Coping with crisis: community resilience in the aftermath of the Ebola crisis

Exploring the gap between policies and reality in Sierra Leone

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Abstract

This study focuses on the interplay between institutional, political and socioeconomic ‘top-down’ factors and the building of ‘bottom-up’ community resilience. Wellington, an urban community in Sierra Leone, offers a valuable lens through which local resilience in the aftermath of the Ebola crisis can be examined. Based on Twiggs’s (2009) framework for community resilience, semi-structured interviews and field-visits are conducted. The institutional, policy and socioeconomic factors (also called ‘the enabling environment’) are addressed through a literature review and the analysis of three key policy documents. Combining all outcomes, leads to the conclusion that a high level of community engagement, as well as a general awareness of resilience issues and willingness to address them is found in the aftermath of the Ebola crisis in Wellington. However, the capacity to act (knowledge and skills, human, material and other resources) remains limited. Despite a political will to collaborate on all scales and work towards resilience, it is observed that policies that support local resilience do not translate well to the ground. In line with the theory, this leads to the conclusion that there is an implementation gap which hampers the development of community resilience.

Because of the observed ability to mobilize people quickly and the level of community engagement, the case of Wellington suggests that, if provided with the right tools and resources, there would be an opportunity to build social capital and further develop in the direction of resilience in Wellington. The literature suggests that a more integrative process, bringing together bottom-up and top-down knowledge and actions, is needed for the policies to have an impact on the ground. By empowering communities through top-down institutions and policies they become better able to adapt, resist, absorb, accommodate and recover from the effects of a hazard in an efficient manner. Local mechanisms for social communication, organization and awareness raising should be encouraged and maintained in the recovery phase and beyond. The challenges to an integrated process are outlined and recommendations to overcome the gap are proposed. If vulnerabilities and hazards are not further reduced in Sierra Leone, another disaster like Ebola will only be a question of time.
<table>
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<tr>
<th>Acronym</th>
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<tr>
<td>ACP</td>
<td>All People’s Congress</td>
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<tr>
<td>CBDRM</td>
<td>Community Based Disaster Risk Management</td>
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<td>CBO</td>
<td>Community Based Organization</td>
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<td>DRR</td>
<td>Disaster Risk Reduction</td>
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<td>EVD</td>
<td>Ebola Virus Disease</td>
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<td>FBO</td>
<td>Faith Based Organization</td>
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<td>GHD</td>
<td>Good Humanitarian Donorship</td>
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<td>GHC</td>
<td>Global Health Cluster</td>
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<td>HFA</td>
<td>Hyogo Framework for Action</td>
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<td>IDP</td>
<td>Internationally Displaced Person</td>
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<td>LRRD</td>
<td>Linking Relief, Rehabilitation and Development</td>
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<td>MIC</td>
<td>Middle Income Country</td>
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<td>Millennium Development Goals</td>
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<td>NERC</td>
<td>National Ebola Response Centre</td>
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<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>PPE</td>
<td>Personal Protective Equipment</td>
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<td>PHEIC</td>
<td>Public Health Emergency of International Concern</td>
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<td>SLBL</td>
<td>Sierra Leone Brewery Limited</td>
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<td>SD</td>
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<td>UN</td>
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<td>UNSDR</td>
<td>United Nations International Strategy for Disaster Reduction</td>
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<td>UNAMSIL</td>
<td>United Nations Mission in Sierra Leone</td>
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<td>UNMEER</td>
<td>United Nations Mission for Ebola Emergency Response</td>
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<td>UNSC</td>
<td>United Nations Security Council</td>
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<td>USD</td>
<td>United States Dollar</td>
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<td>WAS</td>
<td>Western Area Search</td>
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<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
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<td>WHO</td>
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Preface

I was given the chance to conduct research in Sierra Leone in July and August 2015. Back then, the country slowly started to recover from the Ebola crisis. This was the perfect opportunity to combine my interest for post-disaster recovery, my passion for Africa and my background as a sociologist with a relevant topic. This was the beginning of a bumpy and adventurous ride, and from time to time I cursed myself for not choosing an easier way. But, with its beautiful green hills and friendly people, Sierra Leone quickly enchanted me and I would never have want to miss this great experience. In November 2015, I flew back to Wellington for the second time. This was a very useful visit as it allowed me to deepen my analysis and cross check certain findings.

I am still not sure if I want to believe that Sierra Leone, a country so rich, can be so poor at the same time. This study is not the first one to find that local ownership is necessary in order to increase the effectiveness of resilience policies and neither will it be the last. The Ebola crisis in Sierra Leone is a symptom of severe underdevelopment. Only if the impact of hazards like Ebola is reduced, Sierra Leone will get a chance to develop in a sustainable way. Local communities cannot do this on their own, but need support from external actors and institutions. Therefore, my hope is that national and international policy makers and political leaders will move from empty commitments to targeted action and measurable development and resilience building.

I would like to use this section to thank the ones who supported me during the research process. First and foremost, I thank my supervisor Mr. Pennink. It is due to his kind advice, creative input and timely feedback that this thesis finally came together. Furthermore, a special thanks goes out to councilor Tholley Mohammed and councilor Ansu, who allowed me to reside in their communities, guided me through Wellington and equipped me with the latest information. I would like to thank the Sierra Leone Brewery Limited (SLBL) as well, for allowing me to stay in their guesthouse. Many thanks goes out to Victor and Alhaji, my cheerful roommates, who helped me find suitable respondents and introduced me to the councilors. I also want to thank Pieter for his endless support and my father for giving me the opportunity to finalize this thesis, and thereby my studies. Finally, I devote this study to the respondents and all inhabitants of Wellington. I have the utmost respect for their positive attitude and the way they fought themselves through the Ebola crisis, while trying to leave nobody behind. Your positivity and courage is admirable.

Amsterdam, 30th of April 2016.
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1. Introduction

1.1. Main question

This study focuses on community resilience in the aftermath of the Ebola crisis in the Wellington Community, Sierra Leone.

In December 2013, a mysterious disease killed several people in a small village in Guinea. The disease was not recognized as Ebola Virus Disease (EVD) (hereafter: Ebola) until March 2014. In August of that same year, the WHO declared the outbreak of Ebola a Public Health Emergency of International Concern (PHEIC). This means the virus was considered a potential health risk to other nations and required an international response (Who.int, 2016). In the meantime, the disease was able to spread to Liberia and Sierra Leone. With almost 28,000 infections and an average death rate of over 40%, it is the largest, longest, most complex and most severe outbreak of the disease ever reported. Experts have strongly criticized the international response, saying it was too slow and claiming that thousands of lives could have been saved would the response have been more effective. (Ap, 2016; Grünewald, 2015). In the literature, several causes of the occurrence of escalating disasters like Ebola are proposed. One of them is the inability to bridge the gap between bottom up and top down policies, knowledge and actions in the area of resilience building (Gaillard & Mercer, 2012). This explanation is further investigated in this study.

Resilience has become a core element in (inter)national disaster reduction policies: in 2015, the post-2015 sustainable development goals (SDG), a United Nations (UN) climate change agreement and the Sendai framework for Disaster Risk Reduction (DRR) were adopted. All of these international agreements promote sustainable development and present resilience as the solution to tackling poverty and dealing with or preventing disasters (Drolet et al., 2015). In reaching these objectives, the need to engage with local stakeholders is often explicitly expressed. Previous research shows that local knowledge can facilitate the process of resilience building in cost-effective, participatory and sustainable ways (Howell, 2003). At the same time, people’s vulnerability in facing hazardous events results largely from structural forces which are exogenous to local communities and often of national or global origin, e.g. poverty and poor governance, among other social, economic and political constraints (Watts and Bohle, 1993; Wisner et al., 2004 in Gaillard and Mercer 2012). It has been observed that many disaster management programs have failed to be sustainable (Pandey and Okazaki, n.d.). Bottom-up, community based views, vis-à-vis the (inter)national governance of risk and resilience are rarely analyzed and attempts to integrate global top-down and local bottom-up strategies for resilience have so far been sparse (Gaillard, 2010; Wisner, 1995 in Gaillard and Mercer, 2012). As a consequence, many knowledge gaps remain. This might hamper effective resilience building. Therefore, it is informative to know how disasters, Ebola in this case, are explained and dealt
with on the local level and how this relates to the broader institutional context. This may provide useful insights into the interaction between different levels of intervention, the influence of policies on resilience outcomes and the potential for sustainable development. In this study, the level of resilience in the Wellington community (Sierra Leone) in the aftermath of the Ebola crisis is assessed and linked to (inter)national disaster reduction policies. Wellington is an area located in the East of Freetown, the capital of Sierra Leone. Despite its location in one of the most severely affected areas, the Wellington community managed to stay Ebola free from February 2015 on due to the community’s participation in the response. The field visits and semi-structured interviews conducted in Wellington are thus a revelatory case that offer a valuable lens through which the Ebola response can be examined, including the analysis of local and international response and resilience systems (Bryman, 2008). The following question is addressed; How do wider institutional, policy and socioeconomic factors contribute to community resilience building?

‘Wider institutional, policy and economic factors’, refers to the larger relationships between the state and the people; the distribution of power, social, economic and political factors and the level of priority given to resilience building in Sierra Leone. Furthermore, the actors who facilitated the (inter)national Ebola response and policies related to DRR and resilience are taken into account (Wisner et al., 2004 in Gaillard & Mercer, 2012). Together, the institutional, policy and socioeconomic factors form an enabling or disabling environment to community resilience building (Twigg, 2009).

First, the concepts of resilience, disaster risk reduction (DRR) and sustainable development (SD) are defined and linked. Chapter 3 consists of a methodological section. Chapter 4 discusses three national key policies related to resilience in the Ebola response and findings from the interviews and field visits are discussed. An answer to the two sub-questions is provided here. Subsequently, the findings are linked to theoretical literature in the analysis in chapter 5. When combined with a scientific approach, lessons can be drawn for the future and avenues for DRR and resilience building are opened. An answer to the main question, as well as recommendations and lessons learned are formulated in the concluding section, chapter 6.

1.2. Sub-questions & research objectives

The main question to this study is: How do wider institutional, policy and socioeconomic factors contribute to community resilience building? This question is divided into the following sub-questions:

1. What characteristics of community resilience can be identified in the aftermath of the Ebola crisis?

2. What characteristics of an enabling environment for building local resilience can be identified in the aftermath of the Ebola crisis?
The first question is answered by conducting field-visits and semi-structured interviews with Wellington’s community members. An answer to the second question is formulated by selecting three key policy documents and scientific literature (see also methodology, section 3). In answering both questions, Twiggs’s (2009) ‘characteristics of resilience framework’ is used as a benchmark (see section 3.3. and Annex 3). The role of resilience, DRR and SD in the local, national and international response to Ebola is discussed. Furthermore, the possible barriers for building local resilience, grassroots and top-down strategies and interventions are elaborated upon. For the limitations to the research set-up, I refer to section 3.

The research objectives are:

- To investigate the relation between local resilience building mechanisms and (inter)national resilience building policies.
- To contribute to the knowledge gap on community resilience by assessing if/how the Wellington community managed to build resilience against Ebola.
- To identify gaps and recommend actions related to community resilience, which could improve bottom-up to top-down cooperation and the implementation of policies, thereby making disaster responses more effective.

1.3. Contextual Background

In order to fully understand and deepen a case study, it is important to elaborate on the historical and socioeconomic context (Diefenbach, 2008). Therefore, a short overview of Sierra Leone’s history and current socio-economic situation is given before diving into the theoretical framework (chapter 2).

Sierra Leone was one of British’ first colonies in West Africa. The country borders Guinea, Liberia and the Atlantic Ocean. In 1807, the British parliament passed an act that made slave trade illegal. Sierra Leone’s coast, called ‘the province of Freedom’, was used as a base to enforce this act. Thousands of slaves were freed, most of their ancestors – the Krio – still reside in Sierra Leone. The Krio managed to build a flourishing trade on the West African coast. Despite revolts by the indigenous population, the whole country came under British rule in 1896. The British favored the Krio as an ethnic group, which caused tensions when Sierra Leone became independent in 1961. Sierra Leone then adopted a multiparty parliamentary system. However, the British left behind a state with mall functioning political institutions and, unsurprisingly, the years after independence were marked by political unrest (US department of state, 2015; everyculture.com, 2015).

In 1991, the Revolutionary United Front (RUF), an opposition group backed by the Liberian warlord Charles Taylor, tried to overthrow the government. The coupe marked the beginning of a brutal civil war that lasted for more than a decade. The war was motivated by power and control over the diamond-rich areas of Sierra Leone. Diamonds fueled the conflict, as various parties funded their
war activities through mining. The complex reasons of the war are not discussed in further detail here. It suffices to say that the war was devastating. Over half of the population became displaced from their homes and brutal violations such as amputations and rape occurred on a large scale (United Nations Development Programme, 2006; UN.org, 2015).

On the 7th of July 1999, the Lomé Peace Accord was signed. Subsequently, the UN Security Council (UNSC) authorized the establishment of the United Nations Mission in Sierra Leone (UNAMSIL) on the 22nd of October 1999. The goal of the mission was to give support in the implementation of the peace agreement. UNAMSIL assisted, among others, with the disarmament and reintegration of ex-fighters and the voluntary return of more than half a million refugees and Internationally Displaced Persons (IDPs). By early 2002, the government declared that the war officially ended. The first free and fair elections in over 30 years were held in that same year (UN.org, 2014; United Nations Development Programme, 2006).

The war left Sierra Leone impoverished and fragile. From 2003 to 2011, Sierra Leone’s GDP per capita increased by 78%. Despite this remarkable economic progress, Sierra Leone remains extremely poor, with more than 60% of the population living on less than 1,25 United States Dollar (USD) a day. The EU and China are Sierra Leone’s largest trading partners. The main exports are gold, diamonds, rutile, cocoa, coffee, fish, bauxite and titanium (Sun et al et al, 2014; UNDP in Sierra Leone, n.d.).

The current president of Sierra Leone is Ernest Bai Koroma from the ‘All People’s Congress’ (APC) party. Bai Koroma was elected in 2007 and re-elected in 2012.

Sierra Leone is comprised of approximately twenty ethnic groups. In general, relations between the different tribes are friendly. While English is the official language, 24 local languages are spoken. In the Freetown area, most people speak Krio. As for religion, approximately 78% of the population is Muslim and the rest is Christian, they live together peacefully. Most people combine their religion with traditional believes and practices (US department of state, 2015; everyculture.com, 2015).
Box 1: Ebola Virus Disease (EVD)

The Ebola Virus was first discovered in 1976 in the Democratic Republic of the Congo (DRC). About ten waves of Ebola outbreaks have been reported ever since (WHO, Ebola Statistics, 2014). One particular specie of fruit bats are the natural hosts of Ebola. Wild animals eat the bats or the fruits touched by the bats. The eating of (not well cooked) bush meat, such as monkeys and antelopes, is seen as the initial cause for human contagion (Pourrut et al., 2005, 1010). Then, the virus spreads through the human population through close contact with the blood, secretions, organs or other bodily fluids of infected people or with surfaces and materials contaminated with these fluids such as sheets and clothes. Symptoms of Ebola include: fever, severe headache, muscle pain, weakness, fatigue, diarrhea, vomiting, abdominal pains and unexplained hemorrhage. These symptoms appear anywhere from 2 to 21 days after exposure to Ebola (cdc.gov., 2016). People remain infectious as long as they contain the virus, this can take up to several weeks or even months (rumor has it that the virus can be transmitted sexually up to 12 months after recovery) (WHO, Ebola Factsheet, 2014). It can be difficult to distinguish Ebola from other infectious diseases such as malaria and meningitis (Ibid).

The death rate of Ebola is very high and varies from 25 % to 90 %, with an average of 50 % (world health organization, 2016) . At the time of the outbreak, a treatment for Ebola did not exist. Medical personnel could only enlighten the suffering by treating symptoms. In 2015, a vaccine has been developed. Several successful trials have been conducted (Ibid). In Sierra Leone, 14.125 people were infected with the virus. 3956 of them are reported to have died (Grunewald, 2015; apps.who.int, 2015). The urban, slum areas were hardest hit (see map 1).

![Figure 1: the Ebola virus (http://bit.ly/1UpuCsg). Map 1: Ebola cases by district in Sierra Leone. The black part was hardest hit, this area is where Wellington is situated (Richards et al., 2015).](http://bit.ly/1UpuCsg)
2. Theoretical Framework

In this chapter, the most important concepts related to resilience are defined and linked.

2.1. A conceptual jungle

Since the beginning of reliable recording in the 1960’s, disasters all over the world have dramatically increased in frequency and severity (Tesh, 2015). It is expected that the numbers of disasters will increase even more in the foreseeable future, because of phenomena such as urbanization, weak governance, population growth and climate change. At the same time, available funding to cope with disasters is decreasing.

The burden of disasters is unequal: the expected economic losses for low-income countries are five times higher than high-income countries (Schipper and Pelling, 2006). The limited ability of low-income countries to recover from disasters, may increase indirect disaster losses and presents a serious setback to social and economic development (UNISDR, 2015, global risk data platform, 2016). The least developed countries, among them Sierra Leone, thereby run the risk of becoming locked in endemic poverty cycles.

The good news is that the impact of disasters on people’s livelihoods can be greatly reduced by applying measures that built resilience and decrease exposure to hazards. This approach is known as Disaster Risk Reduction (DRR) and/or resilience building and has been widely adopted by policy makers, donors and Non-Governmental Organizations (NGO) as a new organizing principle (Levine et al., 2012; Béné et al., 2014). The introduction of DRR strategies seems to be effective. Statistics show that, despite the increase in numbers of disasters worldwide, a reduction is seen in the numbers of people affected. The World Bank estimated that every dollar spent on DRR saves 7 dollars in relief and repairs. In other words: DRR pays (Tesh, 2015).

Resilience and DRR concepts can apply to all levels; from the individual to the global level. Since little attention is attributed to resilience on the community level, this study is devoted to local resilience building (Wilson, 2012; Wilson, 2013). It is easy to get lost in the confusing jargon surrounding resilience. Therefore, this chapter starts by giving a definition of the concepts closely related to resilience. Please find the definition of less related, but still important concepts in annex 1.
2.1.1. What is (community) resilience?

Many attempts have been made to define resilience. In the past 30 years, more than 46 definitions – ranging in areas from ecology to psychology - can be found (CARRI, 2013). The definition of community resilience, as formulated by the UN is the following: ‘the ability of a (…) community (…), potentially exposed to a hazard, to adapt, by resisting, absorbing, accommodating to and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions.’ (UNISDR, 2009: 24). This definition reflects a common understanding of the concept and is therefore used in this study.

Resilience can be preventive; avoid poor outcomes by developing coping strategies, or it may facilitate recovery after a disaster. As Elms (2015) explains, the basic idea behind resilience is that, following the initial impact of a disaster, a community will take time to recover to a stable level of functioning. During the recovery period, there will be a changing degree of impairment. The community does not necessarily recover to its initial state, but might move to some new stable level lower or higher than the original. In this view, resilience is both a process and an outcome (Ibid).

Box 2: Ebola: ‘natural’ disaster?

DRR and resilience building are often linked to ‘natural’ disasters, as opposed to ‘men made’ disasters. Natural disasters conveys the perception that little can be done except preparing to respond to them, rather than reducing vulnerabilities and building resilience. That is why scholars increasingly avoid to speak about natural disasters and rather refer to ‘disasters’ or ‘natural hazards’ (Briceño, 2015). In this study, the line of thought is that hazards are not naturally disastrous: they occur at the intersection between disease outbreaks, floods etcetera and the particular social, economic and political environment in which these events occur (Wisner 2004 in Dubois & Wake, 2015).

The Pressure And Release (PAR) Model has been invented to estimate the risk of a disaster to occur in a certain country. The potential disaster risk (DR) depends on two variables: vulnerabilities and hazards (DR = V x H). As for Ebola, it is clear that, while the virus causing the disease is a natural hazard, the impact of the disaster itself had everything to do with the vulnerable state of West African health systems, among other issues. For an extensive analysis of the Ebola in Sierra Leone and the PAR Model, I refer to Boeser et al. (2014).
While it should be acknowledged that communities do not control all of the conditions that affect them, they do have the ability to influence many of the conditions that can increase their resilience. What it is precisely that makes a community resilient, depends on the context: a resilient urban community is different from a resilient fisherman community (Twigg, 2009). A more operational way of understanding resilience, is to look at the capacities of a community. According to Twigg (2009), a resilient community possesses the capacities to:

- Anticipate, minimize and absorb potential stresses or destructive forces through adaptation or resistance.
- Manage or maintain certain basic functions and structures during disastrous events.
- Recover or ‘bounce back’ after an event

Building resilience requires a multi-sectorial approach. For example, health interventions such as hygiene education can contribute to building resilience on a community level. But, if a community is prone to earthquakes, the community’s capacity to cope with recurrent crisis must also be strengthened by building earthquake proof houses and schools (Oxfam, 2015 & Kruk et al., 2015).

A focus on community resilience means putting emphasis on what communities can do for themselves and how to strengthen their capacities, rather than concentrating on their vulnerability to disasters. This way, vulnerability can be seen as the antidote of resilience (CARE Nederland et al., 2012). The resilient community should be seen as an ideal state because even the most resilient communities often contain some characteristics of vulnerability. The other way around, even the most vulnerable communities have some resilient characteristics (Heijmans et al., 2013; Twigg 2009; Wilson, 2012).

One difficulty with resilience, is that it becomes a ‘catch all concept’, an empty shell, behind which blurry policies and programs could be implemented (Otto, 2013). At the same time, its broadness makes resilience a powerful integrating concept that can bring together different...
disciplines and communities of practice. Resilience thus offers a more holistic approach to vulnerabilities and as such plays an important role in bridging the gap between humanitarian and development aid. Resilience allows to decrease the rigidity of institutional structures in several disciplines, which could otherwise hamper integrated approaches. This applies to the areas of DRR, SD and Climate Change Adaptation in particular (Levine et al., 2012; Béné et al., 2015).

2.1.1.1. What is meant with ‘community’?
In this specific case, community refers to the ‘Wellington community’ which is located in one geographical area. Communities should be seen as dynamic and heterogeneous: people will move in and out of the community and there will be differences in opinions, wealth and social status, for example (Chaskin, 2008). It is important to bear in mind that communities do not exist in isolation; they are influenced by businesses, social services, infrastructure and socio-economic and political linkages with the world (Twigg, 2009). In this study, communities are seen to be more than the sum of their individuals: they have the ability to function as a unit of collective action and an agent of change (Cutter et al., 2008).

2.1.2. What is Disaster Risk Reduction (DRR)?
The concept of Disaster Risk Reduction (DRR) can be defined as: ‘The concept and practice of reducing disaster risks through systematic efforts to analyse and manage the causal factors of disasters, including through reduced exposure to hazards, lessened vulnerability of people and property, wise management of land and the environment, and improved preparedness for adverse events’ (UNISDR, 2009: 10; DG ECHO, 2013). Adding to this, the United Nations International Strategy for Disaster Reduction (UNISDR) (2009) states that DRR represents the ‘systematic development and application of policies, strategies and practices to minimize vulnerabilities and disaster risks through society, to avoid (prevention) or to limit (mitigation and preparedness) the adverse impacts of hazards, within the broad context of sustainable development’ (p. 11). Thus, DRR involves all aspects of risk: prevention, longer term risk reduction, risk detection, risk termination, risk response, protection, preparedness and risk transfer (see figure 3). Effective risk management strategies reduce disasters in the short to medium-term, while reducing vulnerabilities (increasing resilience) over the long term (World Bank, 2013).

The aforementioned definition implicates that communities need to adapt in order to reduce risks. There is a wide range of DRR strategies: DRR may refer to structural and technical strategies, but effective DRR also relies on good governance, and the implementation of frameworks such as the Hyogo Framework for Action (Mercy Corps, 2013; UNISDR & WMO, 2012). On a community level, Community Based Disaster Risk Management (CBDRM) is believed to be an effective approach to reaching resilience and sustainability, because it is difficult to reduce the losses and scale of disasters unless disaster management efforts are sustainable at individual and community level. A critical
element of CBDRM is the communities’ participation in DRR activities. Common elements of community involvement are the closing of partnerships with and the encouragement of participation, empowerment and ownership by local citizens. Through community-based activities, people should be able to participate alongside government officials and NGOs as the direct stakeholders of DRR activities (Pandey and Okazaki, n.d.). Taking a DRR approach means seeing disasters as complex problems that demand a collective response from different disciplines. DRR initiatives can be integrated in every sector of development and humanitarian work (DG ECHO, 2013; Twigg 2009).

2.1.2.1. The disaster risk cycle

DRR takes different forms in different phases. Taking appropriate measures based on DRR in each phase of the cycle, can reduce overall disaster risks. In the current understanding of DRR, the prevention/mitigation phase consists of efforts to prevent damage (e.g. construction of dams against floods). Preparedness refers to the knowledge and capacities developed by government, organizations, communities and individuals to effectively anticipate, respond to and recover from, the impact of hazard events or conditions (public awareness raising, for instance) (UNISDR, 2009). The definition of response is: ‘the provision of emergency services and public assistance during or immediately after a disaster in order to save lives, reduce health impacts, ensure public safety and meet the basic subsistence needs of the people affected’ (UNISDR, 2009: 24). Thus, response primarily focuses on immediate and short-term needs. The recovery or rehabilitation/reconstruction phase entails the restoration and possibly improvement of facilities, livelihoods and living conditions of disaster-affected communities (UNISDR, 2009). This phase starts during or soon after the emergency response ends and is based ideally on pre-existing strategies and policies that facilitate clear institutional responsibilities for recovery actions. Ideally, adaptation or adaptive resilient strategies take place on collective or individual levels that make people more resilient against disasters (although it is rarely possible to disentangle the multiple changes to which people respond) (Tesh, 2015; Levine et al 2012, Béné et al., 2015). It should be noted that reality is more complex than the schematic figure used here: different crisis and different phases are dynamic and might overlap (Asian Disaster Reduction Center, n.d.). This study focuses mainly on the response and the following recovery phase.
2.1.3. What is Sustainable Development?

‘Our biggest challenge in this new century is to take an idea that seems abstract - sustainable development - and turn it into a reality.’ (Former UNSG Kofi Annan, 2001 in UNESCO, 2001: 2).

In much of the academic and policy literature, SD is proposed as the solution against ‘poverty’\(^1\) in the broadest sense of its meaning. SD is the imperative of the 21\(^{st}\) century, this is reflected in the Sustainable Development Goals 2000 – 2015 and the newly adopted Sustainable Development Goals 2015 - 2030. In this study, SD serves mainly as the long term component to resilience.

The widely agreed definition of SD is: ‘development that meets the needs of the present without compromising the ability of future generations to meet their own needs’ (The Brundtland Report, 1987; 54: UNISDR, 2009; OECD; 2016). In essence, SD is about quality of life and its long term maintenance (Bijl, 2010). A SD approach seeks to balance different, and often competing, needs (for example: climate change and our dependence on unsustainable fossil fuel-based energy sources).

Sustainable development can be divided into three pillars that encompass broad areas: an economic, a social and an environmental pillar (Worldbank.org, 2016). The economic pillar is related to investments in new skills and education, a prosperous economy that generates wealth and long-term investment without destroying the resources on which that economy ultimately depends (Asadi et al., 2008). The environmental pillar refers to the maintenance of the ecosystem and involves a healthy environment with minimal waste and pollution, for instance (Ibid). The next section is devoted to a description of the social pillar as this component of SD is most relevant to this study (Power, 2004).

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\(^{1}\) Poverty is a multi-dimensional problem, it has got social, political, cultural and power dimensions (Wong, 2003).
2.1.3.1. The social pillar

As part of the social pillar, the concepts of ‘social capital’, ‘trust’ and ‘empowerment’ are often mentioned. These are distinct but closely associated terms.

Social capital

In general, social capital refers to a society’s capability to deal with social, economic and environmental problems (Asadi et al., 2008). Putnam (1995), one of the most influential authors in the area of social capital, defines social capital as ‘the features of social life networks, norms, and trust that enable participants to act together more effectively to pursue shared objectives’ (as cited in Islam, 2015: 168). Put together, these social networks and common understandings generate trust and so enable people to work together (OECD, n.d.). According to Putnam, social capital is a means of generating collective action and solving collective problems. Where people are confident that others will do their part or do something in return (the principle of reciprocity), a group will be able to achieve more than if each group member were to behave rationally to serve only his or her own individual interests. Several researchers found that social capital is crucial in achieving equitable and sustainable development and effective governance. For example, Kay (2006) showed the relationship between social capital and community development. He found that higher levels of social capital in terms of the number and quality of grassroots organizations, and the degree of relations between public and non-governmental actors, resulted in a more effective program design, implementation, and significant long-term change. This confirms the idea that SD should include the strengthening of community-based collective action in various ways (Asadi et al., 2008). Furthermore, there is evidence that links social capital to greater innovation and flexibility in policy making.

In short, social capital is a critical instrument for poverty alleviation and SD. It represents a potential link between policy level thinking and community level action (Bijl, 2010).
Trust
Social capital requires mutual trust: in the absence of trust, people are less willing to engage in the cooperative relations which are required for SD (Bijl, 2010). According to Bijl (2010), a low level of solidarity and excessive inequality in a society will undermine the feeling of trust people have in each other and the present institutions. This influences their willingness to participate in the formation of the networks necessary to realize social capital in a negative way (Uslaner and Brown 2005).

Community empowerment and ownership

‘Building resilience requires more than reducing vulnerability – it calls for empowering responses to disasters, which aim to support and foster people’s resilience, enhancing their ability to respond to disasters, against a backdrop of the longer term challenges of building sustainable livelihoods’ (Drolet et al., 2015: 435).

‘Community empowerment’, with the final goal to achieve SD, was one of the major points of the Millennium Development Strategy. According to the World Bank (2013), facilitating empowerment is an effective strategy to reduce poverty. Craig and May (1995) define empowerment as ‘any process by which people’s control (collective or individual) over their lives increases’ (as cited in Ahmad and Tabil, 2014: 640). According to Lawson (2005), (financial) resources, power and collaboration are key to empowerment. Empowering communities means assisting them in gaining expertise, responsibility and accountability over local events and developments (Narayan and Petesch 2002; Asadi et al., 2008; Bebbington et al. 2006 in Ahmad and Talib, 2014). Furthermore, community empowerment consists of community participation, community capacity building and community access to information. Community participation includes people taking part in decision-making processes, and encouraging people’s involvement in development planning, projects and practices. Community capacity building has been described as ‘the combined influence of community’s commitment, resources, and (leadership) skills, which can be deployed in order to improve community strengths and address local community problems’ (Mayer, 1995: 2). Finally, it is important to mention that information is a source of power for marginalized communities (Narayan and Petesch 2002). Informed citizens are better equipped to take advantage of available opportunities, to access services, to better exercise their rights, and to hold local and national institutional actors accountable for their actions. When local communities are empowered, they are able to both provide information about their own priorities and also obtain information from local institutions or outside agencies. The provision of and access to information are valuable means for improving local conditions and increasing welfare of local communities (Ahmad and Talib, 2014).
To conclude this section, it is important to keep in mind that the literature suggests that local authorities and communities can substantially contribute to the implementation of SD, DRR and resilience practices.

2.2. How are these concepts linked?

The international community largely agrees that the areas of SD and DRR should be addressed and linked, in order to increase (local) resilience. The concepts have been discussed in the previous sections. Now, how exactly are they linked?

2.2.1. Disaster Risk Reduction and Resilience

‘Local response to crisis and disaster risk reduction (…) are essential to saving lives and enabling communities to increase their resilience to emergencies’ (DG ECHO, 2013 : 6).

DRR and Resilience are often referred to within the same breath. The Hyogo Framework for action 2005 – 2015, which is the international strategy for DRR, is titled: ‘building the resilience of nations and communities to disasters’. When comparing the two definitions, it becomes clear that resilience can be viewed as an ability, while DRR is described as a practice. Thus, DRR can be seen as an essential practice through which abilities can be built: DRR measures enable communities to anticipate, absorb and bounce back from shocks, and by doing so strengthen their resilience. The ultimate outcome of DRR efforts is thus resilience to shocks (Bosher and Dainty, 2010).

2.2.2. Sustainable Development and Resilience

‘Building resilience will mean breaking down the barriers between humanitarian and development approaches more fundamentally than ever before. Responses to humanitarian and economic crises need to be brought together with responses to foster long-term development’ (Oxfam 2013: 5).

Since the resilience of a community is inextricably linked to the condition of the environment and the treatment of its resources, the concept of SD is central to the study of resilience (Mileti 1999 in Béné et al., 2015). The link between SD and resilience is, among others, clearly embodied in one of the SDG’s that aims to ‘make cities and human settlements (…) resilient (UNSD.org, 2016).

Rodriguez-Nikl (2015), argues that resilience and sustainability share similar paradigms and goals. System thinking is fundamental for both resilience and sustainable development: it is important to consider socio-ecological systems as a whole, since different domains are interdependent (Walker and Salt, 2006). In order to effectively address vulnerabilities in a community, sustainable development is needed. In sustainability terms, a resilient social-ecological system has a greater capacity to continue providing a good quality of life while being subjected to a variety of shocks (ibid). An environment stressed by unsustainable practices may experience more severe impacts of hazards.
For example, poor drainages lead to flooding and mud slides in the rainy season in Sierra Leone (Béné et al., 2015; Cutter et al., 2008).

One difference between sustainability and resilience is that sustainable development usually concerns ordinary events, while resilience often concerns extraordinary events. However, the actions undertaken during these events effect each other. Recovery activities after a disaster may have lasting consequences on a community’s quality of life: Haiti’s slow recovery from the 2010 earthquake is one striking example. Recent efforts have been made to develop frameworks that simultaneously address resilience and sustainability. Furthermore, while poverty alleviation is at the core of sustainable development, resilience is not necessarily a pro-poor concept in the sense that it does not specifically target the poor. It is possible to be both resilient and poor (Béné, 2015; Mercy corps, 2013).

Box 3: theLinking Relief, Rehabilitation and Development (LRRD) debate
When discussing development and resilience, the Linking Relief, Rehabilitation and Development (LRRD) debate should be mentioned. Relief and development are sometimes referred to as ‘two worlds apart’ (Otto, 2013). The two policy areas are characterized by different funding mechanisms, different working cultures, different values and principles, different languages and different working speed (Ibid). Humanitarian aid is free, focused on the individual and on external assistance, based on the humanitarian principles and aimed at live-saving, short-term activities (although nowadays relief organizations tend to be increasingly occupied with long-term objectives (Pérez de Armiño, 2002). Development aid on the other hand, is often focused toward a multi-sectorial, (government) partner approach and focuses on community participation, alleviating poverty and strengthening livelihoods in the long-term (Otto, 2013). Since (government) partners are often party to a conflict, a cooperation may jeopardize the humanitarian principles. These differences have practical implications when it comes to LRRD programming and, unsurprisingly, the two sometimes have a hard time understanding each other. Sometimes, this results in a grey zone in which neither of the two feel responsible.

There are also commonalities to be found. As Otto (2013) points out, the recipients of humanitarian and development assistance are the same, just as the underlying causes that create the needs. The development community profits from effective relief aid since it has seen much of its investment eroded by war and governmental collapse. At the same time, relief agencies have recognized the need for long-term stability for their work to have significance (Smillie, 1998). This advocates for a better cooperation between the two areas of work.
2.2.3. Disaster Risk Reduction and Sustainable Development

‘Sustainable development cannot be achieved unless disaster risk is reduced.’ (GAR 2015: v)

Currently, disaster response and longer term development are almost always separated. Yet, communities face disaster against a backdrop of longer-term development needs (Drolet et al., 2015). In the ‘Global Assessment Report of Disaster Risk Reduction’ that was published in 2015 by the UNISDR, the importance of DRR for effective SD is clearly stated: ‘managing risks, rather than managing disasters as indicators of unmanaged risks, has to become inherent to the art of development; (...) as a set of practices embedded in its very DNA’ (UNISDR, 2015: ix). DRR is essential if development is to be sustainable for the future (sustainabledevelopment.un.org, 2016). Disasters disproportionately affect people in development countries. Disaster events undermine development efforts as they compromise livelihoods and economic activity (Integrated Research on Disaster Risk & International Council for Science, 2014). While disasters can thus amplify social exclusion, economic inequality and poverty, they also provide an opportunity, through risk reduction action and post-disaster recovery, to address such issues as part of the promotion of resilience and sustainable development (Ibid). The incorporation of DRR into development programs are assumed to lead to more durable outcomes that fundamentally improve the living conditions of target groups over time (Mercy corps, 2013; Ibrahim, Koshy and Asrar, 2013; Bendimerad, n.d.).

The recovery phase after a disaster, offers the opportunity to ‘Build Back Better’ (BBB). To fulfil this goal, the resilience capacity of communities and states needs to be built (Drolet et al., 2015).

2.3. Resilience policies

In general, a policy constitutes a set of decisions that guide the actions of government, business and civil society. Resilience or DRR policies deal with the course of action adopted by government to understand hazards, assess vulnerability, evaluate risk and adopt measures to increase resilience (Bendimerad, n.d: 4). For example, legal arrangements that govern land use or the enforcement of construction regulations. Resilience policies are more likely to be successful if the linkage between disasters and developmental needs are recognized. Experience has also shown that even when cases have been enacted by law, there can still be an absence of enforcement of this structure (Bendimerad, n.d.). For example, many developing countries have competent building codes, yet often these codes are ignored in the implementation phase due to a lack of enforcement mechanisms. Resilience policies often raise fundamental socioeconomic issues such as livelihood safety and resource distribution equity. Governments might be reluctant to tackle such huge issues. Hence, dynamic mechanisms to impact disaster reduction policies are needed. These include grassroots advocacy and knowledge and risk dissemination (Ibid).
2.4. Expectations and concluding remarks

The described concepts have become three (quite separate) realms of action and policy in recent years. In this study, disaster resilience is seen as the overarching concept in which sustainable development and disaster risk reduction play a pivotal role. The concepts are inextricably linked and mutually enforce each other. Resilience is concerned with the durability, adaptability and transformative capacities of DRR and development outcomes. DRR and resilience are often used interchangeably, this study is not an exception. DRR can contribute to resilience and sustainability by building disaster-related capacities at individual, community or institutional level. In order for sustainable development to be achieved, DRR and resilience require central consideration (UNISDR & WMO, 2013).

![Figure 5: Resilience, DRR and SD are interlinked.](image)

Based on the aforementioned, the following observations can be expected for the case of Wellington:

- Following Elms’ (2015) model of community resilience, Wellington is expected to be situated in the ‘recovery’ phase. It will take time to recover to a stable level of functioning again. A changing degree of impairment might be observed over time.
- Since sustainable development is a condition to achieve resilience, and considering the fact that Sierra Leone is one of the poorest countries in the world, not much social capital (in terms of relations between bottom-up and top-down actors and mutual support within the community), empowerment and a low level of community resilience are foreseen.
- The absence of sustainable development will most probably complicate effective risk management.
- A lack of trust between the community members and a lack of trust in national institutions is expected to be found.
3. Methodology

The methods used in this study are described. In the third paragraph, the framework to measure resilience is discussed.

3.1. A combination of qualitative methods

In this study, a combination of semi-structured interviews, field visits and literature is used. To ensure good quality research, certain criteria need to be adhered to. Qualitative research needs to be trustworthy (Bryman, 2008). Trustworthiness is created by a sense of credibility (Ibid). In this study, credibility is ensured by using interviews and field visits in combination with literature and policy reports, thereby cross-checking outcomes. The assumption is that, if findings obtained via different methods correspond, the quality of the findings increases (Silverman, 2011). An attempt to adhere to the second criteria required for trustworthiness; transferability, was made by providing a ‘thick’, detailed description of the particular case (Geertz, 1973). By transcribing all interviews and keeping complete records, the criterion of dependability is fulfilled.

It is not the goal of this study to generalize. The respondents are not a sample from a population, neither do they represent the whole Wellington community. By gathering concrete and practical findings, generalizations to theory rather than populations are made. Case studies can be crucial in refuting hypotheses. After all, Karl Popper (in Bryman, 2008) once said that only one black swan is needed to falsify the statement that all swans are white. Hence, the quality of theoretical reasoning is a central issue: how well do the data support the theoretical arguments generated? In this study, the grounded theory approach is taken to process data (paragraph 3.2).

Data is derived from the following sources:

- **Semi-structured interviews**

10 semi-structured interviews were conducted with the community members from Wellington. The community consists of a variety of people with different positions: young, old, male, female, employed, unemployed, chiefs, councilors and religious leaders. The different positions and accompanying perceptions are aimed to be captured in the interviews. Three councilors and one (female) chief were interviewed, a youth leader, a taxi driver, a cook, a priest and so on. The councilors are the ‘gateway’ to the councils and eventually the government, they are valuable in informing the research question and understanding the phenomena subject to this study (Sargeant, 2012). The choice of research participants is constrained by what is practicable. It would have been ideal to speak to all councilors and many more inhabitants of Wellington, but time constraints and dependency on the willingness of authorities to be interviewed, has led to 10 interviews in total. (Fink, 2003; Saunders et al., 2009; Symonn and Cassell, 2014). The interviews lasted between 30 and 90 minutes (see also Annex 4: transcripts). Before interviewing, respondents were informed about the...
interview process. Privacy was ensured by anonymizing the results (although the difference between councilors, chiefs and other respondents is indicated. Because of their leading position this is important information). Interviews during field visits were written down, all other interviews were recorded after consent of the participant. An interview guide, based on the elements of the theoretical framework, was prepared (Annex 2). The questions are inspired by Twigg (2009) and Heijmans et al. (2013). During the interviews, some questions were rephrased to increase understanding. For example, when it became clear that ‘DRR’ is not a common concept to the respondents, the terms ‘adaptation’ and ‘development’ were sometimes used instead (Bryman, 2008).

- Field visits

Six field visits to Wellington were paid. Field notes were taken and worked out immediately to avoid deficiencies in human memory (Ibid). Often, but not always, the researcher was accompanied by a councilor or inhabitant from Wellington. The advantage of having a ‘local guide’, was getting introduced to many people, local organizations and authorities. In addition, visiting the different wards together with a councilor revealed the dynamics between the councilor and the rest of the community: the councilors are famous in their wards! Everybody approaches them and knows their names. The downside of being guided by a councilor, is that their power and position can influence the research.

Pictures taken during the field visits have an illustrative purpose, they visualize the findings. The interviews and field visits were conducted in August 2015 and November 2015. Throughout this study, the phase of the response is specified where relevant and possible.

- Descriptive literature review

Initially, literature was used to get accustomed to the fields of DRR, resilience and SD. While asking questions such as ‘what is already known about this area?’, general search terms such as ‘Disaster Risk Reduction and resilience’ were used in the University of Groningen’s Digital Library. As the search continued, terms were narrowed down. Once the main questions was formulated, three key policy documents were identified for analysis: The Agenda for Prosperity 2013 – 2018, Sierra Leone’s national poverty reduction strategy, is on key document. The final goal of the Agenda for Prosperity is to achieve the status of Middle Income Country (MIC) by 2035. Second, Sierra Leone’s National Ebola Recovery Strategy 2015 – 2017 is looked into. The recovery strategy aims to deal with the setback that Sierra Leone experienced due to Ebola. Still, the Agenda for Prosperity remains the defining document for the overall development of the country and should be seen as the main national anchor for dealing with medium- to long-term challenges posed by the disease (Recovery Strategy, 2015). Lastly, the National Ebola Response Centre’s (NERC) revised ‘Ebola Response Strategy: getting to a resilient zero’ is reviewed. The objective of this strategy is to reach a ‘resilient zero transmission’. In addition to these
policy documents, scientific literature and data from the UN, WHO and World Bank were used, partly to cross-check the statements made in interviews and to deepen the findings. In the analysis, all results are linked to scientific literature. The literature was found via the University of Groningen’s Digital Library, using search terms like ‘community resilience’ ‘implementation gap’ ‘from policy to action’ and so on.

3.2. Grounded Theory

The common approach to analyze data derived from qualitative data - interviews and field visits in this specific case - is known as ‘grounded theory’. The definition of grounded theory is: ‘theory that was derived from data, systematically gathered and analysed through the research process’ (Glaser and Strauss 1967 in Khan, 2014: 226). In this method data collection, analysis and eventual theory stand in close relationship to one another. Often, grounded theory is used to generate concepts and categories, rather than theory (Bryman, 2008).

The different steps of grounded theory, according to Bryman (2008) and Silverman (2011), were followed (Figure 6). First, a general research question was formulated. Then theory / scientific literature was used to get acquainted with the research areas, to select relevant subjects and to formulate broad expectations related to the main question. Throughout this process, there is a constant movement between specifying the research questions and investigating literature. After choosing Twigg’s (2009) resilience framework, relevant data was collected through interviews and field visits. This data was coded and interpreted. Coding is ‘the process of breaking down, examining, comparing, conceptualizing and categorizing data’ (Bryman, 2008: 542). Coding entails three phases. The first phase is ‘open coding’, this initial coding phase is very detailed and has the goal to generate new ideas. After open coding, ‘axial coding’ is used to make connections between different categories. Lastly, ‘selective coding’ is the procedure of selecting a core category and systematically relating this to other categories (Bryman, 2008). After each coding phase, a code tree was developed to gain a more structured overview (Annex 4). During the coding process, memos were added to help crystalize ideas and to increase transparency (Boeije, 2005; Bryman, 2008). Twigg’s (2009) characteristics were used as a sort of benchmark throughout the coding process. By constantly comparing the codes and Twigg’s (2009) characteristics, categories are generated to ensure a fit. This process continued until saturation was reached. Then, as a form of triangulation and the way to investigate the ‘enabling environment’, data from literature and policy reports was collected. This allowed for expectations to be tested, and to link the findings to theory. Eventually, adapted, theoretically underpinned, ideas about the concepts are generated.
1. Research question

2. Literature and theoretical sampling ➔ Selection of Twigg’s framework related to subjects relevant for qualitative outcomes

3. Collect data through interviews and field visits

4. Coding ➔ Concepts (using Twigg’s (2009) characteristics)

5. Constant comparison ➔ Categories (using Twigg’s (2009) characteristics)

6. Saturate categories

7. Explore relations between categories ➔ Hypothesis / Expectations

8. Collect data from policy reports

9. Compare data from policy reports to qualitative data collection

10. Analysis: test expectations. Collection and analysis of theory and data in other setting ➔ Generate formal theory

3.2.1. Limitations

There are several limitations to the research design of this study. First, gaining access to a research site is a political process in the sense that access is mediated by gatekeepers – the councilors – who are concerned about the researcher’s motives. The author was aware of this possible bias and spoke to as many respondents as possible without the company of a councilor. Reliability, the extent to which research can be replicated, is a difficult criterion in qualitative research as it is impossible to ‘freeze’ a social setting. Still, by using Twigg’s framework (2009) in a consistent way, it is possible to repeat the study. Furthermore, it is acknowledged that complete objectivity by the author is impossible and that the researcher’s participation can influence the respondents and their answers. The researcher was well aware of this and acted in good faith (Bryman, 2008). The lack of experience by the researcher to conduct qualitative research in a complex environment is another limitation. By reading a lot and by learning while doing, this knowledge gap is diminished as much as possible.

Another issue is the limited number of respondents. Time, resources and dependency on local leaders resulted in 10 semi-structured official interviews. While similarities in the interviews are observed, saturation was not fully reached and more interviews would have been ideal. Many informal conversations took place in which the author cross-checked findings. Extensive data from literature,
many informal conversations and the field visits compensate for the small number of interviews. Lastly, the author realizes that the combination of methods makes for a complex methodology. The only way to answer the main question, is by combining different methods. The author attempted to be as clear and transparent as possible about the research decisions made.

3.3. Measuring resilience: Twiggs’s framework

Resilience is not easy to quantify, some even argue that resilience per se cannot be measured (Cutter et al., 2008). In addressing the problem of helping a community improve its resilience, it is not necessary to translate resilience to quantitative issues. Rather than viewing resilience as an outcome that can be measured, a more useful way to conceptualize resilience is to understand it as an ability (e.g. the ability to resist, recover form or adapt to the effects of a shock or a change). As Elms (2015) notes: ‘those matters that cannot easily be measures are often the most significant’ (p. 79). The important thing is, to try to get the logic right and to formulate problems in a consistens, systematic way (Elms, 2015).

Following this view, Twiggs’s (2009) framework is used. The framework shows what a ‘disaster-resilient’ community might consist of, by breaking down resilience into many characteristics (Heijmans et al., 2013). These characteristics are used to assess which ones can be identified in Wellington. The level of a community’s resilience is influenced by many national and international socio-economic and political linkages. To capture these external influences, Twigg (2009) added an ‘Enabling Environment’ section. There is not a clear boundary between ‘the community’ and ‘the Enabling Environment’, as there is likely to be a web of relationships and connections between community and external actors (Ibid). What is clear, is that external (government) actors have an important influence on community development. Therefore, the extent to which (inter)national policies support community resilience is examined by using the ‘Enabling Environment’ characteristics as well. Twiggs’s (2009) framework is structured along the five priority actions formulated in the Hyogo Framework for Action (HFA) ‘Building the Resilience of Nations and Communities to Disasters’ (UNISDR, 2005) ²:

1. Governance
2. Risk assessment
3. Knowledge and education
4. Risk management and vulnerability reduction
5. Disaster preparedness and response

This framework was chosen because the HFA is generally accepted by the UN and other international agencies, most national governments and many NGOs.

² In March 2015, the UN Sendai Framework was adopted. However, there are no guidelines for implementation yet.
The framework is intended to be as comprehensive as possible, but does not claim to cover every dimension of resilience. The ‘customizing’ and selecting of relevant aspects of the framework is encouraged, because it makes the characteristics more relevant to the particular needs and capacities of communities and the wider operational and policy environment (Twigg, 2009). The framework was thus somewhat adapted to the context of Wellington. Some components of resilience, such as early warning systems and preparedness and contingency planning, were so obviously absent prior to and during the Ebola crisis in Wellington that they will not be discussed in detail here. Other components, such as SD deserve more attention than Twigg (2009) initially gave them. The amount of characteristics of resilience (not) met in Wellington tells us something about the level of community resilience and the amount of support by the institutional environment, in the aftermath of the Ebola crisis. This provides a basis for analysis and discussion.

Figure 7 serves as an impression of the characteristics table: there are five thematic areas which are divided into different components. Those components are subdivided again into various ‘characteristics of a disaster resilient community’ and ‘characteristics of an enabling environment’. For the complete table, please see annex 3. Due to limitations of space, only the characteristics relevant to this study are chosen, which brings the number of thematic areas to three.
THEMATIC AREA 1: GOVERNANCE

Components of resilience:
1. DRR policy, planning, priorities, and political commitment
2. Legal and regulatory systems
3. Integration with development policies and planning
4. Integration with emergency response and recovery
5. Institutional mechanisms, capacities and structures; allocation of responsibilities
6. Partnerships
7. Accountability and community participation

<table>
<thead>
<tr>
<th>COMPONENTS OF RESILIENCE</th>
<th>CHARACTERISTICS OF A DISASTER-RESILIENT COMMUNITY</th>
<th>CHARACTERISTICS OF AN ENABLING ENVIRONMENT</th>
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| 1. DRR policy, planning, priorities, and political commitment. | 1.1. Shared vision of a prepared and resilient community.  
1.2. Consensus view of risks faced, risk management approach, specific actions to be taken and targets to be met.¹  
1.3. Vision and DRR plans informed by understanding of underlying causes of vulnerability and other factors outside community’s control.  
1.4. Community takes long-term perspective, focusing on outcomes and impact of DRR.  
1.5. Committed, effective and accountable community leadership of DRR planning and implementation.  
1.6. Community DRR (and DP) plans, developed through participatory processes, put into operation, and updated periodically. | • Political consensus on importance of DRR.  
• DRR a policy priority at all levels of government.  
• National DRR policy, strategy and implementation plan, with clear vision, priorities, targets and benchmarks.  
• Local government DRR policies, strategies and implementation plans in place.  
• Official (national and local) policy and strategy of support to community-based disaster risk management (CBDRM).  
• Local-level official understanding of, and support for, community vision. |

2. Legal and regulatory systems | 2.1. Community understands relevant legislation, regulations, codes, etc., addressing and supporting DRR, at national and local levels.  
2.2. Community aware of its rights and the legal obligations of government and other stakeholders to provide protection. | • Relevant and enabling legislation, regulations, codes, etc., addressing and supporting DRR, at national and local levels.  
• Jurisdictions and responsibilities for DRR at all levels defined in legislation, regulations, by-laws, etc.  
• Mechanisms for compliance and enforcement of laws, regulations, codes, etc., and penalties for non-compliance defined in laws and regulations.  
• Legal and regulatory system underpinned by guarantees of relevant rights: to safety, to equitable assistance, to be listened to and consulted.  
• Land-use regulations, building codes and other laws and regulations relating to DRR enforced locally. |

¹ Including agreement on level of acceptable risk.

Figure 7: impression of Twiggs’s (2009) characteristics table (Twigg, 2009: 28)
Chapter 4: assessing community resilience

This chapter aims to answer the two sub-questions: 1) what characteristics of community resilience can be identified in the aftermath of the Ebola crisis? And 2) what characteristics of an ‘enabling environment’ for building local resilience can be identified in the aftermath of the Ebola crisis? In order to answer these questions, the characteristics of resilience in the Wellington community are identified, as well as the extent to which an enabling (policy) environment is present. By doing so, the potential gaps between resilience policies and resilience practices can be addressed and observed. The chapter is structured along Twiggs’s (2009) thematic areas and the associated components and characteristics of a disaster- resilient community and enabling environment.

Findings from field visits and interviews are described in the paragraphs that start with ‘Community Resilience’. The characteristics of resilience are discussed in these paragraphs. Whenever a characteristic is identified, a footnote with the description of this characteristic is added. The color green means the characteristic is present. The color yellow means the characteristic is not fully present, but not fully absent either. The color red stands for the absence of that specific characteristic. Characteristics of an enabling environment are identified in the same way and can be found in the paragraphs that start with ‘Enabling Environment’. These paragraphs are based on literature and policy documents.

The chapter closes with a schematic overview of all characteristics identified. The implications of the findings are discussed in the analysis (chapter 5).

4.1. Scope of the Research: the case of Wellington

In this study, the Wellington community serves as the case to illustrate how a broader institutional, policy and sociopolitical environment can contribute to community resilience. Before discussing the findings, background information about Wellington and Sierra Leone’s decentralized governance structure is provided.

Sierra Leone is divided into 14 districts. Wellington is part of the ‘Western Urban Area’ district in Sierra Leone. One district is divided into several ‘wards’. The Western Urban Area consists of 47 Wards in total. Wellington is comprised of 9 wards. The Western Urban Area is the most populous district in the country, with approximately 1 million inhabitants. It is unknown how many inhabitants Wellington has precisely. The Western Urban Area District is located in Freetown, the capital of Sierra Leone. While still incredibly poor, this district is the wealthiest district in Sierra Leone (Taylor, n.d.; UNOCHA, 2015).

The number of reported Ebola infections in the Western Urban Area is 2283, 16, 6 % of all reported infections in Sierra Leone (WHO.org, 2016). The exact number of Ebola cases in Wellington is unknown.

The 2004 local government Act, in which it was decided to decentralize, led to the creation of
19 local councils. Local councils serve as a sort of ‘local parliament’. They have got the highest level of local political authority in Sierra Leone. A council consists of councilors and is usually headed by a mayor or paramount chief. Councilors are elected by the population every four years. In municipal councils, one councilor represents three wards. Councilors reside in their local communities, which is supposed to enable citizens to engage in decision-making more easily. The task of local councils is to promote development and welfare. Also, councilors have the authority to set taxes and to make and enforce bye-laws (CLGF, 2013; the local government act, 2004). According to Koroma (2012), the local councils are making significant contributions to Sierra Leone’s development. For instance, some councilors in Freetown have used self-help projects to repair roads and bridges. However, it will become clear that the local governance structure is also facing difficulties. Wellington is part of the city council.

Next to councilors, paramount chiefs can also be seen as leading actors within communities. Historically, British colonialism empowered paramount Chiefs as the sole authority of local governments in Sierra Leone in 1896. Only people from the designated families of a chieftaincy are eligible to become Paramount Chief. The paramount chiefs often have a membership in the council. They are supposed to be politically neutral and in support of the council. In practice this is not necessarily the case (Reed and Robinson, 2013).

Map 2: Western Area District divided by Ward (http://bit.ly/24jgfvy). In total, Sierra Leone’s territory comprises approximately 71,000 km².
4.2. Thematic area 1: governance

4.2.1. Community resilience: political commitment, resilience and DRR

'Resilience? We call it ‘to fight’ (councilor).

Political commitment to and policies on resilience and DRR were not explicitly mentioned in the interviews. In fact, none of the respondents were familiar with the terms ‘resilience’ and ‘Disaster Risk Reduction’. A councillor said: ‘the issue of community resilience is not being used (...) if you want to talk about resilience, put it in local words, and break it down in other terms’. The fact that people are unfamiliar with jargon does not necessarily mean they are risk uninformed or less resilient. As one respondent pointed out: ‘So if you talk about resilience, I talk about adaptation sometimes. When you look at some areas where people reside (...) they are ready to cope, they have adapted.’ Adaptation is indeed at the core of DRR and resilience.

When asked what measures need to be taken to fight Ebola, the respondents take a rather short-term perspective. Everyone refers to the measures that directly avoid Ebola, such as ‘do not touch dead people’. While there is much consensus on this idea among the community members, resilience building requires a long(er)-term perspective as well\(^3\). However, the respondents do not automatically link Ebola to long-term issues such as poverty, development and weak health systems\(^4\). Most respondents see poverty as a consequence of Ebola, rather than the other way around:

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\(^3\) Shared vision of a prepared and resilient community

\(^4\) Community takes long term perspective, focusing on outcomes and impact of DRR
I: ‘Do you think Ebola is related to poverty?’
R: ‘O yeah definitely. When you’re sitting without no working, just waiting, that is related to poverty’
I: ‘And is Ebola also more likely to occur in poor places?’
R: ‘Ebola affects anyone, rich and poor.’

In general, the respondents do not have a thorough understanding of the underlying causes of vulnerabilities related to Ebola. Asking explicit questions reveals that the respondents do find that poverty is somehow related to Ebola:

I: ‘But for example, at Hill station (rich area in Freetown red.), could Ebola be there?’
R: ‘Well, I don’t know, I don’t live there. But the rich people have everything, they don’t need to go to the market... they are always at home or in their vehicles so they don’t get infected’.

While the respondents do not link broader issues to the outbreak of Ebola, they are well aware of the vulnerabilities surrounding them.

4.2.2. Enabling Environment: political commitment and policies on (community) resilience

‘We (...) believe that coping with and reducing disaster risk to build resilience for sustainable development is the most critical challenge facing governments, communities and the international community’ (Ministerial Declaration Adopted at the Ministerial, Regional Conference on Disaster Risk Reduction 14 – 16 April, 2010: 1).

Together with 186 other nations, Sierra Leone recently signed the Sendai Framework for Disaster Risk Reduction 2015 – 2030. The goal to build resilience on a community level is explicitly mentioned in the Sendai framework (Sendai Framework for Disaster Risk Reduction 2015 – 2030, 2015). By signing this non-binding memorandum of understanding, the Sierra Leone government acknowledges the importance and relevance of DRR and resilience building and its intention to invest in these areas.

On a regional level, the ‘African Regional Platform for Disaster Risk Reduction’ is working on the implementation of the ‘Africa Regional Strategy for Disaster Risk Reduction (2006 - 2015)’.

On a national level, there is a Disaster Management Department in place. However, it looks

Vision and DRR plans informed by understanding of underlying causes of vulnerability and other factors outside community’s control
Political consensus on importance of DRR.
Linkages with regional and global institutions and their DRR initiatives.
National policy framework requires DRR to be incorporated into design and implementation of disaster response and recovery.
Government (all levels) takes holistic and integrated approach to DRR, located within wider development context and linked to development planning across different sectors.
as if the department stopped reporting on DRR progress in 2011. While the department reportedly still exists, it was not possible reachable via email or phone. A public policy document focused on DRR/resilience is lacking. However, the concepts are integrated into three important documents that are discussed here: Sierra Leone’s poverty Reduction strategy 2013 – 2018 called ‘The Agenda for Prosperity’ (2012), the recently published ‘Recovery Strategy’ (2015) and the National Ebola Response Centre’s (NERC) revised ‘Ebola Response Strategy’ (2015).

The Agenda for Prosperity (2013) is risk informed in the sense that an analysis of vulnerabilities and risks per age group is included. The risk of (natural) disasters and disease is not explicitly mentioned as a threat to the implementation of the policy. One of the strategic objectives of this policy is to ‘strengthen community resilience’ (p. 110). Interestingly, one of the sub-objectives is: ‘Together with public health and infrastructure development specialists, build resilience to epidemic diseases’ (p. 110). DRR is thus integrated into development planning in Sierra Leone. In terms of implementation, the agenda notes that ‘the implementation of the Agenda for Prosperity is the responsibility of all Sierra Leoneans’ (p. xvii). The implementation is supposed to be executed by all organs of Government, local councils, CBO’s, media and the Private Sector. Despite the hiccups that Ebola costed, the goal still is to reach the status of Middle Income Country (MIC) by 2018 (Recovery Strategy, 2015).

In Sierra Leone’s Ebola Recovery Strategy (2015), ‘resilience’ is often mentioned in relation to building resilient health systems. One goal of the recovery strategy is to establish ‘an integrated national security and disaster risk management system’ (p. 42). The recovery strategy strongly links the goal of resilient health systems to other development issues such as education, building trust in public institutions and economics. One of the guiding principles of the recovery strategy is to mobilize communities for efficient and accountable recovery: ‘Sierra Leoneans (particularly at the community level) demonstrated vigilance and resilience (…) again through social mobilization and community participation to resist and fight Ebola. Thus, local resources and mechanisms for social communication, social mobilization, community organization, and social awareness must be encouraged and maintained during the recovery phase and beyond. At the heart of this bottom-up

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10 The most recent report to be found online is the ‘National Progress Report on the implementation of the Hyogo Framework for Action 2009 - 2011’.
11 Focal point at national level with authority and resources to co-ordinate all related bodies involved in disaster management and DRR.
12 Politically supported/approved and clearly articulated national disaster preparedness plan in place and disseminated to all levels; part of integrated disaster management plans with all relevant policies, procedures, roles, responsibilities and funding established.
13 Official (national and local) policy and strategy of support to community-based disaster risk management (CBDRM).
14 DRR a policy priority at all levels of government. • Local government DRR policies, strategies and implementation plans in place. • Risk reduction incorporated into official (and internationally supported and implemented) post-disaster reconstruction plans and actions. * Supportive political, administrative and financial environment for CBDRM and community-based development.
15 National DRR policy, strategy and implementation plan, with clear vision, priorities, targets and benchmarks.
16 Policy, planning and operational linkages between emergency management, DRR and development structures.
action is accountability, transparency and strong engagement by communities, especially the youth, women and civil society.’ (p. 34). Figure 7 shows the allocation of responsibilities of the recovery strategy. The final responsibility lies with the president and the Ministry of Finance and Economic Development. Local committees are in charge of the strategy’s implementation, monitoring and evaluation\(^\text{17}\). Furthermore, the government recognizes that, to achieve development, strengthening good governance is key. The objective of Pillar 7 of the Agenda for Prosperity (2013) is ‘to continue to promote good governance and build the capacity of all public sector and governance institutions and functionaries, to deliver quality and timely public services’ (p. 112).

Community resilience is also at the core if NERC’s revised Ebola strategy called ‘Getting to a Resilient Zero’. A risk analysis is included in the strategy: withdrawal of partner support, poor coordination of partners and the maintenance of technical expertise are mentioned as risks that might threaten the implementation of the ‘resilient zero’ strategy. A way to mitigate these risks is lacking. The strategy recalls that ‘Community ownership has proved to be the critical success factor in the Ebola response - there must be a systematic focus on deepening community engagement in all aspects of the response in order to foster enduring community ownership’ (p. 2).

DRR and resilience are seen as a policy priority by the government, at least on paper. These commitments and acknowledgements are all supportive to building community resilience. However, the fact that the Ebola outbreak did occur despite these commitments, raises the need to discuss the actual implementation of the policies\(^\text{18}\).

\(^{17}\) Committed and effective community outreach services (DRR and related services, e.g. healthcare) *Devolution of responsibility (and resources) for DRR planning and implementation to local government levels and communities, as far as possible, backed up by provision of specialist expertise and resources to support local decision-making, planning and management of disasters.

\(^{18}\) Policy, planning and operational linkages between emergency management, DRR and development structures.
4.2.3. Community resilience: local coordination, cooperation and community participation

‘We should keep engaging people to become very sensitive and aware of things regarding Ebola. (…) So supporting local government structures is one thing the government should do.’ (Councilor).

In December 2014, ‘Operation Western Area Surge’ (WAS) was launched. With this operation, the government decided to involve local partners in the Ebola response. According to a councilor who was team leader in an Ebola response team, the government then finally realized ‘that Ebola is a community owned disease and only the community can disown it’. The councilor continues: ‘(…) since its community owned, if the community does not decide or play a role to disown it, this will be a problem. So you have to engage local partners actively. (…). Before, they were not involving local partners. It was structures from the central government coming upside down. While it must be bottom to top. (…)’ Local ownership is thus deemed important in the fight against Ebola.

During operation WAS, Community leaders and Ebola surveillance teams were bringing house-to-house visits to sensitize the community members and to search for (hidden) sick people. Many

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19 Agreed roles, responsibilities and coordination of recovery activities (involving local and external stakeholders).
20 Local DP/response organizations are community managed and representative.
21 Whole-community participation in development and delivery of contingency, response, recovery plans; community ‘ownership’ of plans and implementation structures.
people were too afraid to work in an Ebola response team but some community members were brave and decided to go\textsuperscript{22}. One respondent explains: ‘most of the people were afraid, some people sacrificed their lives. They also came to my house but I said no, even though I don’t have a job but I said no, I am not interested’. At the time of research, not everybody who served in the Ebola teams had received the amount of money they were promised.

Operation WAS turned out to be successful in Wellington and the number of cases dropped, according to the respondents (see graph 1). Locally, the city council is the main coordination and decision making organ\textsuperscript{23}. One councilor who was also team leader in the Ebola response, showed his minutes, in which he captured details on the outbreak: ‘these minutes we produce and send to councilors in other areas, the other Wards. (...) Like (...) Operation WAS brought Ebola down down down. (...)’ Cooperation with the government is described as follows: ‘there is cooperation with the government but no direct support. For example technical information, passes via government through the council to the locals.’

Community Based Organizations (CBO’s) play a pivotal role in Wellington’s organization. People organize themselves in many different, local groups: from youth organizations to development committees. CBO’s played an important sensitizing role during the Ebola crisis: people rely on local leaders to get information\textsuperscript{24}. One respondent describes the role of the Imam during the Ebola crisis: ‘No need to touch, they (Imams, red.) advise, he says ‘this is not our fault’ and advises not to wash and touch the dead body. If you have been doing well, then you will get a good road in heaven. If you have not been doing well, you will also face the penalties. Your good work will pay you, even if you’re not washed before’. One councilor says that the community is acting as a ‘watchdog’ when it comes to Ebola\textsuperscript{25}. This idea is confirmed by other respondents as well: the community is controlling its people, suspicious events are reported to the councilor. The community also works together to improve the roads and the drainage system\textsuperscript{26}. Sometimes, the councilors bring together the youths of Wellington to clean the community (photo 2). Despite their authority, the local leaders depend on national and international actors for funding\textsuperscript{27,28,29}.

\textsuperscript{22} Community members and organisations trained in relevant skills for DRR and DP (e.g. hazard-risk-vulnerability assessment, community DRM planning, search and rescue, first aid, management of emergency shelters, needs assessment, relief distribution, fire-fighting).

\textsuperscript{23} Defined and agreed co-ordination and decision-making mechanisms with neighboring communities/localities and their organizations.

\textsuperscript{24} Civil society organizations participate in the development and dissemination of national and local-level preparedness plans; roles and responsibilities of civil society actors clearly defined.

\textsuperscript{25} Existence of ‘watchdog’ groups to press for change

\textsuperscript{26} High level of community volunteerism in all aspects of preparedness, response and recovery; representative of all sections of community.

\textsuperscript{27} Roles and responsibilities of local DP/ response organisations and their members clearly defined, agreed and understood.

\textsuperscript{28} Established social information and communication channels; vulnerable people not isolated.

\textsuperscript{29} Micro-finance, cash aid, credit (soft loans), loan guarantees, etc., available after disasters to restart livelihoods. 6.7. Self-help and support groups for most vulnerable (e.g. elderly, disabled).
In terms of partnerships, little aid organizations are present in Wellington\textsuperscript{30}. One NGO working there is GOAL, an organization that focuses on water and sanitation (WASH). GOAL is responsible for many of the wells in Wellington. It should be noted that the majority of the wells is no longer functioning (Photo 1).

\textbf{Photo 1:} Many water pumps in Wellington are no longer working (photo by author).

\textbf{Photo 2:} the councilor and the youth are voluntarily cleaning the community (photo by author).

\footnotesize{\textsuperscript{30} External agencies prepared to invest time and resources in building up comprehensive partnerships with local groups and organisations for social protection/security and DRR.}
4.2.4. Community resilience: trust and accountability

When asked who the respondents hold accountable for the fight against Ebola, most answer ‘the government’ since they possess the resources to make a change. However, for pressing needs, people tend to go to their councilor or chief, rather than a national institution. One respondent said: ‘As for me, the councilor is doing more well than the honorables’ (members of parliament red.). The councilors are elected every 4 years, so they are held accountable for their actions. Wellington’s inhabitants do not show a great amount of trust in the national government. According to some of the respondents, the government was lacking the capacity to manage the response in a proper way. For example, food and water for people in quarantine houses were initially not provided for. Since a quarantine takes 21 days, people tried to escape, thereby creating enormous risks for a further spread of the disease3132.

Some respondents felt neglected and excluded by the government’s response. As one respondent explained: ‘this community is left out, with little to no attention. We simply cannot wait until help comes from them’. Another respondent ads: ‘Nobody is helping. Even the councilors, even the ministers. We vote for them so they can help us in our community, but whenever they take that power they leave this part of Freetown, they will never develop the community. The money they are given is for themselves, they put it in their pocket. ’ This respondent even dares to express his/her dissatisfaction about the councilor, something that people rarely (dare to) do. Many millions have become available to fight Ebola, but the community members mention corruption as a problem: ‘(...) they extend it to their own accounts, taking the money and enriching themselves’33.

4.2.5. Enabling Environment: coordination and leadership

4.2.5.1. Enabling Environment: the International response

There has been much criticism towards the international response, and especially the leading role of the World Health Organization (WHO) in it34. On August 8 2014, almost 5 months after Ebola was diagnosed, the WHO declared the epidemic to be a PHEIC. This response was said to be ‘criminally late’ (DuBois et al., 2015: v). Following this event, resources and equipment finally started flowing. In the meantime, MSF was largely alone on the ground (Wilkinson and Leach, 2014). NGO’s struggled to translate efforts into relevant program activities, in content and scale. Even large organizations did not possess the necessary specialist capacity to react immediately. Slowly, more than 40 organizations and 2500 international personnel (1300 medical) were deployed to treatments centers (WHO 2014 – 2015 in DuBois et al., 2015) (I refer to who.int (2016) for a detailed timeline. ). Francois Grunewald (2015)

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31 Emergency facilities (communications equipment, shelters, control centers, etc.) available and managed by community or its organizations on behalf of all community members.
32 Community trust in effectiveness, equity and impartiality of relief and recovery agencies and actions.
33 Trust within community and between community external agencies
34 The WHO is the leader of the GHIC, the WHO is the directing and coordinating authority on international health work (who.org, 2016). For a detailed analysis on what went wrong from a governance perspective, I refer to Grunewald (2015).
draws the painful conclusion that ‘a timely response could have saved thousands of human lives and could have prevented the devastating impact on local economies’ (p. 26).

The response to Ebola revealed underlying problems of capacity, leadership, technical equipment and finances (Grunewald, 2015). Following the Ebola crisis, extensive WHO reform was demanded and some countries and organizations are publically questioning whether the WHO is suitable for its leading role within the cluster any longer (DG ECHO, 2016).

4.2.5.2. Enabling Environment: the National response

The described international governance failures interacted with national and local health, socio-economic, and political systems deeply compromised by the lack of development over the last few decades (DuBois et al., 2015). In October 2014, it became clear that ‘there was not enough logistical capacity within the Ministry of Health to manage the Ebola response to the scale required’ (AGI, 2015: 16). In response, the NERC was established ‘to provide strategic leadership to the Ebola response working in close collaboration with the Ministry of Health and Sanitation (MoHS), other government bodies and with international partners’ (NERC, 2015: 2). Information management and coordination were left under the oversight of the NERC. The NERC was staffed by local and international civilian and military personnel. Towards the end of 2014, the response got decentralized and Ebola Response Centers were established on a district level (DuBois et al., 2015).

In December 2014, the Western urban Area of Sierra Leone was the epicenter of the outbreak. President Ernest Bai Koroma launched Operation WAS on the 17th of December, 2014. The operation lasted until the 25th of January (mail online, 2014). Operation WAS was focused on activities such as identifying and isolating potential patients, increasing safe burials, ambulance dispatching, quarantine protocols and social mobilization. Operation Western Area Surge (WAS) was a cooperation between local authorities, local volunteers and international aid organization. As Antony Banbury, head of the United Nations Mission for Ebola Emergency Response (UNMEER) said: ‘We have to tailor our interventions to the particular circumstances in each of the 62 districts across the three countries. Operation WAS is part of those tailored interventions’ (Ebolaresponse.un, 2015: 1). The operation was effective in the sense that 459 new suspected cases were reported between 11 and 17 December, thereafter the number of cases dropped in the Western Urban Area (see graph 1). While local authorities were brought in late by the government, a NERC employee admits that they had a key role in the fight against Ebola: ‘especially in the areas of sensitization, contact tracing, surveillance and raising awareness’ (Turay, 2016: 1).

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35 All contingency plans are based on a solid assessment of hazards and risks and the identification of high risk areas throughout the country. Developed and tested contingency plans are in place for all major disaster scenarios in all high risk areas.

36 Government consults civil society, NGOs, private sector and communities. * Organised volunteer groups integrated into community, local and supra-local planning structures.
4.2.5.3. Enabling Environment: trust

Cross-checking the feeling that money disappears into the pockets of leaders, as indicated by the respondents, shows that Sierra Leone indeed ranks number 119 out of 168 countries of Transparency’s International list of world’s most corrupt countries (transparency international, 2015). During field visits, bribing was observed (and experienced) several times. Fighting corruption is mentioned as one of the goals in the Agenda for Prosperity (2013) and a National Anti-Corruption Strategy (NACS) was established in 2008 to realize the goals. The NACS has made considerable progress: over 4 years, a total of Le10 billion (approximately 250,000 USD) was recovered and paid back to the Consolidated Fund (Agenda for Prosperity, 2013). NACS also organized conferences for school principals and councils with the goal to enhance knowledge on corruption (Ibid). Over the course of the response, many incidents of denial, refusal to cooperate and even violence were reported. A campaign named ‘Ebola is real’ is a manifestation of this mistrust; it shows the necessity of having to convince people that Ebola was not a government scam (photo 3) (DuBois et al., 2015; Esmeralda 2014 in Boeser et al., 2014).
4.2.5.4. Enabling Environment: funding and finance

The Ebola outbreak accelerated fiscal pressures in Sierra Leone. The total impact of the outbreak was estimated at USD 130 million in 2014 alone (Grunewald, 2015). Economic growth is estimated to have decelerated to 7 percent in 2014 from a pre-Ebola projected growth rate of 11.3 percent. In total, the government allocated USD 27 million (2.8% of all expenditures) to fund the Ebola response (Recovery Strategy, 2015).

On a national level, the Agenda for Prosperity (2013) prescribed a reform of financial management in 2013. Greater authority over grants is supposed to be given to the local councils (Agenda for Prosperity, 2013). In order to recover from the outbreak financially, a number of pre-Ebola challenges need to be addressed. The recovery strategy (2015) notes that certain parts of the financial reform, as foreseen in the Agenda for Prosperity (2013), were overly positive. One of the strategies to recover financial services, is to inject new capital into small and medium sized enterprises (Recovery Strategy, 2015).

One of the major challenges Sierra Leone is facing, is the high level of unemployment, especially among the youth, women and vulnerable groups (like the elderly or the disabled). As a consequence of Ebola, there was a 70% job loss in the private sector and 50% job loss in manufacturing sectors. Unemployment was high before Ebola already, due to a variety of factors (National Recovery Strategy, 2015). One of them is the dissonance between the skills in demand and those produced by schools and training institutions. The overall goal of the employment strategy is ‘to encourage provision of productive and adequately remunerative employment opportunities, while improving working conditions for all who are willing to work, including vulnerable groups’ (Agenda for
Prosperity, 2013: 101).

Development partners, governments, multilateral organizations, NGO’s and the private sector scaled up their support as soon as they realized the gravity of the outbreak. Internationally, the WHO estimated a need of USD 71 million in beginning of August 2014. By the end of the same month, this figure was adjusted to USD 600 million. Finally, a total of USD 6, 6 billion was and still is needed for the Ebola response (UNMEER, 2015). Out of this 6, 6 billion, USD 42.202 million is reserved for recovery purposes (see graph 2) (Grunewald, 2015; UNMEER, 2015). Transparency is a problem since it is not clear whether all pledges are disbursed and how the money is used exactly. The need for financial reform within the aid system became clear during this crisis: ‘Emergency response requires rapidly disburseable and flexible (or un-earmarked) and needs-based funding to be effective and to respond to changing needs – but the current emergency financing mechanisms fail to provide this’ (MSF, 2014a: 17 in DuBois et al., 2015: 20).

Graph 2: amounts disbursed by purpose in USD million (Grunewald, 2015: 22)

4.2.6. Community resilience: legal and regulatory systems

‘We saw Ebola coming down down down (…). All these measures, bye-laws and penalties came from local authorities, local chiefs. (…)’. (Councilor).

The councilors introduced bye-laws to contain Ebola in Wellington. Consequences of breaking a bye-law vary from (high) financial penalties to imprisonment up to six months. According to the councilors, the installment of these laws in December 2014 was a turning point in the Ebola response in Wellington as the number of cases dropped: ‘We had bye-laws telling if you keep a stranger or if someone is sick and you not bring him to the hospital, you will be penalized. (…) As a council, we had authority to legislate and execute our function yes. We we we create laws, bylaws in our council and we also educate them (...) We were very proactive, very serious (...)’.
At the time of interviewing, all respondents were aware of the measures to take to avoid Ebola, such as not keeping strangers, washing hands regularly and referring sick people to hospitals. The respondents find obedience to the rules the most effective way to avoid transmission. According to most respondents, the Wellington community coped a little better with Ebola than other communities because of their safe behavior: ‘everybody is safe in our community because everybody takes the precautions. Because our councilor and other people, (...) they have this megaphone and so they come and sensitize people not to do this not to do that.’ It can be concluded that all respondents understand the relevant legislation, regulations and procedures in place.

Photo 4: the local court of Justice in Wellington, headed by the Chief / Judge (photo by author).

4.2.7. Enabling Environment: legal and regulatory systems

In 2013, there were only 21 judges and 20 magistrates in Sierra Leone. The Ministry had a core team of 23 professionals to serve the whole country. This shortage of staff causes much delays. One can imagine that Judicial Reform is needed to ensure safety for people, security of property and access to justice through an impartial and accountable legal system. In 2012, the legal Aid Act has been passed, which will improve citizens’ access to justice, and reduce constant adjournments (Agenda for Prosperity, 2013).

In 2004, local governance systems were reformed and given more responsibilities. As a part of this process, the ‘local government act’ authorized local councils to make bye-laws (Local Government Act, 2004). In August 2014, the Ministry of Local Government and Rural Development, and the Local Council of Paramount Chiefs jointly formulated a set of bye-laws on the eradication of Ebola. The bye-laws outline four categories: communication about Ebola, the treatment of Ebola patients, Death and

Community understand relevant legislation, regulations and procedures and their importance.

Disaster preparedness and response: obeying the rules, everybody takes precautions
burial and miscellaneous provisions. The councilors and chiefs disseminated the bye-laws locally\textsuperscript{39,40} (Government of Sierra Leone, 2014).

Responsibilities on DRR or community resilience are not explicitly defined in legislation. However, the local government act prescribes that local councils are obliged to establish a development planning committee. Among other things, they are supposed to ‘mobilize the human and material resources necessary for the overall development and welfare of the people of the locality’ (Local Government Act: 24, 2004)\textsuperscript{41}.

4.2.8. Community resilience: recovery

The councilors are aware of the existence of the recovery strategy. All local leaders indicate that they would need more financial capacity to develop the community: ‘As a local government there are no resources to draw up your own recovery plan, different from the central government’\textsuperscript{42}. As for the community members, if they are lucky they might have family living overseas and transferring money (‘those who are living in the Americas, they are giving support’). Some do have the savings to cope with the crisis, others are literally going hungry. There are no community funds to cope with the disaster. Costs and risks of Ebola are partly shared by the community.

As part of the recovery plan, one new school has been built in Wellington. According to the respondents, work has also been carried out in the energy sector. There is no such thing as a local recovery plan: ‘as a local government there are no resources to draw up our own recovery plan different from the central government’. Some respondents indicate that they have not seen much of the money available for recovery purposes yet.

When asked what is needed to recover from the Ebola crisis, one respondent answers: ‘(...) Send people to Sierra Leone to secure the disease, Chinese people come, even though I think another NGO’s come from England and from the Netherlands, these people come to secure the disease. And they do a lot, they do very well.’

Some respondents are positive about the developments in the recovery phase. Most respondents feel better protected against Ebola: ‘The community is better protected than before. Because I’d say 99% of the people are aware. Most of them are very very afraid of this disease because it is very dangerous, so most people take the time to take precautions’. Another respondent sums up the positive sides to Ebola: ‘Now, more people are trained, we have more ambulances and the government decided that government schools will be free the coming 2 years. Also, people know better how to avoid Ebola now. It looks better, even for malaria and measles’. In relation to this last point, another respondent says: ‘(...) developmental partners make efforts in upgrading the health sector

\textsuperscript{39} Relevant and enabling legislation, regulations, codundes, etc., addressing and supporting DRR, at national and local levels.
\textsuperscript{40} Jurisdictions and responsibilities for DRR at all levels defined in legislation, regulations, bylaws, etc.
\textsuperscript{41} Local leadership of development and delivery of contingency, response, recovery plans.
\textsuperscript{42} Community and other local agencies take lead role in coordinating response and recovery.
because before, there were not more than 20 ambulances nationwide but now, we can boast of over 200 ambulances nationwide’. He also mentions the fact that health staff is better trained than before and the free education initiative that the government started. According to this respondent the transport sector ‘has been beefed up by the government by providing 100 new buses’. The respondent says the energy sector supplies ‘85% of energy now, compared to 40% when Ebola just started’. A final positive development that is mentioned, is that the WHO placed a water tank in Wellington in November 2015.

Not everybody is as positive as these respondents\textsuperscript{43}. One respondent says: ‘(...) the government gives money to the honourables and in different communities to use it to pay some peoples to sacrifices themselves to prevent this Ebola. All over the country, some people (...) develop themselves, extend it to their own accounts, taking the money and enriching themselves\textsuperscript{44}. The director of the brand new school foresees difficulties in the future: ‘it is already a challenge to feed the children regularly. What will happen next year? The problem on the long term is funding’. A councilor says: ‘Presently, my ward is more prone to other hazards/disasters than before the outbreak of Ebola’. During the field visits another problem was observed, the community ran out of chlorine and soap. Now, people washed their hands with water, which is not as effective against diseases. There was no clear follow up on this\textsuperscript{45}.

4.3. Thematic area 2: knowledge, education and cultural beliefs

4.3.1. Community resilience: education and training

‘Once education is absent, development is difficult’ (youth leader).

When asked what Wellington needs to recover and further develop on the long term, four respondents answer ‘jobs’, five respondents answer ‘education’. Some say that both are needed: ‘Well, if you want the community to develop, the government needs to provide jobs for the youths. (...) And at the same time, many people are not educated. So how do you get a job without nothing in your head? So also education’. This respondent manages to link two developmental issues together: a lack of education and job security.

From the interviews, it becomes clear that the Wellington community is suffering from a lack of education and knowledge in general. Education and training on vulnerabilities, DRR or resilience, which are characteristics of resilience, are still very far away in Wellington. The community has dealt with previous crisis, such as flooding, cholera, war and extreme poverty before. As one respondent explains: ‘when cholera came, we secured it in 2/3 months (...) we have a lot of opportunity for these kind of crises. The community members have a certain sense of survival: they know how to cope with

\textsuperscript{43} Community trust in effectiveness, equity and impartiality of relief and recovery agencies and actions.

\textsuperscript{44} Response and recovery actions reach all affected members of community and prioritized according to needs.

\textsuperscript{45} No community disaster fund to implement DRR, response and recovery activities.
very little. However, Ebola is not being directly linked to ‘coping mechanisms’ from the past. Knowledge that might be present is not used for training purposes or shared in systematic ways as a form of DRR. Technical and organizational knowledge that could support resilience strategies does not seem to be present at all in Wellington.

In terms of research and learning, the councilors say they keep track of all Ebola cases in their wards (although most of them could not show me any numbers). At this point, this information does not seem to be managed for learning and research purposes. Documentation and ME evaluation systems could support DRR and resilience mechanisms. Especially because there is much local, valuable knowledge present among the councilors.

4.3.2. Enabling environment: education and training

In 2012, the average years of schooling among people above 25 years in Sierra Leone was 2,9 years. As a comparison, in the Netherlands this was 11,9 years in 2012 (hdr.undp.org, 2016). Only 43 % of Sierra Leonese above 15 years of age is able to read and write (indexmundi.com, 2016). Enrolments and completion rates have improved. Now, 74 % of all children go to primary school. In an environment like this, learning about DRR and resilience in school is not likely. No evidence was found on the existence of scientific programs targeted at risk analysis and DRR. Therefore, it is likely that there is little awareness among general public on how to manage disaster risks.

Due to Ebola, schools in Sierra Leone have been closed for about 8 months. Approximately 78 teachers are reported to have died (Recovery Strategy, 2015). One of the strategies mentioned within the recovery strategy (2015), which can be seen as a DRR initiative, is to train teachers on Ebola related issues. Another positive initiative that followed from the Ebola crisis, is that government schools will be free the next two years (Ibid).

While there was an enormous lack of human resources in the beginning of the outbreak, thousands of people were trained throughout the response, and volunteers received training in safe burials, sanitation and contract tracing (UNFPA, 2014).

In terms of policies, education is given an important role in the Sendai Framework. The
framework calls, among others, for increased investments in the resilience of education systems and education facilities. So, it is not just education on resilience and DRR that is needed, resilience of education systems should be built too (unisdr.org, 2016).

The agenda for Prosperity (2013) notes that ‘education plays a key role in the achievement of developmental goals’ (p. 60). Related to this, is the goal to ensure that by 2018, access to primary education will be ‘fee free’ and access to all levels of education will be greatly improved (in line with MDG 2). One way to achieve this, is to train more teachers and to improve teacher training. In line with the Sendai Framework, the Agenda for prosperity thus aims to build a more robust, accessible and resilient education system.

As part of the decentralization process, the government has trained 85 paramount chiefs and councilors in Good Governance and Human Rights. Unfortunately, trainings did not take place in the Western Urban Area (yet) (Agenda for Prosperity, 2013).

In the Agenda for Prosperity (2013), the need for better statistical data collection is brought up. Most social data systems are not adequate. The goal is to improve data collection in order to build effective policy responses and make informed decisions.

4.3.3. Community resilience: information and communication

‘We should keep engaging people to become very sensitive and aware of things regarding Ebola. That is why we keep communicating’ (councilor).

At first, there was much miscommunication and fear surrounding the Ebola response. One respondent explains: ‘People cannot read and write, most of them. So you’ll find it very difficult if you go there and tell them “this is a disease called Ebola”. They never heard of this word Ebola, you understand. So you cannot just come, you have to have an approach for them to understand, you have to find a way. Preventive measures rather than talking negatively, that is a very wrong approach.’

The rumor that Ebola was not real thrived in Wellington too: ‘when it started, (…) people did not believe it was real. Until they came to a point when you saw people dying with your own eyes’. Multiple respondents say the government contributed to all the confusion: ‘Ebola affected this country because of politics. Because (…) when the ruling party said Ebola is real, the opposition party said Ebola is not real’. Even at the time of interviewing, some respondents gave remarkable answers when asked why Ebola was able to spread. One chief answers: ‘because people did not believe in it, they are stubborn and they do not go to church’. One councilor says that ‘chronic sickness leads to Ebola’.

Not everybody fully understands that Ebola is a virus but, this does not seem to influence risky behavior very much: everybody is well aware on precautions to take\textsuperscript{54}. There is much consensus on

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\textsuperscript{54} General public aware of and informed about disaster risks and how to manage them.
the way to avoid Ebola. During the interviews, radio was mentioned as a possible source of information. However, many people lack access to electricity in Wellington: ‘(...) I don’t normally listen to the radio. This is some of the constraint that we are facing. Because over the radio station, they give all the information. (...) But if you don’t have electricity then you don’t know how things are going on. You can only know that if you have electricity and it would be better to watch over the news everyday’. Another constraint that is mentioned in relation to information and communication, is the high illiteracy rate among the people from Wellington. This was a problem especially in the beginning of the crisis. An alternative way to inform the inhabitants is seen in Wellington. Neighborhood support teams that carried out awareness raising activities were present. One councilor explained: ‘In our neighborhood support team we had town criers, we bought megaphones. We divided the ward into zones. 5 zones in the ward. (...) Very early in the morning we start giving information about Ebola. (...) from 5 o’clock, 6, and 7 and again at night at 7 when people are back home until 10 when people are going to bed, we would give the message. And those message are very much effective. (...) we make people conscious. The effect of Ebola is very serious to everybody. It’s not a joke, it’s a killer disease, it is real (...) we had teams (...) they emphasize again and again how dangerous it is, how serious and the bye-laws, the penalties if you take up anybody is sick, if we catch you, you go to jail’.

Besides using town criers, the neighborhood support teams paid house to house visits to disseminate information and to see if any suspicious activities occurred during and after Operation WAS. Through this operation, the whole community got involved in the awareness campaigns. Visiting Wellington showed that the councilors, who live in the community themselves, are continuously approached by the community members. They ask questions and express their problems. This indicates that there is space for debate within the community. The local awareness raising mechanisms have led to safer behavior according to the community members. Communication and awareness raising in Wellington is also reflected in the many posters hanging in the community (photo 5). The posters usually contain information about the signs and symptoms of Ebola and ways to avoid Ebola. The posters are very visual so people who are illiterate understand them. Some posters are in Krio, which is the local language in Wellington.
During the Ebola crisis, the councilors of Wellington met regularly in the city council. Information management largely happened through this institution: (technical) information on Ebola passed via the government through the council and eventually to the community members. Every councilor has an ‘Executive Working Committee’. One councilor explains: ‘we are like local cabinet, we call regular work committee meetings, every month it is obligatory (...) Because when you come to local meetings, people come with information, take information. And we tell the council information from the meeting.’ One councilor explains that these type of local structures need to be supported more. At this point ‘nothing is provided for us’, meaning that the councilor thinks that he should receive a higher salary.6263.

Photo 5: posters in Wellington provide information about Ebola (photo by author).

4.3.4. Community resilience: Ebola emergency hotline 117

117 is the national, free Ebola hotline. As is mentioned on all posters, one is supposed to call this number when somebody passed away or whenever you suspect somebody of having Ebola. Everyone knows the number by heart. One respondent elaborates on his experience with 117: ‘It is just recently that we talk about 117. Initially, there was no system. (...) I can give you a practical example from my own grandmother whom I love so much, she passed away, but not because of this Ebola. She aged and she became sick, but there was no hospital to go to (...). So what happened? (...) after one, two, three moths she passed away. Then I had to call 117. I cannot say the system is effective or efficient. You call call call, even if they pick your call, they will say ‘we are coming there’ (...). But they will not. So unless you have to go and look for the councilors and squeeze them to take actions, 117 will never respond.

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6 Information on risk, vulnerability, disaster management practices, etc., shared among those at risk. * All sections of community know about facilities/services/skills available pre-, during and post-emergency, and how to access these.
   1 Content and methods of communicating information developed with communities (i.e. ‘communication’ not ‘information dissemination’). * Maximum deployment of indigenous, traditional, informal communications channels.
That death body was there for a period of 3 good days, it took them that long to come’. This anecdote gives the impression that the national telephone number did work smoothly.

Photo 6: a poster encourages to call 117 (photo by author)

4.3.5. Enabling Environment: information and communication

The dissemination of information about Ebola took place via several channels. According to the UNICEF survey (2014), the main source of information in the Western Urban Area is radio (76, 1%) and television20 (43, 7%). Church, mosques and other religious venues also play an important role in spreading information (32, 7%). Information via town criers is indicated by 15, 6% as a means to learn about Ebola6465 (UNICEF, 2014). Access to electricity is among the lowest in Africa. Unreliable and limited energy services in urban areas and the near absence of energy services in rural areas were a major obstacle in the Ebola response. Many health centers were without light and a cold chain for medicines. Structural deficiencies in service delivery systems were clearly exposed by the Ebola outbreak (Recovery Strategy, 2015).

In April 2014, MoHS developed an Ebola prevention and control communication strategy, in collaboration with stakeholders and partners such as UNICEF, CDC and WHO. In the early stage of the response, communication was taking place top-down and bottom-up initiatives were sidelined. As a consequence, the messages did not engage well with communities. Public messages on prevention were often reported to be untargeted, insufficient and uncoordinated (ACAPS, 2015). Information was reported to cause misunderstanding. For example, in the Western Urban Area, 34% of the respondents thought Ebola can be transmitted via mosquitos. 40% believed bathing with salt and hot water will prevent Ebola (UNICEF, 2014). And, people concluding that hospitalization is not necessary

Media involvement in communicating risk and raising awareness of disasters and counter-disaster measures.* Information on risk, vulnerability, disaster management practices, etc., shared among those at risk.

Official and public acceptance of precautionary principle: need to act on incomplete information or understanding to reduce potential disaster risks.
because Ebola is deathly (Acaps, 2015). In addition, information used to be available in English and French, while 95% understands Krio as a language, for instance. As time passed, information spread and public awareness about Ebola increased. The ones in charge of communication learned and messages were adapted by local organizations on a district-level as the crisis continued. The type of messaging changed: from ‘If you catch Ebola you will die’ into ‘If you catch Ebola, you can survive’, for example (Acaps, 2015: 12).

4.3.6. Community resilience: cultural beliefs, local values and practices

Most people living in Wellington are Muslim, some are Christian and some are both (people have very liberate views on religion). In addition, there are indigenous beliefs that influence everyone. Religion and cultural values caused difficulties during the Ebola crisis. For example, the Islam prescribes that in order to have a dignified burial, men and women should be picked up and buried by someone from the same sex. When someone passed away during the Ebola crisis, burial teams came to pick up the body. However, there were very few women represented in the burial teams. The respondent whose grandmother passed away explains: ‘So if you only have 1 female, and there are various burial teams (…) maybe the female does not belong to that team. (…) When you start to think how these people are treating us… for me, to see someone whom I love so much, my grandmother who cared for me, when I lost that individual I am supposed to give a safe burial. I have no power to stop them, but there is no female there’. Another example is the following: ‘we like cassava leaves, potato leave, so you cannot bring sardines and a bottle of oil. We are used to eat rice first thing in the morning. Even if you give me everything, biscuits and so on, rice is my first food’. Once people in quarantine homes finally received food, this food was not adjusted to local practices.

4.3.7. Enabling Environment: Cultural beliefs, local values and practices

Next to rumors, traditional beliefs guided a great part of society’s perception when Ebola arrived. The eating of (uncooked) bush meat is a dangerous cultural practice that is hard to control, for instance. Another unsafe practice is the washing of a dead body before the funeral, which is a common Muslim and indigenous traditions (Ohlheiser, 2014). These rites of mourning are believed to safeguard a good afterlife for the deceased, as well as safety for the remaining family (Richards et al., 2015: Haglage, 2014). To limit the risk of transmission, behavioural change was thus needed. According to

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Wilkinson and Leach (2014), the assumption that public health experts and scientists possess the knowledge needed to stop the epidemic and that local populations do not, has led to an insistence on protocols and procedures that deny valuable and necessary input from communities. Funerals are one such area. The example from Wellington shows that prohibiting community members to honor their deaths according to their traditions, can worsen distrust towards institutions (Haglage 2014).

Significant improvements in community perceptions came when religious elements were incorporated in the messages. Religious leaders warned against washing and touching dead bodies and they encouraged people to seek medical treatment as this was commanded by the Bible and the Quran. Slowly, the messaging became more compatible with faith and tradition (Acaps, 2015).

4.4. Thematic area 3: risk management and vulnerability reduction

A broad range of vulnerabilities and hazards, other than Ebola, can be identified in Wellington. Resilience means being aware of all vulnerabilities and hazards, in order to estimate the disaster risk and reducing risks in effective ways. As a part of community resilience, the broader SD context is assessed by looking at the social economic circumstances in Wellington.

4.4.1. Community resilience: hazards and environmental management

Garbage disposal, poor WASH facilities, bad roads, air pollution, poor drainages and flooding are all mentioned as hazards by the respondents.\textsuperscript{71} The chief said: ‘For development, the most pressing needs are water, bad roads, the poor drainages and garbage disposal. Also a hospital and public toilets are lacking’\textsuperscript{72}. From the field visits, this can be confirmed.

Water shortage forces some children and women to fetch water in the nighttime. This poses them under severe risks. One respondents explained: ‘(…) especially the female and you can see the young boys they take the advantage and that is where the high rate of teenage pregnancy comes from, because there is no water’\textsuperscript{74}.

The councilor linked the WASH situation to the transmission of Ebola: ‘Peoples go out fetch water, they get themselves clustered, so in that situation you see (…) that became the hotspot because after Michael (first one in this councilors ward to get Ebola, red.) we had series of cases in that area of Maxwell street’.

The development of WASH facilities and solving the garbage problems are seen as priorities in risk management by the respondents\textsuperscript{76}. The councilors explicitly mentioned that improvements in

\begin{itemize}
  \item Safe locations: community members and facilities (homes, workplaces, public and social facilities) not exposed to hazards in high-risk areas within locality and/or relocated away from unsafe sites.
  \item Infrastructure and public facilities to support emergency management needs (e.g. shelters, secure evacuation and emergency supply routes).
  \item Resilient transport/service infrastructure and connections (roads, paths, bridges, water supplies, sanitation, power lines, communications, etc.).
  \item High levels of personal security and freedom from physical and psychological threats.
  \item Access to sufficient quantity and quality of water for domestic needs during crises.
  \item Consensus view of risks faced, risk management approach, specific actions to be taken and targets to be met
\end{itemize}
These areas could lead to a reduction in diseases. Most community members understand this too but, full awareness of means of staying healthy has not been reached:

- ‘What is done with the waste then?’
- ‘We throw it.’
- ‘Where?’
- ‘In the streets, so in that case we don’t have mosquitoes in our own house, thank God for that’.

This citation illustrates that not all ‘health measures’ are effective: throwing garbage in the street will eventually lead to the presence of more mosquitoes. Another example of a failed DRR attempt is related to flooding: ‘To reduce risk, we tried to move the people but they will tell you ‘we are born here, we are used to here, and we have been here for over 50 years’’.

All wards have a ‘development committee’ in place that is supposed to deal with the aforementioned issues by implementing structural mitigation measures. One councilor is trying to set up a garbage system, for example. However, the community members complain about the required contribution (equivalent to 20 euro cents per month). The adoption of sustainable environmental practices that reduce hazard risks is thus difficult.

Improvements in the development of Wellington can be seen as resilience building measures so in a way, local authorities are dedicated to DRR. However, according to the councilors there is a lack of (the ability to mobilize) financial resources to move forward. One councilor who is very motivated to develop his ward, explains that he searches but does not know where to find donors. Hence, the committees are not as functional as they could be. Ebola had a deteriorating effect on development in the Wellington community: development projects, such as a project on care for the elderly, stopped. According to most respondents, more support from NGO’s would be desirable in order to develop the community. According to one respondent, one condition for success would be that NGOs cooperate with the local community. The councilors are having a hard time to convince organizations to work in Wellington, or to apply for the funding of projects.

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77 Informed, realistic attitudes towards risk and risk management. * Community understanding of characteristics and functioning of local natural environment and ecosystems (e.g. drainage, watersheds, slope and soil characteristics) and the potential risks associated with these natural features and human interventions that affect them.* Awareness of means of staying healthy (e.g. hygiene, sanitation, nutrition, water treatment) and of life-protecting/saving measures, and possession of appropriate skills.
78 Adoption of sustainable environmental management practices that reduce hazard risk.
79 Representative community organizations dedicated to DRR/DRM
80 Community-managed funds and other material resources for DRR and disaster recovery. * Community knowledge of how to obtain aid and other support for relief and recovery.
81 Access to government and other funding and resources for DRR and recovery
82 Community capacities and skills to build, retrofit and maintain structures (technical and organisational).
83 Resources available to support necessary actions identified by community-level plans.
84 Access to community-managed common property resources that can support coping and livelihood strategies in normal times and during crises. * Structural mitigation measures (embankments, flood diversion channels, water harvesting tanks, etc.) in place to protect against major hazard threats, built using local labour, skills, materials and appropriate technologies as far as possible.
themselves. According to the councilors, this is due to the fact that the priority for NGO’s are the areas hardest hit by Ebola, and Wellington is not considered one of them.

Photo 7: Wellington is at risk of flooding and mud slides in the rainy season (photo by author).

Photo 8: Poor drainage and garbage system pose the community under great health risks (photo by author).
4.4.2. Enabling Environment: hazards and environmental management

‘Environment is where we live; and the development is what we all do in attempting to improve our lot within that abode. The two are inseparable.’ (Agenda for prosperity 2013: 45).

While it does not reflect in its country’s prosperity, Sierra Leone is one of the richest countries in the world when it comes to natural resources. Diamonds, gold, bauxite, rutile and iron exist in large quantities (eiti.org, 2016). (Iron) mining contributed around 27% percent of GDP in 2014, for instance. Recently, oil has been discovered (BBC, 2012). At this point, Sierra Leone’s natural resources do not generate equal opportunities and they are ‘liable to shocks’. Therefore, diversified economic growth, creating long-term potential for inclusive and sustainable growth, is one of the pillars of the Agenda for Prosperity (2013)85.

Due to the outbreak, gold and diamond activities are reported to have ceased because of restrictions on movement of people. The virus has had little direct effect on mineral production in 2014. However, the sharp decline in the price of iron ore and world oil prices have got major impact

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Diversification of national and subnational economies to reduce risk.
on business in Sierra Leone (Recovery Strategy, 2015).

Pilar 2 of Sierra Leone’s Agenda for Prosperity (2013) consists of ‘managing Natural Resources’ (p. xiv). In the agenda for prosperity, it is mentioned that in the past, the environment was not managed in sustainable ways. This is exemplified by the rapidly diminishing natural forest cover: between 1990 and 2000, Sierra Leone lost 3% of forest annually due to activities such as charcoal burning and firewood collection. It is written that ‘the objectives and strategies of the environment sector will be focused on preventing or reducing the impact associated with prioritizing short term economic gains at the expense of environmental degradation’ (Agenda for Prosperity, 2013: 44). Essentially, this is DRR in the long term.

In terms of hazards, flooding, epidemics, water shortage and hazards induced by climate change are prevalent in Sierra Leone. Deforestation aggravates the risk of erosion, mud- and landslides and floods (Thieme and Jacobs, 2012). Many of these risks tend to be higher in densely populated places such as Freetown (Ibid). According to Acaps (2015), Sierra Leone scores a 4.3 out of 10 on the Index for Risk Management. Socio-economic crisis are seen as a main risk. According to Acaps’ (2015) analysis, hazard exposure in Sierra Leone is low but vulnerability is very high. WASH and poor hygiene practices were problems pre-Ebola and will remain problems post-Ebola. The recovery strategy (2015) aims to improve the situation in order to support and scale up hand-washing and to ensure the prevention of outbreaks of water-related diseases. All stalled road projects will be restarted, according to the recovery strategy (Ibid). The risk of flooding and mud- or landslides is not mentioned in the recovery strategy and neither in the Agenda for Prosperity.

Lastly, climate change is shortly mentioned as a risk in the agenda for prosperity (2013). Task forces are supposed to be set up to manage these risks. While it is positive that Sierra Leone has got ambitions in this area, and identifies risks such as water pollution and the decimation of fisheries, there seems to be a discrepancy with the situation on the ground.

4.4.3. Community resilience: health and well being

Wellington does not have a hospital, it does have a small health clinic. The respondents indicate that health care and medicines are less accessible now than before Ebola. Because of Ebola, hand washing is a practice that was newly introduced in the community. This is a good health practice that increases resilience, not only resilience to Ebola but also to other communicable diseases. One respondent says...
that the ultimate solution against Ebola would be the availability of a vaccine. At the time of interviewing, the vaccine was still in a testing phase, meanwhile, some health workers from Wellington received the vaccine.

Most people in the community are informal traders. There is no job security or business protection: ‘I would not say they (the community members red.) are unemployed but, it’s very very challenging. Sometimes they do trading for what they eat that day. So you go to the garden, you do your garden work, take it to the market and sell just to make a living, to have a little.’ The local brewery does generate some income for the Wellington community, although some complain that the brewery is hiring too much people from outside of Wellington. Ebola had a big impact on employment in Wellington, a respondent explained:

➤ R: ‘It got worse during Ebola because most people were stopped, like me. I was working here (Sierra Leone Brewery Limited, red.) So some of us people were affected like that, they stopped them from their office because there was no more production, but now I think it’s getting better. Because the Ebola is almost finished now and they are calling some of them’.
➤ I: ‘And how did the community cope with that? For example, you were home for how many months?’
➤ R: ‘9 months’
➤ (…) I: ‘How do you deal with that, because the children still need to eat?’
➤ R: ‘Yes, I’ve managed because when you work, you have to save some for the bad days ha-ha. You don’t eat everything ha-ha’.

In this explanation, a certain resilience to disasters is uncovered. This may not be the kind of resilience discussed during high level international meetings, but the inhabitants of Wellington have a good sense of survival. Another example of ‘local resilience’ is given by a local youth leader, he has set up a system for sharing clothes among the members of the youth organization.

The availability of food is not a given in Wellington. Ebola deteriorated the situation even more. Some children show visible symptoms of malnutrition. When asked what the needs of the community members are, one respondent answers ‘Well, like me for example. I need help in terms of food and medicine, we don’t have these things’.

Engaging in unsafe livelihoods is not seldom in Wellington, especially for young men: some get into mining, which is dangerous and barely pays, other make a habit out of stealing.

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91 Cultural attitudes and values (e.g. expectations of help/self-sufficiency, religious/ideological views) enable communities to adapt to and recover from shocks and stresses.

92 Physical ability to labour and good health maintained in normal times through adequate food and nutrition, hygiene and health care

93 High levels of personal security and freedom from physical and psychological threats * Food supplies and nutritional status secure (e.g. through reserve stocks of grain and other staple foods managed by communities, with equitable distribution
respondent says: ‘The thief’s are stealing, they come into the house at night. That is the problem of the Wellington area’. Many stories about (armed) robberies buzz around in Wellington.

4.4.4. Enabling Environment: health and well being

Sierra Leone’s malfunctioning health system contributed largely to the severity of the outbreak (note that the outbreak was successfully contained Mali, Nigeria and Senegal)\(^94\) (DuBois et al., 2015). In 2011, Sierra Leonese health facilities had on average 35% of the required essential drugs in stock (WHO, 2015 in DuBois et al., 2015)\(^95\). A total of 136 doctors covered a population of 6 million people (compared to 18,000 doctors in Denmark for roughly the same population) (Boeser et al., 2014).

Malaria, respiratory and diarrheal diseases – all linked to poor WASH facilities -have accounted for 75% of deaths among children under 5 (Agenda for Prosperity, 2013)\(^96\). Sierra Leone thus suffers from an immense lack of human resources when it comes to healthcare, among others because of poor working conditions that lead to a ‘brain drain’. As a consequence, there is a heavy reliance on NGO’s and Faith Based Organizations\(^97\) (DuBois et al., 2015).

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\(^94\) DuBois et al., 2015
\(^95\) WHO, 2015
\(^96\) Agenda for Prosperity, 2013
\(^97\) DuBois et al., 2015

* High level of local economic activity and employment (including among vulnerable groups);
  * Stability in economic activity and employment levels;
  * Fewer people engaged in unsafe livelihood activities (e.g. small-scale mining) or hazard-vulnerable activities (e.g. rainfed agriculture in droughtprone locations);
  * Small enterprises have business protection and continuity/recovery plans.
  * Public health structures integrated into disaster planning and prepared for emergencies.
  * Resilient and accessible critical facilities (e.g. health centres, hospitals, police and fire stations – in terms of structural resilience, back-up systems, etc.).

For many years, Sierra Leone has been suffering from one of the highest under 5 mortality rates in the world. 120 out of every 1000 newborns die before the age of 5 in 2015\(^96\) (compared to 4 out of 1000 in the Netherlands) (data.worldbank.org, 2015).

Health education programs include knowledge and skills relevant to crises (e.g. sanitation, hygiene, water treatment).

Policy, legislative and institutional commitment to ensuring food security through market and non-market interventions, with appropriate structures and systems.

Sufficient number of trained organizational personnel and community members to carry out relevant tasks (e.g. communication, search and rescue, first aid, relief distribution).
In 2005, all primary health care activities were devolved to local councils. Since the reform, some progress in the health system has been made (Agenda for Prosperity, 2013). One groundbreaking initiative aims to provide free healthcare for children under five and lactating and pregnant women. Female respondents are aware of the existence of the initiative but said they still have to pay for health care. Berghs (2016) and Wilkinson & Leach (2014) write that the initiative has been conditionally implemented. Women have to ensure informal fees or bribes to health care professionals because health care professionals could not survive on their salaries.

After the 2012 cholera outbreak, a plan was put in place to integrate ‘outbreaks of communicable disease of epidemic potential’ into national risk reduction strategies. Attempts to employ the plan when Ebola struck where unsuccessful. It is remarkable that pre-Ebola investment in the resilience of Sierra Leone included reportedly ‘successful’ measures towards the prevention and containment of infectious diseases (DuBois et al., 2015: Wilkinson and Leach, 2014). In practice, some of these health initiatives are a façade. As Abramowitz et al. (2015) note, the health reforms that created health sector functions, which, due to chronic underfunding, exist in name only. The recovery strategy (2015) admits that ‘despite efforts to improve the availability of services (...) gaps persisted in the quality of care’ (p. 24). There is consensus that disease surveillance systems on the level of the community were weak or non-existent (DuBois et al., 2015). Denney and Mallet (2015) found that Sierra Leone’s health system is characterized by weak communication between the local, district and the national level.

These health system shortages revealed during the outbreak: financial resources for addressing Ebola containment were lacking (Youde, 2014). There was an inadequate number of beds, PPE’s, disinfect and basic medical supplies (Schnirring, 2014; Reuters, 2014 in DuBois et al., 2015). Many health workers died. Another problem was capacity. While messages encouraged people to isolate sick family members and call 117, only 3 ambulances used to be available in the whole country; a fraction of what was necessary (Boeser et al., 2014). The other way around, the health system was put under even more pressure than before. Sierra Leone experienced a 39% decline in children being treated for malaria and a 21% drop in children receiving basic immunizations as a consequence of Ebola. As a consequence, the likelihood and potential impact of an epidemic have risen. Especially vulnerable, urban communities suffered from a gap in the provision of WASH services (Acaps, 2015). As Elms’ (2015) model predicts, a changing degree of impairment and an adverse DRR trend is seen.

In the recovery strategy (2015), the situation is framed as an opportunity to ‘Build Back Better’. The strategy has got two objectives: 1) to build a sustainable national health system that delivers safe, efficient and quality health care services that are accessible, equitable and affordable for
To build a resilient national health system that can respond robustly to possible recurrence of EVD outbreaks and outbreaks of any other deadly diseases (p. 36). Keeping in mind the (absence of) success of former health system improvements, the feasibility of these strategies remain to be seen.

4.4.5. Enabling environment: food security and livelihoods

According to a study conducted by UNDP, 91% of the respondents from the Western Urban Area expressed concerns about worsened livelihoods after Ebola.

Food security did significantly increase since 2001 (wfp.org, 2008). The World Bank measured that in 2013, the prevalence of undernourishment (% of population) in Sierra Leone was 25, 5, compared to 40% in 2001 (tradingeconomics.com, 2014: foodsecurityportal.org, 2013). Still, malnutrition rates are among the highest in the world: 35% of children under five are chronically malnourished, including 10% severely (WFP, 2011).

Ebola reduced agricultural and food production with approximately 5% in 2014, mainly because of labor shortage as the traditional work gangs were disbanded. Prices for staple food such as rice increased up to 30%. Export of crops like cocoa fell by 30%. Livestock dropped significantly, due to the restriction of movement. It has been reported that many farmers depend on wild animals as a source of protein and income, again this is reverse DRR (the very cause of Ebola is uncooked bush meat) (Boeser et al., 2014). The recovery plan aims to recover agriculture and thereby improve food security through several activities (‘restock livestock and initiate programs for providing alternatives to bush meat as a source of animal protein for communities’, for instance) (Recovery Strategy, 2015: 38). The risk of a food crisis is higher now than before the Ebola outbreak (Acaps, 2015).

4.4.6. Community resilience: social protection and physical protection

The inhabitants of Wellington keep themselves save by taking the advice of the MoHS very serious: ‘(…) if any advice is coming out ‘don’t do this’, ‘if you do this you become infected’, try to do what the advice says. That is the way we are doing in our own area. If you do that, then maybe you will survive’.

The respondents explain that it takes a behavioral change to fight Ebola: ‘we did not allow people in our house and we don’t go to another place. When I come from work, I go straight to the house’.

The quarantine houses, PPE’s and hand washing facilities of Wellington can be seen as short-term protective measures against Ebola. It has to be noted though, that these facilities are not available everywhere and where they are available, they do not always work properly: disinfecting gel was finished regularly, for example.

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100 Security of access to public health and other emergency facilities (local and more distant) integrated into counterdisaster planning
101 Engagement of government, private sector and civil society organisations in plans for mitigation and management of food and health crises.
102 Safer behavior as result of awareness raising.
103 Adoption of short-term protective measures against impending events (e.g. emergency protection of doors and windows from cyclone winds).
In terms of recovery, one issue that came up several times are the victims. According to the respondents, orphanages and widowed elderly are very vulnerable. Orphanages literally wander through the community without a home. A councilor explained: ‘the most difficult problem we are facing now, is how to cater for the orphanages and widows as some of the deaths used to be the breadwinners of these families’. Another problem is the stigmatization of Ebola survivors. One councilor tries to inform his people about the transmission of Ebola in order to fight the stigma\textsuperscript{104}.

Social protection in the form of financial support was promised for Ebola survivors and health care personnel. So far, the government has not lived up to the promise yet.

\textbf{Photo 11:} orphanages and their newly installed water pump (photo by author)

\textsuperscript{104} Adoption of short-term protective measures against impeding events (e.g. emergency protection of doors and windows from cyclone winds)
4.4.7. Enabling Environment: social and physical protection

Available data suggests that Sierra Leone spends 0.5% of its GDP on social insurance (pensions) and 3.5% on social assistance. Expenditures on all social sectors was 8.2% of GDP in 2011, which is lower than most African countries (Agenda for Prosperity, 2013). Governmental family protection services do exist but are reported to be ineffective due to limited reach, weak technical and human capacity and logistical constraints. Sierra Leone has experienced significant economic growth over the years, this did not translate into substantial reduction in poverty, increased equality and lessened vulnerability to risks. The proportion of people living below the 1,25 USD poverty line remains as high as 54.3% in 2011. Looking at inequality, the poorest 20% of the population own 7.9% of total income, compared to 42.4% that is owned by the richest 20% of the total population (povertydata.worldbank.org, 2016). Responsibilities for most basic social services have been devolved to the local councils. As mentioned before, challenges need to be overcome for more effective results. The government is committed to improve the situation. As a manifestation of this commitment, the National Protection Policy was adopted in 2011. One of the main policy goals is to ensure that the most poor and vulnerable are afforded an equal opportunity to access basic services. In line with this policy, one of the 8 pillars described in the Agenda for Prosperity (2013) is ‘Strengthen Social Protection Systems’. In order for the poorest to benefit from the foreseen economic growth of over 10...
% during 2013 – 2018, inclusive growth needs to be ensured\textsuperscript{105,106}. Sierra Leone’s Agenda for Prosperity (2013) identifies vulnerabilities among all age groups. One of the concrete goals is to ‘provide cash and in-kind transfers for poor and vulnerable households and communities during periods of emergency and early recovery’ (p. 110). In Wellington, not much signs of the actual implementation of this strategy could be discovered (yet?)\textsuperscript{107}. The recovery strategy (2015) aims to target assistance at those who are most vulnerable and most affected: Ebola survivors, orphans, widows and widowers. It is estimated that there are 8345 orphans, 954 widows and 465 widowers. There are approximately 1300 registered survivors. Survivors reported lasting health problems, financial burden and psychosocial issues such as stigma and shame that prevents reintegration into their community. According to a survey conducted by Estrada (2014) (in Boeser et al., 2014), 96% of respondents have a discriminatory attitude towards suspected Ebola cases and that 76%. One action to relief the suffering is to build interim care centers and homes. The reintegration of Ebola survivors and health workers into communities is said ‘to be facilitated and livelihood will be provide' (Recovery Strategy, 2015: 9). Despite these wonderful intentions, one respondent who used to be a health worker says ‘Nothing like this is happening for health workers. Only small aspect is going on for survivors’\textsuperscript{108}. No plans regarding physical protection were found in the policies.

4.5. Concluding thoughts

The final goal of this chapter is to answer the two sub-questions: 1) what characteristics of community resilience can be identified in the aftermath of the Ebola crisis? And 2) what characteristics of an ‘enabling environment’ for building local resilience can be identified in the aftermath of the Ebola crisis? A total of 74 characteristics of community resilience have been identified, 36 of them as absent (48, 6 %), 17 of them as present (22, 9 %). The rest is not fully absent and neither fully present. 59 characteristics of an enabling environment were identified. 18 of them as present (30, 5 %), 13 of them as absent (22, 0 %). 47, 5 % of the characteristics of an enabling environment is neither fully absent nor fully present (please see Figure 10 below).

Based on the fact that a minority of all characteristics is fully present, and using Twiggs’s (2009) scale, it can be concluded that a ‘level 2’\textsuperscript{109} of community resilience is present in Wellington.

\textsuperscript{105} • Official agencies willing and able to guarantee public safety after disasters and to protect highly vulnerable groups. • Formal social protection schemes and social safety nets accessible to vulnerable groups at normal times and in response to crisis. * Response and recovery actions reach all affected members of community and prioritized according to needs. 
\textsuperscript{106} • Government and private sector supported financial mitigation measures targeted at vulnerable and at-risk communities. • Official continuity and recovery plans in place or capable of being developed, supported by appropriate systems and capacities.
\textsuperscript{107} • Poverty reduction strategies target vulnerable groups. • Support programs for livelihood-focused recovery (e.g. cash for work, replacement of productive assets, emergency loans or startup capital).
\textsuperscript{108} • Coherent policy, institutional and operational approach to social protection and safety nets, ensuring linkages with other disaster risk management structures and approaches.
Level 2 stands for ‘awareness of the issue(s) and willingness to address them. Capacity to act (knowledge and skills, human, material and other resources) remains limited. Interventions tend to be one-off, piecemeal and short-term’. In the following chapter, the findings of this chapter are discussed and the main question is answered.

**Figure 10:** characteristics of community resilience in Wellington and characteristics of Wellington’s enabling environment, divided by thematic area.

### Thematic area 1: governance

<table>
<thead>
<tr>
<th>Characteristics of community resilience</th>
<th>Characteristics of an enabling environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Agreed roles, responsibilities and coordination of recovery activities (involving local and external stakeholders).</td>
<td>1. Political consensus on importance of DRR.</td>
</tr>
<tr>
<td>2. Local DP/response organizations are community managed and representative.</td>
<td>2. Linkages with regional and global institutions and their DRR initiatives.</td>
</tr>
<tr>
<td>3. Existence of ‘watchdog’ groups to press for change</td>
<td>3. Community understand relevant legislation, regulations and procedures and their importance.</td>
</tr>
<tr>
<td>4. High level of community volunteerism in all aspects of preparedness, response and recovery; representative of all sections of community.</td>
<td>4. Disaster preparedness and response: obeying the rules, everybody takes precautions</td>
</tr>
<tr>
<td>5. Defined and agreed co-ordination and decision-making mechanisms with neighboring communities/localities and their organizations.</td>
<td>5. Official (national and local) policy and strategy of support to community-based disaster risk management (CBDRM).</td>
</tr>
<tr>
<td>6. Community understand relevant legislation, regulations and procedures and their importance.</td>
<td>6. DRR a policy priority at all levels of government.</td>
</tr>
<tr>
<td>7. Disaster preparedness and response: obeying the rules, everybody takes precautions</td>
<td>7. Local government DRR policies, strategies and implementation plans in place.</td>
</tr>
<tr>
<td>8. Risk reduction incorporated into official (and internationally supported and implemented) post-disaster reconstruction plans and actions.</td>
<td>8. Risk reduction incorporated into official (and internationally supported and implemented) post-disaster reconstruction plans and actions.</td>
</tr>
<tr>
<td>10. Government (all levels) takes holistic and integrated approach to DRR, located within wider development context and linked to development planning across different sectors.</td>
<td>10. Government (all levels) takes holistic and integrated approach to DRR, located within wider development context and linked to development planning across different sectors.</td>
</tr>
<tr>
<td>11. Government consults civil society, NGOs, private sector and</td>
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109 Twigg’s levels:
- Level 1 Little awareness of the issue(s) or motivation to address them. Actions limited to crisis response.
- Level 2 Awareness of the issue(s) and willingness to address them. Capacity to act (knowledge and skills, human, material and other resources) remains limited. Interventions tend to be one-off, piecemeal and short-term.
- Level 3 Development and implementation of solutions. Capacity to act is improved and substantial. Interventions are more numerous and long-term.
- Level 4 Coherence and integration. Interventions are extensive, covering all main aspects of the problem, and they are linked within a coherent long-term strategy.
- Level 5 A ‘culture of safety’ exists among all stakeholders, where DRR is embedded in all relevant policy, planning, practice, attitudes and behavior.
1. Shared vision of a prepared and resilient community
2. Whole-community participation in development and delivery of contingency, response, recovery plans; community 'ownership' of plans and implementation structures.
3. Community members and organizations trained in relevant skills for DRR and DP (e.g. hazard-risk vulnerability assessment, community DRM planning, search and rescue, first aid, management of emergency shelters, needs assessment, relief distribution, and fire-fighting).
4. Civil society organizations participate in the development and dissemination of national and local-level preparedness plans; roles and responsibilities of civil society actors clearly defined.
5. Roles and responsibilities of local DP/ response organizations and their members clearly defined, agreed and understood.
6. Established social information and communication channels; vulnerable people not isolated.
7. External agencies prepared to invest time and resources in building up comprehensive partnerships with local groups and organizations for social protection/security and DRR.
8. Community trust in effectiveness, equity and impartiality of relief and recovery agencies and actions.
9. Local leadership of development and delivery of contingency, response, recovery plans
10. National policy framework requires DRR to be incorporated into design and implementation of disaster response and recovery.
11. Focal point at national level with authority and resources to coordinate all related bodies involved in disaster management and DRR.
12. Politically supported/approved and clearly articulated national disaster preparedness plan in place and disseminated to all levels; part of integrated disaster management plans with all relevant policies, procedures, roles, responsibilities and funding established.
13. National DRR policy, strategy and implementation plan, with clear vision, priorities, targets and benchmarks.
14. Policy, planning and operational linkages between emergency management, DRR and development structures.
15. Devolved and effective community outreach services (DRR and related services, e.g. healthcare)
16. Devolution of responsibility (and resources) for DRR planning and implementation to local government levels and communities, as far as possible, backed up by provision of specialist expertise and resources to support local decision-making, planning and management of disasters.
17. Policy, planning and operational linkages between emergency management, DRR and development structures.

**Characteristic not fully present**

1. Trust within community and between community external agencies.
2. Community takes long term perspective, focusing on outcomes and impact of DRR.
3. Vision and DRR plans informed by understanding of underlying causes of vulnerability and other factors outside community’s control.
4. Response and recovery actions reach all affected members of community and prioritized according to needs.
5. No community disaster fund to implement DRR, response and recovery activities.

**Characteristic absent**

1. All contingency plans are based on a solid assessment of hazards and risks and the identification of high risk areas throughout the country. Developed and tested contingency plans are in place for all major disaster scenarios in all high risk areas.
2. Jurisdictions and responsibilities for DRR at all levels defined in legislation, regulations, bylaws, etc.
6. Community and other local agencies take lead role in coordinating response and recovery.
7. Response and recovery actions reach all affected members of community and prioritized according to needs.
8. No community disaster fund to implement DRR, response and recovery activities.
9. Community and other local agencies take lead role in coordinating response and recovery.
10. Micro-finance, cash aid, credit (soft loans), loan guarantees, etc., available after disasters to restart livelihoods. 6.7. Self-help and support groups for most vulnerable (e.g. elderly, disabled).
11. Emergency facilities (communications equipment, shelters, control centers, etc.) available and managed by community or its organizations on behalf of all community members.
12. Community trust in effectiveness, equity and impartiality of relief and recovery agencies and actions.

<table>
<thead>
<tr>
<th>Thematic area 2: knowledge, education and cultural beliefs</th>
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</thead>
<tbody>
<tr>
<td><strong>Characteristics of community resilience</strong></td>
</tr>
<tr>
<td>Characteristic present</td>
</tr>
<tr>
<td>1. General public aware of and informed about disaster risks and how to manage them.</td>
</tr>
<tr>
<td>2. Community knowledge of hazards, vulnerability, risks and risk reduction actions sufficient for effective action by community (alone and in collaboration with other stakeholders).</td>
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<tr>
<td>3. Open debate within community resulting in agreements about problems, solutions, priorities, etc.</td>
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<tr>
<td>4. Whole community has been exposed to/taken part in ongoing awareness campaigns, which are geared to community needs and capacities (e.g. literacy levels).</td>
</tr>
<tr>
<td>5. Community and other local agencies take lead role in coordinating response and recovery.</td>
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<tr>
<td>6. Content and methods of communicating information developed with communities (i.e. ‘communication’ not ‘information dissemination’).</td>
</tr>
<tr>
<td>7. Maximum deployment of indigenous, traditional, informal communications channels.</td>
</tr>
<tr>
<td>Characteristic not fully present</td>
</tr>
<tr>
<td>1. Possession of (or access to) the information, resources and support desired/needed to ensure safety.</td>
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</tbody>
</table>
2. Whole-community participation in development and delivery of contingency, response, recovery plans; community ‘ownership’ of plans and implementation structures.
3. Response and recovery actions reach all affected members of community and prioritized according to needs.
4. Incorporation of DRR into community and local recovery plans.
5. Information on risk, vulnerability, disaster management practices, etc., shared among those at risk.
6. All sections of community know about facilities/services/skills available pre-, during and post-emergency, and how to access these.

2. Official and public acceptance of precautionary principle: need to act on incomplete information or understanding to reduce potential disaster risks.
3. Appropriate, high-visibility awareness raising programs designed and implemented at national, regional, local levels by official agencies.
4. Public communication programs involve dialogue with stakeholders about disaster risks and related issues (not one way information dissemination).
5. Government (national and local) is committed to information sharing (transparency) and dialogue with communities relating to information about risk and DRM.
6. Official and public acceptance of precautionary principle: need to act on incomplete information or understanding to reduce potential risk

Characteristic absent

1. Collective knowledge and experience of management of previous events (hazards, crises).
2. Possession (by individuals and across community) of appropriate technical and organizational knowledge and skills for DRR and response actions at local level (including indigenous technical knowledge, coping strategies, livelihood strategies).
3. Existing knowledge collected, synthesized and shared systematically (through disaster management information systems).
4. DRR/DRM and other training addresses priorities identified by community and based on community assessment of risks, vulnerabilities and associated problems.
5. Community experience of coping in previous events/crises, or knowledge of how this was done, used in education and training.
6. Participatory M&E systems to assess resilience and progress in DRR.
7. Mechanisms for disaster-affected people to express their views, for learning and sharing lessons from events.

1. Levels of education provision, access, literacy, etc., facilitate effective information dissemination and awareness raising.
2. National and sub-national research capacity in hazards, risk and disaster studies (in specialist institutions or within other institutions), with adequate funding for ongoing research. Comprehensive agenda for scientific, technical, policy, planning and participatory research in DRR.
3. General public aware of and informed about disaster risks and how to manage them.
4. External agencies understand communities’ vulnerabilities, capacities, risks, risk perception and rationality of risk management decisions; and recognize viability of local knowledge and coping strategies.

Thematic area 3: risk management and vulnerability reduction

<table>
<thead>
<tr>
<th>Characteristics of community resilience</th>
<th>Characteristics of an enabling environment</th>
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<tbody>
<tr>
<td>Characteristic present</td>
<td>Characteristic absent</td>
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</table>

1. Concensus view of risks faced, risk management approach, specific actions to be taken and targets to be met.
2. Safer behavior as result of awareness raising.
3. Adoption of short-term protective measures against impending events (e.g. emergency protection of doors and windows from cyclone winds).

1. Diversification of national and subnational economies to reduce risk.
2. Government and private sector supported financial mitigation measures targeted at vulnerable and at-risk communities.
3. Official continuity and recovery plans in place or capable of being developed, supported by appropriate systems and capacities.
4. Engagement of government, private sector and civil society organizations in plans for mitigation and management of food and health crises.
### Characteristic not fully present

1. Cultural attitudes and values (e.g. expectations of help/self-sufficiency, religious/ideological views) enable communities to adapt to and recover from shocks and stresses.
2. Physical ability to labor and good health maintained in normal times through adequate food and nutrition, hygiene and health care.
3. Access to sufficient quantity and quality of water for domestic needs during crises.
4. Representative community organizations dedicated to DRR/DRM.
5. Informed, realistic attitudes towards risk and risk management.
6. Community understanding of characteristics and functioning of local natural environment and ecosystems (e.g. drainage, watersheds, slope and soil characteristics) and the potential risks associated with these natural features and human interventions that affect them.
7. Awareness of means of staying healthy (e.g. hygiene, sanitation, nutrition, water treatment) and of life-protecting/saving measures, and possession of appropriate skills.

### Characteristic absent

1. Safe locations: community members and facilities (homes, workplaces, public and social facilities) not exposed to hazards in high-risk areas within locality and/or relocated away from unsafe sites.
2. Infrastructure and public facilities to support emergency management needs (e.g. shelters, secure evacuation and emergency supply routes).
3. Resilient transport/service infrastructure and connections (roads, paths, bridges, water supplies, sanitation, power lines, communications, etc.).
4. High levels of personal security and freedom from physical and psychological threats.
5. Community-managed funds and other material resources for DRR and disaster recovery.
6. Community knowledge of how to obtain aid and other support for relief and recovery.

1. Official agencies willing and able to guarantee public safety after disasters and to protect highly vulnerable groups.
2. Formal social protection schemes and social safety nets accessible to vulnerable groups at normal times and in response to crisis.
3. Response and recovery actions reach all affected members of community and prioritized according to needs.
4. Poverty reduction strategies target vulnerable groups.
5. Resources (human, institutional, material, financial) available for long-term reconstruction and recovery.
6. All contingency plans are based on a solid assessment of hazards and risks and the identification of high risk areas throughout the country.
7. Support programs for livelihood-focused recovery (e.g. cash for work, replacement of productive assets, emergency loans or startup capital).
8. Coherent policy, institutional and operational approach to social protection and safety nets, ensuring linkages with other disaster risk management structures and approaches.
9. Community structures integrated into public health systems.
10. Security of access to public health and other emergency facilities (local and more distant) integrated into counter disaster planning.
11. Policy, legislative and institutional structure that supports sustainable ecosystems and environmental management, and maximizes environmental resource management practices that assist DRR.
12. Effective official action to prevent unsustainable land uses and resource management approaches that increase disaster risk.
13. DRR policies and strategies integrated with other adaptation policies and strategies.
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<tbody>
<tr>
<td>7.</td>
<td>Access to government and other funding and resources for DRR and recovery.</td>
</tr>
<tr>
<td>8.</td>
<td>Community capacities and skills to build, retrofit and maintain structures (technical and organizational).</td>
</tr>
<tr>
<td>9.</td>
<td>Resources available to support necessary actions identified by community-level plans.</td>
</tr>
<tr>
<td>10.</td>
<td>Access to community-managed common property resources that can support coping and livelihood strategies in normal times and during crises.</td>
</tr>
<tr>
<td>11.</td>
<td>Structural mitigation measures (embankments, flood diversion channels, water harvesting tanks, etc.) in place to protect against major hazard threats, built using local labor, skills, materials and appropriate technologies as far as possible.</td>
</tr>
<tr>
<td>12.</td>
<td>Adoption of sustainable environmental management practices that reduce hazard risk.</td>
</tr>
<tr>
<td>13.</td>
<td>High levels of personal security and freedom from physical and psychological threats.</td>
</tr>
<tr>
<td>14.</td>
<td>Food supplies and nutritional status secure (e.g. through reserve stocks of grain and other staple foods managed by communities, with equitable distribution system during food crises).</td>
</tr>
<tr>
<td>15.</td>
<td>High level of local economic activity and employment (including among vulnerable groups); stability in economic activity and employment levels.</td>
</tr>
<tr>
<td>16.</td>
<td>Fewer people engaged in unsafe livelihood activities (e.g. small-scale mining) or hazard-vulnerable activities (e.g. rain fed agriculture in drought prone locations).</td>
</tr>
<tr>
<td>17.</td>
<td>Small enterprises have business protection and continuity/ recovery plans.</td>
</tr>
</tbody>
</table>

6. Local government experts and extension workers available to work with communities on long-term environmental management and renewal. 

7. Developed and tested contingency plans are in place for all major disaster scenarios in all high risk areas. 

supported by access to emergency health services, medicines, etc.
5. Analysis

Based on Twiggs’s (2009) framework, it was concluded in the previous chapter that a ‘level 2’ of community resilience is found in Wellington and the surrounding environment. This means there is a general awareness of resilience issues and willingness to address them. However, the capacity to act (knowledge and skills, human, material and other resources) remains limited. In this chapter, an in-depth analysis relates the reasons behind this outcome to literature per thematic area. By doing so, a concluding answer to the main question: ‘how do wider institutional, policy and socioeconomic factors contribute to community resilience building?’ can be formulated in chapter 6.

5.1. From policy to practice: exploring the implementation gap

‘The field of DRR is a battlefield of knowledge and action, which often results in poor outcomes in terms of actual reduction of disaster risk for those most vulnerable’ (Long and Long, 1992 in Gaillard and Mercer, 2012: 94)

Based on the plans expressed in the policy documents, a quite enabling environment towards community resilience could be expected: the importance of DRR, SD and resilience has been emphasized in various regional, national and international documents, such as the Sendai Framework (2015). Despite this consensus, a sharp disconnection between the policies and the harsh reality on the ground is observed. Many aspects of community resilience, such as local resources and expertise, are lacking in Wellington. This leads to the conclusion that there is an implementation gap which hampers the development of community resilience. A disengagement between policies and practical action is thought to further increase vulnerability (Turnbull, Sterrett and Hilleboe, 2013; Heijmans et al., 2013). The overarching finding that policies do not translate well on the ground, is reflected in all thematic areas and is therefore highlighted here. The disabling factors that hamper the development of community resilience and contribute to this implementation gap, are now discussed.

5.2. Thematic area: governance

The assessment of the three policies and the wider institutional environment, leads to the following observations. 27 characteristics of community resilience, related to thematic area 1, are identified. 25, 9 % as present, 44, 4 % as absent. 24 characteristics of an enabling environment, related to the area of knowledge, education and cultural beliefs, are met. 54, 1 % as present, and 8, 3 % as absent.

5.2.1. The international response

The international response to the outbreak was heavily criticized for being slow and inadequate. The international response revealed underlying problems of capacity, leadership, technical equipment and finances. Extensive reform of the WHO, the leader of the GHC, was demanded following the crisis (DG ECHO, 2016).
An international crisis like Ebola is headed under the ‘International Health Regulations’, which bind countries to manage disease outbreaks. However, many countries are too poor or just not willing to meet these requirements (Wilkinson and Leach, 2014). The (aid) organizations responding set their own priorities and work on a project to project basis, focusing on short-term successes and ‘sexy’ targets. Additionally, in the absence of strategic interest or mass empathy as was the case with Ebola, political commitment and hence donor funding will not materialize (DuBois et al., 2015). As a result, political and financial dynamics create a tendency towards cure, rather than prevention. The nature of this work does not encourage longer term commitments and the building of resilience. ALNAP concluded that ‘one of the main problems in the humanitarian sector is that there are no consequences for operational agencies when they fail to meet the expectations of other actors and hence, no ‘real’ accountability between aid agencies and many of their stakeholders’ (ALNAP, 2015 in DuBois et al., 2015: 36). Efforts to improve accountability produce enormous investment in policy but little improvement in practice (DuBois et al., 2015). As Ebola showed, this constitutes a severe impediment to the timely prevention of crises and the building of resilience.

While the benefits of DRR and resilience are constantly outlined in policies, for example by emphasizing that it is less costly than disaster response, many policy-makers still hesitate to actually invest in actions which will provide little political outcomes (it is hard to measure what has been prevented after all) (Gaillard and Mercer, 2012).

Ebola should be a wake-up call for international donors to ensure that they are giving countries longer-term support to build comprehensive (health) systems (Save the Children, 2015). The Good Humanitarian Donorship (GHD) initiative, calls for donors to ensure predictable, flexible and timely funding. Greater flexibility into contracts should also be considered. For example, it takes about 8 months for the WHO to deploy its personnel (DG ECHO, 2016). DuBois et al. (2015) conclude that there is no need for a policy reform on the donor side, ‘merely’ the implementation of existing commitments.

5.2.2. The national and local response

At first, the national response was ineffective in Wellington. This turned around with Operation WAS, and the involvement of local leaders. Local sensitization efforts made the community believe that ‘Ebola is real’. Because of sensitization via among others town criers and house to house visits, the community began to understand the risks they were facing and the measures to avoid transmission. The bye-laws installed seem to have contributed to this behavioral change. This is contrary to the observation of Youde (2014), who says the punitive rules that were implemented ‘criminalize’ Ebola: ‘these punitive measures can encourage families to hide and avoid the health care system’ (p. 2).

In the policies, a multitude of plans that aim to reduce risks (such as diversification of the economy) is written down. Promises made in these programs have not been lived after in Wellington
One explanation for the implementation gap is the slow pace of the decentralization process (Agenda for Prosperity, 2013). National ministries have held control of service delivery and unclear lines of management impede local councils in performing functions that have already been devolved to them. In addition, the Ward Committees, the lowest unit of the decentralized structure, do not function as properly as they should (Ibid). Financial resources are a big part of the issue here: while Sierra Leone heavily depends upon donors for funding, local councils in turn depend on the central government for the financing of programs. This is a risk to local resilience building as it holds back the possibility to seriously participate in the development of local development plans in Wellington. Another problem is that, even if resources would be available, there is little knowledge on how to write proposals and how to obtain support for relief and recovery programs.

5.2.3. Resilient health systems

The delayed response has to be understood in the context of long-standing challenges in Sierra Leone’s health system.

It is remarkable pre-Ebola investment in the resilience of Sierra Leone included reportedly ‘successful’ measures towards the prevention and containment of infectious diseases (DuBois et al., 2015). None of these measures were actually applied in Wellington before the outbreak. There is consensus that disease surveillance systems on the level of the community were weak to non-existent and that one of the reasons for the severity of the outbreak is Sierra Leone’s poor health system (Ibid). This is illustrated in Wellington, a community where healthcare is so expensive that people can barely afford it. Ebola put the health system under even more pressure, which caused an increasing amount of community members to suffer from diseases such as malaria.

The country did develop a policy on Community Health Workers, emphasizing their vital role as community liaisons, prior to the outbreak (Marais et al., 2015). A study by Calain (2006) underlines the need to build capacity and ‘empower front-line health workers and communities for an effective surveillance system’ (p. 14). He argues that an emphasis on local empowerment is likely to be more effective than expensive top-down interventions. This is in line with the finding that during operation WAS, local medical teams were deployed to conduct house to house visits in Wellington. As a result, suspected cases were quarantined and the caseload dropped.

Effectively addressing an epidemic in the future would require a ‘resilient health system’. This would at least include an increase in the number of local health workers and improving health care infrastructure, including better surveillance and reporting systems. This devastating crisis creates the opportunity to ‘Build Back Better’, which could pave the way for more sustainable health development.

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5.3. Thematic area: risk management and vulnerability reduction

‘Humanitarianism is an action of solidarity alone if it has a long-term perspective’ (Mattei, 2005 in Audet, 2014: 2)

This thematic area is mainly concerned with the longer term component to resilience: sustainable development. In the previous chapter, we have concluded that 27 characteristics of community resilience, related to risk management and vulnerability reduction, are identified. 11, 1% of them are present, 62, 9% are absent. 24 characteristics of an enabling environment are met. 16, 6% are present, while 29, 1% of the identified characteristics are absent. This indicates that Wellington and its environment are facing many developmental challenges.

5.3.1. A holistic approach towards vulnerabilities

In this study, we take the view that disasters are not naturally catastrophic. Rather, they are seen to be the result of a complex interplay of cause and effect (Gaillard and Mercer, 2012). In fact, disasters often reflect social injustice, poor governance and poor development contexts (UNISDR, 2011). Sierra Leone’s socioeconomic weaknesses, combined with a weak disaster management system, make the country highly vulnerable to external shocks. Even the smallest hazard could lead to disastrous outcomes in such an environment. In line with Gaillard and Mercer (2012), addressing all these factors in a holistic approach is needed to reduce risks. Unfortunately, underlying sociopolitical causes of vulnerability are usually not addressed in policies.

The policy documents show that certain hazards impose a threat to the implementation of their programs. But, more often, external risks, such as landslides and flooding, or even another epidemic, are not addressed. A precise view on how to mitigate the mentioned risks is usually missing too. On top of that, risk reduction plans are believed to be based on quite unreliable data and needs analysis (Ibid). In contrast to what the policies promise on paper, the environment is disabling: there is no business protection, there is no access to community managed funds for recovery and all public facilities are absent or functioning poorly.

Furthermore, it is striking that there is consensus among the respondents on what a resilient community looks like while these views do not align with literature on what resilience actually is. A long term view and an understanding of underlying causes of the outbreak is largely missing. A majority of the people live in a necessarily ‘short-term’ world because they don’t have the type of financial security that would give them a ‘long-term’ horizon, which is a prerequisite for resilience (Pragcap.com, 2015). As a result, people take a short-term perspective and they engage in unsafe livelihood activities. It is not surprising that little sustainable development practices were discovered at the local level. Resilience policies are more likely to be successful if the linkages between disasters and developmental needs are recognized: a high level of development prevents disasters from happening and long-term stability is needed for relief and recovery efforts to make a difference. The
absence of sustainable development in Wellington complicates effective risk management. A more holistic approach by local, national and international agents towards hazards and vulnerabilities is thus necessary.

5.3.2. A focus on cure, not prevention

As a consequence of the fact that underlying causes of vulnerability are usually not addressed in policies, DRR and resilience policies and actions are often focused on response and preparedness (Gaillard and Mercer, 2012). This trend is seen in Sierra Leone too, and is particularly reflected in the allocation of financial resources: Sierra Leone relies on emergency funding to deal with the crisis. However, the resources are insufficient to address all dimensions of vulnerability and to recover in a sustainable way. According to the calculation in the Recovery Strategy (2015), a financial gap of 1,3 billion USD (!) still needs to be filled, in order to be recovered by 2017 (the total costs of the Ebola response and recovery are estimated 1,7 billion USD) (p. 53). If Sierra Leone wants to ‘build back better’, more resources are urgently needed. In chapter 2, it was pointed out that effective resilience building requires work in all phases of the disaster management cycle (figure 3).

In line with Elms’ (2015) model and the expected observation from chapter 2, the crisis led to an impairment of resilience which poses the community under even more risks than before (e.g. food insecurity, unemployment). On a positive note, the Ebola crisis did lead to safer behavior that might have an effect on the longer term, such as regular hand washing.

5.3.3. Social capital and trust

‘Social capital’ and trust allow people to work together, therefore they are considered a means to enhance community resilience (Drolet et al., 2015). One expectation was that not much social capital and trust would be present in Wellington. Indeed, DuBois et al. (2015) describes the outbreak of Ebola as ‘an epidemic of mistrust’ (p. 31). However, on the community level this expectation did not hold. Strong ties within the community were discovered. All respondents know the councilors by name, trusted him with and there is space for the respondents to engage in dialogue. Many community based organizations exist in Wellington, there is a high level of volunteerism and the Ebola crisis proved that Wellington has got the capacity to mobilize people and disseminate information quickly.

According to sociologist Antony Giddens (Ritzer, 2010: 553), trust becomes necessary when we no longer have full information about social phenomena, as a result of increasing distanciation in terms of either time or place. This distanciation is a characterizing aspect of the modern world, in which bottom-up and top-down practices are dissociated. Following this line of thought, Gaillard and Mercer (2012) name a lack of trust between stakeholders which interact at different scale, as a challenge that complicates the integration of local and scientific knowledge and bottom-up and top-

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111 In this study social capital refers to: relations of mutual support between and within community groups and between bottom-up and top-down actors.
down actions into DRR. According to Asadi et al. (2008), excessive inequality in a society, which is the case for Sierra Leone, undermines the feeling of trust people have in the present institutions. Another expectation was that a low level of trust would be found between the Wellington community and the present institutions. In line with the theory, little trust between the community and national institutions was found in Wellington. During and after the civil war, communities have had to rely on traditional structures and local solutions rather than state institutions. The limited resources available are compounded by corruption. This lack of trust contributed to the spread of rumors around Ebola, such as the belief that the government was injecting people with Ebola to increase the number of cases to obtain more funding (Acaps, 2015). Distrust and fear influenced the willingness of the Wellingtonians to adhere to the initial Ebola advice disseminated by the government as well (Uslaner and Brown 2005; ACAPS, 2015).

Several scholars found that a higher level of trust between bottom-up and top-down actors enhances social capital and eventually community resilience (Kay, 2006; Asadi et al., 2008). The effectiveness of the local response, in combination with a young population indicates that there is an enormous potential for social capital in Wellington. If national agents guide the community members in the right directions and provide them with the right tools and resources, the potential capital can be used to build resilience. To increase social capital, a dialogue to exchange knowledge and ideas across different scales should be fostered.

5.3.4. Ownership by the community

Because of Sierra Leone’s overall state of development, a low level of ownership was expected. Some respondents expressed feelings of powerlessness indeed. For instance, when a respondent’s grandmother passed away and was picked up by a male health worker, instead of a female which is the tradition. Access to information is a valuable means for increasing local power and community resilience. Throughout the Ebola response, local ownership slowly increased as more responsibilities were devolved to local authorities (UNICEF, 2014).

5.3.5. Stigma and vulnerable groups

Disasters strike hardest at the poorest communities, and within them, individuals and groups who suffer marginalization and discrimination are most vulnerable to their negative effects. Women have been estimated to be seven times more likely than met to die in disaster, and to receive less aid (Bradshaw and Fordham 2013). In Sierra Leone, 52.3% of all reported cases were female (IASC, 2015 & Drolet et al., 2015).

In the aftermath of the crisis, widows and widowers, survivors, orphanages and the elderly are identified as the most vulnerable by the councilors. Building the resilience of vulnerable groups requires strong community and government institutions that can support efforts to cope with devastating events, offering social protection and social development initiatives to support at-risk or
There is evidence showing that community-based stigma reduction initiatives have been very effective in the past. In Wellington, a clear need for support to the stigmatized and vulnerable was expressed. Using strategies like counselling, training on coping skills and promoting public contact with persons who have had Ebola could help. In the long run, education, prevention and vaccination are the optimal solutions for reducing the stigma associated with Ebola. The CDC recommends to train councilors on the importance of survivor acceptance in the recovery process (cdc.gov, 2016).

5.4. Thematic area: knowledge, education and cultural beliefs

20 characteristics of community resilience, related to knowledge, education and cultural beliefs 2, are identified. 7 of them as present, 7 as absent. 16 characteristics of an enabling environment, related to the area of knowledge, education and cultural beliefs, are met. 2 are identified as present. 14 characteristics are neither fully present nor fully absent because the response changed over time. Throughout the response, the ‘enabling environment’ changed their top-down approach to a more inclusive approach.

5.4.1. The value of local knowledge

‘Local’ knowledge has long been dismissed as inferior to ‘expert’ or ‘scientific’ knowledge (Gaillard and Mercer, 2012). The study showed the enormous amount of valuable information the councilors possess. And, maybe even more important, the level of confidence the community members have in their local leaders. Community based organizations and the councils worked together and acted as a watchdog to avoid transmission. Operation WAS proved that a community led process was very effective. The idea that the encouragement of community participation increases resilience, and that resilience measures should be based on context specific knowledge, is backed up by evidence from Hitchen (2015). Hitchen (2015) found that community engagement was key in the Ebola response in Pujehun, the first Ebola-free district in Sierra Leone. This achievement is attributed to a proactive district-led strategy, rather than decisive central government intervention (Hitchen, 2015). Previous studies have also shown that involving communities in understanding risks and designing appropriate response plans can transform vulnerable groups into disaster-resilient communities.

Communities usually take a holistic approach towards vulnerabilities (Lavell et al, 2012). They are aware of the parameters that determine the success of local risk reduction policies and actions. Furthermore, communities have perceptions that may or may not be based on reality, but are still important to consider (Ibid). For example, the chief who thinks that Ebola is caused because people do not go to church enough is probably wrong, yet because of her influential position the idea should still be considered.

While the value of local knowledge and participation is acknowledged, it is important not to over-romanticize local knowledge. The limited expertise within the Wellington community is an issue.
The belief that traditional healers can make Ebola go away increases risks, instead of reducing them, for instance. Reducing vulnerabilities requires people to understand how they can best protect themselves, their property and their livelihoods. Only then, people can make informed decisions and take action to ensure their resilience to disasters (UNISDR.org, 2016). Local knowledge should be assessed carefully to ensure its applicability and effectiveness in addressing disaster risk (Gaillard and Mercer 2012). It is the combination of different types of local (‘inside’) and global scientific (‘outside’) knowledge that is beneficial for resilience building (Ibid). The adoption of sustainable practices that reduce disaster risks is hampered in Wellington partly because of the lack of expertise on resilience, SD and DRR. Education and training on vulnerabilities, DRR or resilience, which are characteristics of resilience, are still very far away in Wellington. More sensitization and education is needed.

5.4.2. Communication and culturally appropriate messaging

Berger and Tang (2015) say that the outbreak of Ebola was ‘a crisis of information in the right language as much as anything else’ (p.33). In the beginning, medical teams, looking like Martians in their Personal Protective Equipment (PPE), came to the communities to prescribe them what to do. They took with them the suspected community members, some of them never to be seen again. In an atmosphere of distrust and fear, one can imagine that these practices became a vector for transmission as people started hiding and caused resistance. Early messages designed to change behavior worked counterproductive because they failed to take into account deep rooted cultural practices and beliefs (Wilkinson and Leach, 2014). Claudia Evers, MSF’s Emergency Coordinator said: ‘we made a big mistake. (…) Instead of asking for more beds we should have been asking for more sensitization activities’ (in Hussain, 2015). More sensitive messaging and knowledge of local practices such as burials could potentially have saved people, thereby diminishing the impairment of resilience (DuBois et al., 2015). The lack of ‘culturally appropriate messaging’ missed the opportunity to encourage communities to adopt effective anti-transmission behaviors in the early stage of the response (Ibid). The councilors played an immensely important role in the dissemination of this information.

Denney and Mallet (2015) found that Sierra Leone’s health system is characterized by weak communication between the local, district and the national level. This confirms the idea that ultimately, to increase local resilience, a strengthening of communication and cooperation between the ‘enabling environment’ (top-down stakeholders such as government agencies, scientists, NGO’s) and the local community (bottom-up stakeholders such as civil society organizations, community based organizations and local leaders) is needed (GNDR, 2011). Next to involving local communities, Muller (2014) suggests to involve an even more diverse range of actors into disaster management response. For example, anthropological engagement could lead to recommendations that foster culturally acceptable messages and measures (Muller 2014 in DuBois et al., 2015). Antony Banburry
(2016), formed head of the UN Ebola response mission revealed the following institutional problem in the New York Times: ‘too often, the only way to speed things up is to break the rules. That’s what I did (...) when I hired an anthropologist as an independent contractor. She turned out to be worth her weight in gold. Unsafe burial practices were responsible for about half of new Ebola cases in some areas. We had to understand these traditions before we could persuade people to change them. As far as I know, no United Nations mission had ever had an anthropologist on staff before; shortly after I left the mission, she was let go’ (New York Times, 18th of April).

5.4.3. The integration of local knowledge into DRR / Resilience policies

According to Gaillard and Mercer (2012), top-down policies have largely failed to prevent the occurrence of disasters. A top-down approach, still in practice in many countries, fails to involve people in development planning, vulnerability identification and disaster reduction (Ibid). The analyzed policies seem to have been developed far away from the reality of the community concerned. In Wellington, we found that ‘resilience’ is not a meaningful concept, for example.

Actively involving local communities in the design and implementation of projects helps them to better organize themselves for local and social development. Therefore, scholars suggest that bottom-up approaches should be integrated into national policies in a better way. Despite widespread recognition on this idea, no shift has taken place in the way international response mechanisms work. The question now, is how to bring together top-down and bottom-up approaches?

Inspired by Gaillard & Mercer’s (2012), the model below is proposed. This ‘road map’ for integrating knowledge and stakeholders for improved resilience policies reconciles different forms of knowledge from different stakeholders, at different scales. This may create a more enabling environment and this can ultimately leads to an increased level of community resilience.

**Figure 11:** Road map for integrating knowledge, actions and stakeholders for resilience building (inspired by Gaillard & Mercer, 2012)
For the road map to be transformed into policy and action, a dialogue between the actors operating at different scales is needed. Without communication and coordination between those most at risk and associated stakeholders, any DRR effort is doomed to fail (Weichselgartner and Obersteiner, 2002; Bendimerad, n.d.). An honest commitment from governments, community leaders and other stakeholders to engage in dialogue is required. Furthermore, the development of common tools that integrate bottom-up and top-down initiatives for resilience and DRR should be considered (Gaillard and Mercer, 2012). For example, ‘participatory road mapping’ is a tool whereby all actors draw a hazard map in which they identify hazard-prone areas. This enables all stakeholders, even the most marginalized, to collaborate for resilience building.

The integration of local knowledge into policies requires support for these kind of initiatives from national and international institutions, because the institutionalization of good practices in reducing risks at the community level is the only way to achieve large scale results (Wisner et al, 2012). National and international policies should strengthen community-led response structures. For example by working together with the traditional leaders, who have the potential to diminish the impact of an epidemic. Or by funding local action plans within existing community structures, such as the Development committees. Utilizing such tools gives ‘voice’ to and empowers communities. It ensures ‘local knowledge’ becomes tangible. Resilience measures developed by all stakeholders are obviously more credible and sustainable than measures produced top-down. Without appreciating local knowledge, we are in danger of engaging in resilience strategies that contribute to increased vulnerabilities rather than reducing them (Ibid; Gaillard and Mercer, 2012).
6. Conclusion and recommendations

In this concluding section, the main question is answered and recommendations to strengthen community resilience are given. The chapter concludes by pointing out the limitations to this study.

6.1. Conclusion

‘The government needs to prevent this from happening again, because so many souls have gone’ (respondent).

The main question to this study is: ‘how do wider institutional, policy and socioeconomic factors contribute to community resilience building?’

The study focused on Wellington in the aftermath of the Ebola outbreak. In the midst of a crisis, Wellington managed to stay Ebola free from February 2015 on. Therefore, the case study offers a valuable lens through which DRR and resilience can be examined. Since community based views on resilience are rarely analyzed, this study attempts to contribute to existing knowledge gaps. Useful insights into the interaction between different levels of intervention, the influence of policies on local resilience outcomes and the potential for sustainable development have been found.

Communities do not exist in isolation, they are influenced by institutional, socio-economic and political linkages with the world (Twigg, 2009). Many circumstances that shape life in disadvantaged communities like Wellington, such as inequality and poverty, are neither generated nor reproduced at the local level (Chaskin, 2008). The way the ‘enabling/disabling environment’ influences community resilience is therefore investigated.

The level of community resilience and the extent to which the ‘enabling environment’ is supportive of community resilience, was assessed in chapter 3, by using Twiggs’s (2009) framework and a combination of methods. We have concluded that in Wellington, a general awareness of resilience issues and willingness to address them is found in the aftermath of the Ebola crisis. However, the capacity to act (knowledge and skills, human, material and other resources) remains limited. Now, how exactly is this outcome related to the wider institutional, policy and socioeconomic environment? When looking at socioeconomic factors, it became clear that the Wellington community (and Sierra Leone in general) suffers from poverty in all its dimensions, this includes a lack of social protection and economic security. With a dysfunctioning health system and 136 doctors to cover 6 million people, Sierra Leone was not in the least prepared to deal with an epidemic. Living in poverty as part of a marginalized community creates few opportunities to build up the resources needed to respond to a disaster effectively, let alone prevent them (Drolet et al., 2015).

One observation is that a holistic approach towards hazards and vulnerabilities is lacking in the analyzed policies. Underlying causes of risks and the way to deal with these risks are often left unaddressed. The political environment creates a tendency towards a sole focus on recovery and
response. However, community resilience can only be build when the whole DRR cycle is given priority by policy makers. For example, a resilient Wellington can never be achieved without addressing pre-Ebola challenges, such as WASH and unemployment. This requires longer-term commitments and funding by donors. If Sierra Leone’s socioeconomic environment remains as unsustainable as it was before the outbreak, the occurrence of a new disaster is only a question of time.

The recovery phase provides the opportunity to ‘build back better’ and achieve a higher level of resilience (Elms, 2015). However, this demands for the recovery strategy to be implemented according to plan. To realize this, much funding is needed. Another recovery issue is the stigma that Ebola caused among survivors and health workers. Social protection and community based stigma reduction initiatives should support these groups of people.

We have seen that the wider institutional and political factors largely contribute to community resilience as well. From the national and international documents, we observed that there is a political will to collaborate on all scales and work towards resilience. Based on the idea that policies trickle down to local societies, a quite ‘enabling environment’ was expected. However, the level of community resilience found in Wellington was ‘2’ on a scale of 1 to 5 (with ‘5’ representing ‘a culture of safety’). Hence, a sharp disconnection between the policies and the harsh reality on the ground was observed. This leads to the conclusion that there is an implementation gap which hampers the development of community resilience.

Initially, the international Ebola response was carried out in a slow and ineffective way. The institutions and organizations involved were challenged, among others, by the gap between top-down technical solutions and the socio-cultural context (DuBois et al., 2015). A range of constraints to local resilience building have been observed. The Wellington community was very active at the front line and successfully fought the disease through social mobilization. This demonstrates the ability to rapidly build social capital and act as an agent of change. It can be assumed that, if provided with the right tools and resources, there would be even more potential to build social capital and develop in the direction of resilience in Wellington. One constraint to resilience building is Wellington’s dependency on national and international donors when it comes to funding. By empowering communities through top-down structures, they are able to adapt, resist, absorb, accommodate and recover from the effects of a hazard in an efficient manner. This advocates for more local ownership and financial responsibility. Within the community, there are also limitations that threaten the development resilience. For instance, little knowledge on how to obtain support and write a project proposal is available in the community. Education and training can be of help here.

The study shows that policies should be embedded in local culture and the socioeconomic environment to be implemented effectively. This requires that institutional frameworks developed at the national level need to be flexible enough to adapt to specific contexts when decentralized to the
local level. To achieve this, the value of local knowledge in disaster response should be acknowledged. (Scientific) knowledge produced top-down, and local knowledge need to converge to provide sustainable solutions to disaster risks. By involving different stakeholders, such as anthropologists and local leaders, policies become better adapted to the local context. In the case of Ebola, such a culturally appropriate messaging could have saved lives. On top of that, many studies have shown that involving local communities in the process of resilience building, is cost-effective and more sustainable. Local mechanisms for social communication, organization and awareness raising should be encouraged and maintained in the recovery phase and beyond (Recovery Strategy, 2015). Attempts to integrate global top-down and local bottom-up strategies for resilience have so far been sparse (Gaillard, 2010). More research is needed to understand the factors for success and develop effective mechanisms for engaging communities.

Another observation is that, in contrast to the strong local ties found in Wellington, the community members have little trust in government officials and institutions. This caused much difficulty in the response at first. The creation of trust is imperative to address the gap between the scales. Trust is the foundation for fruitful cooperation and improved communication. In enhancing dialogue, trust is restored. An honest commitment to engage in dialogue from all stakeholders is the starting point to achieve this. Eventually, this may lead to DRR and resilience policies that have an actual impact on the ground.

The study reminds us that communities do not exist in isolation and that wider institutional, policy and socioeconomic factors influences community resilience in many ways. The Ebola crisis emerged from long term institutional, political, economic and social underdevelopment. It became clear that community resilience is built from the very foundation of SD and DRR. Communities need to be supported and empowered by top-down actors and policies. It is time that policy commitments are turned into action and measurable results. Collaboration between government, civil society and external agents provides many explored and unexplored opportunities to create resilience policies and processes (Wilkinson and Leach, 2014). If a transition from a predominantly disabling environment to an enabling environment does not take place, the occurrence of a new disaster is only a question of time.

6.2. Lessons learned

Based on the findings in this study, valuable and concrete lessons have been learned. The following recommendations, pointed at international and nation policy makers and political leaders, are made:

> **Acknowledge the link between disasters and development & take a holistic approach towards vulnerabilities:** building resilience requires a multi-sectorial approach in which the underlying causes of vulnerabilities are addressed. This study shows that progress with community resilience is more effective when the link between disasters and development is
acknowledged. In Sierra Leone, response and recovery should not focus solely on ‘fighting Ebola to zero’. Given the country’s overall fragility broader issues, such as an accessible health system, WASH and education, need to be addressed.

- **Prioritize prevention over cure**: addressing underlying vulnerabilities, rather than their symptoms, saves lives and money. This implies that the whole DRR cycle has to be addressed. Ebola should be a wake-up call for international donors to ensure that they are giving countries and their communities longer-term support to build resilient (health) systems (Save the Children, 2015). Funding structures need to be available for local communities.

- **Appreciate and incorporate local knowledge and empower local communities**: local knowledge should be incorporated in national and international DRR/resilience policies. Community involvement and local knowledge may facilitate the process of resilience building in cost-effective, participatory and sustainable ways (Howell, 2003: Asadi et al., 2008).

- **A systematic focus on community engagement, informed by anthropologists and community leaders**: local leaders have shown their potential to mobilize people and transform information into action. An obstacle to integrating scales might be culture and language, therefore it is recommendable to involve anthropologists. The expertise of an anthropologists might improve culturally appropriate messaging, in the case of Ebola this could have saved lives.

- **Exploit social capital**: the case of Wellington shows that much potential for collective action and social capital exists locally. If guided in the right directions and provided with the right tools and resources by national agents, this untapped resource can be exploited for recovery and rapid return to the sustainable development pathway.

- **Improve cooperation and communication between scales**: Delivering the right message reinforces the need to bring into the response community opinion leaders. Conscious efforts should be made to create opportunities for dialogue, reflection, participation and collaboration with communities through simple and participatory approaches [NERC, 2015].

- **Rebuild trust**: it is imperative that trust between the local communities and government officials is rebuild to close the implementation gap.

- **Improve governance**: stakeholders should go beyond rhetoric and commit to actual results. Political leaders should transform SD, DRR and Resilience related commitments to relevant targets and measurable indicators (Save the Children, 2015). This can be achieved through greater transparency and accountability on the side of all stakeholders (Twigg, 2009). More research is needed on how to achieve this.

- **More research** in the area of community resilience is needed. Research that identifies the barriers between different scales in the area of resilience is useful. More research is needed to understand the factors for success and develop effective mechanisms for engaging
communities. When it comes to Ebola, much can be learned from survivors. Comparative research with local leaders in different communities can also be instructive. It could be insightful to repeat this study to see if the recovery strategy is making more impact on the Wellington community and to compare the different phases of recovery.

6.3. Constraints

Like every study, this research has got its limitations. The following bottlenecks were identified:

- **One danger with the concept of resilience**, is that it becomes a ‘catch all concept’ (Otto, 2013). The author was aware of this risk and tried to be as clear as possible. At the same time, resilience offers a more holistic approach to vulnerabilities and as such plays an important role in bridging the gap between different scales and disciplines.

- **A higher number of respondents** would have been ideal. Due to the combination of time constraints and the complex environment, only 10 interviews have been conducted. Even though many similarities and repetitions have been observed, full saturation has not been reached. The interviews with people who hold different positions give an impression of the diversity present in the community. This research does not claim to represent the whole, diverse, community of Wellington. The author realizes that the study would have benefitted from a larger amount of respondents.

- **Experience of the author**: although the author conducted semi-structures interviews before, the author had never done this in a complex, recovery context like Wellington. It was challenging to find respondents and to figure out the structures that characterize Sierra Leonean societies. The language barrier (most people speak Krio) contributed to this as well.

- **Subjectivity**: councilors are political figures who have interests and want to be re-elected. The author was aware of this from the start of the research. By cross checking if certain claims were reliable and by reading much literature, this constraint was limited as much as possible. Naturally, the author is not fully objective but influenced by experiences during the data collection and analysis. The author was aware of this possible bias and acted as objective and open minded as possible.

- In retrospect, the structure of this study is quite complex. Careful reading is necessary to fully understand how Twiggs’ framework has been used. The presence of resilience is not something one can calculate, it is a soft, qualitative matter. The author did her very best to be as clear and transparent as possible about the research process.
Literature


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Annex 1: terminology

Based on UNISDR (2009):

- **Risk** is ‘an uncertain consequence of an event or activity with regard to something humans value’.

- A **disaster** can be defined as ‘a serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses and impacts, which exceed the ability of the affected community or society to cope using its own resources’ (UNISDR, 2009: 9).

- **Disaster risk** is defined as: ‘the potential disaster losses, in lives, health status, livelihoods, assets and services, which could occur to a particular community or a society over some specified future time period’ (UNISDR 2009: 9, 10)

- **Hazard**: a dangerous phenomenon, substance, human activity or condition that may cause loss of life, injury or other health impacts, property damage, loss of livelihood and services, social and economic disruption, or environmental damage.

- **Vulnerability**: ‘the characteristics and circumstances of a community, system or asset that make it susceptible to the damaging effects of a hazard’. In addition it should be mentioned that there are many aspects of vulnerability arising from various physical, social, economic and environmental factors. Examples may include poor design and construction of buildings, inadequate protection of assets, lack of public information and awareness, limited official recognition of risks and preparedness measures, and disregard for wise environmental management.
Annex 2: interview guide

Based on Twigg’s framework of community resilience and on Heijmans’ et al. (2013) handbook for resilience, the following interview guide was prepared to assess the level of resilience.

Context

- How many people live in Wellington approximately?
- What would you say are the main challenges/problems this community is facing?
- People infected with EVD?
- What was the impact of Ebola on the community?
- Did the community experience other hazards/disasters in the past? Diseases / floods / storms / lack of food etc? Was knowledge on this useful in dealing with Ebola?
- What do most people do to make a living?
- How was your community affected by Ebola? What are the main problems the community is facing (is this a consequence of Ebola)? (employment, food, clean water)
- Do you have access to a doctor or traditional healer (does the whole community)? Did you have that before Ebola / during / after?

Framing and explaining EBV

- What is the cause of Ebola?
- Why was Ebola able to spread in Sierra Leone? What are the root causes, underlying reasons for the outbreak?
- Does everybody know what Ebola is? Aware of the risks? How this information spread? Did behavior change thanks to this knowledge?
- How did the community cope with Ebola? What measures were taken to fight Ebola community? Was everybody involved in this?
- Are people trained in dealing with Ebola? Is there a collective system to deal with the losses?
- Did behavior change thanks to this knowledge?
- What are the priorities at this stage of the response? And, on the longer term? - What activities are needed to recover? Is there anything that could undermine these efforts?

Cooperation

- Who is responsible for fighting Ebola? What is / should be the role of the IC / government / chief / community?
- Did the community receive external help to cope with Ebola (is this necessary)? From who? And NGO’s? (cooperation with other stakeholders)
- Do you think there is a common view about the ways to fight Ebola? (among community and internationally / nationally). What are the differences / similarities?
- Is the Wellington community part of an aid program? What kind?
- Is there an overview of your cooperation with others?

Link DRR – PR

- Does the Ebola response have an impact on the long term? What is needed for a sustainable / long term improvement?
- What can be done to prevent disasters like Ebola from happening in the future? (access to power, structures, resources)
- Any prevention measures? Adaptation?
- Do you think the community is prone to other disaster risks as well? Now more than before Ebola?
- Do you think Ebola is linked to a lack of resources/poverty? How?
  Yes: What is needed to reduce poverty?
  * Are disaster risks and poverty linked?
- What is needed to reduce disaster risks?
- When, do you think, the situation is safe again?
- Do you think your community is better protected against Ebola and other disasters now than before? Does the Ebola response have an impact on the long term? What is needed for a sustainable/long term improvement?
- Is the concept of Disaster Risk Reduction ever mentioned in this context? What does that involve to you?
- Is resilience ever mentioned in this context? What does a resilient community mean to you?
- Is the concept of Disaster Risk Reduction ever mentioned in this context? What does that involve to you?

Resilience and SD

- Costs of crisis shared in community? (group savings?)
- Activities needed for recovery? ‘volunteers’ to do this?
- Access to community health care facilities? f.e. traditional healer/doctor? (meaning of health/staying healthy)
- Level of employment
- Equal distribution of health?
- Enough food? normally and now? sufficient water “and”?
- (use of indigenous knowledge)
- Knowledge of Ebola. Informed, informed about DRR.
- Experience in coping with previous disasters? Cholera outbreak maybe?
- Awareness raising? everybody involved. Did this lead to safer behavior?
- Any form of community hazards/risk assessment? by whom?
- Training or education in the areas of DRR/PR/Resilience
- Did community participate in response? is there a will to do so? are there funding possibilities for this?
- How was knowledge/information disseminated?
- What is needed for sustainable development? top priorities?
- Do you feel these measures can be taken by the community? external help needed?
- What has been the direct impact of the EVD epidemic on structures and systems?
- What are the critical recovery priorities for the short term (12 months) and for the medium-to-long term (three to five years)?
- What are existing Ebola-related capacities and resources on which recovery should be based?
- What immediate and medium-term risks could undermine recovery efforts and outcomes if no mitigating measures are put in place?
- Long term perspective?
- Underlying vulnerabilities?
Annex 3: components of resilience
Source: Twigg (2009) p. 28 - 44

**THEMATIC AREA 1: GOVERNANCE**

Components of resilience:
1. DRR policy, planning, priorities, and political commitment
2. Legal and regulatory systems
3. Integration with development policies and planning
4. Integration with emergency response and recovery
5. Institutional mechanisms, capacities and structures; allocation of responsibilities
6. Partnerships
7. Accountability and community participation

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<tr>
<th>COMPONENTS OF RESILIENCE</th>
<th>CHARACTERISTICS OF A DISASTER-RESILIENT COMMUNITY</th>
<th>CHARACTERISTICS OF AN ENABLING ENVIRONMENT</th>
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</thead>
<tbody>
<tr>
<td>1. DRR policy, planning, priorities, and political commitment.</td>
<td>1.1. Shared vision of a prepared and resilient community.</td>
<td>• Political consensus on importance of DRR.</td>
</tr>
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<td></td>
<td>1.2. Consensus view of risks faced, risk management approach, specific actions to be taken and targets to be met.¹</td>
<td>• DRR a policy priority at all levels of government.</td>
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<td>1.3. Vision and DRR plans informed by understanding of underlying causes of vulnerability and other factors outside community’s control.</td>
<td>• National DRR policy, strategy and implementation plan, with clear vision, priorities, targets and benchmarks.</td>
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<td>1.4. Community takes long-term perspective, focusing on outcomes and impact of DRR.</td>
<td>• Local government DRR policies, strategies and implementation plans in place.</td>
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<td>1.5. Committed, effective and accountable community leadership of DRR planning and implementation.</td>
<td>• Official (national and local) policy and strategy of support to community-based disaster risk management (CBDRM).</td>
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<td></td>
<td>1.6. Community DRR (and DP) plans, developed through participatory processes, put into operation, and updated periodically.</td>
<td>• Local level official understanding of, and support for, community vision.</td>
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</tbody>
</table>

| 2. Legal and regulatory systems | 2.1. Community understands relevant legislation, regulations and procedures, and their importance. | • Relevant and enabling legislation, regulations, codes, etc., addressing and supporting DRR, at national and local levels. |
|                                | 2.2. Community aware of its rights and the legal obligations of government and other stakeholders to provide protection. | • Jurisdictions and responsibilities for DRR at all levels defined in legislation, regulations, by-laws, etc. |
|                                |                                           | • Mechanisms for compliance and enforcement of laws, regulations, codes, etc., and penalties for non-compliance defined in laws and regulations. |
|                                |                                           | • Legal and regulatory system underpinned by guarantees of relevant rights: to safety, to equitable assistance, to be listened to and consulted. |
|                                |                                           | • Land-use regulations, building codes and other laws and regulations relating to DRR enforced locally. |

¹ Including agreement on level of acceptable risk.
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<tr>
<td>3. Integration with development policies and planning</td>
<td>3.1. Community DRR seen by all local stakeholders as integral part of plans and actions to achieve wider community goals (e.g. poverty alleviation, quality of life).</td>
<td>• Government (all levels) takes holistic and integrated approach to DRR, located within wider development context and linked to development planning across different sectors. • DRR incorporated into or linked to other national development plans and donor-supported country programmes. ² • Routine integration of DRR into development planning and sectoral policies (poverty eradication, social protection, sustainable development, climate change adaptation, desertification, natural resource management, health, education, etc.). • Formal development planning and implementation processes required to incorporate DRR elements (e.g. hazard, vulnerability and risk analysis, mitigation plans). • Multi-sectoral institutional platforms for promoting DRR. • Local planning policies, regulations and decision-making systems take disaster risk into account.</td>
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<tr>
<td>4. Integration with emergency response and recovery</td>
<td>4.1. Community and other local-level actors in sustainable development and DRR engage in joint planning with community and local-level emergency teams and structures.</td>
<td>• National policy framework requires DRR to be incorporated into design and implementation of disaster response and recovery. • Policy, planning and operational linkages between emergency management, DRR and development structures. • Risk reduction incorporated into official (and internationally supported and implemented) post-disaster reconstruction plans and actions.</td>
</tr>
<tr>
<td>5. Institutional mechanisms, capacities and structures; allocation of responsibilities</td>
<td>5.1. Representative community organisations dedicated to DRR/DRM.</td>
<td>• Supportive political, administrative and financial environment for CBDRM and community-based development. • Institutional mandates and responsibilities for DRR clearly defined. Inter-institutional or co-ordinating mechanisms exist, with clearly designated responsibilities. • Focal point at national level with authority and resources to co-ordinate all related bodies involved in disaster management and DRR. • Human, technical, material and financial resources for DRR adequate to meet defined institutional roles and responsibilities (including budgetary allocation specifically to DRR at national and local levels).</td>
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<tr>
<td>5.2. Local NGOs, CBOs and communities of interest engaged with other issues capable of supporting DRR and response. ²</td>
<td>5.3. Responsibilities, resources, etc., defined in community disaster plans.</td>
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<tr>
<td>5.4. Shared understanding among all local stakeholders regarding DRR responsibilities, authority and decision making.</td>
<td>² Poverty Reduction Strategies, national Millennium Development Goal reports, National Adaptation Plans of Action, UNDP assistance frameworks, etc.</td>
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<td>² i.e. emergent, extending or expanding organisations. Expanding organisations are expected to take on additional functions at times of crisis, which they do by increasing their capacity or altering their organisational structures (e.g. a local Red Cross branch calling on trained volunteers to support its small core of professional staff). Extending organisations are not expected to respond to disasters but during disasters may perform non-regular tasks (e.g. a construction company clearing debris to assist rescue operations). Emergent organisations do not exist before a disaster event but form in response to it (e.g. spontaneous search and rescue groups). See Webb GR 1999, Individual and Organizational Response to Natural Disasters and other Crisis Events: the continuing value of the DRC typology (University of Delaware, Disaster Research Center, Preliminary Paper #277), <a href="http://dspace.udel.edu/dspace/handle/19716/562">http://dspace.udel.edu/dspace/handle/19716/562</a></td>
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## Thematic Area 1 - Continued

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<tr>
<td>5.5. Community-managed funds and other material resources for DRR and disaster recovery.</td>
<td>• Devolution of responsibility (and resources) for DRR planning and implementation to local government levels and communities, as far as possible, backed up by provision of specialist expertise and resources to support local decision-making, planning and management of disasters.</td>
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<td>5.6. Access to government and other funding and resources for DRR and recovery.</td>
<td>• Committed and effective community outreach services (DRR and related services, e.g. healthcare).</td>
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<td><strong>6. Partnerships</strong></td>
<td>• DRR identified as responsibility of all sectors of society (public, private, civil), with appropriate inter-sectoral and co-ordinating mechanisms.</td>
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<td>6.1. Local stakeholders committed to genuine partnerships (with open and shared principles of collaboration, high levels of trust).</td>
<td>• Long-term civil society, NGO, private sector and community participation and inter-sectoral partnerships for DRR and emergency response.</td>
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<td>6.2. Clear, agreed and stable DRR partnerships between local stakeholder groups and organisations (communities and CBOs with local authorities, NGOs, businesses, etc.).</td>
<td>• Linkages with regional and global institutions and their DRR initiatives.</td>
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<td>6.3. Processes are community-led (supported by external agencies).</td>
<td>• Community and local groups/organisations have capacity to recruit, train, support and motivate community volunteers for DRR, and work together to do so.</td>
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<td>6.4. Local capacity and enthusiasm to promote DRR and scale up</td>
<td><strong>7. Accountability and community participation</strong></td>
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<td><strong>7.1. Devolved DRR structures facilitate community participation.</strong></td>
<td>• Basic rights of people formally recognised by national and local government (and civil society organisations: CSOs): to safety, to equitable vulnerability reduction and relief assistance, to be listened to and consulted (implies responsibility to guarantee these rights where appropriate).</td>
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<td>7.2. Access to information on local government plans, structures, etc.</td>
<td>• Effective quality control or audit mechanisms for official structures, systems, etc., in place and applied.</td>
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<td>7.3. Trust within community and between community and external agencies.</td>
<td>• Democratic system of governance holding decision makers to account.</td>
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<td>7.4. Capacity to challenge and lobby external agencies on DRR plans, priorities, actions that may have an impact on risk.</td>
<td>• Government consults civil society, NGOs, private sector and communities.</td>
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<td>7.5. Participatory M&amp;E systems to assess resilience and progress in DRR.</td>
<td>• Popular participation in policy development and implementation.</td>
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<td>7.6. Inclusion/representation of vulnerable groups in community decision making and management of DRR.</td>
<td>• Citizen demands for action to reduce disaster risk.</td>
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<td>7.7. High level of volunteerism in DRR activities.</td>
<td>• Existence of ‘watchdog’ groups to press for change.</td>
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THREATICA AREA 2: RISK ASSESSMENT

Components of resilience:
1. Hazards/risk data and assessment
2. Vulnerability/capacity and impact data and assessment
3. Scientific and technical capacities and innovation

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<tbody>
<tr>
<td>1. Hazards/risk data and assessment</td>
<td>1.1. Community hazard/risk assessments carried out which provide comprehensive picture of all major hazards and risks facing community (and potential risks). 1.2. Hazard/risk assessment is participatory process including representatives of all sections of community and sources of expertise. 1.3. Assessment findings shared, discussed, understood and agreed among all stakeholders, and feed into community disaster planning. 1.4. Findings made available to all interested parties (within and outside community, locally and at higher levels) and feed into their disaster planning.</td>
<td>• Hazard/risk assessments mandated in public policy, legislation, etc., with standards for preparation, publication, revision. • Systematic and repeated assessments of hazards and disaster risks undertaken in higher-level development programming. High-risk areas identified. • Good-quality data on hazards and risks (scientific databases, official reports, etc.) made available to support local-level assessments. • Existing knowledge collected, synthesised and shared systematically (through disaster management information systems). • Participation of all relevant agencies/stakeholders in assessments. • Government (local and/or national) and NGOs committed to providing technical and other support to local and community hazard/risk assessments.</td>
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2. Vulnerability/capacity and impact data and assessment

2.1. Community vulnerability and capacity assessments (VCAs) carried out which provide comprehensive picture of vulnerabilities and capacities.

2.2. VCA is participatory process including representatives of all vulnerable groups.

2.3. Assessment findings shared, discussed, understood and agreed among all stakeholders and feed into community disaster planning.

2.4. VCAs used to create baselines at start of community DRR projects.

- VCA mandated in public policy, legislation, etc., with standards for preparation, publication, revision.
- Vulnerability and capacity indicators developed and systematically mapped and recorded (covering all relevant social, economic, physical and environmental, political, cultural factors).
- Disaster impact data and statistical loss information available and used in VCA.
- Systematic use of VCA in higher-level development programming. Vulnerable groups and causes of vulnerability identified.
- Existing knowledge collected, synthesised and shared systematically (through disaster management information systems).

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Thematic Area 2 - Continued

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<tbody>
<tr>
<td>2.5. Findings made available to all interested parties (within and outside community) and feed into their disaster and development planning.</td>
<td>2.5. Findings made available to all interested parties (within and outside community) and feed into their disaster and development planning.</td>
<td>- Participation of all relevant agencies/stakeholders in assessments. - Government (local and/or national) and NGOs committed to providing technical and other support to local and community VCA.</td>
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<td>2.6. Ongoing monitoring of vulnerability and updating of assessments.</td>
<td>2.6. Ongoing monitoring of vulnerability and updating of assessments.</td>
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<td>2.7. Skills and capacity to carry out community VCA maintained through support and training.</td>
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3. Scientific and technical capacities and innovation

3.1. Community members and organisations trained in hazards, risk and VCA techniques and supported to carry out assessments.

3.2. Use of indigenous knowledge and local perceptions of risk as well as other scientific knowledge, data and assessment methods.

- Institutional and technical capacity for data collection and analysis.
- Ongoing scientific and technological development; data sharing, space-based earth observation, climate modelling and forecasting; early warning.
- External agencies value and use indigenous knowledge.
### THEMATIC AREA 3: KNOWLEDGE AND EDUCATION

**Components of resilience:**
1. Public awareness, knowledge and skills
2. Information management and sharing
3. Education and training
4. Cultures, attitudes, motivation
5. Learning and research

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<tbody>
<tr>
<td>1. Public awareness, knowledge and skills</td>
<td>1.1. Shared vision of a prepared and resilient community.</td>
<td>• General public aware of and informed about disaster risks and how to manage them.</td>
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<td>1.2. Whole community has been exposed to/taken part in ongoing awareness campaigns, which are geared to community needs and capacities (e.g. literacy levels).</td>
<td>• Appropriate, high-visibility awareness-raisin programmes designed and implemented at national, regional, local levels by official agencies.</td>
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<td>1.3. Community knowledge of hazards, vulnerability, risks and risk reduction actions sufficient for effective action by community (alone and in collaboration with other stakeholders).</td>
<td>• Media involvement in communicating risk and raising awareness of disasters and counter-disaster measures.</td>
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<td>1.4. Possession (by individuals and across community) of appropriate technical and organisational knowledge and skills for DRR and response actions at local level (including indigenous technical knowledge, coping strategies, livelihood strategies).</td>
<td>• Public communication programmes involve dialogue with stakeholders about disaster risks and related issues (not one-way information dissemination).</td>
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<td>1.5. Open debate within community resulting in agreements about problems, solutions, priorities, etc.</td>
<td>• External agencies understand communities’ vulnerabilities, capacities, risks, risk perception and rationality of risk management decisions; and recognise viability of local knowledge and coping strategies.</td>
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<tr>
<td>2. Information management and sharing (more formal)</td>
<td>2.1. Information on risk, vulnerability, disaster management practices, etc., shared among those at risk.</td>
<td>• Government (national and local) is committed to information sharing (transparency) and dialogue with communities relating to information about risk and DRM.</td>
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<td>2.2. Community disaster plans publicly available and widely understood.</td>
<td>• Legislation specifies right of people to be informed and obtain information about risks facing them.</td>
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<td>2.3. All sections of community know about facilities/services/skills available pre-, during and post-emergency, and how to access these.</td>
<td>• Common understanding among external agencies of principles, concepts, terminology, alternative approaches in DRR.</td>
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<td>2.4. Content and methods of communicating information developed with communities (i.e. ‘communication’ not ‘information dissemination’).</td>
<td>• Public and private information-gathering and -sharing systems on hazards, risk, disaster management resources (incl. resource centres, databases, websites, directories and inventories, good practice guideline) exist and are accessible.</td>
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<td>2.5. Maximum deployment of indigenous, traditional, informal communications channels.</td>
<td>• Active professional networks for disaster risk management (sharing scientific, technical and applied information, traditional/local knowledge).</td>
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<td>2.6. Impact of information materials and communication strategies evaluated.</td>
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1 i.e. on community and individual attitudes towards disaster risk and risk management strategies
Thematic Area 3 - Continued

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</table>
| 3. Education and training| 3.1. Local schools provide education in DRR for children through curriculum and where appropriate extra-curricular activities.²  
3.2. DRR/DRM and other training addresses priorities identified by community and based on community assessment of risks, vulnerabilities and associated problems.  
3.3. Community members and organisations trained in relevant skills for DRR and DP (e.g. hazard-risk-vulnerability assessment, community DRM planning, search and rescue, first aid, management of emergency shelters, needs assessment, relief distribution, fire-fighting).  
3.4. Householders and builders trained in safe construction and retrofitting techniques, and other practical steps to protect houses and property.  
3.5. (rural) Community members skilled or trained in appropriate agricultural, land use, water management and environmental management practices.  
3.6. Community experience of coping in previous events/crises, or knowledge of how this was done, used in education and training. | • Inclusion of disaster reduction in relevant primary, secondary and tertiary education courses (curriculum development, provision of educational material, teacher training) nationally.  
• Specialised vocational training courses and facilities for DRR/DRM available, at different levels and for different groups, linked through overall training strategy. Certification of training.  
• Appropriate education and training programmes for planners and field practitioners in DRR/DRM and development sectors designed and implemented at national, regional, local levels.  
• Training resources (technical, financial, material, human) made available by government, emergency services, NGOs, etc., to support local-level DRR. |
| 4. Cultures, attitudes, motivation | 4.1. Shared community values, aspirations and goals (and positive sense of the future, commitment to community as a whole, agreement of community goals).  
4.2. Cultural attitudes and values (e.g. expectations of help/self-sufficiency, religious/ideological views) enable communities to adapt to and recover from shocks and stresses.  
4.3. Informed, realistic attitudes towards risk and risk management.  
4.4. Justifiable confidence about safety and capacities of self-reliance.  
4.5. Possession of (or access to) the information, resources and support desired/needed to ensure safety.  
4.6. Feelings of personal responsibility for preparing for disasters and reducing disaster risk.  
4.7. Safer behaviour as result of awareness raising. | • Political, social and cultural environment that encourages freedom of thought and expression, and stimulates inquiry and debate.  
• Official and public acceptance of precautionary principle: need to act on incomplete information or understanding to reduce potential disaster risks. |

² Assumes high levels of school attendance; and if not, outreach activities.
Thematic Area 3 - Continued

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| 8. Learning and research | 6.1. Documentation, use and adaptation of indigenous technical knowledge and coping strategies.  
6.2. Participatory M&E systems to assess resilience and progress in DRR. | • National and sub-national research capacity in hazards, risk and disaster studies (in specialist institutions or within other institutions), with adequate funding for ongoing research.  
• Encouragement of inter-disciplinary and policy-oriented research.  
• National, regional and international cooperation in research, science and technology development.  
• Comprehensive agenda for scientific, technical, policy, planning and participatory research in DRR. |

THEMATIC AREA 4: RISK MANAGEMENT AND VULNERABILITY REDUCTION

Components of resilience:
1. Environmental and natural resource management
2. Health and well being
3. Sustainable livelihoods
4. Social protection
5. Financial instruments
6. Physical protection; structural and technical measures
7. Planning regimes

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</table>
| 1. Environmental and natural resource management | 1.1. Community understanding of characteristics and functioning of local natural environment and ecosystems (e.g. drainage, watersheds, slope and soil characteristics) and the potential risks associated with these natural features and human interventions that affect them.  
1.2. Adoption of sustainable environmental management practices that reduce hazard risk.  
1.3. Preservation of biodiversity (e.g., through community-managed seed banks, with equitable distribution system).  
1.4. Preservation and application of indigenous knowledge and innovative practices that support sustainable livelihoods. | • Policy, legislative and institutional structure that supports sustainable ecosystems and environmental management, and maximises environmental resource management practices that assist DRR.  
• Effective official action to prevent unsustainable land uses and resource management approaches that increase disaster risk.  
• Policy and operational interface between environmental management and risk reduction policies and planning.  
• DRR policies and strategies integrated with other adaptation policies and strategies.  
• Local government experts and extension workers available to work with communities on long-term environmental... |
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<tbody>
<tr>
<td>2. Health and well being (including human capital)</td>
<td>2.1. Physical ability to labour and good health maintained in normal times through adequate food and nutrition, hygiene and health care.</td>
<td>• Public health structures integrated into disaster planning and prepared for emergencies.</td>
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<td>2.2. High levels of personal security and freedom from physical and psychological threats.</td>
<td>• Community structures integrated into public health systems.</td>
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<td>2.3. Food supplies and nutritional status secure (e.g. through reserve stocks of grain and other staple foods managed by communities, with equitable distribution system during food crises).</td>
<td>• Health education programmes include knowledge and skills relevant to crises (e.g. sanitation, hygiene, water treatment).</td>
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1 e.g. soil and water conservation, sustainable forestry, wetland management to reduce flood risk, conservation of mangroves as buffer against storm surges, maintenance of water supply and drainage systems.

Thematic Area 4 - Continued

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<tr>
<td>2.4. Access to sufficient quantity and quality of water for domestic needs during crises.</td>
<td>2.5. Awareness of means of staying healthy (e.g. hygiene, sanitation, nutrition, water treatment) and of life-protecting/saving measures, and possession of appropriate skills.</td>
<td>• Policy, legislative and institutional commitment to ensuring food security through market and non-market interventions, with appropriate structures and systems.</td>
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<td>2.6. Community structures and culture support self confidence and can assist management of psychological consequences of disasters (trauma, PTSD).</td>
<td>• Engagement of government, private sector and civil society organisations in plans for mitigation and management of food and health crises.</td>
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<td>2.7. Community health care facilities and health workers, equipped and trained to respond to physical and mental health consequences of disasters and lesser hazard events, and supported by access to emergency health services, medicines, etc.</td>
<td>• Emergency planning systems provide buffer stocks of food, medicines, etc.</td>
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3. Sustainable livelihoods

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<tbody>
<tr>
<td>3.1. High level of local economic activity and employment (including among vulnerable groups); stability in economic activity and employment levels.</td>
<td>3.2. Equitable distribution of wealth and livelihood assets in community.</td>
<td>• Equitable economic development; strong economy in which benefits are shared throughout society.</td>
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<td>• Diversification of national and sub-national economies to reduce risk.</td>
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<td>• Poverty reduction strategies target vulnerable groups.</td>
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<td>• NRR seen as integral part of economic...</td>
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<td>4. Social protection (including social capital)</td>
<td>4.1. Mutual assistance systems, social networks and support mechanisms that support risk reduction directly through targeted DRR activities, indirectly through other socio-economic development activities that reduce vulnerability, or by being capable of extending their activities to manage emergencies when these occur.</td>
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<td>4.2. Mutual assistance systems that cooperate with community and other formal structures dedicated to disaster management.</td>
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<td>4.3. Community access to basic social services (including registration for social protection and safety net services).</td>
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<td>4.4. Established social information and communication channels; vulnerable people not isolated.</td>
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<td>4.6. Collective knowledge and experience of management of previous events (hazards, crises).</td>
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<tr>
<td>5. Financial instruments (including financial capital)</td>
<td>5.1. Household and community asset bases (income, savings, convertible property) sufficiently large and diverse to support crisis coping strategies.</td>
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<td>5.2. Costs and risks of disasters shared</td>
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<td>4.5. Government and private sector supported financial mitigation measures targeted at vulnerable and at-risk communities.</td>
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<td>5.4. Economic incentives for DRR actions reduced insurance premiums for vulnerable groups.</td>
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<td>DRR seen as integral part of economic development, reflected in policy and implementation.</td>
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<td>Adequate and fair wages, guaranteed by law.</td>
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<td>Legislative system supports secure land tenure, equitable tenancy agreements and access to common property resources.</td>
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<td>Financial and other incentives provided to reduce dependence on unsafe or hazard-vulnerable livelihood activities.</td>
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<td></td>
<td>Chambers of commerce and similar business associations support resilience efforts of small enterprises.</td>
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</tbody>
</table>
5.2. Costs and risks of disasters shared through collective ownership of group/community assets.
5.3. Existence of community/group savings and credit schemes, and/or access to micro-finance services.
5.4. Community access to affordable insurance (covering lives, homes and other property) through insurance market or micro-finance institutions.
5.5. Community disaster fund to implement DRR, response and recovery activities.
5.6. Access to money transfers and remittances from household and community members working in other regions or countries.

2 These comprise informal systems (individual, household, family, clan, caste, etc.) and more structured groups (CBOs: e.g. emergency preparedness committees, support groups/buddy systems to assist particularly vulnerable people, water management committees, burial societies, women's associations, faith groups).

3 E.g. Insurance/reinsurance, risk spreading instruments for public infrastructure and private assets such as calamity funds and catastrophe bonds, micro-credit and finance, revolving community funds, social funds

<table>
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<tr>
<th>COMPONENTS OF RESILIENCE</th>
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<th>CHARACTERISTICS OF AN ENABLING ENVIRONMENT</th>
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<tbody>
<tr>
<td>6. Physical protection; structural and technical measures (including physical capital)</td>
<td>6.1. Community decisions and planning regarding built environment take potential natural hazard risks into account (including potential for increasing risks through interference with ecological, hydrological, geological systems) and vulnerabilities of different groups.</td>
<td>• Compliance with international standards of building, design, planning, etc. Building codes and land use planning regulations take hazard and disaster risk into account.</td>
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<td>6.2. Security of land ownership/tenancy rights. Low/minimal level of homelessness and landlessness.</td>
<td>• Compliance of all public buildings and infrastructure with codes and standards.</td>
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<td>6.3. Safe locations: community members and facilities (homes, workplaces, public and social facilities) not exposed to hazards in high-risk areas within locality and/or relocated away from unsafe sites.</td>
<td>• Requirement for all public and private infrastructure system owners to carry out hazard and vulnerability assessments.</td>
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<td>6.4. Structural mitigation measures (embankments, flood diversion channels, water harvesting tanks, etc.) in place to protect against major hazard threats, built using local labour, skills, materials and appropriate technologies as far as possible.</td>
<td>• Protection of critical public facilities and infrastructure through retrofitting and rebuilding, especially in areas of high risk.</td>
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<td>6.5. Knowledge and take-up of building codes/regulations throughout community.</td>
<td>• Security of access to public health and other emergency facilities (local and more distant) integrated into counter-disaster planning.</td>
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<td>6.6. Adoption of hazard-resilient construction and maintenance practices for homes and community facilities using local labour.</td>
<td>• Legal and regulatory systems protect land ownership and tenancy rights, and rights of public access.</td>
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<td>• Regular maintenance of hazard control structures.</td>
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<td>• &quot;Hardware&quot; approach to disaster mitigation is accompanied by &quot;software&quot; dimension of education, skills training, etc.</td>
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<td></td>
<td>• Legal, regulatory systems and economic policies recognise and respond to risks arising from patterns of population density and movement.</td>
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</table>
practices for homes and community facilities using local labour, skills, materials and appropriate technologies as far as possible.

6.7. Community capacities and skills to build, retrofit and maintain structures (technical and organisational).

6.8. Adoption of physical measures to protect items of domestic property (e.g. raised internal platforms and storage as flood mitigation measure, portable stoves) and productive assets (e.g. livestock shelters).

6.9. Adoption of short-term protective measures against impending events (e.g. emergency protection of doors and windows from cyclone winds).

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<tbody>
<tr>
<td>6.10. Infrastructure and public facilities to support emergency management needs (e.g. shelters, secure evacuation and emergency supply routes).</td>
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<td>6.11. Resilient and accessible critical facilities (e.g. health centres, hospitals, police and fire stations – in terms of structural resilience, back-up systems, etc.).</td>
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<tr>
<td>6.12. Resilient transport/service infrastructure and connections (roads, paths, bridges, water supplies, sanitation, power lines, communications, etc.).</td>
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<tr>
<td>6.13. Locally owned or available transport sufficient for emergency needs (e.g. evacuation, supplies), at least in the event of seasonal hazards; transport repair capacity within community.</td>
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</table>

7. Planning régimes

7.1. Community decision making regarding land use and management, taking hazard risks and vulnerabilities into account. (Includes micro-zonation applied to permit/restrict land uses).

7.2. Local (community) disaster plans feed into local government development and land use planning.

- Compliance with international planning standards.
- Land use planning regulations take hazard and disaster risk into account.
- Effective inspection and enforcement régimes.
- Land use applications, urban and regional development plans and schemes based on hazard and risk assessment and incorporate appropriate DRR.
THEMATIC AREA 5: DISASTER PREPAREDNESS AND RESPONSE

Components of resilience

1. Organisational capacities and co-ordination
2. Early warning systems
3. Preparedness and contingency planning
4. Emergency resources and infrastructure
5. Emergency response and recovery
6. Participation, voluntarism, accountability

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Organisational capacities and coordination</td>
<td>1.1. Local and community DP/response capacities assessed by communities (themselves or in partnership with external agencies).</td>
<td>• National and local policy and institutional frameworks recognise and value local and community DP as integral part of the national preparedness and response system.</td>
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<tr>
<td></td>
<td>1.2. Local organisational structures for DP/emergency response (e.g. disaster preparedness/evacuation committees).</td>
<td>• Defined and agreed structures, roles and mandates for government and non-government actors in DP and response, at all levels, and based on co-ordination not command-and-control approach.</td>
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<td>1.3. Local DP/response organisations are community managed and representative.</td>
<td>• Emergency planning and response responsibilities and capacities delegated to local levels as far as possible.</td>
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<td>1.4. Roles and responsibilities of local DP/response organisations and their members clearly defined, agreed and understood.</td>
<td>• Ongoing dialogue, coordination and information exchange local and</td>
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</table>
14. Roles and responsibilities of local DP/response organisations and their members clearly defined, agreed and understood.

15. Emergency facilities (communications equipment, shelters, control centres, etc.) available and managed by community or its organisations on behalf of all community members.

16. Sufficient number of trained organisational personnel and community members to carry out relevant tasks (e.g. communication, search and rescue, first aid, relief distribution).

17. Regular training (refresher courses and new skills) provided by/for local organisations; regular practice drills, scenario exercises, etc.

18. Defined and agreed co-ordination and decision-making mechanisms between community organisations and external technical experts, local authorities, NGOs, etc.

19. Defined and agreed co-ordination and decision-making mechanisms with neighbouring communities/localities and their organisations.

- Emergency planning and response responsibilities and capacities delegated to local levels as far as possible.
- Ongoing dialogue, coordination and information exchange (vertical and horizontal) between disaster managers and development sectors at all levels.
- National and local disaster management capacities (technical, institutional, financial) adequate for supporting community-level DP/response activity.
- Adequate budgets for DP activities included and institutionalised as part of DP planning at all levels.
- Funds to strengthen the capacity and activities of civil society stakeholders active in DP.

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1 These may be groups set up specifically for this purpose, or existing groups established for other purposes but capable of taking on a DP/response role.

### Thematic Area b - Continued

<table>
<thead>
<tr>
<th>COMPONENTS OF RESILIENCE</th>
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<tbody>
<tr>
<td>2. Early warning systems ²</td>
<td>2.1. Community-based and people-centred EWS at local level.</td>
<td>• Efficient national and regional EWS in place, involving all levels of government and civil society, based on sound scientific information, risk knowledge, communicating and warning dissemination and community response capacity.</td>
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<td>2.2. EWS capable of reaching whole community (via radio, TV, telephone and other communications technologies, and via community EW mechanisms such as volunteer networks).</td>
<td>• Vertical and horizontal communication and co-ordination between all EW stakeholders, with roles and responsibilities clearly defined and agreed.</td>
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<td>2.3. EW messages presented appropriately so that they are understood by all sectors of community.</td>
<td>• Local government included in all planning and training and recognised as key stakeholder in EWS.</td>
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<td></td>
<td>2.4. EWS provides local detail of events and takes local conditions into account.</td>
<td>• Communities and other civil society stakeholders active participants in all aspects of the development, operation, training and testing of EWS.</td>
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<td>2.5. EWS based on community knowledge of relevant hazards and risks, warning signals and their meanings, and actions to be taken when warnings are issued.</td>
<td>• Mass media part of EWS, not acting independently.</td>
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<td></td>
<td>2.6. Community DP/response organisations capable of acting on EW messages and mobilising communities for action.</td>
<td>• EWS linked to DP and response agencies.</td>
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<td>2.7. Community trust in EWS and organisations providing EW.</td>
<td>• EWS backed up by wider public awareness campaigns.</td>
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<td></td>
<td>2.8. Technical resources (monitoring and communications equipment) in place, with systems and trained personnel for maintenance and operation.</td>
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<tr>
<td>3. Preparedness and contingency planning</td>
<td>3.1. A community DP or contingency plan exists for all major risks. ³</td>
<td>• Politically supported/approved and clearly articulated national disaster preparedness plan in place and disseminated to all levels; part of integrated disaster management</td>
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<td></td>
<td>3.2. DP/contingency plans developed through participatory methods and understood</td>
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and supported by all members of community.

3.3. Plans co-ordinated with official emergency plans and compatible with those of other agencies.

3.4. Roles and responsibilities of different local and external actors defined, understood and agreed – and appropriate.

3.5. Planning process builds consensus and strengthens relationships and co-ordination mechanisms between various stakeholders.

3.6. Linkages (formal/informal) to technical experts, local authorities, NGOs, etc., to assist with community planning and training.

3.7. Plans tested regularly through e.g. community drills or simulation exercises.

3.8. Plans reviewed and updated regularly by all relevant stakeholders.

3.9. Households and families develop their own DP plans within context of community plan.

3.10. Local businesses develop their own continuity and recovery plans within context of community plan.

3.11. Contingency planning informed by understanding of broader local planning provisions and facilities.

4. Emergency resources and infrastructure

4.1. Community organisations capable of managing crises and disasters, alone and/or in partnership with other organisations.

4.2. Safe evacuation routes identified and maintained, known to community members.

4.3. Emergency shelters (purpose built or modified): accessible to community (distance, secure evacuation routes, no restrictions on entry) and with adequate facilities for all affected population.

4.4. Emergency shelters for livestock.

4.5. Secure communications infrastructure and plans with all relevant policies, procedures, roles, responsibilities and funding established.

- Roles and responsibilities of each state and non-state actor are clearly defined for each disaster scenario and have been disseminated accordingly.
- Civil society organisations participate in the development and dissemination of national and local-level preparedness plans; roles and responsibilities of civil society actors clearly defined.
- Community planning seen as key element in overall plans and incorporated into them.
- Resources available to support necessary actions identified by community-level plans.

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2 See also Table 2, Risk Assessment. The terms DP or contingency plan are used broadly here to cover all kinds of plan for preparing and responding to disasters and emergencies. It is assumed that the plan, like all good DP/contingency plans, has clearly stated objectives, sets out a systematic sequence of activities in a logical and clear manner, assigns specific tasks and responsibilities, is practical and based on realistic parameters (i.e. appropriate focus, level of detail, format for local users’ needs and capacities), is process-driven (i.e. does not overemphasize the importance of a written plan) and leads to actions. For more detailed guidance on preparedness and contingency planning, see UN OCHA 2001, Disaster Preparedness for Effective Response: Implementing Priority Five of the Hyogo Framework for Action (Geneva: Office for the Coordination of Humanitarian Affairs); Chouvarian R 2001, Contingency planning and humanitarian action: a review of practice (London: Humanitarian Practice Network, Network Paper 50).
4.4. Emergency shelters for livestock.
4.5. Secure communications infrastructure and access routes for emergency services and relief workers.
4.6. Two-way communications systems designed to function during crises.
4.7. Emergency supplies (buffer stocks) in place, managed by community alone or in partnership with other local organisations (incl. grain/seed banks).
4.8. Community-managed emergency/contingency funds. *

5. **Emergency response and recovery**
   
   5.1. Community capacity to provide effective and timely emergency response services: e.g. search and rescue, first aid/medical assistance, needs and damage assessment, relief distribution, emergency shelter, psychosocial support, road clearance.
   
   5.2. Community and other local agencies take lead role in co-ordinating response and recovery.

   * These could be part of or separate from other savings and credit or micro-finance initiatives.

   • Pre-arranged agreements signed with donor agencies for access to funding or loans at the international or regional level as part of emergency and recovery plans.

   • Civil protection and defence organisations, NGOs and volunteer networks capable of responding to events in effective and timely manner, in accordance with agreed plans of co-ordination with local and community organisations.

   • Capacity to restore critical systems and infrastructure (e.g. transport, power and communications, public health facilities) and agreed procedures for action.

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**Thematic Area 6 - Continued**

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<tbody>
<tr>
<td>5.3.</td>
<td>Response and recovery actions reach all affected members of community and prioritised according to needs.</td>
<td>• Support programmes for livelihood-focused recovery (e.g. cash for work, replacement of productive assets, emergency loans or start-up capital).</td>
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<tr>
<td>5.4.</td>
<td>Community psychosocial support and counselling mechanisms.</td>
<td>• Resources (human, institutional, material, financial) available for long-term reconstruction and recovery.</td>
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<tr>
<td>5.5.</td>
<td>Community knowledge of how to obtain aid and other support for relief and recovery.</td>
<td>• Government relief and recovery resources inventoried; information on resources and how to obtain them made available to at-risk and disaster-affected communities.</td>
</tr>
<tr>
<td>5.6.</td>
<td>Community trust in effectiveness, equity and impartiality of relief and recovery agencies and actions.</td>
<td>• Official agencies willing and able to guarantee public safety after disasters and to protect highly vulnerable groups.</td>
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<tr>
<td>5.7.</td>
<td>Community/locally led recovery planning* and implementation of plans linking social, physical, economic and environmental aspects and based on maximum utilisation of local capacities and resources.</td>
<td>• Official continuity and recovery plans in place or capable of being developed, supported by appropriate systems and capacities.</td>
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<tr>
<td>5.8.</td>
<td>Agreed roles, responsibilities and co-ordination of recovery activities (involving local and external stakeholders).</td>
<td>• National policy framework requires DRR incorporation into design and implementation of response and recovery.</td>
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<tr>
<td>5.9.</td>
<td>Incorporation of DRR into community and</td>
<td>• DRR ‘mainstreamed’ into relevant</td>
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<tr>
<td><strong>6.1. Local leadership of development and delivery of contingency, response, recovery plans.</strong></td>
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<tr>
<td><strong>6.2. Whole-community participation in development and delivery of contingency, response, recovery plans; community ‘ownership’ of plans and implementation structures.</strong></td>
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<td><strong>6.3. Justifiable community confidence in EW and emergency systems and its own ability to take effective action in a disaster.</strong></td>
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<td><strong>6.4. High level of community volunteerism in all aspects of preparedness, response and recovery; representative of all sections of community.</strong></td>
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<td><strong>6.5. Organised volunteer groups integrated into community, local and supra-local planning structures.</strong></td>
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<td><strong>6.6. Formal community DF/Response structures capable of adapting to arrival of spontaneous/emergent groups of volunteers (from within and outside community) and integrating these into response and recovery.</strong></td>
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<td><strong>6.7. Self-help and support groups for most vulnerable (e.g. elderly, disabled).</strong></td>
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<td><strong>6.8. Mechanisms for disaster-affected people to express their views, for learning and sharing lessons from events.</strong></td>
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<td>• Recognition by external and local emergency responders of people’s right to appropriate assistance after disasters, to participation in disaster recovery planning and to protection from violence (defined in legislation).</td>
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<tr>
<td>• Internationally accepted principles of rights and accountability in disaster response and recovery agreed and adopted by national authorities, local government, civil society organisations and other stakeholders.</td>
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<tr>
<td>• Legal instruments mandating specific actions by public organisations in emergency response and disaster recovery.</td>
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<tr>
<td>• Participatory mechanisms ensuring all stakeholders involved in the development of all components of disaster management planning and operations at all levels.</td>
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<td>• Local government and other agencies have planned for co-ordination of ‘emergent groups’ of volunteers.</td>
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<td>• Application of social audits, report cards and other mechanisms enabling those affected by disasters to evaluate emergency response.</td>
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<td>• Independent assessments of DF capacities and mechanisms carried out and acted upon.</td>
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<tr>
<td>• Effective and transparent mechanisms for monitoring and evaluating DF and response.</td>
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5 Including resettlement plans.
6 e.g. HAP Principles of Accountability, Sphere, Red Cross Code of Conduct.
Annex 4: interview transcripts, including grounded theory.

Legend:
- **Open coding**
- **Axial coding**
- **Selective coding**
- **Memo**

- The codes in the selective coding phase have been compared to the codes in Twigg’s framework.

- Open coding tree

**Thematic area 1: Governance**
- More friction between wards
- Government doesn’t want people to be educated
- Authority = minister of health
- Local: buy rubbers, chlorine, continue sensitization
- Usually developments by NGO, not government
- Collective action
- Send proposals > local financial capacity building
- WYO
- Community is watchdog
- Poor government response
- Fear and trust building
- Local FBO donated to government
- Key stakeholders will never feel the way we feel
- Youths are change agents of society
- Religious leader
- Honourables
- Corruption
- Councilor is doing well
- DERC
- Neglectance by government
- No familiarity with the word resilience
- "" "" DRR
- Operation Western Area Search
- Lack of knowledge on rights and responsibilities
- Local decision making
- Local laws and penalties
- Wellington Youth organisation
- Wellington Muslim Association
- GOAL
- Community participation
- Councilors responsibilities
- Cooperation NGOs / councilors – government & local partners (top down – bottom-up)
- Local solutions
- Free communication
UNFPA
Masala garbage initiative
Cooperation SLBL
Develop Africa
GOAL – in reality support is lacking
CBO
SMAC
Lack of power to influence change
Those elected do not follow up on what has been promised
Opposition: Ebola is not real
WHO, IOM, UN, Red Cross
Private financial support
Environment Protection Agency
Government created medical facilities
army took management quarantine homes over, distribute food rations
Friction between people in community as a cause of Ebola. We were family before, let's fight to zero together. Collective action.
youth leader: change agents of society rather than causing friction
private financial support
no quarantine homes, no Ebola
Governance: relations between wards more friction due to Ebola
Governance: Nobody is helping to develop the community, not the councillors nor the ministers. Neglectance government.
Help from religious organisation, WASH
local financial capacity lacking, councillor
NGO cooperation would be appreciated
Government created medical facilities
NGO that build a dam
cooperation with NGOs, just GOAL some WASH projects
EPA
Pictogram rather than written English K/E
local level: buy chlorine, rubbers, soap and sensitization
national recovery plan, some government initiatives have started.
Funding IC and government through DERC
Role military
authority is MoHS
felt neglected
Government/politicians don't want people to be educated
leaders are not influencing change, corruption
Management of wells / Lack of authority/power to influence change / Those elected do not follow up on what they promised
no one is representing me well in politics
Poor response,
Fear & building trust
cooperation govern – local
community based organization
cooperation SMAC
it would never effect government people, they live comfortable lives.
They will come and just do whatever, you are supposed to be inclusive and involve the local organisations. Even without government, we would do it.
no IC, all via government. Difficult because not inclusive.
Wellington Youth Organisation, local organization
Local FBO, Role WMA
- Local governance
  - Send garbage collection to NGOs, they will never respond
  - Key stakeholders will never feel how we feel, it did not happen to them
  - Corruption # Ebola # National response
  - First phase of the response, money given to honourables. They eat the money.
  - Role of religious leader # Corruption
  - Neglectance government / Corruption
  - WHO
  - International response needed. Obey the rules
  - Operation western area, did well. Councilors talk with government.
  - Government really tried, cooperation NGO: WHO, NERC
  - Bottom-up approach pays in positive way
  - Advice ministry of health
  - Penalties, Local decision making.
  - Disaster Management city council level
  - Governance: cooperation government / local authorities
  - WHO, Red Cross, IOM, UN
  - Honourables gave 64 million to fight Ebola
  - Government, honourables, councilors
  - Ebola was used as a political tool. Opposition said that Ebola was not real.
  - Government has got resources
  - Government responsible for fight against Ebola
  - Council imposes laws to make orphanage house legal
  - Cooperation government. No direct support, technical info and policies pass via government.
  - Initiatives by government
  - Cooperation government / local authorities
  - Positive: some NGOs provided work.
  - Private financial support
  - Local decision making.
  - Councilor is doing well.
  - Ebola # denial, political game,
  - Operation Western Area Search. Involvement local partners in government response.
  - Local decision making, local laws and penalties # success → no quarantine houses anymore since February.
  - Community participation
  - Councilor held responsible for arranging needs of people
  - Cooperation counselors NGO’s (not enough)
  - Local decision making. Pro-active.
  - Minutes send to council
  - Local decision making
  - Cooperation: little was coming to community
  - Cooperation SLBL
  - Governance: cooperation with SL brewery
  - Neglectance by government
  - Local leadership
  - Cooperation GOAL
  - Cooperation NGOs. ACF, Oxfam in other communities.
  - Cooperation NGO GOAL, social mobilization
  - Free communication (by UNFPA)

- Local collective action
  - Government should support local government structures
- Community neglected with little attention
- Cooperation Develop Africa
- Cooperation GOAL: In reality support is lacking.
- Legal and regulatory systems
- Involve local government
- Lack of local financial capacity building
- Community as watchdog
- Poor response government / neglectance by government
- Fear and trust building
- Corruption
- Access to information
- Local solutions
- Governance: Top down → bottom up. Local solutions.
- No familiarity with the word resilience / DRR
- Local response, local decision making
- CBO
- Community participation
- Cooperation government & local partners (top down – bottom-up)
- Government response

**People are usually not familiar with the jargon used on a policy level (‘resilience, disaster risk’), this does not mean there are no DRR/Resilience mechanisms in place.**

**While there is cooperation with government and NGO’s to a certain extent, the people of Wellington do not have much trust in the government and do not feel supported by them.**

- Governance: Role of people in community is watchdog.
- Governance: No familiarity with the word resilience
- Integration with recovery / institutional mechanisms, capacities and structures; allocation of responsibilities
- Difficult to get funding
- Ebola is a community owned disease and only the community can disown it
- Community participation / partnerships

**Thematic area 2: Risk assessment**

- No justice
- WASH
- Regular food
- Bednets
- Medicines
- WASH (# school drop out, sexual harrassment, pregnancies)
- Clustered in slum areas, forced to gather
- (Youth) unemployment
- Clothing
- Housing
- Public toilets
- Roads
- Hospital
- Water pollution
- Water born diseases
- Ebola
- Community members trained
- Floods
- No drainage system
- Stealing
- Cholera
- Malaria
- Garbage
- Internal security system
- Lack of access to drinking water
- Infrastructure
- Lack of electricity
- Losing relatives, no care takers
- Poverty
- If there are PR measures, not effectively managed.
- No jobs despite factories
- Chemical and air pollution
- Water
- Bad roads
- Poor drainages
- Garbage disposal
- Hospital
- Public toilets
- Lack of food, medicines
- Keep community clean, no muskito’s in the house
- No justice
- Lack of healthcare
- Sensitization
- WASH (# school drop out, sexual harrassment, pregnancies)
- Migration
- (youth) unemployment
- Water born diseases
- No drainage system
- Stealing
- Garbage
- Infrastructure
- Lack of electricity
- Environmental hazards
- Vulnerabilities
- Hazards
- Holistic approach
- Disease
- Lack of basic needs
- Disaster risks, consisting of vulnerabilities x hazards, are approached holistically: they are widespread and go beyond Ebola.

Thematic area 3: Knowledge and education (# SD)
- (no) logic
- Lack of knowledge on rights and responsibilities
- Lack of understanding as cause
- Root causes Ebola
Education not accessible (# early marriage)
Sensitization via pictograms
Ebola because of chronic sickness
Ebola is a chemical
Misunderstanding precautions
Spreading of Ebola
Ebola is invented by politicians
Ebola because people do not believe in God, people do not go to church
Misunderstanding Ebola
General lack of education
Sensitization
Fear of admitting you are sick
Ebola becomes endemic
Illiteracy
Awareness through oral info / pictograms
Denial
Communication
Information
School 1st priority
Towncriers
Radio
Ebola sensitization song for children and adults as well
logic: poverty is bad, as well as Ebola
sensitization: divide ward into zones, penalties, pass the message
Rich people do not get infected
Ebola is not real
misunderstanding, cause of Ebola
Education and awareness raising
denial Knowledge and education: denial, misunderstanding, chemical causing Ebola,
sensitization priority in eradicating Ebola
Lack of understanding caused Ebola to spread
no logic...
water =/ Ebola
Fear
Training
Lack of acces education → early marriage
Education is not accessible
Education # Ebola
Illiteracy # Ebola
sensitizations, check points, awareness raising
not infected because of God.
Misconceptions
Saw doctor die, end of denial
Does not see consequences, understand questions very well
Rich people do not get infected
Denial
Lack of knowledge
Ebola is real
Fear makes family reject orphanages
Misunderstanding precautions
Ebola is man made
Ebola is political vehicle
More denial in provences
Ebola is real
If it is not Ebola, we hold the government accountable later
No information on prevention
Access to information
Unfamiliarity with Ebola virus caused infection → aid workers in contact with virus
Ebola spread because people don’t believe its real, people are stubborn and people do not go to church
sensitization by community leaders
school first priority

Misunderstanding spreading/cause of Ebola
illiteracy
Sensitization
General lack of education
Denial (fear)
Communication
Information
Behavioral change
Training
no electricity → no information
Behavioral change

Misunderstanding, as a consequence of a lack of education/information, contributed to the spread of Ebola.
Sensitization on a local level is seen as the key to reduce Ebola.

Thematic area 4: risk management and vulnerability reduction

ABC (avoid body contact)
No system statistical data
Migration
Sensitization
Local garbage initiative
Hand washing
Hand sanitizer
Check points
Quarantine homes
Lack of food in quarantines
Water wells
Management wells
Knowledge on health
Rape and early marriage
Wish to have clean community
117
Dignified and safe burial
Health care facilities
Poor – rich differences
High level unemployment
Local protection and security systems
Lack of finance
Stigma orphanages and Ebola survivors
Do not eat bushmeat, open fruits
Clean environment
Measures not available for poor
People want to be quarantined
DRR measures not working
Individual protection measures
Apply government measures, obey the rules
Ebola = poverty
Obey the law and sickness will go
Keep the house clean
sharing clothes, poverty
Individual risk management measures
Protect and prevent ourselves
Obey the rules
Unemployment (# Ebola)
Wellingtonians do not profit from work in industrial area. They suffer from pollution and smoke.
while most factories in sierra leone can be found in Wellington, this is not represented in employment levels
food in quarantine is not adjusted to cultural preferences, we even start with rice in the morning, no rice etc.
thieves and lack of electricity
quarantine without food → spread of Ebola, poor logistics
Situation – lack of food, resources, job - makes people criminals
WASH, Sexual harassment because of lack of water
water shortage, WASH
dont wash dead body, someone who is sick should go to hospital
youth unemployment
hazard: cholera
loss of jobs due to Ebola, drainages, garbage
rich men don’t get Ebola
garbage gets worse in dry season
obey the rules, strict monitoring, health rules, 117, hand washing ministry of health advice, house to house visits
nr of Ebola infections
garbage initiative, costs money
air pollution, chemicals, no CSR
garbage collection initiative
garbage disposal, health care, air pollution, flooding, road pipes
medicines
migration is risk for Ebola
No Ebola risk management.
bednets, medicines
deplorable conditions Ebola victims
cholera, malaria
fear of admitting you are sick
dysentery
typhoid
not keeping stranges, sick go to hospital
Losing relatives, left without caretakes
Need housing
Need food
lack of clean water > gathering > spread of Ebola
measures not available for poor / hand sanitizer
no public toilets
lack of access to clean water.
- Clustered in slum areas
- Quarantine homes / free food quarantine homes / people want to be quarantined
- Water borne diseases
- Quarantine homes, quarantine homes / free food quarantine homes / people want to be quarantined
- Water born diseases
- WASH most pressing need, including garbage
- Regular feeding, clothing
- Housing
- Disaster committees not effective
- Flooding
- Many environmental hazards
- Lack of water → rape → teenage pregnancy
- WASH → school drop out
- More prone to diseases now due to Ebola
- Lack of electricity # Ebola
- WASH situation → teenage pregnancy, school drop out
- Garbage disposal / lack WASH → contamination of infectious diseases, chronic illnesses, loss of lives, diseases
- Ebola affects economy / Ebola → poverty
- No public toilets → water pollution
- Wash problems # Ebola (more easily infected)
- Ebola → more prone to other disasters
- Measures not always effective
- No system statistical data
- Migration
- Vulnerable to disease
- Sensitization
- Ebola measures
- Quarantine homes
- Dignified and safe burial
- Poor – rich differences
- Quarantine homes without food → escape
- Community as watchdog
- Clean environment
- Cultural believe
- Measures not always effective
- Obeying the rules by the ministry of health is the most effective way to fight Ebola

Thematic area 5: Disaster preparedness and response

- Poor logistics initially
- Engaging the community
- Avoid large crowds
- Stay home
- Ebola spreads because people don’t take precautions
- Do not touch dead bodies
- Call 117
- Poverty as result of Ebola hit these children hardest
- Food in quarantine homes not adjusted to cultural preferences
- Poor response related to cultural attitude
- 117 not effective
No women in burial teams ➔ no dignified burial.

- Trained personnel
- Army deployed
- Emergency facilities
- Do not touch dead bodies
- Do not hide sick people in your house
- Penalties
- By laws
- Community knowledge on Ebola
- Counseling
- Volunteer initiatives
- Funding
- Poverty ➔ hit orphanages hardest
- Lack of women in burial teams, dignified burial

- Burial teams cannot provide dignified burial because of a lack of women [a dead woman needs to be washed by women]. Most people do not see this since gender is not recognized when in full PPE.

117, why can’t you give the body to the family to give dignified burial, if person did not die of Ebola?

- Training volunteers
- You will never have dignified burial during Ebola
- System for statistical data initially
- Importance radio
- Lack of statistical data as key challenge in Ebola response
- While you are not allowed to bury body, nobody picks up (before 117)
- 117 not rapid, dead body for 3 days in the house. System not effective or efficient
- House to house visits, advice, cases were coming down Response: by laws / penalties
- Don’t wash dead body
- Sensitization in Wellington Response: hand washing as prevention measure.
- Measures are not always effective # lack of trained personnel # lack of resources
- Sensitization in Krio, local language by (UNICEF)
- Feels excluded in response
- Obey the rules
- Penalties, bilaws, go to jail
- DRR measures not working, cultural belief
- Risk management: ABC
- Sensitization house to house
- People use too much chlorine
- Internal security system within community
- Response: no food quarantine homes
- R too slow
- Do not touch dead bodies, call 117
- Disaster Management city council level
- Local engagement ➔ successful Ebola response
- Not keeping strangers, sick persons to hospital
- Ebola spread because of fear of admitting sickness.
- Handwashing
- Do not eat mango that was eaten, do no eat bushmeat
- People in community received training
- Obeying the rules, everybody takes precautions
- Do not attend funeral
- Keep yourself safe
- Local engagement ➔ successful Ebola response
- Local security systems
Awareness
- Teamleader in Ebola response
- Towncries, megaphones, sensitization
- Sensitization is continuous process
- Temperature 3 times a day. Preventive measure: well
- Resilience & adaptation: Africans don't get harsh malaria as white people. The mad men in the street can eat from the dussbin without getting sick.

Poor response
- Upgrade health systems
- Ebola → unemployment → recovering
- Cultural preferences
- Cultural behavior, attitude of Sierra Leoneans as key factor to change situation
- No dignified burial
- Obey the rules
- Penalties and bylaws

# SD / Poverty
- DRR: community takes NO long-term perspective, focusing on outcomes and impact DRR
- DRR clean community
- Vaccination DRR
- Response without involving community is not effective
- DRR: occupied with immediate needs rather than longer term development
- DRR: When you have jobs, life is good.

Thematic area 6: Recovery
- More are trained
- More problems because of Ebola
- School and school material, tv, clothing
- More awareness, gov school free for 2 years, even better or measles and malaria now
- Family members of orphanages neglected them
- Long term problem = funding
- More ambulances
- Government schools free for next 2 years
- Medical facilities
- Free health care initiative for children < 5, pregnant and lactating mothers
- Free education initiative
- Clean community, toilet facilities, diseases spread
- Transport sector development
- Energy sector developed
- Jobs needed
- Education needed
- Vulnerable group: orphanages, widows, survivors and family of those affected
- Packages for family members
- Keep community clean
- Survivors marginalized, need to be integrated, community engagement required
- Internal security system
- Personal protection; no other people in the house allowed
- Long term dev: education, finance, jobs
- Priorities: 1. Road 2. Hospital 3. Water
- People are suffering more since Ebola
- Jobs, education, medical facilities
National Recovery Plan, positive, starts to come down. Orphanages and widows left out in this plan, vulnerable group; care for them problematic.

- education → job → development
- Youth employment necessary solution for development / poverty
- ‘poverty reduction measures’ are not effectively managed
- no poverty reduction measures
- In order to integrate survivors into the community, community engagement is required first and foremost
- Integrating survivors into the community again
- Ebola survivors and family members, packages needed
- poverty increased due to Ebola
- development hampered due to Ebola
- Vaccination
- Youth employment as solution for poverty / development
- BBB: quarantine homes, change furniture etc., everything that was possibly in contact with the virus, in return new stuff received.
- take care of widows and orphanages, need for education
- Free health care for children < 5, pregnant and lactating mothers
- Free education
- Transport sector more developed
- Energy sector
- Education needed
- Ebola becomes endemic on long term?

- Vulnerable groups
- Survivors are marginalized
- Training
- Health care / health systems
- Education
- Employment

- Ebola is a ‘community owned disease’: the community acts as a watchdog and the by laws and penalties that were imposed on a local level are effective
- Poverty and Ebola are bedfellows

All interviews conducted between July and November 2015.

Freetown, western urban area. Wellington. [H1][H2]

Respondent 1 - 55 yrs, cook for the Sierra Leonean Brewery Limited guesthouse.

- Were there people infected with Ebola there?
- Hmm I think down the other side, because I stay at water street but the community is called Congo Town so on the other side I think we have 2 people affected.. as far as I can recall it. [H3]
- And eh for what you know, how did eh the virus affect the community?
- Because eh sometimes, sometimes eh somebody got the virus from somewhere else and come and stay with the people there so they got eh [H4][H5]
- No i mean how, how what are the consequences for the community?
Eh

Any problems now, more than before?

No no now its ok. Because before, they dont understand the precautions to take. Because they have to avoid infected people. Death people you should not wash death body, if any of your relatives are sick you have to call 117 because eh you dont have to attend because you dont know if he is affected or not, you see. So you have to call 117.

And ehms does the community face more difficulties now than before? For example unemployment or acess to clean water or food?

O yeah. Employment is always key because most of them dont have employment. But in the community we have water, we have enough water there. But electricity is eh on and off like that, its not stable. Yes that is it.

But employment was already a problem before Ebola or did it got worse?

It got worse during Ebola because most people were stopped, like me. I was working here. Because the people we were working with they said ok lets go and wait so there was nobody to work with. So they said ok lets wait until there are other people, so i was affected as well. So some of us people were affected like that, they stopped them from their office because there was no more production, but now i think its getting better. Because now the Ebola is almost finished now and they are calling some of them.

And how did the community cope with that? For example, you were home for how many months?

9 months

9 months! Its a lot.

Yeah hehe. 9 months you see.

How do you deal with that, because the children still need toe at?

Yes ive managed because when you work you have to save some for the bad days haha. You dont eat everything haha.

Did your community, how long do you live there now?

In that particular community is my third year now.

Did you experience other hazards or disasters like Ebola before?

No no no no, no nothing nothing. Everybody is safe in our communirt because everybody takes the precautions. Because our councilor and other people who the elder people, they come around they have this megaphone and so they come and sensitize people not to do this not to do that. Sensitize the people yes.

Is there access to a doctor or traditional healer? I dont know to which..

No no at that point in time you dont have to go anywhere, you have to go to the only public hospital is 117 – no no no traditional helaer, nothing.

And normally, is there a doctor?

Yes normally we have community hospitals, they are there.

Ok ehm. Why do you think Ebola could spread in sierra leone?

Because people dont take precautions hehe. You have to take your precautions. Because you know that you have to avoid death body, dont attend funerals because you dont know whether they are infected or not. So you have to keep yourself away from this. Dont go into large crowds, dont mingle yourself with large crowds. You have to stay home where you know your family is well.

And if you think about more the root causes? Like the underlying reasons for the outbreak?

... Because the only thing I know is that when people are sick, sometimes they dont like to say they are sick you see. Because they have to go to the hospital and tell your nearest relative that you are not well so they can take you to the hospital. If not, people will get sick, even your own son or daughter or relatives. If youre sick you have to tell them, im sick, dont come near me, take me to the hospital, that kind of things.

Yeah, people where afraid maybe?

Yeah people are afraid. Mostly why people where afraid is because of the way we are doing the thing. Because when you are sick and when you are taken to the hospital, maybe sometimes
its not Ebola. Maybe it malaria or other sick. Maybe when you go they say its ebol so they have to keep you there. [H19]

- You mean that people where afraid that they would keep them there?
- Yes keep them there, because sometimes if you have a fever you know that its just a headache or just a malaria because sometimes tell them i have fever, they will take you immediatly. Its a problem. That is why people where afraid, that is one of the reasons why Ebola was spreading because of the fear. [H20]

- And ehm what kind of measures where taken apart from the knowledge spreading?
  - There was this handwashing, these buckets put around in the community, you have to wash your hands whatever you want to do. Dont have to shake hands with nobody. Even your son or daughter or family you have to keep your hands to yourself you see, that is some of the precautions. You dont eat this mango’s like the mango that have been eaten, you see they say its bats maybe or monkey you dont eat that one. And you dont eat this bushmeat, this bushmeat you dont eat that one see. [H21]

- And you normally eat bushmeat?
  - Nah nah i dont like it. no monkeys, not me haha.

- Where people trained in the community to deal with .. ?
  - Yes yes yes they were trained. Some where taken to the .. Because in our community we have the stadium, the national stadium and there was a training center there. Most were taken to train there. [H22]

- Do you think evrybody knows now what Ebola is and what the risks are?
  - Yes id say everybody knows but some people they are still denying. i dont know why for what reason maybe political or i dont know. Because some people know there is Ebola but still they dont act like.

- They dont act like
  - They dont accept that there is Ebola. Some people say its a chemical they brought in sierra leone that brought the disease. [H24]Haha its funny haha.

- What do you think are the priorities in fighting Ebola ?
  - Well... continu sensitizing this people and make sure,because some people are very careless should have more people should be there to sensitize them.i fyoudont do that then you eradicate Ebola.[H25]

- And on the long term? For it to never come back?
  - Aiil i dont think the Ebola, i dont think i twill be eradicated totally. I feel like Ebola now is like malaria fever, they can control it, they can suspend it for some time. [H26]

- It like endemic?
  - Yeah yeah endemic you see. If you dont continue the doing like washing your hands and sensitization maybe it will gradually come again you see, you have to continue, its a continuous process, have to continue to sensitize people.[H27]

- And, what do you think is needed for the community to recover from the losses like employment or..?
  - Yes unemployment, some people need food, some people need houising. Because some they lost aaaaall their relatives. Maybe only one person left. Just other friends are looking taking care of that person. [H28][H29]

- So there is really a need?
  - Very very very, they need very urgent things to eat, clothing, food. Things like that.

- And who do you think should arrange that? Who is responsible?
  - Well, in our community we have a councilor. We dont have a chief, i dont know any chief i know the councilor. You can go to the councilor and they will arrange ... for the one affected.[H30]

- Also if someone, if people dont have food you go to the councilor?
  - Yes yes that possible. At least they will call a meeting. People will explain whatever theyve gone through so you know who has been affected. Some of them they know, community
people know who has been affected. They say this house, so so and so that area, quarantine, have been affected.  

- And do you think there is a role for the government in this? Should the government do anything?  
- Yes, that's what I am saying. Have to take strict measures in fact to see that people obey to the rules of sensitizing and doing what is good. Because like if you...like lets say in the month 2 months in the month it should have to do general cleaning.  
- What is that?  
- To clean your environment. Make sure the environment is clean.  
- With chlorine?  
- With chloring all the rubbish out of the area. Because that is what is causing this sick. Because they dont do healthy living you see.  
- So that is also an underlying cause?  
- Yes.  
- Are there also other NGOs or international organizations?  
- Yes other NGOs working with the government, other NGOs working with the councilors. Like that. Going out to see that this thing should be eradicated. But this is not enough.  
- And do you think the community is now better protected than before?  
- It is better. It is better protected than before. The community is better protected than before. Because id say 99% people are aware. Most of them are very very afraid of this disease because its very dangerous, so most people take the time to take precautions.  
- What can be done to prevent disaster like this, can be Ebola but can also be cholera or floods or just disasters in general, what can be done to prevent that from happening in the future?  
- Like, what im saying. Do this thing with cleaning, then sensitization. tell the people that if you do this this will happen, if you do that that will happen. You have to sleep under your muskito net, you have to do this if you get malaria if you do this .. like that you see.  
- I have a few more questions. Eh do you think Ebola is linked to poverty or a lack of resources?  
- Yes it is linked. Because now, the poverty rate is very very high. Very very high you see. Plenty of people are not working now they are just sitting because they dont have any job because eh if you o in the office they will tell you that there is no business because of the Ebola ..  
- ... and the other way around? Does poverty cause Ebola in a way?  
- Yes yes poverty is causing Ebola because if you go to work or you go to school you have to risk so you prefer to stay at home and there is no money you see. Because most people who are staying at home, now they dont have money to pay school for their children.  
- Do you think if poverty was reduced, would that help with fighting Ebola?  
- Yes yes it would it would help you see.  
- The concept of ‘resilience’ do you know that?  
- Pardon?  
- ‘resilience’ do you know that word?  
- Eh resilent. The consequence?  
- No, its called ‘resilience’. Its a word that is often used in policies to fight Ebola. Like a resilient health system for example.  
- Like resisting?  
- No resilience  
- No no i dont know that  
- You dont use it in the community?  
- No no, that one is too big for the community. These people in the community are so illiterate. Too illiterate.  
- They are illiterate?  
- Very very illiterate.  
- Ok thank you very much Victor. Thanks a lot, this is very usefull for me.

- So what is the name of your community?
- Ok. And ehm where there people in your community infected with Ebola?
  - Yes yes yes, we had people infected with Ebola. Ehm it started sometime in August. We had the first case inPokos. Ms. Vandi was the first one who died in my own ward. Yes. At Mellon street. She was a teacher and her daughter Jane Vandi came from another community and when she came, she was sick. She was taking care of her and both of them died. At that time there was little or no experience in handling this Ebola Virus Disease. That was the first case in my ward. Also we had Ms. Lamin also Died at lemon street, she was a nurse and was working in the … hospital. She was treated by Alfred Kuma, who was a colleague, they have so much passion that they treated her without any suspicion of any kind of thing. Even to the point of burying. When she died they realized that ‘oh that just was Ebola’. Alfred he died in another community, close to Botongo town. But it was the case that involved Lamin from our own community. So, she also lost her husband; Frank Lamin. He also died because, his wife was coming home. She was infected when she was coming home she was also infected. She take him to the center but before practitioner could he died. He died. And then we had those [H45] at Maxwell street. We had mr Kabo, he also died. He died in September. He died in September. Jane died in August. That was the other case at Maxwell street. Sorie died there and lots of others. [H46]
- Do you know the number up till today of total people infected in your community?
  - Ehm in totality I would say that.. let me look at it [getting the paperwork]. Yes, so as you can see this records, these are our minutes. We send this to council. [H47]In this minutes we mention all quarantine homes [(names everyone who died and everyone who was infected]. All of these died up to December of last year.
- They all died in the wellington community?
  - Yes wellington community. Specifically ward 253. We have different wards, we have other wards, 353, 351 by the seaside, 352 the main road. And off course 353. Usually, you respond to Ebola according to your ward. I was a teamleader in the Ebola response team. [H48]
- Very interesting. So, after November 2014 no infections .. ?
  - We had some cases in December and some in January few cases but that was the last. This one is up to December. [The quarantine homes] [H49] were discharged and up to this time in February, no cases. From February till now, no new cases. These are survivors (names all survivors).
  - This was a family member right?
  - Family member yes. Alice is the mother, the guider of Daniel. Geradine Lamin is the daughter of Frank Lamin, she survived. Bangura and Alhaji also survivors.[These minutes we produce and send to councilors in other areas, the other Wards. Basically, November, December Ebola came at its peak so our community meetings were all on Ebola. And we put that in our minutes. [H50]Like this one, In November we launched ‘operation western area search’. This operation brought Ebola down down down down down down. [H51]In this operation, the central government decided to involve local partners. The councilors, the chiefs because, they realized that Ebola is a community owned disease and only the community can disown it.[H52] and because they realized that, since its community owned if the community does not decide or play a role to disown it, this will be a problem. So you have to engage local partners actively. [H53]They have to participate, you have to involve them. Before, they were not involving local partners. [H54]It was structures from the central governm coming upside down. While it must be bottom to top. So we love to see an approach coming together in local
community, because they see local solutions and we look at it. very much great divident, [...]

Really it was way better?

Yes it was way succefull. We started this at the end of December, 30th and not only, no chrismas, no new year. We are all fighting Ebola, very strongly because it was really eating us and very seriously. [...]

That is very interesting to hear. And were all the people in the community involved? what was their role?

Yeah well, all played a role in the sense that we created, their role was support. Whenever you see that someone is infected with Ebola than you should report it. See it as possitively gossip. You see somebody that is strange to you: report Also if you realize that someone is sick, you report. It has been very effective. ‘Councilor, i suspect somebody is sick there, come with your team’. You call and we go there to see the person, if you see he is sick, we call 117. Most times, malaria, but we want to make sure, we dont gamble it. as long as you are sick, we pick you off the community. We treat you because we not know i fit is Ebola. Because some of the symptoms are very similar. You know, vomiting, weakness. Very very similar. so as long as you are sick, Ebola or not [ claps his hand ] hospital.

And how did you make sure that everybody had the information, the knowledge?

We had towncriers. In our neighborhood support team we had towncriers, we bought megaphones. We divided the ward into zones. 5 zones in the ward. In each of the zones we have a towncrier with a megaphone. Very early in the morning we start giving information Ebola. And that if your caught or you keep information and you dont give information, you will also be held responsible. So very early in the morning, from 5 oclock, 6, 7 and again at night. 7, 8, 9 when people are back home until 10 when people are going to bed. We would give the message. And those message are very much effecive. so very early in the morning and very late in the evening, everybody was very contious. we make people contious. The effect of Ebola is very serious to everybody. Its not a joke, its a killer disease, it is real. When it started, some time back people did not believe it was real. Until they came to a point when you saw people dying with your own eyes. Not in Kalaba anymore, but in Freetown. They saw it with their own eyes.

Then we started passing bylaws, and if you dont do ABC and someone is death, just dont touch, complying. and to understand not everybody that died in our ward, died of Ebola. Now, people die in the hospita land not in the community. Even those that died at Maxwell, where picked up. Those who were to die, died in the hospital not in the community. So the towncriers were very much effective. We had teams in all 5 zones, they emphasize again and again how dangerous it is, how serious and the bilaws, the penalties if you take up anybody is sick, if we catch you, you go to jail.

Really? You go to jail?

Yes! 6 months. If you hide in your bed. or you take a sick person or you hide a sick person in your home, we will penalize you, we penalize you. When someone is sick, they will call. My phone was always engaged. ‘councilor, we have a sick person here, councilor you have to come,’. So, i moved my team , we go there. So, to a good extend we have these proactive measures, we took it as our own fight. Because the community realized it is our own fight. We did our best, cause little was coming to us. Even resources, not much was
given to us. For this operation they provided us phones for free calls for .. around and to a
good extend we had communication that was free. Sometimes when I want communication
with you possibly there is no credit on the phone. But when there was a free line, they
always called ‘councilor’. [H71][H72]

And the free line was for proved by?

UNFPA. I had 15 contact resources. Always, when people had problems they call me. They
call me directly and we go to house adres, we meet you there shortly, so to a good extend ...
We also had social mobilization that was GOAL is an NGO, consist of 5 NGO and we had
also GOAL Ireland was working in our ward with social action.[H73]

So you were working with 5 NGOs ?

No, this mark is composed of 5 NGOs. We have one of them is GOAL, they were working wit
hus in our community that was GOAL. So GOAL was working with us in this Ebola response
as NGO.

Also other NGOs?

There are other NGOs. But specifically GOAL is very responsible but also ACF, Oxfam was
providing WASH facilities, working in other communities. [H74]We also have GOAL working
in our ward.

Ok. And was it a good cooperation?

Well to an extend it was a good cooperation. Just that with the WASH. The area of deprived
area that have less WASH facilities, they are not able to bring facilities back in the area of
Maxwell. The water comes from that end, there is a rich stream at Maxwell and this water is
tapped and brought down to the reservoir and send to other communities. While those
communities are left deprived without water, even though they have the actual stream. So
the water is taken and supplied in another community. So weve been talking to GOAL to
show that they move back facilities, its very challenging. It is tapped and taken to other
community. It is very much challenging, were still engaging GOAL to provide those facilities.
It is an area that is richly endowed with natural water and still they are deprived, they tapp
it, they take it. Water is up to the gravity, flows down and has to be treated and has to be
taken back. We have to foster the reservoir to treat it.[H75][H76]

Because it gets more dirty along the way?

Yeah. But we have to take it back tot he community. Because they think the water cannot
go back. So those above the tank level dont benefit, its a very serious problem. Very serious
challenge. And also the area of public toilet, when you have streams running down to the
community you have poor facilities. It will just go to the streams and when they do the
bathing or laundry, even urination and defication takes place in the stream. That is not
hygienic at , it is very disturbing, so we need room for public toilets around, so that if they
do their bathing and washing and they feel like it, they go to the toilet other than doing it in
the stream.[H77] That is really disturbing.

I see. And what are the main problems the community is facing due to Ebola ?

Well, as ive been telling you the main problem is ehm... basically i would say its WASH. [H78]Because the lack of having water facilities that keeps you away from going into ques,
going struggling, fighting for water and toilet facilities, then, the issue of you touching and
doing your things , also when you dont have toilet facilities, there is the risk that somebody
that is sick and can easily infect the other since it is not proper. [H79]So, these are some of
the things that are

.. And the employment?

There is communities, i would say those that are working. In public and private sectors less
than 20 %. Most people i would say the others, employment i would say is about 60% but 40%
is in the informal sector. They do business for themselves, they work for
themselves.[H80] And id say 20% works formally in the private or public sector. Then 40 %
self employed and 40% unemployed. We have lot unemployed. They just go and si tand
just dicuss issues. Employment among the youths very high.[H81]And others in the
informal sector work for themselves, some are traders, some are farmers, its a challenging. I
would not say they are unemployed but it's very very challenging. Sometimes they do trading fort what they eat that day. So you go to the garden, you do your garden work take it to the market and sell just to make a living, to have a little. So livelihood support for those people would be very much interesting. Sometimes the relatives decide to do something for themselves even though it is not adding much more income but it's better than doing something and even those things must be encouraged. Even those that have kids that are going to school and have to pay the charges or prepare themselves with school materials. we go out there, sell something to have food for the day. Its good that they are not totally unemployed, self employment so they go out and create for themselves livelihood.

- Yeah, a few more. Do you have time for more questions?
- Off course, I am here for that.
- What do you think, are priorities in fighting Ebola? Right now and also on the longer term?
- Well, the priorities in fighting Ebola. Well, the issue of communication and information. We should keep engaging people to become very sensitive and aware of things regarding Ebola. That is why we keep communicating. That is why we have been talking talking talking to the central government for the councils, cause we have structures. We have work committees, 10 of them. We like local cabinet, we call regular work committee meetings, every month it is obligatory. So supporting local government structures is one thing they should do, its a solution. Because when you come to local meetings, people come with information, take information. And we tell the council information from the meeting, it goes a long way. Every ward, we have 49 in Freetown. Every Ward has meetings every month. So having local community meetings, enshrining the local government of 2004, should be supported. I am talking about they are not, nothing is provided fort hem. And this ward committees they are not reinumerated, provided for them. We also as councilors are not paid.

- Councilors are not paid?
- No, so its very challenging because when you look at a job it is very time consuming. Almost call at night ‘councilor we have a problem’ ‘There is a problem there, we need you’
- So you are always on call?
- So they are looking at it as a part time job but the community assistance committee wants to .. anything that happens so ‘councilor councilor’ So you are engaged endlessly.
- And you are the only counsellor?
- No, we have 49 councilors in this city.
- Yes but I mean in your community?
- Yeah yeah, in every ward there is only one councilor.
- So you are a busy men.
- Very very much.
- But very very interesting, i like it because you have time to give to your people. In terms of giving to people you are the best platform. You have to give them attention and if you have ideas you're on the best level to take new initiatives as a councilor. Because it is alla bout you putting ideas together, Because as the ward committee there is a focal point we are discussing problems within the community. Even when this is we used to, water and sanitation is the most pressing need. Water is most pressing need. Sanitation, we dont have a dust bin. Garbage we just put there cause there is no dump sides around. People take the garbage and throw them in the streets. It is really disturbing.

- Do you feel supported by the government? In finding solutions for this?
- Well yes, to an extend because we have masala working in that line, masala is contracted to do cleaning in the future. But it is still challenging, community that are off they are possibly also, we have the ministers they are way down in the west so they pay less attention to us. I also did a project on water sanitation with the brewery, that has been done. Because Susan came here some time back, visits and so we accessed the form, ... follow the form water and sanitation project we had a vehicle that was going allong the streets to pick up garbages and then take it down to dump sites. They are also going to help us with the
water resource we have, they are going to take it up there on melon street. Well if that is implemented then, to a great extent problems will be solved. [H92] The water issue is very serious because when you look at other diseases, water born diseases if you don't get garbage properly cleared of the community. [H93][H94]

- Yes, because I wanted to ask you if the community is vulnerable to other disasters like Ebola or other diseases?
- [phone rings, picks up the phone] this is important, very serious, 10 cases today. Close to Liberia.
- O...
- So as I said, water and sanitation most pressing need because they link us to other diseases. When water and sanitation is neglected, they create a place for other diseases to survive like diarrhea malaria, tyfus, cholera, .... Even when the water will settle it is a breeding space for moskitos, lots of breeding ground for muskitos because of water and sanitation. That is why almost as an emergency for us. Get the tools, get the vehicle, whose commission needs, no garbage in the street anymore. [H95] That alone for the sierra leone brewery that will be so popular every household, every doorstep realize that brewery with cooperation is helping this community to do this and they really affect every individual, every doorstep in the home.

- Very important yeah
- [Yeah very important, when you take of, when you do it effectively then 'o brewery, brewery, they have been helping us yeah'. The elderly know it was there, cooperation in personizing, o these are our friends, they have been helping us so we will buy the products, we will go for the products and avoid other products because [H96]
- Ok, good cooperation, nice. Eh m I have a couple of other questions. I was wondering, what do you think is the link between poverty and Ebola? Is there a link?
- Yes I would say there is a link. Because, if you look at vulnerable communities, if you have people clustered in slum areas, if you are not poor I don't see any reason why those house are so clustered, they are not proud to call it homes in fact. So when you see the toilet facilities, very close your eating there you have poor sanitation, poor hygiene in those communities and that is were Ebola wants to triumph. Other communities, they have access to water it is very deployable. Not clean, safe, tapwater people go there and so poverty has a lot to do with Ebola because, ehm well poverty ignorance and illiteracy are key elements of poverty, when you lack education, you are the poorest of the poor. [H97] You see, because most of these communities, the issue of ignorance, when people have questions, what is life? what is Ebola, they have got information, the people they take it very serious always want to seef or themselves, there are always things they don't want to believe that this thing is real. Because, when homes are quarantined to a point they got free food. They want to look at it as a kind of livelihood. New livelihood is Ebola. Because your home is quarantined and a supply of free food you think. We had a case, when a quarantine home was supplied with food, somebody came come and see my home and i want quarantine, for the food you see. So poverty has a lot to do with Ebola, it is key. Whatever it is that is given, people want it. People go into quarantine homes for free food. People have got infected with Ebola because of it. When the resources are there, they don't mind the danger they go fort he resources, thats poverty. People want it, people want to mingle with those who are quarantined because they want the food! Poverty line here is very serious concern ...

- Oo .. And because of Ebola it also goes down i think?
- [Yeah the Ebola now is also hitting on the economic. So, people because of poverty ehm people it affects Ebola, and povery effects Ebola and Ebola effects the economy][H99]
- So its both ways?
- Yes yes, vice versa you see. And because most businesses, we will appreciate the initiative of the WHO who are coming to support but this sickness is here, it is a real dreadfull disease. Poverty is and Ebola are bed fellows. [H100] When you want to go for things, you’re
trapped .. when you go to homes ... I would not say their power, we have a lot of control measures you see. You go there, I have my hand sanitizer, I will test my temperature. But in poor environment, you can not do that. So poverty has very much to do with Ebola.

- Do you know the concept of Disaster Risk Reduction?
- Hm Disaster Risk? Prevention?
- It is actually almost the same as prevention yes.
- Because we do have disaster prone areas, areas that are prone to disasters.
- Yeah and then if you take preventive measures, that is disaster risk reduction. Because then you reduce the risk of
- Ah yeah. Disaster Risk. The issue of reducing the risk for disaster, yeah because as I said, if you some time back as a councilor, it could be lots of times the area gets flooded. To reduce the risk, we try to move them but they will tell you 'we are born here, we are used here, i have been living here for over 50 years'.
- Really, they dont want to?
- Ah its its a very serious challenge. The issue of moving them. If you want them to go on their own they will say 'i was born here'. The attitude of, its an issue of adaptation, so you dont move them. Also, in the inside community we have a community that is prone to disaster. People just go inside, the area of marketing cause most times in our laws ... Government control but people want to build in the street, I have my documents and even though the area is very much prone to disaster they will go there just to say I live in Freetown, I live in the city. So we can move disaster committees, so lots of disaster prone areas that risks have to be reduced by way of well the line ministries because like, state house we have a disaster management. Laws are there but actions to move them from those areas, those are the areas people dont go. They want to resil in the city. Its a very very serious challenge, very disturbing.
- I see. And eh my last question is, the concept of resilience, does that ring a bell, is that ever mentioned?
- The concept resilience..
- It is a word that is in policy documents of the government or NGOs, they use the term community resilience very often. But is this used in the community itself or not?
- Yeah because well in local communities, the issue of community resilience is not being used. Possibly, maybe in another form but it is not being used in another form. If you want to talk about resilience, put it in local words, break it down in other terms.
- Well, i think we talked about resilience all the time because for me it means that a community is able to cope with disasters and diseases, without ehm suffering too much. So it means for example, if the WASH measures would have been there, then the community would be more resilient because it would be better able to cope with Ebola. Do you understand what I mean? but its very interesting that you told me that the councilors and chiefs and community itself that is doing the most important work actually and there is a gap maybe with the government, right?
- Yeah yeah off course. I will emphasize again and again. As a counrty, from 2004 we are local functions. When it comes to particular towns we dont see these ministries government agencies, they dont want to devolve authority to the councils. So if you talk about resilience, and I talk about adaptation sometimes, people when you look at some areas where people reside, and they have been there fort he past decades, over half a century, they are ready to cape, they have adapted. Whilst if you go there, you’ll be sick. They have adapted, they have been living there. So if you talk about the issue of resilience, then eh as i said it has to do a lot with adaptation.
- Yeah yeah off course. I will emphasize again and again. As a counrty, from 2004 we are local functions. When it comes to particular towns we dont see these ministries government agencies, they dont want to devolve authority to the councils. So if you talk about resilience, and I talk about adaptation sometimes, people when you look at some areas where people reside, and they have been there fort he past decades, over half a century, they are ready to cape, they have adapted. Whilst if you go there, you’ll be sick. They have adapted, they have been living there. So if you talk about the issue of resilience, then eh as i said it has to do a lot with adaptation. Even in some areas , when you go there something smelly but when you’re inside you dont be sensitive... you’re part of it. so, adaptation, we africans we have very much we will be sick from the bites of a muskito whilst the whites very quickly get sick. Eh, well the system in Africa ... I also want to refer to the issue of those that are crazy. The mad people. You see the madmen, what the
madmen does or what he eats, in the dusbin or just imagine when they, this is very much, Ebola is strong but that crazy men he hardly gets it. People that have the mental disorder or leap in the they are very much vulnerable to Ebola and all disasters but they somebody that is not going close to whatever he is doing. They have been there, in the slum, in the street, they are adapted to those situations. So adaptation .. So whatever has been done .. those conditions, those facilities, if you have malaria and you are not treated for it its Ebola. Do your best not to get diarrhoea. Those kids not adapted, are just few months, close tot he garbage. You try it, you will get very sick. It is in any kind of food. Because of the issue of adaptation, cause they cannot adapt to the system in short time .. and it affects the human resource of the country …reduce the risk of disaster, of people getting sick. Our resilience is not good for human beings cause they cant adapt. […]

➤ I understand. Thank you very much for all the information.

Visit to Ward X, Wellington community (together with councilor) [H109]

3) Interview during field visit - visit to the pastor, also owner of the Ebola orphanage house. [H110] [H111]

Children of several communities, 16 girls and 5 boys. For now, school is the first priority [H112].

Problem on the long term is funding. [H113] Everything is new and looks good, there are bednets. It is a challenge to feed the children regularly. [H114] Not just now but particular worries about longer term, what will happen next year? Clothing is also a priority, it will give them more confidence. [H115] The orphanages all used to live with their parents but family members now neglected them because of minimal resources. [H116] Measures that are taken against Ebola: 3 times a day temperature. The well has just been built, this is a preventing measure for they do not have to collect water etc: Not going out means not carrying it inside. [H117] There is cooperation with the government but no direct support. For example technical information, passes via government through the council to the locals. For example, the policy of having a home. [H118] These orphanages were registered formally and are recognized as such. The councilors drops by to check if the rules are adhered to (3 times feeding per day for example). The council imposes laws etc to make orphanage legal. [H119] [H120] There is also cooperation with one NGO: Develop Africa. Do the NGOs respond to the needs on the ground? Sometimes. Such programmes are driven by funding. So not always. HR aspect: GOAL. WASH: they say they are building wells but in reality, support is lacking. Probably because their attention is pointed toward the 'real' slums. These have priorities. [H121] This community left out with little to no attention. We simply can not wait until help comes from them. [H122] [H123] What would be your priorities in helping these kids?

- Ensure academics and school materials
- Environment
- Clothing
- City council: tv is needed. Now only 1.
- They do have solar light. [H124]

Visit to a second orphanage (not necessarily Ebola survivors):

- 42 kids and more to come. No bednets, no medicine.
- No real Ebola prevention measures (resources are lacking). [H125] According to the councilor they dont go out. [H126]
- Fully registered. Policy guidelines. Close to the home
- Better after Ebola.
- Medicines needed. Try to feed them 3 times a day this is also obligatory according to the council and they gave them food when we arrived [H127]

Council: devolved government staff into council. [H128] [H129]

• Visit to School project: boys and girls Aid. Locally. School director. [H130]
80 children in school, goal is to make sure that all Ebola orphanages go to school. Fear of disease makes relatives reject these children. Poverty because of Ebola hits them hardest. 

- Organization SMAC gave sanitizer and chlorine to community.
4) Interview during field visit: Chief & judge of taoroad hillside (only speaks Krio, translated by counselor)

The chief says there was no quarantine here, no Ebola. There was Ebola pretty close, just a few streets away. At this point, street laws are active. Nobody got infected because they did not allow no strangers. If you do, you should pay a 500.000 LE fee and go to jail. For development, the most pressing needs are water, bad roads, the poor drainages and garbage disposal. Also a hospital and public toilets are lacking. Usually these kind of development projects are run by NGOs and not the government. Most of the people here are informal traders. The role of the chief is to be a kind of judge within the local court. She is occupied with conflict settlement if something bad happens and she helps the youth from time to time, also she coordinates self help programs. During the war things weren’t easy. The rebels came and overrun the place. Everybody had to run away to the city center. They burned the houses and they rebuild them afterwards. There are some positive sides to Ebola. Now, more people are trained, we have more ambulances and the government decided that government schools will be free the coming 2 years. Also, people now better how to avoid Ebola now. It looks better, even for malaria and measles. Ebola is poverty related because when Ebola come there is no business. Business means you’re not poor. Also, you are not easily affected if not poor. It would never arrive at hill station (e.g. rich area). We have to go out. What does poverty mean to you? (counselor answers: lack of education, not having basics in life). Why was Ebola able to spread? people dont believed in it, stubborn and they dont go to church. The chief is also part of the working committee member of council, she works with several organizations. Now, the priorities for development are: 1. Road 2. Hospital 3. Water. Ever heard of resilience? [silence] No.
Respondent 5 - guard (male, age around 20)

H: what would you say was the impact of Ebola on your community?
I: the impact of Ebola on my community?
H: yes. The impact.
I: well. ... of course have affect us in the community so much. Because some of us like ... we have people that use to help us ok? But because of Ebola that has stopped. So because of Ebola, we are suffering. People who used to help you, because of Ebola, people we meet ...
H: what do you mean with people who used to help you?
I: well, in terms of our problems.
H: yes but who are those people for example?
I: maybe like our elders, or even the counselor, when you meet him and explain things to him maybe he will help you but because of this Ebola this is now closed.
H: its not possible anymore?
I: its not possible anymore yeah.
H: So, uhm, you are suffering in terms of what?
I: in terms of Ebola.
H: yes, but is there for example lack of food, medicine? or what is it that is needed?
I: well, like me for example. I need help in terms of food, medical, we dont have these things.

H: is your whole family living in the Wellington community?
I: did your community ever experience similar things like Ebola?
I: yeah, like cholera, malaria, [ silence ]
H: and how is that similar?
I: vomiting..
H: and if you look at the consequences?
I: yes it is similar ...
H: Ok. How did the community react to Ebola?
I: To reject?
H: No react, to cope with Ebola?
I: To cooperate with Ebola?
H: How to deal with Ebola,
I: o to deal. Well, people told us that you have to wash your hands, don't have to touch death bodies, when someone is sick you have to call 117. All this ways we are fighting Ebola.

H: and do you think that everybody did that? everybody took those measures in the community?

I: Yes, like all of my neighbours died from Ebola.

H: Wow, really. So how did you make sure that you did not get infected?

I: Well, like the example of our neighbours. In that time, we had so many small children. We had to put them in one place and let them not go to other peoples with Ebola. So these are the ways we prevent ourselves, up till this day no contact with them.

H: so they had to stay inside?

I: Yes, putted them in one place. Because for small children you don't know you see.

H: And how did it affect you? Did you work during the peak?

I: our uncles working in african mineral but because of Ebola, up till this time no work.

H: and for you? Did you work?

I: No. I stopped working in June 2014 and started in February 2015.

H: so they had to stay inside?

I: Yes, putted them in one place. Because for small children you don't know you see.

H: And how did it affect you? Did you work during the peak?

I: our uncles working in african mineral but because of Ebola, up till this time no work.

H: and for you? Did you work?

I: No. I stopped working in June 2014 and started in February 2015.

H: and was everybody involved in responding to Ebola?

I: what do you mean?

H: well, was everybody participating in fighting Ebola?

I: o yeah yeah, everybody because some people started denying but because we have seen people dying people started to respond to Ebola and realized that Ebola is real. But when people started everybody said Ebola is not real. Government aws finding money to keep it .. because Ebola have almost come closer to us, now we believe it because we have seen people dying. 9 of them .. all of them died. So we believe that Ebola is real. So now we are starting to apply the measures that the government was telling us.

H: I see. And some people were trained right? Who? Was it voluntary?

I: yes its voluntary.

H: and you didn't want it?

I: haha no i never trained.

H: And why? were you afraid?

I: yess off course.

H: so people are dealing in a different way with Ebola than before?

I: Yeah.

H: what do you think is needed to eradicate Ebola?

I: well. People now believe that Ebola is real, when someone die your relative die you have to call 117. so if we do that, Ebola will go.

H: And, from the community to recover from all this? What is needed fort hat?

I: the help that i need for the community?

H: yes what is needed to recover? because there were losses right, financially, .. So what do you think is needed to recover from that, to come back to the standards you were used to?

I: O. these questions are interesting hehe. Eh..

H: you dont have to answer.

I: when Ebola is finish, what i need is that what you mean?

H: what is needed to get back to the standards, that it gets back to normal, whta do you need fort hat?

I: ...

H: maybe jobs or ..

I: yes yes we need jobs, because if we have jobs people can return to the normal business. And also education, medical, someone cannot live without medicals.

H: you know that you can go to the doctor there if you need he?

I: ok.

H: who is the onethat is responsible for fighting Ebola you think?

I: [immediatly] the government.
H: Ok. And, can you describe the role of the government? what they did?
I: like this disease Ebola. The government can recall from donor partners, government response, ... doctor when they are working government is responsible to pay them. So finance is the body of the government. And to sensitize peoples. All these things. [H168][H169]
H: and did they do that for Ebola?
I: yes yes.
H: so do you think they played a positive role?
I: yes at least they tried. Problem is that Ebola, Ebola affected this country because of politics. Because someone used Ebola as politics because when the ruling party said Ebola is real, the opposition party said Ebola is not real. That is why it affected this country so much. [H170]
H: but now everybody admits that its real right?
I: yeah.
H: and, do the communtiy and the government cooperate?
I: yes. We have government people there. The councilors, the MP.
H: and the councilor is in between the government and the community?
I: yes. Because when Ebola came the government peoples came to us to tell that Ebola is real and be carefull you see. So that is why i said that they were working together. Because the government is passing the message to the councilors to the honourables, the honourables meeting ... [H171][H172]
H: and ... for example, do they also giver resources to figth Ebola?
I: yes. The honoroubles gave 64 millions ... came with this money telling people ... buying this rubbers, soaps, ... [H173]
H: so 64 million for the Wellington community?
I: No for the constituency.
H: Ok. And did the community receive help from other organisations?
I: Yes. WHO. Responsible for children without going to schools, those who are not working anymore so WHO take these people to fight Ebola.
H: Ok. And other organisations?
I: IOM. UN, Red Cross. [H174]
H: and local aid organisations?
I: Like which?
H: Like built by someone from Sierra Leone.
I: No.
H: i know for example, there is a pastor on the hillside and he set up an orphanage for Ebola survivors ...
I: O yes i know about that. And those who are living in Americas, they are giving support.[H175]
H: and is there cooperation with other communties?
I: let me just say, all communityies are participating. We are all tired so we are ... 
H: what do you think can prevent diseases like Ebola, for the future?
I: according to the well body people, when someone is sick you have to go to the hospitals, dont sit at home. So when sick go to the hospitals, when someone dies, dont wash the body. When we do this we prevent Ebola. [H176]
H: hm. And, maybe more in general, what is needed to prevent diseases like this from happening?
I: what i think, in the community, you have to clean the community. When its clean, disease will .. because some communities dont have toilets and then diseases spread. [H177][H178]
H: is the community in some ways better now than before Ebola? are there any positive sides?
I: yes. Like the neighbours those who got well from Ebola. The governemtn is responsible, they took them, to help them yes. Those who are working presently, government gave them work. Like these organisations IOM they give them work. [H179][H180]
H: good. And would you say there is more money available for development?
I: I dont know.
H: Ok. Do you think Ebola is related to poverty?
I: relating to property?
H: No poverty, being poor.
I: O yeah definitely. When youre sitting without no working, just waiting that is related top our.
H: And is Ebola also more likely to occur in poor places?
I: Ebola affects anyone, rich and poor.[H181]
H: But for example, at hillstation, could Ebola be there?
I: Well, i dont know, i dont live there. But the rich people have everything, they dont need to go to the market ... they are always at home or in their vehicles so they dont get infected ...
H: what do you think is needed to reduce the poverty in your community?
I: to help us?
H: yes, sustainable, that the living standard is becoming better on the long term.
I: its alla bout education. And finance, because some are not able to go to school now. And also jobs. When you have jobs, life is good.[H183][H184]

Respondent 6 - Visit to ward 350 with councilor [H185]

[The government devolved some tasks to city council level: primary health care and partly disaster management.][H186] Garbage disposal, air pollution and drainage as biggest problems.[H187][H188] All hazard, leads to disease. [H189] Road pipes working on. Flooding problem(mud): comes from down the hill, Bednets are supplied. Government triest to mitigate floods. Road was built as initiative from government, [H190] but blocs water drainage which does not allow the water to get through. The water now stays still and is filled with garbage. Mentor (engaged in building bridge): water destroyed the house, bridge being built now, in the end we will build sort of damms. [H191][H192]

[The most difficult problem we are facing now is how to cater for the orphans (educationally, housing, clothing and feeding) and widows as some of the dead are the bread winners of these deplorable families.][H193]

[Presently my ward is prone to other hazards/disasters than before the outbreak of Ebola.][H194] Such disasters can be categorized as tangible and intangible. Tangibly, as you yourself identified, the manner of garbage disposal in my ward is disastrous and unhygienic which is a recipe for the contamination of infectious diseases which at times leads to the loss of lives or chronic illnesses such as cholera, dysentery, typhoid fever, malaria to name but a few. [H195] Also because the national water company (Guma Valley Water Company) is inefficient and cannot supply the entire municipality of Freetown, there is a high shortage of water especially for people living in mountainous communities like my ward were over 75% cannot access safe, pure and clean water. This also is another factor that causes disaster for residents of my ward especially school going children who at times misses school or go to school late. Others became pregnant as they spent the larger portion of the night fetching water. This factor is a recipe for teenage pregnancy and then early drop out of school. [H196] Intangibly, the disaster my ward faces now than before Ebola is the deplorable conditions Ebola victims are facing as mentioned in question one above. These has created a lot of hardship for these category of people especially women and children of these victims.[H197]

- Do you see any positive developments related to Ebola?

[The positive developments I have seen with relation to Ebola is the government’s and developmental partners efforts in upgrading the health sector because before, there were not more than 20 ambulances nationwide but now, we can boast of over 200 ambulances nationwide. Also before Ebola national staffs medical caliber was low but after going through vigorous and sustainable training sessions and programmes, the profession has greatly improved. The free health care for children]
under five years, pregnant and lactating mothers instituted by the government even before the advent of Ebola is still a development to reckon with as it is ongoing. Also, government has instituted a free educational scheme for girls so as to help them recovering from the nightmares of Ebola which is a development highly welcomed. The transport sector has also been beefed up by government by providing 100 new buses to alleviate the deplorable transport sector created by the advent of Ebola. Lastly government was strenuously striving to upkeep the energy sector as it has to side by side fight Ebola but now, there is immense development in the energy sector as there is 85% supply of energy for now as compared to the 40% during the early days of Ebola. This also is a massive development. 

[H198][H199]

[Only in this ward: There is a law that prohibits to dump garbage, you need to pay 500.000 and get arrested. But is ineffective, people are used to it and will do it at night. [H201]since 2 months garbage collecting initiative. People need to pay 2000 leones per week (€ 0,40), takes time to get used to it. [H202]Educate / awareness raising necesary for it to make it work. [H203][H204]Youth initiative. Pass on info. Imam used, church, youth leaders. Air polution because of industrial estate. Chemicals, CSR but some factories dont adhere. [H205]When we pass the market, a lifely discussion with the market women follows: they want the garbarge collection to cost 1000 Leones a week (€ 0,20) [H206] NGO helping would be ideal. [H207][H208]Garbage comes down. In this ward, about 15 people with Ebola[H209]. If you compare, this comunity a little better than others. Because, strict measures. If someone dies, he monitors until people come to pick him up. If someone is sick, he monitors until picked up. [H210][H211]According to the counselor, chronic sickness leads to Ebola. [H212]Everyone who is sick removed. Biggest issue now is how to take care of the widows and Ebola orphanages. In some houses only children. Need to go to school, big problem. [H213]

House to house visits. First top-bottom approach, did not work. Then bottom-top approach, is better. It pays in positive way.

Before Ebola PR measures. For example, initiative by government to create a forum for aged people. Sort of local pension. Some old people have nothing and are in extremely poor situation. Everything went down when Ebola came. Other programmes. By youth atire base.

Poverty and Ebola are highly related. People don't go to hospital to be cured, then it becomes Ebola. Dependency also an aspect. People here have got to take care of many many people if they have a job. Is related to poverty. Also the other way around, no money from one to other, they run and spread it elsewhere. To believe in traditional healing is more cheap (now it's free).

Resilience? What? We call it to 'fight'.

Youths important role.

Only NGO that has done something in community from 2012 on, is GOAL. No further interventions.

Garbage disposal >> disease. Cholera, typhus,

Points made during another meeting:

- The government left us out.
- From April 2014 on, more involved. Before they were just writing some reports and doing radio, but locally we did house to house visits. It was way more effective.
- There is national recovery plan, starts to come down. However, care for orphanages and widows is big problem. This group is not part of Ebola survivors and are among the most vulnerable.
- The orphanages literally wander through the communities without a home.
- Funds via IC and government through DERC to communities.
- November: some development projects have been started. They are building a school now (government initiative).
- No help from NGO's except for GOAL who is doing some WASH projects.

Respondent 7, male, driver, approximately 40

What do you think are the main challenges the community is facing, due to Ebola?

... That's a big question you know... so the problem eh for stop the Ebola, is going to keep by yourself, don't touch death person, don't touch person that is sick, don't touch the wets, sweat, all the way the Ebola can stop.

Dont go to the Q bar haha

Haha no dont go to the Q bar. Dont meet with people, you see.

What are the effects of Ebola? How does it influence the community?

Well, if one person get the virus, and they don't go into the hospital, keep on going. They hide and go from one place to another and leave the virus no, so the virus can spread. But if you have the sick, you find out you have the Ebola. The first you are going to do is go to the hospital. They are going to check you. If you're getting the Ebola treatment, maybe you'll survive. Like this you see, this is the biggest problem.

Do you think the community is suffering now, more than before Ebola? Like is there enough food, employment?

Eh suffering... Well the government, if they find this house with Ebola there, you understand, they put the people there together to quarantine. No food, no water, how you expect the person to heal? Is going to be more sick, that is the problem. But if you put now people in quarantine, first thing they give water, soap, and some people use coal to cook or use the stick, all of that... nobody get children in the house and buy biscuits and give them drinks... one of the Ebola, government has to take care of them you know. So the
biggest problem: the food. Thats why they put the quarantine in this house, 1 day no food, 2 days no food the next they broke the door and escaped.[H234][H235]

- But I thought they were given free food to quarantine homes, right?
- Yes yes but some people hold the food to themselves. Thats why the army take over. You know the one time I showed you the ration of the army, so they look after the people. They give ration. [H236]
- It was ration for everyone?
- Yes yes.
- And that is new, they do that since Ebola came?
- Hm hm Yes, since Ebola came.
- I see. Do you think there are some positive sides toe bola? Maybe any development?
- In the community, yes because, they come in this house. They will going to change the bed sleep with, going to change the pillow, most of the things you where in contact with, put fire on it, burn it. Spray the house with chlorine, clean and they get other things to you. To the survivor.[H237]
- Ah so you get new things?
- Yeah all new things.
- Ok Ok. Do you think the Wellington community is prone to other disasters?
- Like well , the wellington community Ebola not come yet, wasnt here, the biggest problem is the thieves. They are stealing, come into the house in the night. That is the big problem of wellington area. Cause power is down and gets darker you know and watch people, how are you doing, enter the night in the house and steal the property, take money. [H238]
- So you think that is the biggest problem?
- Yes. But now is Ebola, no stealing again.
- And other problems?
- Eh like .. No. Biggest problems is thieves. So the area is safer, because we dont always sleep.
- How did the community cope with Ebola?
- Well, some areas are safer because people look after each other. Some poeple look healthy, or the other time i saw him. Say maybe in the corner and make the call ‘I have somebody in the area that dont look bright, so please come’. Secretly, maybe the person will come and say that person is a bad enemy .. going to help .. [H239]
- And are people educated to deal wit hit?
- Yes yes. Because, some community, we go there and ... stranger and they dont know me in that area. Then somebody will come and say hey friend how are you, where are you going. Are you telling the commmunity or the elders or the chief? Say no..... i just visit and come back if you want to stay, they wont allow, go back where you come from. [H240]
- Did the community receive help from other organizations for example?
- WHO, NERC, some others I dont know th name where all NGOs come as one to fight ...UNMEER...
- What do you think is needed to recover from Ebola?
- The problem is left with government .. during ramadan you saw the beach you see, crowded ... so, that ... government really tried.[H241]
- So you think they should be more strict?
- Yes. You know the police .. ? Ok, they should give the money and .. quarantine and go out ... virus maybe person Ebola ...
- And why do you think Ebola was able to spread ?[H242]
- Denial. And politics, the government want to play game, we have the true men party, we have SLPP – the green Party. So, .. they not calling the sick ... so presidents they say no, they no want the people to come out, they want the vote... denial caused this problem ... [H243]
- What do you think is the role of the community itself in fighting Ebola? What do they do?
- Because most of the people, ... some neighbours ... people still go in the water – that is why it spreads. People from Guinee come inside Sierra Leone you know, they left the Guinee
People still pass the border, .. thats why government banned more and more boats
... They said any boat coming in, we turn him back where he is coming from.

- But thats not the case now anymore, right?
- Its better now.
- Do you think that Ebola is related to poverty ? Poor people ?
   - Yes, .. i dont see the big man with money having Ebola, the only thing .. big man in the
     finished house .. poor people live there. Since they finish their house, ... maybe build a small
     .. one day a big men .. But one day i dont see the Ebola patients .. They no come closer
     haha.. somebody died

- Do you know what resilience is ?
- Hm no. 
- Ok.

After recording:

- WHO put tank for water. Was daarvoor heel groot probleem. No Ebola at all-in this ward.
  Now: chlorine finished
- Mentions Ebola songs. Before entering the school, they sing a song.
- People from port loko etc come in from sea, daarom military aan de kust.

Respondent 8, male 22 yrs, cleaner. 

- So ehm where there people within your environment infected with Ebola?
  - No. In my own environment. No cases in first 30 houses within my own environment. No
    Ebola there.
- Ok. And can you describe the main challenges that your communiy is facing due to Ebola?
  - Ehmm the challenges that the community is facing duet o Ebola is like no good food for
    people, some lost their job during the period of Ebola, so that is not good even in drainage.
    We dont have good drainaging in our community and garbage, can’t collect garbage we
    don’t have this kind of opportunity. People take their garbage through the drainage , even
    in front of our own houses the drainage is very damage and people put their garbage there.
    These are the problems and challenges we have in our own community.
- And is that related to Ebola?
  - Ehmm i mean that causes a lot of problem. But for us, if someone gets a fever you go tot he
    hospita land i fits only fever they will treat i tand i twill become okay.
- And do you think, all those challenges you described, ehm did the problems got bigger
  because of Ebola?
  - Ehmm yeah in some community yes.
- Okay.
- Not everybody got electricity, me for example we dont have electricticy in our own house.
  And that is related to Ebola because some people go tot he other houses with electricity,
  watch a film and other peple come from anoth
  - OK. And did the community face other hazards like this in the past?
  - Ehmm in the past. cholera have been for i think for 3 years also in my own community in may
    areas and we survived that and no one got it.
  - We have a lot of opportunity for some of these crises affect us. Really the finance, the food that all affects is. Those diseases that
    come into the country but our own house no problem.
- Hmm so why do you think that was the case? Were you very carefull or ..?
- When something is coming up that is very dangerous, if any advice is coming out ‘don’t do
  this’, ‘if you do this you become infected’, try t do what the advice says. That is the way we
  are doing in our own area. If you do that then maybe you will survive. That is how we do it
in our own area as earlier, when we heared about Ebola. The advisers say that protect yourself and be very careful dont touch that particular person...[H258][H259]

- And you immediately believed?
- Yeah we immediatly believed, yeah it was true when we see the doctor die securing the disease. so if, [H260]
- Did you know the doctor?
- No, during that time we don’t know. The only doctor we know now in Sierra Leone was securing the disease in Khailam, dr Khan yeah and he died. Because he was securing the disease maybe between one month. He got contacted through another person, some people were surviving some die, some die some survive. And doctor Khan sais the disease gets spread all over the country. A way to control to international organisations, WHO and other organisations to help pushing the Ebola out of sierra leone, up till now. Some country locked, some [H261]
- It is getting better now, there were only 4 cases last week
- Only 4 okay
- There were 9 int he other week
- Okay
- And do you think, compared to other communities in Freetown your community is doing better or worse?
- Yeah i think so, because our councilor is doing well. And even those who are becomming infected or his relatives become infected, we try hard to talk tot he parents of these people. Tell them not tob e contacted with the disease anymore. People will go into the quarantine for 21 days, in some other communities where they do the quarantine, some escape at midnight and go tot he other community. And then maybe she or he will spread the disease when you go tot he other community and some die there. Up till now, if people dont stop migrating from one community tot he other, this will be a problem. 21 days quarantine. After 3 weeks you’re free, you dont have job you sit at home. [H262]
- And what kind of measures where taken by you and also by your community to prevent yourself?
- Hm the measures i take, wash your hands every time and every where, don’t contact person, avoid too much crowd, if you do this i twill be better. And we see people visiting [H263]and it is not yet decleared yet .. maybe because the disease is still around. It is not declared finished. If anyone of these people have had contact with this people, i twill get very dangerous, maybe because 2 or 3 more than 30 people they see. So i think, the community allow to my own decision, you have to stop that first. [H264]
- Yes, and for example, in your home you did not allow people?
- No we did not allow people in our house and we dont go to another place. When i come from work i go straight tot he house. [H265]
- And where people trained in the community to deal with Ebola?
- Yeah the councilors, they set their own eh people talk to the governmet of the organization operation western area, that is one of the organizations that did very well.[H266]
- Which one?
- Operation Western Area Search yes. That was doing very well because they come house to house to sensitize the people, advise them, tell them what to do and tell them what not to do so that the disease will stop. And they also tell them that if you continue to do so, the disease will not end. During that time, cases have been coming down and down.[H267]
- And there were also penalties right? There is a la wand you can get a fine?
- Yeah if you keep sick person in your house, and they will find out or if you allow a stranger from another place, you will need to pay big money or else you will go to the jail. Even the jail and the money that is why people are afraid,[H268][H269]
- Yeah
- You dont allow strangers to come or to keep a sick person
- No
If you have a sick person, surveillance will be there and they will advise you to not teach him or her. Ambulance will come and take him to the hospital.

And do you think the behavior of the people changed? Are they living up to those measures?

Some people changed, because even some do not believe in god. And because some are not believing, it affects their own personal. Even those, some get affected to the disease and then if they go to hospital, some survive. The disease is real.

Do you know actually the number of infections in your ward?

No.. no because i dont normally listen to the radio. This is some of the constraint that we are facing. Because over the radio station, they give all the information. But,

Even for a ward?

Yeah, but if you dont have electricity then you dont know how things are going on. You can only know that if you have electricity and it would be better to watch over the news everyday.] [H270][H271]

I see. Hm can you describe the role of the youths in the fight against Ebola? Do they have a particular role?

Yeah.. some of the youths work, for people to start them to work but most of the people were afraid, some people sacrificed their lives. They also came to my house but i said no, even though i dont have a job but i said no i am not interested. [H272]

Too afraid to do it?

Yes too afraid. Even some people in our community 2,3 did it. Even now, people sacrificed their lives.

Do you think the community is now more prone to other hazards, such as malaria, due to Ebola?

Hm yeah, we have now more people than before with fever. Cholera but not as dangerous as Ebola. [H273]

And are those things more likely to spread now than before?

Ebola? Yeah

More vulnerable?

Yes more than before. Because when cholera came, we secure dit in 2/3 months but for Ebola we had the first case in May 25th up ton ow it is still in sierra leone.

And what do you think is needed to recover from this?

Just like what the other countries have been doing. Send people to sierra leone to secure the disease, chinese people come, even though i think another NGO’s come from England and from the Netherlands these people come to secure the disease. And they do a lot, they do very well. The beginning of the disease it started with 20/30 and within one week we had over 300 disease. And last week we noly had 4 cases so if people continue to take the advice, wash your hands, avoid body contact then the disease will be gone. [H274]

And on the longer term? Like, what kind of development is needed to prevent it from ever coming back?

Hm because when they said disease is a disease i dont know i fit will finish there will be another security set but maybe just like HIV came to sierra leone, its not yet finished. But whenever, some women become pregnant and take a test and they will be protecting you and treating you and the baby wont get HIV. So if we have this kind of set for Ebola, [H275]

Ah you mean like a vaccination?

Yeah like a vaccination. [H276]

They are working on a vaccination at the moment. Hopefully it will be available soon. Ehm can you describe what are the stakeholders in fighting Ebola in your community, the most important persons fighting Ebola?

The councilor is doing well because the honourables ... The government was giving 53 or 63 million leones to fight Ebola, but we dont see a lot from it. but maybe the councilor know about it. the honourables are not working towards us. [H277]The councilor is.
Ok. And the honourables are part of the parliament? The national parliament so that is government?

Yeah yeah within city council. As for me, the councilor is doing more well than the honourables.

And others? For example the imam?

The imam, for example when we see people die then the imam would go there to wash the body and advise. Because they declared that we should not wash the dead body if we suspect. No need to touch, they advise he says this is not our fault and advise not to wash the dead body. If you have been doing well, then you will get a good road in heaven. If you have not been doing well, you will also face the penalties. Your good work will pay you even if you’re not washed before. And we pray for the good road to heaven. [H278] Depends on what you have been doing before. The imams have been advising the people in the mosques, the youths, the old persons, children.

I see. And the role of the government?

The role of the government.

Hm because as i was saying, the government give money to the honourables and in different communities to use it to pay some peoples to sacrifices themselves to prevent this Ebola. [H279] All over the country, some people do well with their own develop themselves, extend it to their own accounts, taking the money and enriching themselves. [H280] And [H281] the government and they give money twice to some of these people to stop the disease but the disease will continue continue continue even the president have been doing some trading so that if they have any case in any community that chief or that councilor take the post of funding because he is not advising his community member how to prevent.

Do you think that poverty and Ebola are related?

Yeah, very very much.

How?

Because the strenght of poverty is more here in this Ebola time. We dont have job but maybe in the morning we go out and find out what you will eat for the day. No finance, people are not frequently been doing what they were doing before. Look out for what they eat and bwe dont sell as much as we did before and all this causes poverty. Because we dont have jobs as we did before, maybe we have been working and even if they are not paying much but at the end of the month it will be better. We go home sit down and nowhere to get money this causes problems. [H282]

And the other way around? did poverty also contribute to Ebola?

Ehm yeah. Yeah really, because, if you see some of the quarantine house, people whenever they see that place, some other people come from another home to get tot his quarantine house for food. And people say, i would like quarantine because i get free food. And this is the way it happens. [H283]

And what do you think is needed to reduce poverty?

[sight] if employment would be better. Most of the youths, [H284] not 100 % will have employment but if 90 % of the youths are employed it would be much better. Now its around 60 % or maybe 70 %. [H285] now they are sitting at home, they have nothing too at. And that leads some young men to steal. [H286]. When you go tot he town in the night, that is the most dangerous area they will steal, they will stop you and slap you and take it from you. This happens because they dont have employment.

And are there any development programs going on? For example, to deal with the drainage system or garbage or anything else to develop the community more?

Ehm its happening in other communities, but for us in our community that kind of development people do some because the money was there to have our own drainage system but as the work was going on everything got cut off because the money was finished and it stopped up to now. Drainage work stopped, is very dangerous because every time in the rainy season it will dig deeper and even though the place with good drainages is not
comfortable because it will flush on the other side, and drainage will flood into the street. Even if you have a cart to go up there it will not be easy.

- Do you know the word resilience?
  - No.

It is a word that is used in aid programs and policies and if a community is resilient, it means it is able to cope with hazards such as Ebola without losing too much, without everyone losing their jobs for example.

**Respondent 9- student (disaster management) and youth leader**

- So, the first I'm not sure if you know about this but do you know how many people were infected with Ebola in Wellington?
- Eh in Wellington. It's going to be difficult to find the exact number the reason being that no proper system was set up but it is supposed to be displayed in each ward how many infected, those that are positive. There supposed figures and statistics displayed in each ward: those that are positive, those that are not positive, those that have already recovered. But they are not always there. Only recently they started to give statistics through the radio. Usually we listen to the radio to find out numbers for community A and community B but initially nothing like that, no system was set so you can find very difficult. This is one of the KEY challenges, you understand. Even in some cases nobody would even pick your call initially, they will tell you that you have no right to bury the body and that you should take sick person to the hospital. They will just tell you to do that. But when you call them to respond, nobody would pick your call.

- You mean 117?
- It is just recently that we talk about 117. Initially, there was no system. So, even when there is a system, the attitude here of Sierra Leoneans is also a key factor to change situation. Because some of them are working coherently right. I can give you a practical example from my own grandmother whom I love so much, she passed away but not because of this Ebola. She aged and she became sick, there is no hospital for you to take them to or them to be cured. So what happens? Unless you know some people who can give drugs to my grandmother – may her soul rest in perfect peace – so after one, two, three months she passed away. Then I had to call 117. I cannot say the system is effective or efficient. You call call call, even if they pick your call, they will say we are coming there and that they will send someone. But they will not. So unless you have to go and look for the councillors and squeeze them to take actions. 117 will never respond. These are key challenges. Even recently, I have a friend of mine who lost his daughter. Can you imagine. We called 117. I myself was there, I also called 117. Nobody responded to us, nobody responded to us. What happened? That death body was there for a period of 3 good days, it took them that long to come.

- Of course. So, you called 117 and they came 3 days later?
- 3 days later!

- Unbelievable.

- It is unpathetic. You will never feel the pain unless it happens to you, some people will look at how dangerous is this Ebola maybe very comfortable from maybe they have never lost any individual. Because, for you to have dignified burial, you will never have dignified burial. But some people, because it never happened to them they are comfortable, especially those key stakeholders. They will never feel the way we are feeling. These are some of the things we face. So really there is no statistical data I can give to you. And fort his story, there is a dog, ehm there is a dog that this friend who lost his daughter. And this girl loved the dog so much. So when she passed away, the dog has been doing the job of the security. The dog was with that dead body for a period of 3 days. The dog stayed inside that room.

- And this little girl died of Ebola?
No not out of Ebola. Everybody now who is sick has to call 117. But the question i normally ask myself, indeed i fan individual this not have Ebola, why cant you give the body tot he family fort hem to give dignified burial? And the method that they are using is a so called dignified burial but you look most of those people in the burial team who wash the dead body, you will see only 1 female, because most are refusing to joint he team, so all the rest are male. So if you only have 1 female, and there are various burial teams, but female can only attend one team, so maybe the burial team that you call may the female does not belong to that team. You have to show respect fort he dead also. That is why the imam has to wash. It is only because of our intelligence, we want to be the change agents of society rather than causing friction. But when you start tot hink how these people are treating us... for me, to see someone whom i love so much, my grandmother who cared for me, when i lost that individual I am supposed to give a safe burial. I have no power to stop them, but there is no female there. What happens, see imam very pathetic. Im expecting a women because everyone was dressed in full PPE’s you know. And i said ‘now stop, do you understand that the individual that died is a women?’ that should be part of your act and i also said, who of you is going to attend tot hat women? They said that i was stopping them to doing their job and i said no i am not stopping you to do your job, it is your responsibility yo have signed up to it right. I am not trying to compromize you but i have to ask, do you have a women among you? He said no the women is not within our own team, the women belongs tot he next burial team. Do you want us to stop the work and wait fort hat team? I said no no no, when you talk about the word dignify, you have to give respect tot he death. That is why it is called dignified and safety burial. So they had to wait there fort he various stakeholders and they tried to change the women from that burial team to the other. This it he way they have been doing all this work, because i put a check on this one on my own path i just thank god for that. For some of us, the phenomenon of Ebola is very new. I had never heart about Ebola before. But it was seen in some countries in history in Congo, it is deadly and so on but it has never happened before in this country. Ignorance tot he fact that we had never heart about Ebola, that is the reason that many aid workers have been contacted with the virus. They never heart anything about Ebola. They are new tot his thing, the prevention method etcetera so when they decided to go and fight Ebola they fin dit very dificult and some get in contact with the virus. If i am familiar with something i will know the methodology to use to tackle that thing. But it was not there. And, are there less people infected in Wellington then in other parts of Freetown? Eh because even African, i myself sitting down here at the time i was having a job in minerals, i was located in bonbuna in the provincial area. One of my brothers, because i
myself sitting because I lost my mother, father and grandmother so I cater for myself and form y brother.

- Oh.. so how did you manage to go to university?
- I write letters to people for help, i do some jobs for people, ironing their clothes, because I tried to have job there is no way to have job.
- So you where working for african minerals in the provinces?
- Yes yes because when i go there, the situation was too difficult for me so i went to bonbona. Fortunately they gave me the job to weed out the grasses, so my auntie said how can you accept that job. But it is the only opportunity i have, i cannot go out and steal. I cannot do that. I said because im making myself now, maybe tomorrow i want to become president and then somebody can point a finger at my past. There is a big opposition so it is better for me to do this job than doing something illegal. So i was weeding out the grasses and at the end of the month they gave us something like 500,000 leones per months. So when i have that money, i have to calculate my feeding. And i have tos end money form y younger brothers and the house rent.

- But then what happened when Ebola came?
- So i left my brothers and then they called me and said ‘brother, we have been quarantined’. We have close to 10 rooms, it is a very big compound in Wellington, close to Loko town. And they told me that 2 ladies had become infected with Ebola disease and those two ladies came from Kaba Town but they decided to come to stay with their sister in Wellington. The virus just started with them,

- It was in September or November?
- Yeah November, it just started with them. So they have to travel from Kaba town to Wellington. And the eldest lady stayed with her husband and decided to accomodate these ladies but without the knowlede for the rest of the compound. So during the night they bring them out to wash them and at the time they knew that somebody got infected. So somebody passed away, also the sister who housed them became infected and the husband also became infected and also 3 children. All of them passed away. So they decided to quarantine the whole house.
- Your brothers were not infected?
- Not at all. Thank god. I really appreciate God, its a great god. So, that happened with them. even the counselors paying visits by them. Initially there was no food available so I needed tos end money. I had to talk to my close friends to buy food in the market and bring the food tot he security and they can give it

- And otherwise the people would be locked in the house , no water no food?
- Nothing like that. So that changed. After a period of a week they started tob ring food, and the quarantine lasted for 21 days.
- And then later on the military took over right?
- Yes
- Because some even told me that people are really in need for food they wanted tob e quarantined.
- Yes that is happening now, but initially not. That is how the disease started to spread. Because you cannot quarantine someone without giving them food. If you quarantine someone, let all the logistics be available fort hat person. You understand? After a week they came tob ring food. Now they changed the approach. Now, the very first who go to quarantine we make sure everything is available fort hem so they dont go out. And also, when they bring the foods they only bring food that its not like daily bread, its not like the food that they are used to eat . its not good fort hem, because we like rice. We like casava leave, potato leave so you cannot bring sardines and a bottle of oil. We are used tor ice first time in the morning. Even if you give me everything, biscuits and so on, rice is my first food. It has tob e prepared with potato leaves, beans. People just
look at i tand let it down, you are not able to satisfy people like that. So maggi, casava leave, fish and so on we have to ring some of that. These are the things that really affected us.

- And what is the effect now in the community? What has changed since Ebola came?
- Do you mean the positive things that we are seeing now?
- Hm either positive or negative, how are people coping now.
- For now, the new thing that has been added to our behavior now. We found it very difficult to wash our hands but because of this Ebola, it is a new system. Whatever people do now they wash their hands you can see that. So whatever activity, they start washing their hands. We get used to some of these good things. And also, we are caring for one another.

People want to know the health status of the people in the neighbourhood, the way he is seeing recognition, then people can call 117. If you are not seeing somebody fort he last day so that type of internal security system within the community is good now.

And then, also we can see that there is a division now to some extent. Because initially, we started to live as a family but because of this Ebola, there are some family who individuals may not be infected with Ebola. But when they see the ambulance and the chlorine, it people to become infected with Ebola. I myself, the people use too much of the chlorine. Therefore, we use soap instead of chlorine to wash your hands. Some relations between wards get more friction. Now even we started to explain, lets try to leave this behind our back and try to fight Ebola to zero together. We were family before, let Ebola not divide us, we do it together.

So we have to go house to house to sensitize the people. This is the only way. I am supposed to love my country, i am supposed to be caring for another, i am supposed to be caring. The way i am not feeling so good, because sometimes i can become frustrated because i want my community to be clean without all the garbage.

It is not good you see. So we are supposed to have control measures, I wrote a proposal about that and sent it to see if they can help us with some money. So, i use it, would collect those garbages, guys for now we are not going to have money it can become developed, right, i tried to mobilize them several times but if you think we have please help us, we can be able to take care of all of these garbages. We can use the medium, telling people to come to these exposure areas, come house to house, and we can target with reasonable. Because if you target too high then people dont want it. but the vehicles use patrol. For veryday we come collect garbages and then they give thousand or something and we can use that to finance the project. Every household will give the contact number. So you can pay the money, we go there and dispose all the garbages that is the way to keep the community clean. Last week i send an elektronical proposal to Norway and Italy. But people normally maybe they will recognize it but sometimes they never send money. You have good people who want to do it, this is also a key challenge we have.

Ok. Lets see, do you know any organizations who helped to respond to Ebola in the Wellington community? was there a cooperation with others?

Eh yes, i can tell the organization some religious organizations. We have the WMA which is the Wellington Muslim Association.

And what did they do?

They donated some 20 million leones and the donation is made to the government and also to the government and not to the community?

To the government. The only thing in three different occassions, every Saturday in the week that the members they stand at various strategic check points and they have water mixed with chlorine and soap, and everyone who is supposed to pass should wash their hands. That is the role they played.

Ok, and other organizations?

Also, like my organizations I did the same thing. I want to use that initiative, i have a mebership of 50 and i organized them.

What is your organization called?
Wellington Youth Organization

And you are the leader?
Yes I am the leader.
And we have a motto that cleaningness is next to bodyness. That is our motto.
And any international organisations?
Ehm no international organisations that came, all the IC’s that come from the government. Even if they want to come and implement they will find it very difficult to deal with the community organisations. So they just come and do their activities. But I think, when it is not inclusive you will always find it very difficult. That is the reason, because you may have one case today and today it might be four and then it can increase from 4 to 15. Next it goes to 30. Because you leave people out, because those people know those people right, because the people are supposed to act as a watchdog. But, because you left them out, they will be sitting there watching you to see if you succeed.

So you think its not effective?
Its no effective. They will come and just do whatever, you are supposed to be inclusive and involve the local organisations. Even without government, we would do it. those people this would never affect them, they are living comfortable lives. They wont be sitting down, seeing them die like that, no. Let’s do it on our own.

How would you describe the role of the government in the Ebola response for the Wellington community?
Well, for the Wellington community, initially it was poor. And even the country, it was poor initially. Because, before everything started in a small village in the provinces. I cant remember the name of the exact village. By then, we had a female minister of health. I am not questioning her in terms of gender but I am looking at it in the perspective of professionalism and the perspective of a Sierra Leonean, caring for people, caring for people and caring for one another. That is the perspective i look at, you understand. Because when it initially started, the response of that minister was very poor. All the time she gave confidence that she was on top of the situation, that everything was in place, that people where doing there jobs, in fact they were escalating the disease. Built trust in the mind of the Sierra Leoneans that is important, when you have a dangerous situation like that, you cannot put one in fear, but you should find control mechanisms, we where expecting her, let the people understand the control mechanisms and also how dangerous this virus is. But if you fail to obey tot he control measure that you will lose your life, let the people understand. Lets put some restriction, please you should not move anymore. And you should have adequate logistics fort hem because if you quarantine people, you need adequate logistics and also a good team of medical staff doing their job to contain the disease, instead of allowing the disease to spread. Should not say the people in the provinces are careless people and they dont obey, they fail to understand that its their colleague sierra leonians and they fail to understand that people living in the provincial areas do not have adequate education. People cannot read and write, most of them. so youll fin dit very difficult if you go there and tell them this is a disease called Ebola. They never heard of this word you understand. So you cannot just come, you have to have an approach fort hem to understand, you have to find a way. Preventive measures rather than talking negatively, that is a very wrong approach. In the capital city,

And here people believed it more, you think?
Yes here they believe it more.

So and what did the government do in your community ? did they do anything?
Well you can see,

Or through the council maybe?
In fact, the council is very very dominant. We have a very good councilor, that is very true. He is very very active, i like that man. He always collaborates with me, he always listens to
my vision, my ideologies, you understand. Even he wants to support us. But he himself lack the capacity, the financial capacity to help us. He has been trying but then he always gets on slippery grounds. Because he goes to council to advocate, somebody can help, unless he goes to visit some international organisations and out of the 10 maybe 2 will respond you see. [H343]Last year, there is other distinct [H344]that is a religious organization, were able to help us to respond with 3 wells. They did very well for us, may God continue to bless them. because the community really needs water, they fin dit very difficult, some people wake up in the night hour to fetch water, they will be fetching water during the night hours, until 4 clock the whole night. [H345]so it is very very big contraint and those children have to go to school. Especially the children in the age of 12, 13, 14 especially the female and you can see the young boys they take the advantage and that is where the high rate of teenage pregnancy comes from, because there is no water. [H346]and the parents cannot do it so the children have to go, and you wake them up maybe at 11 to get water. [H347]

- And why in the night?
- Because the tap will not open during the normal hour. In the local language we say ‘pomp ou da open’, it means the tap has opened. We have access to water. And the females become victimized. They will sometimes control the pump water, they will tell you ‘i love you’ and will tell you – sorry for the language – seks with them and if you refuse they will not allow you to get water.

- So there is sexual harassment?
- Definitely. [H348]I am the controller of that water well and if you refuse you dont get water. But you need water. These things happen. We are the ones who should influence this but they are not doing their job properly. This is very difficult. The last time i decided to go into politics, because right no wit is not representing me well. [H349]And we said: we expect you to represent us well and to have positive influence, but there is nothing like that, i am not able to influence change but you have the authority and power to influence change. And i said, believe me, next election we will vote against you. About one month back, he send for me he said lets forget about what has passed, let us turn to a new page, yes but we are sierra leoneans, you have to work for the interest of the people. Maybe for me i am struggling for me to finish my education and i strongly believe that if i finish i can attach myself to survive and if i marry i have something to give. But now i am single, i dont have nobody by my side. But i am thinking about people who have children, who have wife, they are struggling to survive, i feel fort hem you understand. What are they going to make life look like? There is one philosopher, one of my professors, he said in Sierra Leone there is one thing he believes. He said nobody was born as a criminal, it is the situation that makes them that. Indeed, in Sierra Leone most of the youths, because even fort hem to find food, even when you go your collegues you have to give reason why you need food. It means you have to lie to him or her to see its easy to help, these are basic needs you are supposed to be having. Let me ask why are we [H350][H351]not given these things? We need to ask our leaders, we dont need to be suffering. We have to lie to my collegues and i want to work but work is not available, but i have my wife, i have my children, so in some cases people have to engage into thieves. The situation defines that, they were not born like that but the situation forces them to become like that. People have skills, various skills.

- And do you think that poverty increased due to Ebola or was there also a positive effects?
- Yes, and i believe poverty increased every day. Because it increased every day we always find it very difficult to another level as far as development is concerned. Because, even when we see only suffering, even if our leaders are not influencing change. But lets see we are 2 or 3 months before the election, you will see that ehm they are bringing money tot he people. They will bring money to influence your people. And people forget about what has passed. and, fort hem to vote fort he right people that is what is happening. So poverty, to me has increased. Thieves, you have to employ a private gard that is supposed to secure you, you have to go extra mile they will engage in bad things directly or indirectly. Even if
go somewhere and say guys i have toe at, my money was stolen you see. You have to
convince them, let me give you some rice or something, thats it. And any positive developments?

And there is nothing positive i can point my fingers at. The reason being, i am looking from the perspective of wellingtonians and when i see my collegues you see the good of some of these factories. They have to be getting bag of rice or bag of sugar and at the end of the day they just give 2 cans and when you want to talk and say this is not what you are supposed to be giving me , in fact, well i am not going to, what's happened, you are the one who gave the contract and then you call the police. But the police also has no money so they won't look at the whole justice part, at what really happened, they will just come to arrest. We love our country and we want to move another level of development you see.

And what do you think is necesarry to get this development? What are priorities ?

Eh, the government. The government is supposed to give us education to help us develop. Once education is absent, development is difficult. They cannot think the way we are thinking, they cannot see the basical education. But when people are educated, they will know what is good fort hem and what is bad fort hem. It will changes their lives, their way of thinking, their mindset. Politicians will not just come tot hem and tell them, no they will ask questions. They will critical. That is the reason why politicians doesn't want them to be educated.

Are you saying the government does not want its people to be educated?

Yes, the government does not want people to be educated. Because here, i cannot say it is privilege but there is no other adverb to describe it. it is definitely like that. I believe, there is one professor that is saying 'education is a weapon of liberation from ignorancy,poverty and disease'. Only education can dot hat. They can liberate me from ignorance, from poverty and from disease. But the people are not educated. The few people that are educated who hold this strenght and power they just come and do anything against it. Right now,i am paying a million leones form y master. How do you expect me to have money? How should i pay? People have paid 7, 600 leones for undergraduate education.

Education is not accessible you see. It is not accessible for people.

And what do you think is needed to recover for the wellington community from the shocks?

Ok. but before i come back tot hat question, i just want to say that for what i just said the reason most of the women when they already make the 6th exam then they dont have money to go to university. And they will decide to give them up to marriage. I cannot fully blame the payer or the family but there is no finance, so let me come back to what is needed for recovery. First and foremost, we have to look at the people who have been affected: the family members. Those people have passed away their family members. We have to get packages for them. because some of those people have passed away, maybe the breadwinners passed away. How is the family supposed to survive? So in other words, we have to get a package fort hem. And then not only having the package fort hem but also telling them how they are supposed to invest in that package. Because you cannot expect people to give money money money it means you're doing more harm than good. When you give me this money tell me how am i supposed to go with this money, that will give me more benefit you understand. So no just coming to you for more resources, more money more understanding but for this package please explain ho wam i supposed to invest in it so that i can have more. That is the type of package we need. Can able to gain more, and we also have to get counceling to them. there is more fort hem he future and let spray fort hat individual, so we have to get some counceling to make them understand. And also, we have to look into survivors. Survivors are also very important. Because these people now are marginalized from their colleagues. because normally you used to sit down as a brother and we extern ideas, we just buy grounnut and share it among us that is the way we normally do. Now, they will not sit opnly and people dont want to sit next tot hat individual, you have to be moving swiftly from that individual. So unless i have to go tot hem, talk tot hem, counceling himthat is one of my key works. I normally go to these
people, engaging them you understand. Let them see that we have much to do in the future, pulling their thoughts from negative things. I don't have money to give them, I don't have the finance but there are some things that I can exchange right, that are able to change them positively. So those survivors, we need to care for them. Maybe some of them, for integrating survivors into the community back because that is one of the main failures. First, you have to get community engagement first for them to understand why they are supposed to accept these survivors back into the community. They have a disease and now they become well, let people understand that the disease cannot come back, community engagement. Put yourself in the same shoes, would you like to be segregated? You cannot just bring a survivor back without engaging the community. When somebody become well from this virus, maybe it will spread but the people need the mindset of these are our colleagues, these were our brothers before. Let's do things together, let's do things we used to do. Because Helen, to be kind with you, especially when I lost my people, even clothes we share clothes, this is my personal experience I am sharing with you. I share vest, even my pants I share with them, that is the real institution you understand. Because I believe, I believe the future has got something to hold for me. I will use this as a memory to educate other people, we do things like that. Because if I have one I don't need to share even my pants with people, I don't need to do that. You can find that the best clothes are find by the ones who woke up early in the morning. So you have to be determined, even the slippers and shoes, if you want to have the good ones you have to wake up early in the morning to was hand be able to get access. Because if I will visit someone who is very important, I will have to wake up very early. That is the situation we find ourselves in. And I don't believe we are supposed to continue living like this. And for me, I like my profession, these procurement that I am doing. I believe that it will not be enough to solve the situation of my people. The suffering that they are going through, I have to go into politics. Because Helen trust me, those other people they have everything, it's a reverse, now they will discover oil in Solima,

- Really they discovered oil? Just now?
- Yeah yeah a good quantity of oil about a year ago. You understand, place called Solima. All these minerals you can think about; we have it you see. But it is not reflecting the lives of the people, we ask the question why? You want to tell me it is the people responsible for that? But no, those people we call our leaders, the key stakeholders, are they making a better decision? Are they representing us well? Are they transforming our lives? I cannot be sitting there and talking about change, I want to become so professional so that I can do my procurement and at the end of the month then I can care for my family. I believe in that life, but I have to think form my colleagues at the back. Those that cannot afford education, we have to think of them, there are many of them over there. Because I was there like that, even if everything is good for me. So I believe that even if I finish my masters, I have to penetrate more, I have to go into politics, I believe and I have a strong conviction, that I can make a change.

- Ok. Can you tell me something about the disaster risk measures that were taken eh when Ebola came?
- Eh
- Where there any?
- Just like myself, these people never include us. They will never include us.
- And if you take it on a local level?
- Yes on a local level, we only do it we remind you that the restriction is given. Only the ministry of health, only they have the authority. If somebody is sick, you call them-h I hope you have Ebola they have the responsibility. So everything is in the hands of the ministry of health you see. So the only thing we did is, we have to continue to buy chlorine, buy rubbers, fetch water, have soap and then we do sensitization that is what we did, we sanitize the people. Even in some cases, people don't understand in this language and
we do pictograms I personally I have to use some money for them to understand the message

- Are there any poverty reduction measures in Wellington right now?
- Haha no there is nothing like that haha. Poverty is increasing every day.
- Hm but for example the well that were built, that is a form of poverty reduction right?
- Ehmm well I am not convinced, the reason being because I expect real change. I am thinking about real life situation, in the well it gets dry, even the water that will fetch from the well, there is nothing like chlorine. So people are infected with malaria, even apart from the garbage. The water is not well filtered, you see. There must be a committee, this has to be set up, to manage the well you understand. But, these organizations when they built the well they never set up a committee to manage it. because there is now a committee that is supposed to manage the well and the money should be used to buying chlorines, cleaning the well, good proper management but this way it doesn't make any sense.

- I see. Hm ok those were all my questions, thanks so so much for your insights.
- And something interesting, when you're talking about Wellington, you're talking about Wellington industrial area and the funny thing is that most of the factories in the country you can find them here in Wellington. And interestingly, it is the opposite for human resources. Most of these Wellingtonians, most of the workers are from other areas and those people have to be recognized they are outside Wellington. So the people who live in Wellington do not have access. So it is wrong, hazardously the people in Wellington suffer the greatest. If you think about the smoke, the pollution they suffer from all these things. The smoke coming out from this factory is very dangerous, not the people coming from Kalaba town, you name it you know. So at the end of the day you are creating more harm if you don't employ the people of Wellington. I am suffering from these thing so give me an opportunity to also enjoy it. the last I wrote a letter to the EPA (environmental protection agency) our environment is not well protected and at the same time we are not giving privilege to work in these factories. only few Wellingtonians work in these factories, those areas like the administrative work, the officer positions, you cannot find Wellingtonians there. Those people come from outside. There is a lot of chemical pollution, air pollution, you see. And then you go and take somebody else to come and manage. Then you're not doing good for the Wellington community. These are things that make me bittered, people don't care for the people in Wellington.

- Hm yeah.
- It should not be like that, it think you should be given the right to work. But pollution is not being advertised. People are working in wellington they have the qualification or not. And then you see they suffer the greatest. that is when its come to environmental hazards, that is injustice. Even if it takes 10 /20 years we are going to develop this country.

- Good. Thank you.
Respondent 10, female, cook for the Sierra Leonean Brewery

- My research is about Ebola and if its okay with you i’d like to ask you some questions.
- Ebola. Ok I am ready to answer.
- Very good. Ok. so where in Wellington do you live?
- Wellington Maxwell street nr 1,
- With counselor Ansu?
- Yeah.
- Were people in your environment infected?
- Nobody. Nobody. Thank god for that.[H378]
- What would you say, are the main challenges the community is facing in general ? what kind of problems do you have in the community ?
- The kind of problem that we have in the communities, water facilities: lack of water that is our main problem. [H379]
- Do you think that water problem is related to Ebola ?
- No no no, water is not related to Ebola. [H380]
- Ok. and what was the impact of Ebola on the community ?
- Because whenever i watch the TV i always say people suffering from vomitting, diarrhoea and other effects. So in that case, whenever somebody was vomitting that was Ebola.[H381]
- Yes, but in terms of, is there more unemployment or more in need of food or .. ?
- Aah yeah people are in need of employment. More than before because since this Ebola started, thousands of people lost their job because of this Ebola. [H382]
- Also in your community ?
- Yeah yeah.
- And did you community face other hazards like this before ? other disease or disasters ?
- No no, no floods you know we dont have any problems like that.
- And do you think your community was doing better or worse compared to other communities ?
Yeah our own community was doing better, because our environment is always clean. Like in my house, I don't have muskitoes, no flies. The place is very clean and descend. Many muskitos in the water in other communities.

What is done with the waste then?

Where?

In the streets, so in that case we don't have muskitoes in our own house, thank god for that.

Ok. and how did people in your community cope with Ebola? What kind of measures were taken?

As far as I'm concerned, people in my own community, people obey the law. Don't touch a sick person, in that person in our community nobody touch any sick person. Even your own son or your own mother you call the hospital.

Were people trained to deal with Ebola in the community? Like education or training or?

Yeah. Yeah anyway some of them in our community are educated some are traders.

And were there any organizations that helped in the response? Like NGO's or the government that was helping the community?

Anyway I don't have much time, because Indian I I I saw one of the organizations to get water, they have already made a dam. Something like Indian... something like that.

What do you think is most important right now in the Ebola response?

Well, what am I thinking about is one people are response to and if people obey the law, the sickness will go. If people don't obey the law, the sickness will not go. So in that case, I think people are doing well. And the disease was already decreased.

Do you think poverty and Ebola are related?

Yeah its almost the same thing. Let me tell you this, if you don't have money or work in Africa you have nothing. Even if you have want to say something in the community, they won't listen. So poverty is very, bad as well as Ebola. It is similar if it is in your family they will all go.

Hm. So do you think Ebola is causing poverty?

No no.

And the other way around?

Yeah.

So poverty is causing Ebola?

[laughing].

What do you think is necessary for the community to develop?

Well, if you want the community to develop, you need to provide jobs for the youths. Because if the youth do not have jobs, so the government need to provide jobs for the youths. And at the same time, many people are not educated. So how do you get a job without nothing in your head? So also education.

Why do you think Ebola could spread in Sierra Leone?

Because of lack of understanding, that is why it could spread. Because when the ministry of health when somebody is sick don't touch i tand all peoples died, don't wash the dead person so that is the problem.

Can you describe for me the role that the government played in fighting Ebola?

Yeah, the government has done so many things. A lot of things so that Ebola will be gone. It created medical facilities, it create a lot of medical facilities, Ebola centers so that Ebola patients do not mix with the others. They have done so many things fort hat.

Ok. what do you think can be done to prevent diseases like this from happening in the future?

The government need to prevent this, because this sickness is very dangerous. The government need to prevent this from happenings again, because so many souls have gone.

Yes. And do you feel the community is now more prone to other risks than before?
Let me tell you, the community since this Ebola started, people are suffering, some of them had to leave their job. So in that case, people are suffering, it is not going well for them. Some of them don’t even have kids because if you have kids to sit at home, for me, I know how to cook, if I left.

And you worked here all the time?
Yes thank god for that. So fort he Ebola, it has to stop so many people without a job are suffering.

Do you know what resilience means?
No

Ok never mind, we will skip that question. And, is there poverty reduction programs going on in the community right now?

No no no, not any projects. Nobody is helping. Even the councilors, even the ministers. We vote for them so they can help us in our community but whenever they take that power they left this part of Freetown they will never develop the community.

The money they are given is for themselves, they put it in their pocket.

Field visit to ward, together with respondent.