

## PARES Case Study of Engagement & Involvement for Resilience

**Case Study Title:** Sierra Leone, Lassa Fever, Multi-stakeholder collaboration & coordination platforms

**Country/location:** Sierra Leone, Eastern Province, Kenema District (Nongowa, small Bo and Lower Bambara chiefdoms).

**Crisis/challenge type:** Lassa fever

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### PARES Domain illustrated by this case study:

**Operational System:** multiple stakeholder collaboration and co-development of coordination platforms with local people enhance resilience

### Recommended Actions

**Communities:** Establish village alert teams with youth, women, traditional healers, and chiefs to enable early detection and rapid reporting of suspected cases.

**Government:** Formalize community engagement roles within District Health Management Team standard operating procedures and surveillance guidelines.

**NGOs:** Broker sustained relationships between biomedical researchers, district health authorities, and community governance structures through locally recruited facilitators embedded for minimum three-month periods.

**Funders:** Fund sustained embedding of facilitation teams rather than short-term consultative visits or rapid project cycles.

### Data for this case analysis

FGD (6), Key Informant Interviews (20), In-Depth Interviews (30), participant observation, document review and reflexive field journals; also literature review.

### Key Message

Multi-stakeholder coordination platforms enable operational coherence and system responsiveness: The establishment of coordination platforms involving village members, clinic staff and district health teams enabled rapid operational adjustments, sustained coordination, improved surveillance responsiveness.

## Case Study Summary

In Kenema, the research team established operational coordination platforms to address fragmented vertical structures that had limited connectivity between biomedical and community systems. Embedded CEI facilitation teams comprising CHWs, frontline health workers, and volunteers were positioned at chiefdom level for approximately three months to serve as boundary-spanners between communities and formal health authorities. Standardized reflection templates were developed through which these teams documented community concerns, feeding into monthly DHMT-Tulane-KGH reflection meetings where operational implications were discussed. Community representatives were enabled to participate directly in district coordination platforms, and negotiated role clarification between chiefs, CHWs, and surveillance officers was brokered to resolve tensions around authority and accountability. This multi-level architecture enabled rapid operational adjustments, such as pre-referral family engagement to address resistance, sustained coordination, improved surveillance responsiveness, and operational coherence across district, chiefdom, and community levels; that transitioned from externally facilitated project to community-led practice with institutional integration.

## Detailed Explanation of engagement mechanisms

### Context that provides the conditions in which the observed actions work

Historical Lassa fever response in these chiefdoms relied on vertically organized surveillance and clinical systems anchored at Kenema Government Hospital, with technical excellence but limited horizontal integration with community governance structures. Biomedical actors possessed strong laboratory capacity and case management expertise, yet operated in isolation from local social systems, generating resistance, delayed presentation, and episodic trust breakdowns. Community health workers existed but were positioned as message carriers rather than dialogue facilitators. Traditional leaders, religious authorities, and ward committees held social legitimacy but were not systematically integrated into response coordination. District Health Management Team structures provided coordination platforms, yet community voices were absent from routine surveillance reviews. These conditions meant that operational information flowed upward through formal reporting channels but rarely fed back into community-

level adaptation, while community concerns about fear, isolation practices, and communication gaps remained invisible to system-level decision-making.

### **The actions (mechanisms) that were observed to lead to resilience outcomes**

The community engagement approach deliberately established embedded facilitation teams at chiefdom level, creating organizational infrastructure for sustained boundary-spanning between communities and formal health systems. When locally recruited facilitators fluent in Krio and Mende were positioned within routine response structures, generated a relational resource of proximity and continuity. However, this resource required activation through procedural mechanisms to influence system behavior. When documented community concerns were systematically presented at DHMT reflection meetings, health system actors interpreted them as actionable intelligence rather than anecdotal complaint. This cognitive shift reframed community engagement as complementary to surveillance function, transforming motivation from resistance or peripheral tolerance to active institutional integration. As operational linkages strengthened, practices such as pre-referral family engagement, direct chief-to-DHMT communication, and community-validated messaging became standardized rather than exceptional. Joint reflection sessions further activated procedural resources, challenging the assumption that "command-and-control" approaches were optimal for outbreak response. Additionally, negotiated role clarification between chiefs, CHWs, and surveillance officers embedded coordination within existing authority structures, reinforcing adherence through recognized governance arrangements rather than parallel project mechanisms. Together, these mechanisms strengthened operational coherence, system responsiveness, and sustained institutional integration, embedding community engagement principles into routine district health operations.

### **Observed outcomes**

**Intermediary outcomes:** Improved coordination between district, chiefdom, and community levels through structured feedback loops. Increased responsiveness of formal health systems to locally identified barriers and concerns. Institutionalized community representation in DHMT coordination platforms. Negotiated clarity on roles and boundaries between biomedical and community actors. Standardized documentation and escalation pathways for community feedback.

**Health-related outcomes:** Reduced delays in referral through pre-referral family engagement protocols. Increased timeliness of case reporting through village alert team networks. Improved acceptance of isolation procedures through operational adjustments based on community feedback. Earlier presentation for febrile illness due to streamlined communication channels.

**System-level outcomes:** Sustained operational coordination beyond project facilitation period. Deeper integration of community engagement into routine DHMT surveillance and planning functions. Enhanced legitimacy of CHWs and community facilitators as operational partners. Preservation of feedback loop mechanisms and coordination platforms for future outbreak preparedness. Transition from externally driven to community-led prevention with institutional anchoring.

## Case Evidence

Vignette # 4 in Sierra Leone – Lassa Fever Supporting Evidence document.

## Related case studies

### Social Relations and Structures

Sierra Leone – Lassa Fever – Legitimate, trusted leaders and intermediaries  
Sierra Leone – Lassa Fever – incorporation of local and scientific knowledge

### Operational Systems

Sierra Leone – Lassa Fever – Information and Communication Systems

### Learning and Capabilities

Sierra Leone – Lassa Fever – Social Learning  
Sierra Leone – Lassa Fever – Institutional Learning

## Other relevant case studies

Sierra Leone – Traditional-Biomedicine tensions – Knowledge systems alignment  
Sierra Leone – Traditional-Biomedicine tensions – Social Learning  
Sierra Leone – Malaria-CHWs – Trusted leaders  
Sierra Leone – Malaria-CHWs – Social Capital  
Sierra Leone – Water Insecurity – Social learning  
Ethiopia – Covid19 – Multisectoral Collaboration