UN EBOLA RESPONSE MPTF
ANNUAL PROJECT NARRATIVE REPORT
Year: __2016__

Project Number and Title: MCA06 #48 SLE Social Mobilization & Provision of WASH Services For Achieving & Sustaining a Resilient Zero **Project ID:** 00096725 (Gateway ID)	**PROJECT START DATE[1]:** 06-11-2015	**AMOUNT ALLOCATED by MPTF** *(please indicate different tranches if applicable)* $856,000	**RECIPIENT ORGANIZATION** UNICEF **IMPLEMENTING PARTNER(S):** Government, Ministry of Health and Sanitation, Ministry of Social Welfare, Gender and Children's Affairs and NGOs
Project Focal Point: Name: Sandra Lattouf E-mail: slattouf@unicef.org	**EXTENSION DATE:** N/A	**FINANCIAL COMMITMENTS** $...	
Strategic Objective (STEPP) SO3 – Ensure essential services **Recovery Strategic Objectives** RSO# - Description **Mission Critical Action** MCA06 – Access to basic services	**PROJECTED END DATE:** 01/11/2016	**EXPENDITURES as of [01/11/2016]** $679,149.54	
Location: Sierra Leone		**Sub-National Coverage Areas:** Kambia and Bombali districts	
Report Submitted by:		**Report Cleared by:**	
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OUTPUT INDICATORS					
Indicator	**Geographic Area**	**Projected Target (as per results matrix)**	**Quantitative results for the reporting period**	**Cumulative results since project commencement (quantitative)**	**Delivery Rate (cumulative % of projected total) as of date**
Description of the quantifiable indicator as set out in the approved project proposal					
COMMUNITY ENGAGEMENT					

[1] The date project funds were first transferred.

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1. Number of chiefdoms /wards with established and functional Rapid Response Teams	Bombali, Tonkolili, Kambia, Port Loko and Kailahun	75 chiefdoms	56 chiefdoms	MPTF funds were used to support the response to the EVD event in Kambia and Tonkolili and preventive and preparedness interventions in Port Loko, Bombali and Kailahun. A total of 56 chiefdoms were targeted across all districts.	100%
2. Number of community structures including VDCs trained	Bombali, Tonkolili, Kambia, Port Loko and Kailahun	139 VDCs	426 VDCs around PHU catchment areas were trained.	Chiefdom taskforces and 426 VDCs across Bombali, Tonkolili, Kambia, Port Loko and Kailahun were trained to mobilize community stakeholders and influencers, including village headmen and religious leaders.	
3. Percentage of VDCs that have developed Community Action Plans	Bombali, Tonkolili, Kambia, Port Loko and Kailahun	100%	In all the districts, based on the district specific hazard mapping, a social mobilization / community engagement response plan has been developed. This has been further shared with the Paramount Chiefs to ensure that VDCs in their respective	MPTF funds were used to support the response to the EVD event in Kambia and Tonkolili and preventive and preparedness interventions in Port Loko, Bombali and Kailahun. All VDCs in these districts developed CAPs.	

			chiefdoms develop preparedness plans.		
4. Percentage of social mobilizers and youths trained in hotspot communities on key messages and participatory approaches	Bombali, Tonkolili, Kambia, Port Loko and Kailahun	100%	100%	Over 430 trained social mobilizers were deployed across districts to engage communities during the response and preparedness phases.	
WASH					
1. Number of EVD care centres/ communities provided with comprehensive WASH services	Bombali, Kambia	Quarantined communities in Kambia	Five water points were rehabilitated and providing safe water to an estimated 1,250 people (637 females & 613 men).	A total of five community water points completed and installed with hand pumps, perimeter fence and drainage system	100%
2. Number of communities triggered and declared Open Defecation Free in Kambia	Kambia	10 quarantined communities in Kambia	10 communities with an estimated population of 12,000 people are living in an Open Defecation Free environment	An estimated 12,000 people are living in Open Defecation Free environment and using individual household latrines	100%
3. Number of health care facilities supported;	Bombali, Kambia	7 health care facilities	An estimated population of 10,500 people within the catchment areas accessed health care facilities with functional WASH services	A total of seven water points were rehabilitated and installed with motorized solar pumping stations. Seven sanitation	100%

			as per the new national WASH in health standards.	facilities and waste management pits were also constructed.	
3. Number of schools with WASH facilities as per Government of Sierra Leone guidelines	Bombali, Kambia	10 public primary schools	Over 2,000 children are benefiting from child friendly WASH facilities in 10 primary schools.	10 primary schools were provided with functional water points and 20 blocks of latrines, each with three drop holes were constructed. A total of 14 focal point teachers trained, 10 school management committees and 10 health clubs were formed and are supporting school sanitation and health education activities.	100%
4. Number of wastage management facilities constructed / installed in health and educational institutions	Bombali, Kambia	See above based on the need	Wastage management facilities have been implemented alongside sanitation facilities	All seven health care facilities were provided with soakaway pits and septic tanks for liquid waste management	.100%
EFFECT INDICATORS (if available for the reporting period)					

PROGRAMME REPORT FORMAT

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EXECUTIVE SUMMARY

This report submitted to UNDP is for the "Sierra Leone Social Mobilization & Provision of WASH Services For Achieving & Sustaining a Resilient Zero project", which was implemented by UNICEF Sierra Leone in five target districts[2] to support Resilient Zero. This report covers project activities implemented between 6 November 2015 and 1 November 2016. Out of the funded amount of USD $856,000; a total of USD $679,149.54 was utilized for the two components. For WASH services, the project target was provision of WASH services to seven health care facilities, ten primary schools and the rehabilitation of five water sources in quarantined communities in Kambia and Bombali.

The UNICEF WASH programme worked with two national non-governmental organizations and achieved the following results:

- Increased access to sanitation for an estimated 12,000 in 10 communities through community led total sanitation approach.
- An estimated 1,250 people are accessing safe drinking water from five rehabilitated hand dug wells
- An estimated 10,500 within the catchment population are accessing seven health care facilities provided with comprehensive WASH services.
- 200 children are benefiting from child friendly WASH services in 10 primary schools supported by the project.

The project was implemented within the framework of the early recovery programme and anchored on the existing post Ebola Virus Disease (EVD) outbreak community support structures and within the existing government promotion of sustainability. The working arrangement greatly enhanced community participation and ownership and led to marked involvement of the community in improving the status of their water sources, public institutions and general community sanitation, particularly reduction of open defecation. All these community efforts in addition to UNICEF and government inputs greatly influenced and improved hygiene practices, consumption of safe drinking water and reduced open defecation which resulted in improved and equitable use of safe drinking water, sanitation and healthy environment and improved hygiene practices. The improvement of WASH services in public institutions (schools and health care facilities) has greatly contributed to the compliance of infection prevention and control requirements which are prerequisite for resilient zero.

Guided by national strategy to get to zero and the national recovery strategy, the project was able to integrate community engagement as an inherent component getting to and maintaining zero and to facilitate better results for programme delivery by promoting convergence and equity at community level. The project established and strengthened community platforms to organize individuals, community networks, civic and religious groups and others in a more sustainable structure working collaboratively with and through groups of people to enable dialogue that

[2] Original districts: Kambia and Bombali.

allows communities, especially the marginalized, to speak out, express their aspirations and concerns and participate in the decisions that affect them.

Current Situation and Trend

Sierra Leone is progressively recovering from a devastating EVD outbreak which negatively impacted on gains made in respect of the previous programme. The EVD outbreak led to the disruption of regular rural WASH services which led to some communities which had been declared open defecation free (ODF) relapsing to open defecation (OD). Various water supply sustainability mechanisms that had been put in place became dysfunctional. Specific activities like household treatment, which had been sanctioned by the government, stalled as most of the consumables such as chlorine tablets / kegs were diverted to the EVD response.

Sierra Leone is among the countries that did not meet the Millennium Development Goals (MDGs) targets, notably MDG 7 on ensuring sustainable access to safe drinking water and basic sanitation. Sierra Leone had set targets of 74 per cent of the population with access to improved water sources and 66 per cent of the population with access to sanitation. However, the country only managed to reach 63 per cent and 13 per cent for water and sanitation respectively (Joint Monitoring Programme (JMP) 2015). For Sierra Leone to now meet the Sustainable Development Goal (SDG) 6 on ensuring access to water and sanitation for its rural population, 3.1 million people (based on 3,133 water points per year times 250 people per water point) must gain access to safe water points while 5.6 million people must have access to improved sanitation (translating into the construction of 280,179 improved latrines per year) by 2030. Large inequalities exist between urban and rural communities with regard to current access to safe water sources and sanitation. According to 2015 national population data, the population of Sierra Leone is estimated at 7,075,641 people, of whom 1,050,301 lives in urban areas (Western Area urban). The rural population, including Western Area rural, is estimated at 6,025,340 people.

While lack of access to WASH services contributes significantly to children's survival and development, the majority of vulnerable children in Sierra Leone live under constant challenging environmental contexts. In Sierra Leone, vulnerable populations include EVD outbreak-related orphans, and poor families in rural and urban slum areas in Freetown and in other provincial cities or major towns. According to the 2015 'A Promise Renewed Report', Sierra Leone remains one of the five countries with the highest under-five mortality rates in the world. Malaria, respiratory and diarrheal diseases are among the leading causes of death for the country's children under-five[3]. Undernutrition is a serious problem in Sierra Leone: over 12 per cent of children under-five are underweight and 29 per cent are stunted (National Nutrition Survey 2014). Malnutrition contributes directly or indirectly to almost half of the underlying causes of child deaths. These illnesses are closely linked to the water and sanitation situation in Sierra Leone and leaving children to continue living in this setting is likely to sustain underdevelopment.

3 UN Inter-agency Group for Child Mortality Estimation (2015)

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Sierra Leone is still experiencing various institutional and governance issues which are impeding effective, efficient and transparent implementation of WASH services. Based on key pillars for sustainable WASH programme which include: enabling WASH environment, quality assurance, access to sustainable services and infrastructures and demand for services; a number of key determinants have been identified which still need to be addressed to ensure effective change processes which can support holistic projects sustainability.

Narrative section:

All project outputs both in the communities and public institutions (health and schools) were achieved and are currently functional and being used. The provision of comprehensive WASH services (community sanitation, WASH in school and health care facilities and community water supply) in these communities greatly contributed to the overall behaviour change being observed currently. All targeted ten communities have been declared ODF and the population now have increased access to household sanitation latrines through community led total sanitation approach. The project improved five water sources within the ODF communities as a reward for their behaviour changes but also to increase access to safe drinking water for the population. The five hand dug well (two new constructions and three rehabilitation of exiting dysfunctional wells) are functional and safely managed by the communities members. Through the project support, an estimated population of 10,500 people are now receiving health care services from the seven health care facilities with improved WASH services. The health care facilities were provided with a safe water supply, and improved toilets and waste management facilities as per the WASH in health standards. The project provide five primary schools with comprehensive child friendly WASH services which is now benefiting at least 2,000 children (980 boys and 1,020 girls).

- **Key Achievements:**

COMMUNITY ENGAGEMENT

Output 1: 56 Chiefdoms established rapid response teams for outbreak response and preparedness

The grant was used to strengthen community engagement as part of the rapid response initiated following the case in Tonkolili in early 2016. A range of interventions including mass mobilization using media and engagement of over 30 key stakeholders, especially Paramount Chiefs, local council members and religious leaders were conducted. Following these, chiefdom level community dialogues were conducted across the districts to ensure community support to the response and adaptation and adherence to preventive behaviours. This was extremely important since there were wide spread (false) rumours that it may actually not have been an Ebola case. UNICEF supported activation of the district Social Mobilization Pillar and deployed over 150 social mobilisers and 100 community health workers (CHWs) in all 11 chiefdoms in close partnership with local civil society organizations and women and youth networks. The engagement of traditional and religious leaders was also critical in ensuring community support for the ring vaccination conducted in the relevant chiefdoms.

Similar interventions were also conducted across Kambia, Bombali and Port Loko districts guided by the surveillance information of potential contacts linked to the Tonkolili case. The focus in the district was to

engage the community stakeholders and influencers to trace and track the contacts. The integrated rapid response teams comprising of social mobilizers and surveillance officers were deployed in each chiefdom for this. Cross-border meetings were conducted with Liberia to ensure adequate information sharing for potential threat.

In Kailahun district, mobile teams were constituted and assigned for community engagement in specified geographical locations, especially around bordering communities. As part of the district preparedness high risk community members, particularly those involved in conducting funerals, traditional healers and midwives and home care-givers (often women, who are in charge of familial care and funerals and carrying out specific communication activities with those groups) were reoriented and mobilized. Information, education and communication (IEC) materials were pre-positioned and made available at district level for the SM pillar partners to use in the field.

Output 2: 56 Chiefdom taskforces and 426 VDCs were trained for outbreak response and preparedness

During the reporting period a comprehensive mapping of VDCs across the country was completed. Following sustained advocacy with the traditional leaders, especially the Paramount Chiefs, the CHWs have been included as a member of the VDCs along with a representative from the PHU Facility Management Committees. Together they will serve as bridge between the health services and communities and also guide the VDC members on priority health issues, including outbreaks, in the respective areas. Over 75 per cent (818/1,086) of mapped VDCs across all districts have been meeting monthly during the reporting period. The active engagement and leadership by the Paramount Chiefs (PCs) is facilitating the process with over 76 per cent PCs chairing the monthly development meetings in their respective chiefdoms.

During the Tonkolili district case response, to strengthen district and field social mobilization and community engagement interventions the district social mobilization and national teams were provided with vehicles to improve field support and monitoring of activities. This ensured better coordination of partners in the district, facilitated district specific social mobilization and community engagement planning and rapid response in the eventuality of a spike in cases at sub-district level. These vehicles also served as mobile public address units. Monitoring and supervisory visits to observe field activities conducted by district and community teams were conducted by UNICEF Communication for Development (C4D) specialists and the chair of the national social mobilization pillar. They also contributed to build capacity of community volunteers and social mobilisers, and monitoring of partners' activities and progress.

Output 3: 426 VDCs were trained for outbreak response and preparedness

As part of the outbreak response in Tonkolili and Kambia and preparedness activities in Port Loko, Bombali and Kailahun district, the VDCs played a crucial role in identifying challenges to rapid response like handwashing buckets, thermometers, phone and torch lights for quarantined people and security personnel. Across five districts over 430 VDCs together with other stakeholders were dully engaged on the plan, focus,

aim and ownership modalities.

In response to the EVD threat from Guinea and a suspected case from Kailahun (that was eventually declared negative) a high level Rapid Response Team from the national level led by the Chief Medical Officer and including the Director of Health Education Division visited the district in the first 48 hours as per the national standard operating procedures. The rationale was to heighten alert on the positive cases across the border and assess the readiness of the district to respond to any eventuality.

Output 4: 100% social mobilizers and youth trained during outbreak response and preparedness

Youth engagement was an integral part of the community engagement process for rapid response and community level action planning. In partnership with Restless Development, UNICEF mobilized and engaged young people at community level to be part of the integrated rapid response teams, especially to trace missing contacts. As part of 'roving teams', young people conducted theatre performances at prominent market places and transportation hubs to create awareness about the threat of Ebola and preventive behaviours. In Kambia youth teams were also part of the special mobilizers deployed for cross border mobilization and monitoring.

In addition to these, UNICEF engaged young people through its SMS based youth and civic engagement platform, U-Report. Regular polls were conducted during the outbreak response period to gauge the knowledge and awareness levels and sentiments of young people. The response proved to be an effective barometer on community perceptions and attitudes and guided the messaging.

WASH

Output 1: 10 communities consisting of an estimated 1,250 people declared Open Defecation Free.

All targeted 10 communities were triggered and are now ODF. The programme trained 20 natural leaders (two per each community) and 10 facilitators on quality triggering. All communities were reached with hygiene awareness messages. The triggering process was undertaken in two phases: pre-triggering and actual triggering. Pre-triggering involved establishing relationships and this enabled facilitators to enter the community. The trained facilitators visited the respective communities, met the local leaders to determine the level of their readiness and to get an idea of the size of the village and population. The intervention communities were selected by the communities on the basis of village size, prevalence of diarrhea, toilet coverage (OD), social cohesion, no history of subsidy and defined leadership, settled village among others. Pre-triggering was followed by actual triggering which focused on sanitation situation analysis.

The project mainstreamed sanitation activities into district health management team activities, with

environmental health superintendent as the focal point to continue supporting post open defection monitoring. The focal point is expected to share the monitoring report with district council monitoring and evaluation focal points as well as provide feedback to WASH partners during district WASH coordination meeting. UNICEF leveraged the monitoring support of the project activities with resources from other donors in the geographical area to ensure continued monitoring and follow-up plans. The resources, which included motorcycles, have enabled the sanitation focal points to conduct spot check visits to project areas, particularly to observe any relapse to open defecation and improvements of basic latrines to construction of hygienic toilets.

Output 2: 1,250 people provided with safe drinking water from five constructed/rehabilitated water sources

In collaboration with the Government, the construction and rehabilitation of targeted five water sources within the ODF communities were completed and they are functional. The project trained ten caretakers and five hand pump mechanics on operations, maintenance and management of water sources. These resource persons were identified by their respective communities to support the management and functionality of the five completed water sources. This group of people have been linked with VDCs to ensure accountability and ownership.

Based on previous experiences on hand pump management, UNICEF in collaboration with the Government is working on restoring community-based operation and maintenance mechanisms which were adversely affected by the EVD outbreak. UNICEF is supporting various communities to restore the community-based financing mechanism (village saving schemes), particularly for paying for minor repairs and routine maintenance. Consultations with the MoWR and district councils are ongoing on how to promote the interest of local traders in developing a hand pump spare parts business by local traders, specifically hardware and motor bikes spare parts.

Output 3: Estimated 10,500 people are accessing health care services from seven facilities provided with WASH facilities

All the targeted seven PHU facilities were provided with comprehensive WASH services as per the new WASH in health standards. The new standards included mandatory provision of running water, construction of sanitation facilities (pour flush toilets, showers, laundry spaces) and waste management options such as incinerators in every health care facility. All water sources are motorized by solar system and piped to a reservoir tank elevated on a tower with a capacity of 3,000 litres. In collaboration with the Ministry of Health and sanitation and other WASH sector partners, UNICEF provided accompanying hygiene education to reinforce the use of these facilities and continued monitoring of their use. The provision of WASH services in these facilities significantly improved health workers sense of safety and the patients'/communities' confidence in the health facilities' quality and safety. It is estimated that 10,500 people from the catchment area are benefiting from the improved WASH services.

Whereas the project completed all planned activities, the main challenge under this output area is the fact that the majority of health care facilities across the country either have poor /or no WASH facilities. Furthermore,

the already installed WASH facilities, particularly the motorized water supply system, will also require continuous maintenance to ensure their sustained functionality.

Output 4: 200 children are provided with child friendly WASH services in 10 primary schools
WASH in schools:

The project provided all the targeted ten primary schools with comprehensive child friendly WASH services which are now benefiting at least 2,000 children (1,020 girls and 980 boys) according to Ministry of Education, Science and Technology standards. The comprehensive child friendly WASH package includes water supply facilities (infrastructure), school sanitation, and health education/school led total sanitation. The school health clubs disseminate behaviour change messages including the promotion of proper use of sanitation facilities through their peers while the school management committees are responsible for ensuring the functionality of the WASH infrastructure through community-based operation and maintenance mechanisms

During the reporting period, ten school management committees (90 people), six school health clubs and 20 school focal teachers were trained to support the management of school WASH services and promotion of safe behaviour change among children respectively. Whilst the project met its target, the status of WASH services in the majority of schools across the country is still poor as the project discovered that some of these facilities also require maintenance and this is likely to require additional resources.

Delays or Deviations

No marked delays or deviations were experienced as the targets were completed within the agreed timeline. The funding was earmarked to support the achievement of sustainable resilient zero of which all the above described outputs contributed to.

While the original proposal had identified Bombali and Kambia as project districts for the community engagement component, with the case being reported from Tonkolili and the potential threat of cross border transmission in Kailahun, activities were expanded to cover Tonkolili, Bombali, Kambia, Port Loko and Kailahun districts.

Best Practice and Summary Evaluation

Based on the lessons learnt from the EVD outbreak and its impact on health care and education systems, UNICEF in collaboration with WASH line ministries reviewed and developed new WASH in health and schools standards and guidelines to enhance infection prevention and control. The new standards, have significantly increased the overall cost for the improvement of WASH facilities in these institutions. However they have improved health workers' sense of safety and the patients'/communities' confidence in the health facilities' quality and safety, and influenced the Government to prioritize WASH services in health care

facilities after realizing that the existing facilities are suboptimal. The use of a community engagement framework which focused on using the national and traditional social structures as entry points to social mobilization was very instrumental during the EVD outbreak and UNICEF will apply the same innovative approach in future community sanitation interventions, particularly during CLTS restoration.

Lessons learned

This project was implemented during the last phases of EVD outbreak. Key lessons learnt included, first, the added value of working through the national WASH sector coordination platform. This approach greatly strengthened the institutionalization of sector coordination and enhanced the stewardship by the Government. Secondly, the use of established social structures within the communities through a community engagement framework was useful and supported social mobilization for behaviour change, including hand washing with soap and water. The EVD outbreak exposed the pre-existing poor WASH situation in both in the communities and in public institutions and helped in getting the issue on to the national agenda. The Government priority in the early recovery period is now focusing on improving wash services in public institutions, specifically schools and health care facilities.

Community Engagement:

- Mapping and activation of VDCs took longer than anticipated primarily due to the movement of key influencers following the declaration of the end of Ebola in November 2015.
- Engaging and managing youth during the unexpected outbreak in Tonkolili was a significant challenge since major markets were shut down and it affected their livelihoods.
- The availability of national and district level SM pillar platforms greatly facilitated coordinated rapid response.
- Engagement of Paramount Chiefs and the consolidation of VDCs as an overarching community platform remains one of the key legacies of the EVD response.

Story from the Field

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Developing communities in Sierra Leone

Two things immediately strike you when you arrive in the village of Thigbonor in Lokomasama chiefdom: the place is extremely tidy, and the high street is almost deserted. After a four hour drive from Sierra Leone's capital, Freetown, we park under a large banana plant, and follow people's indications to the outskirts of the village. I've been caught out before in West Africa when villagers promise "a short walk" under a hot sun, but in this case within two minutes the trees have given way to large open grassland and we quickly find much of the village digging, weeding and planting the rich brown soil.

If it wasn't already apparent that this is one organised village, a cardboard sign next to the road spells out what's going on. With the help of the men, women and youths actively at work, this patch of land is being transformed into a village okra and pepper garden under the guidance of the 'VDC' or Village Development Committee.

"This sort of VDC thing wasn't existing before," the village headman and chair of the VDC, Aboubakar Kamara, tells me during a short break from hoeing. He says it was during the Ebola outbreak, which was declared over on 7 November 2015, that the community started to work together.

This village of around 700 people was a hotspot for Ebola infections, with at least 25 confirmed deaths. During the quarantine period imposed on the village, crops ripening in the fields went to waste because villagers weren't allowed to leave their homes.

Now, through the VDC, they are getting back on their feet. The villagers work together on Thursdays and Sundays to implement the community action plan they have drawn up, which is proudly displayed on a notice board in the centre of the village. Their initial priorities are the agricultural project to re-launch food production, a toilet block, and also a scheme to encourage the continual practice of hand-washing as a safe-guard against Ebola and other deadly diseases. Each home has a hands-free 'tippy tap' hand-washing station made within the village from a jerry can, string and a wooden frame.

Community groups – like development committees, neighbourhood watch groups, and village taskforces – were a key part of the successful response to the Ebola outbreak. The government and agencies like UNICEF hope to build upon the achievements of the past 18 months. Chiefdom and village development groups have existed in Sierra Leone in various forms since colonial times, though many are no longer in operation. A mapping exercise commissioned by UNICEF in 2015 found that 31 per cent of over 1,200 VDCs were active (meeting at least once a month) across the country.

A UNICEF partner in Port Loko district, OXFAM, is working to revive the VDCs as a way for communities to gain more control and say over their development. Each VDC has around 11-13 members including the village headman, a chairwoman, religious and traditional leaders, school teachers, health workers, and youth representatives.

"People here felt they were not considered," says OXFAM's chiefdom coordinator Mohamed Bangura. "They would go to sleep and the next day someone had built a toilet in the community without asking or informing anyone." Now, the idea is that when development actors come into a village they will take account of the

community's own development plan rather than imposing a project without consultation.

A short drive away in the village of Kambia 1, another VDC has made the village's main road a priority to boost local industry. As we arrive, the entire community appear to be armed with shovels and pickaxes as they work to improve the road.

The male youth representative on the Kambia 1 VDC, Abdul Majid Kamara, tells me the Ebola outbreak taught them what they could achieve as a team. "We mobilized all the youth to organise the community and protect our village from sick strangers," he told me. "If we've now defeated Ebola, it's thanks to our working together."

A nearby school project shows the power of community mobilization. The village members decided to construct their own school building without waiting for support. Once the foundations were laid and the structure was three bricks high, they received the support of the local MP, and the building is now almost complete. The abrupt change in brick colour from the initial local construction is testament to how the community started the project themselves before it received backing from the authorities.

Back in Thigbonor village, just as I'm leaving, I meet 19-year-old Yeanor Kamara, who lost her father and mother to Ebola, which she recovered from herself.

"As a survivor, I am optimistic and glad about the Village Development Committee," she told me. "The whole village has come together. There are some things that we can do ourselves. We continue washing hands because we don't want Ebola to return. It doesn't cost us a thing and it stops illnesses. But we're only subsistence farmers so we can't do everything."

She adds as we head off. "I miss my family, but these things give me courage."