place to another and to enforce Ebola by-laws.

From the data obtained, it was also clear that, most of these NGO's and International Non-Governmental organizations (INGOs) helped in uplifting the socio-economic status of the youths during the Ebola epidemic. For instance, WHO upgraded medical workers through training and employment. International medical corps (IMC), Partners in Health (PIH), Red Cross, UNFPA, Goal, etc. employed youth as contact tracers, Burial teams, Swab takers, Cleaners etc. through this, the socio-economic status of some youth were greatly improved.

The Socio-Economic Impacts of the Ebola Epidemic on the Youths

TABLE 7. Shows the Extent to which the Socio-economic sectors affected youths during the Ebola outbreak in Marampa chiefdom.

Socio-economic impacts of Ebola on youths	No extent	Small extent	Great extent	Very great extent	Total
Trade	-	10	53	87	150
Mining	-	15	45	90	150
Agriculture	4	34	58	54	150
Employment	-	25	68	57	150
Education	-	15	48	87	150
Sporting/games	10	35	56	49	150
Psychological impact	8	27	53	62	150
Mobility	6	38	56	50	150
Infrastructure	12	32	52	54	150
Frequency	40	231	489	590	1350
Percentage	3	17	36	44	100

Source-Researcher 2017

The table below shows the Socio-economic impact of Ebola on youth and the extent to which such impacts affected the youths in the chiefdom. In the trade sector, 87 respondents out of the 150 respondents, to a very great extent confirm that youths were not actively involved in trade. Most of them had business centers especially at weekly markets organized in Foredugu, Gberay junction and Magbele. Such weekly markets were banned because of the Ebola epidemic and the daily survival of these youths with their families became a serious setback.

In the mining sector, 90 respondents which are 60% to a "very great extent" said the youths were seriously affected. Before the Ebola, most youths were employed in mining companies like London mining, Africa minerals, Cape Lambert, etc.

With the Ebola outbreak, the mining companies were forced to close down and these youths were laid off from these companies.

In the agricultural sector, majority of the respondents to a "great extent" and "very great extent" mentioned that Ebola affected the youths. These youths were no longer involved in agricultural activities.

The employment sector also saw a large amount of youths phasing off from most jobs. This seriously affected the youths to a great extent from the analysis given above. Most of them who were working with the Josephite fathers, the xavarian sisters, local NGOs etc. lost their jobs because of the Ebola outbreak.

Another serious impact of the Ebola epidemic is on the educational sector. Most youths dropped out of school after the Ebola epidemic. About 90% of the respondents highly agreed that the epidemic affected the youths in the educational sector. This was confirmed when researchers visited different educational institutions like Our Lady of Guadalupe Secondary School Lunsar, Murialdo Secondary School Lunsar, Maria Ines Junior Secondary School Lunsar, Movement of Faith Secondary School Gberay Junction, and A.D Wurie Secondary School Lunsar. Records from these institutions reveal that, many pupils dropped out of school after the epidemic. Most girls became pregnant during the epidemic and some still find it difficult to go to school today.

The games and sporting sector was also disrupted as could be seen from the table. This largely affected the youths as a ban was placed on all social activities including games and sports. Youths who were interested in playing games as if soccer and watching sporting activities were also denied these social programmes.

Psychologically, the Ebola had very great impact on the youths especially those that were infected and later survived the virus and those who lost their relatives to the disease. A total number of 62 respondents, which is 41%, confirm that, psychologically the youths were to a very great extent affected. Those who survived the virus experience health problems like pains, eyesight, fever etc. they were also discriminated during the peak of the epidemic. Their promised package from the government is yet to be fulfilled and post Ebola programmes for them are yet to be realised.

Youths who lost their relatives to the epidemic are still finding it difficult to cope with the memories of the past. Most of these youths lost their entire relatives to the epidemic and they are today struggling to survive. As such, there has always been a psychological impact on such youths in the chiefdom especially in Lunsar town, Labour compound, Mamusa, Komrabai and Magbafth villages where the epidemic strongly hit.

In the area of mobility, most youths were also affected, as they were not free to move from one place to another.

Infrastructurally, youths had little access to infrastructural development, as government's focus was to stop the epidemic.

Overall, the extent to which the stated socio-economic sectors affected the youths during the Ebola outbreak in the chiefdom reveals the following percentages.

No-extent -3%, small extent 17%, great extent 36% and very great extent 44%. These percentages indicate that the Ebola outbreak seriously affected the social and economic sectors of the youths in the chiefdom.

IV. Conclusion

The study generally showed that the Ebola outbreak had a negative impact on the socio-economic status of youths in the study area.

The Ebola epidemic extremely originated from Guinea and internally in Sierra Leone Kailahun District and spread in most parts of the Country. The major causes of virus in the study area were contact with infected person, cultural beliefs and behavioural practices, inadequate knowledge on how to cure the diseases, poor public health infrastructures, public health messages that showed negatives impacts to cure the diseases and poor road network to transport suspected cases of Ebola.

The part of the chiefdom where the virus started in the chiefdom was at the Mabessenerh hospital, Lunsar where a patient admitted was found to be an Ebola positive, and many health workers contacted him and became infected.

The study also reveals that there were various means of spreading the virus including body contact with Ebola patients handshaking, washing dead bodies and secret burials.

Various stakeholders stood very firm to fight against the virus in the chiefdom including paramount chiefdom, local authorities, religious leaders, youth groups, Osman Karankay conteh, Police and armed forces, health workers and NGOs These stakeholders played an important role to contain the virus. This includes provision of 95, ambulances, enforcing by-laws, sensitizing people, supplying veronica buckets challenges faced in the control of Ebola in the chiefdom include inadequate funds some stakeholders to contain the virus, cultural and behavioural practices of the non-adherence to Ebola by-laws, people lost confidence in some stakeholders for embezzling Ebola funds and marginalization of some youth groups, as they were not involved in the fight against the virus. Cultural practices that hindered the control of the Virus include caring for the sick, washing of dead bodies, handshaking attending Funerals and secret burials. The study also pointed the role played by government and NGO's has to improve status of the youths in the chiefdom. This includes employing them as contact burial teams, surveillance officers, and some NGO's like street Child, Red Cross, Goal WHO, PIH etc. employing them as Aid Workers. The respondents also highlighted lessons learnt from the Ebola epidemic. The lesson learnt included the need to train more health workers on viral diseases, provision of ambulances to hospitals, early reporting to medical centre in cases of out breaks, need to focus on education, suspension of some cultural practices during Ebola crisis, continuous hygiene practices, and close monitoring of Ebola survivors.

Recommendations

Base on the conclusion the following recommendations were made:

1. The need to train sufficient health workers especially on viral diseases like Ebola.

2. Setting up of structures that support the training of health workers e.g. ambulances, hospitals etc.
3. Early reporting to medical, Centre's saves lives.
4. All suspected cases of Ebola must be reported to health authorities
5. Continuous hygiene practices especially washing of hands. We should not be complacent of such practices.
6. The need to focus on education as illiteracy fueled up the epidemic.
7. Some cultural practices should be suspended in certain emergency crisis.
8. Survivors of the Ebola disease should be closely monitored to prevent them from passing the virus to others.

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