PARES Case Study of Engagement & Involvement for Resilience

Case Study Title: **Sierra Leone, Lassa Fever, Institutional Learning**

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:

Learning & Capabilities: Institutional (health systems) learning was enabled through dialogue and feedback and internal feedback loops & co-designed tools can achieve procedural change

Recommended Actions

Communities: Share honest feedback through dialogue and testimonies to improve care. Governments must convene regular reflection sessions to adapt protocols based on community input.
NGOs/health programmes: Embed reflexive learning that helps health workers interpret resistance constructively.
Funders: Invest in institutional feedback systems linking community experience to adaptive planning and sustained trust.

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

As reflexive learning (regular meetings with nurses, surveillance officers, researchers and district officials to review community feedback and testimonies) became embedded, community feedback informed coordination meetings and operational planning, creating iterative feedback loops. This adaptive process strengthened perceptions of responsiveness and accountability, enhancing trust, institutional legitimacy and the overall flexibility of the Lassa fever response.

Case Study Summary

In Kenema District, clinical and surveillance practices at KGH and the DHMT focused mainly on standardised biomedical protocols with limited incorporation of community experience. The introduction of regular, facilitated reflection sessions brought together nurses, surveillance officers, researchers and district officials to review community feedback and testimonies. Exposure to these perspectives activated reflexive reasoning, reframing perceived non-compliance as rational responses to communication gaps. Institutional actors became more willing to adapt practices, shifting from rigid, top-down messaging to empathetic, context-sensitive communication. Narratives about isolation and family separation fostered institutional empathy, prompting procedural changes such as clearer referral explanations, revised patient information materials and family-inclusive pre-isolation counselling. These adaptations reduced confrontation and improved cooperation. As reflexive learning became embedded, community feedback informed coordination meetings and operational planning, creating iterative feedback loops. This adaptive process strengthened perceptions of responsiveness and accountability, enhancing trust, institutional legitimacy and the overall flexibility of the Lassa fever response system.

Detailed Explanation of engagement mechanisms

Context that provides the conditions in which the observed actions work

Clinical and surveillance practices at Kenema Government Hospital and within the District Health Management Team were guided by standardised biomedical protocols focused on technical correctness and outbreak containment. These institutions had limited structured opportunities to reflect on how their practices were experienced by communities or to incorporate community perspectives into operational decision-making. Health workers and officials often interpreted community resistance, fear or non-compliance as knowledge deficits or irrational behaviour rather than understandable responses to past experiences of isolation, stigma or poor communication. Community feedback existed but was treated as peripheral to core clinical and surveillance functions, creating disconnect between institutional protocols and lived realities. The community engagement programme had capacity to introduce facilitated reflection sessions, and existing coordination structures including hospital management meetings and district health team

planning provided channels through which reflexive learning could inform operational change. These conditions meant that institutions possessed technical competence and resources but lacked adaptive capacity, while community experience remained untapped as a source of intelligence for improving response effectiveness and trust.

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

The community engagement programme established regular reflection sessions where institutional actors reviewed community feedback and testimonies, replacing isolated professional judgement with collective exposure to community perspectives. While this created an organisational resource for learning, behavioural change required activation through reasoning processes. Through structured reflection, non-compliance and resistance were reinterpreted as rational responses to prior experiences and communication gaps rather than ignorance. This cognitive shift reduced defensive protocol adherence and fostered openness to adaptation. Subsequently, health workers and researchers adjusted communication and care practices to acknowledge community concerns. Exposure to narratives about isolation, stigma and family separation highlighted emotional dimensions of response, prompting more empathetic roles, clearer explanations and family-inclusive counselling. As reflexive practice became routine, community feedback informed coordination meetings and operational planning, establishing informal feedback loops. These iterative adjustments reinforced perceptions of responsiveness and accountability, strengthening institutional legitimacy, cooperation and sustained community engagement.

Observed outcomes

Intermediary outcomes: Shift from rigid top-down message delivery to empathetic, context-sensitive two-way communication. Reframing of community resistance as rational response rather than knowledge deficit. Revised professional roles incorporating emotional reassurance alongside clinical care. Reduced confrontation during referral and isolation processes. Perceptions of institutional responsiveness and accountability reinforced through visible practice adaptation.

Health-related outcomes: Improved cooperation between families and health facilities during referral and isolation. Better patient and family understanding of

procedures through clearer explanations and pre-isolation counselling. Reduced anxiety and stigma associated with seeking care. Increased willingness to engage with formal care pathways due to trust in institutional responsiveness.

System-level outcomes: More flexible and responsive Lassa fever response system better equipped to manage endemic disease dynamics. Strengthened trust and legitimised health system authority encouraging continued community engagement. Embedded feedback loops between community experience and institutional planning. Preservation of reflexive learning practices that can inform future outbreak preparedness and health system strengthening.

Case Evidence

Vignettes # 6 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
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

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 – Malaria-CHWs – Resource Mobilisation
Sierra Leone – Water Insecurity – Social learning
Sierra Leone – Water Insecurity – Universities as enablers
Ethiopia – Covid19 – Multisectoral Collaboration
Ethiopia – Covid19 – Resource Mobilisation