PARES Case Study of Engagement & Involvement for Resilience

Case Study Title: **Sierra Leone, Lassa Fever, Legitimate, trusted leaders and intermediaries**

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:

Social Relations & Structures: working with local leaders & community members who can validate information, improves compliance and mobilises collective action.

Recommended Actions

Communities: Support trusted local messengers.

Government: Train respected community figures as primary health communicators.

NGOs and health programme implementors: Develop survivor networks and engage cultural leaders.

Funders: Invest in local champion programmes, recognising that culturally embedded peer testimony builds credibility and community ownership that external health messaging cannot achieve.

Data for this case analysis

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

Key Message

Legitimate and trusted leaders and intermediaries enabled culturally validated health communication and improved confidence in messages. This increased credibility of health communication, strengthened community ownership, reduced

stigma toward survivors, stimulated demand for early testing and improved willingness to engage with formal care.

Case Study Summary

In Kenema District, Lassa fever messaging had previously been delivered by socially distant hospital staff and external partners, empowering local champions transformed community response. Respected figures such as religious leaders, traditional authorities, survivors and community health workers were trained to communicate biomedical information through trusted cultural channels. Messages were reinterpreted as locally endorsed guidance rather than external directives, making preventive practices socially acceptable and reinforced within communities. Survivor testimonies shared in public forums and radio programmes countered fatalistic beliefs, reframed treatment-seeking as achievable and reduced stigma. Religious and traditional leaders linked disease prevention to moral and communal responsibilities, shifting adherence from individual compliance to collective obligation grounded in shared values. This integrated approach increased credibility of health communication, strengthened community ownership, reduced stigma toward survivors, stimulated demand for early testing and improved willingness to engage with formal care.

Detailed Explanation of engagement mechanisms

Context that provides the conditions in which the observed actions work

Historical Lassa fever communication in these chiefdoms relied on hospital staff and external partners who possessed technical grounding but were socially distant from community realities. Their association with isolation, fear and loss of control generated resistance and limited credibility. Community members had existing trust relationships with religious leaders, traditional authorities and local peers, yet these figures had not been systematically engaged as health communicators. Survivors of Lassa fever faced stigma and shame, discouraging open discussion and perpetuating fatalistic beliefs that treatment was futile. The community engagement team had capacity to identify, train and sustain local champion networks, and existing community structures including religious institutions, chiefdom leadership and community health worker programmes provided

channels through which empowered communicators could operate. These conditions meant that biomedical information existed but lacked culturally legitimate delivery, while trusted local figures and survivor experiences remained untapped resources for generating community ownership and action.

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

The community engagement approach deliberately identified, trained and supported respected local figures to serve as communicators, shifting message delivery from external actors to trusted community channels. By using individuals who shared social identity, lived experience and moral authority, the initiative created a relational resource of familiarity and legitimacy. However, this resource required activation through community reasoning to influence behaviour. When health messages were delivered by trusted local figures, community members interpreted them as grounded in shared realities rather than imposed by distant authorities. This cognitive shift reframed prevention as culturally legitimate and socially acceptable, transforming motivation from resistance or passive compliance to active reinforcement.

As legitimacy increased, preventive behaviours such as early reporting, referral acceptance and participation in dialogue forums became socially endorsed and locally sustained. Survivor testimonies shared in public forums further activated experiential resources, challenging fatalistic beliefs and reframing Lassa fever as treatable rather than inevitably fatal. This reduced stigma and encouraged earlier care-seeking. Additionally, religious and traditional leaders embedded prevention within shared moral and communal obligations, reinforcing adherence through values of family protection and collective wellbeing. Together, these mechanisms strengthened credibility, ownership and sustained participation, integrating prevention practices into everyday community life.

Observed outcomes

Intermediary outcomes: Increased credibility of health communication through trusted local delivery. Stronger community ownership of Lassa fever prevention efforts. Reduced stigma toward survivors and increased social acceptance of open discussion. Shared understanding of prevention as collectively responsible rather than individually enforced. Public encouragement of reporting and preventive behaviours.

Health-related outcomes: Increased demand for early testing and diagnosis. Greater willingness to engage with formal care pathways. Earlier presentation for fever illness. Reduced delays in seeking treatment due to normalised care-seeking. Improved acceptance of referral and isolation procedures.
System-level outcomes: Sustained participation in health promotion activities through local champion networks. Deeper integration of community engagement principles into everyday community life. Enhanced legitimacy of community health workers, religious leaders and traditional authorities as health partners. Preservation of local champion and survivor testimony approaches for future outbreak preparedness.

Case Evidence

Vignette # 1 in Sierra Leone – Lassa Fever Supporting Evidence document.

Related Case Studies

Social Relations and Structures

Sierra Leone – Lassa Fever – Knowledge Systems Alignment

Operational Systems

Sierra Leone – Lassa Fever – Communication and Information Systems
Sierra Leone – Lassa Fever – Multi-stakeholder Collaboration

Learning and Capabilities

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

Other relevant case studies

Sierra Leone – Malaria-CHWs – Trusted leaders
Sierra Leone – Malaria-CHWs – Social Capital
Sierra Leone – Malaria-CHWs – Research Mobilisation
Sierra Leone – Malaria-Science Shops – Universities as enablers
Sierra Leone – Water Insecurity – Universities as enablers
Sierra Leone – Water Insecurity – Social learning
Sierra Leone – Traditional-Biomedicine tensions – Knowledge systems alignment
Sierra Leone – Traditional-Biomedicine tensions – Social Learning
Ethiopia – Covid19 – Multisectoral Collaboration