

PARES Case Study of Engagement & Involvement for Resilience

Case Study Title: Sierra Leone, Lassa Fever, Co-production and incorporation of local knowledge

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: blending traditional/indigenous knowledge with scientific or technical knowledge systems enhances trust.

Recommended Actions

Communities: Recognise the value of local knowledge about illness and transmission, and participate actively in dialogue sessions with health workers to shape disease responses in your chiefdoms and villages.

Government: Make community engagement a standard part of outbreak response protocols, ensuring district health teams allocate time and resources for two-way dialogue rather than one-way health messaging.

NGOs/health programme implementors: Train and deploy community engagement facilitators who can build sustained, respectful relationships with communities, using open interviews, storytelling, and discussion methods that value local expertise alongside medical science.

Funders: Fund long-term community engagement infrastructure and facilitator capacity, not only disease-specific programmes, recognising that trust-building and co-production require sustained investment beyond acute outbreak periods.

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

Co-produced knowledge and embedded trust enabling early reporting and preventive action: Deliberate dialogue that values local expertise creates relationships of mutual respect, generating community ownership of disease response and sustained engagement with surveillance and prevention.

Case Study Summary

In research chiefdoms where prior Lassa fever responses had dismissed local illness understanding and provoked resistance, community engagement created conditions for fundamentally changed relationships. Facilitators and health workers replaced predetermined messaging with facilitated dialogue through open interviews, storytelling, and respectful comparison of local and medical explanations. Community members felt heard, valued, and safe to share knowledge about rodents, fever patterns, and care-seeking pathways, generating mutual respect and recognition. This triggered a shift in thinking that reinterpreted engagement as collaborative rather than corrective. Consequently, community members assumed active roles in awareness-raising, household monitoring, and early case reporting. Locally expressed concerns about isolation, treatment rumours, and social consequences were incorporated into message design and response procedures, reinforcing shared ownership. Community leaders, ward committee members, and CHWs then proactively reinforced agreed messages within their networks, resulting in transparent communication, reduced resistance, earlier care-seeking, and community-driven uptake of control measures.

Detailed Explanation of engagement mechanisms

Context that provides the conditions in which the observed actions work

Historical Lassa fever responses in these chiefdoms had used top-down health messaging that dismissed local understanding of illness causation, risk perception and appropriate response. This generated community scepticism, resistance to surveillance activities and delayed or avoided engagement with formal referral pathways. Communities possessed relevant knowledge through lived experience with rodents, seasonal illness patterns and traditional healing practices, yet this knowledge had not been systematically elicited or incorporated into previous response strategies. The research technical team had capacity and mandate to

implement community engagement approaches, and the study settings contained existing social structures including ward committees, community health worker networks and chieftdom leadership through which engagement could be channelled. These conditions meant that community members possessed relevant knowledge and social organisation but lacked recognition and channels to contribute to formal response efforts, while health workers had information to convey but lacked community trust and uptake.

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

Facilitators and health workers deliberately shifted from didactic health education to dialogical engagement, using open interviews, storytelling and respectful comparison of local and biomedical explanations. By eliciting and valuing existing community knowledge, they created safe spaces in which people felt heard, respected and recognised as knowledgeable actors. This relational resource was necessary but insufficient on its own; it required activation through cognitive processes to influence behaviour. As community members experienced genuine recognition, they reinterpreted health encounters as collaborative rather than corrective. Engagement was no longer perceived as externally imposed instruction but as grounded in lived realities. This shift transformed motivation from passive compliance to active contribution.

Subsequently, community members assumed proactive roles in awareness-raising, household monitoring for febrile illness and early reporting of suspected Lassa fever cases. Mobilisation occurred collectively through established social networks, enhancing legitimacy and reach. As trust deepened, communities voiced concerns about isolation, rumours and referral consequences. The technical team responded by adapting explanations and procedures, demonstrating responsiveness and reinforcing trust. This visible adaptation strengthened shared ownership, prompting local leaders and community health workers to sustain messaging and reporting through formal and informal structures, thereby embedding engagement beyond facilitator presence

Observed outcomes

Intermediary outcomes: Transparent and honest communication between communities and health workers replaced previous patterns of concealment and mistrust. Resistance to surveillance activities and referral discussions diminished

substantially. Community-driven uptake of preventive messages and practices emerged, particularly regarding early disclosure of fever illness and avoidance of high-risk behaviours. Jointly developed actions included adapted referral protocols that addressed community concerns, and community-led monitoring systems for household illness.

Health-related outcomes: Earlier and more consistent engagement with the formal health system, evidenced by increased early care-seeking for fever illness. Increased informal surveillance reporting through community channels to health facilities. Greater consistency in preventive practices at community level, including safer rodent handling and food storage.

System-level outcomes: Strengthened operational coordination between formal health structures and community systems through embedded partnerships. Enhanced legitimacy of community health workers and ward committees as intermediaries between communities and the district health management team. Preservation and validation of local knowledge about Lassa fever transmission, contributing to learning practices that can inform future outbreak preparedness.

Case Evidence

Vignette # 2 in Sierra Leone – Lassa Fever Supporting Evidence document.

Related case studies

Social Relations and Structures

Sierra Leone – Lassa Fever – Legitimate, trusted leaders and intermediaries

Operational Systems

Sierra Leone – Lassa Fever – Information and Communication Systems

Sierra Leone – Lassa Fever – Multiple stakeholders and development of coordination platforms with local people enhance resilience

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

Ethiopia – Covid19 – Multisectoral Collaboration