

PARES Case Study of Engagement & Involvement for Resilience

Case Study Title: Sierra Leone, Lassa Fever, Information & Communication Systems

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 Systems: two-way communication between health program staff and community members enabled mutual learning & trusted, co-created messages.

Recommended Actions

Communities: Actively engage in dialogue platforms to shape Lassa fever messaging.

Governments: Replace one-way communication with participatory forums and radio call-ins that enable real-time response.

NGOs/health program implementors: Train health workers in reciprocal communication and contextualised messaging.

Funders: Support community radio and sustained two-way engagement systems that foster mutual learning, trust and collaborative outbreak response.

Data from which this case analysis is drawn

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

Key Message

Two-way communication promotes mutual learning and sustained trust: Participatory dialogue platforms that allow communities to articulate fears and experiences while health workers respond in real time, generate reciprocal sense-

making, reduce misinformation and sustain collaboration with disease surveillance and care.

Case Study Summary

In Kenema District, where previous Lassa fever communication relied on one-way health talks and outbreak announcements allowing no feedback, participatory dialogue platforms fundamentally changed information flow. Village forums, radio call-in programmes, and facilitated question-and-answer sessions replaced didactic instruction with reciprocal interaction. Community members articulated fears, rumours, and lived experiences directly to health workers and researchers, who responded in real time to clarify misconceptions and contextualise medical procedures. This two-way exchange enabled mutual learning: communities revised understanding of isolation, referral, and treatment, while health actors gained insight into social consequences of their practices. As participatory communication became routine and community input visibly shaped response messaging, trust was reinforced. Communities saw their questions reflected in modified health messages as proof that engagement was genuine, strengthening confidence in health authorities. The result was sustained community engagement, increased voluntary care-seeking, improved cooperation with surveillance, and reduced misinformation in previously resistant villages.

Detailed Explanation of engagement mechanisms

Context that provides the conditions in which the observed actions work

Historical Lassa fever communication in these chiefdoms had been delivered through didactic health talks and outbreak announcements that prioritised instruction and compliance. Community members had limited opportunity to provide feedback, ask questions or clarify information. This one-way approach generated misunderstanding, perpetuated rumours and created distance between communities and health workers. Communities possessed relevant lived experience with fever illness, isolation practices and treatment seeking, yet had no channels to share this with health authorities or to seek clarification of confusing medical guidance. Health workers and researchers had technical information to convey but lacked understanding of how their messages were interpreted or the social consequences of response practices. The research technical team had

capacity to implement participatory communication platforms, and local radio infrastructure and community meeting structures existed through which two-way dialogue could be established. These conditions meant that communication flowed in one direction only, preventing mutual learning and eroding trust, while both communities and health actors possessed knowledge that could improve response effectiveness if exchanged reciprocally.

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

The initiative established participatory platforms, including village forums, radio call-in programmes and facilitated question-and-answer sessions, shifting communication from one-way information delivery to reciprocal exchange. These platforms created a social resource of open dialogue in which community members articulated fears, rumours and lived experiences while health workers and researchers listened and responded. However, dialogue alone was insufficient; it required activation through reasoning processes to generate shared understanding and behavioural change.

When health actors provided real-time responses, clarified misconceptions and contextualised biomedical messages within local realities, communities were able to reinterpret isolation, referral and treatment more constructively. Simultaneously, health workers gained insight into the social consequences of their practices. This mutual sense-making transformed communication from imposed instruction to collaboratively constructed meaning.

The cognitive shift prompted behavioural adaptation on both sides. Communities became more willing to collaborate with surveillance and care processes, while health workers revised messaging and procedures based on community insight. As community input was visibly reflected in subsequent communications, trust was reinforced. Repeated participation through radio and village forums sustained engagement, embedding collaboration within established social networks and supporting continued cooperation during outbreak response and surveillance activities.

Observed outcomes

Intermediary outcomes: Reduced misinformation and rumours about Lassa fever, isolation and treatment. Increased credibility of official response messages among

community members. Transparent communication channels established through radio programmes and village forums. Jointly developed health messages that reflected community concerns and medical accuracy.

Health-related outcomes: Greater willingness among community members to collaborate with surveillance and care processes. Increased voluntary presentation to health facilities for fever illness. Improved cooperation during surveillance visits, particularly in previously resistant communities. Earlier care-seeking and reduced delays in reporting suspected cases.

System-level outcomes: Sustained community engagement with dialogue platforms beyond initial implementation. Strengthened operational coordination between health workers and communities through embedded communication systems. Enhanced capacity of health workers to adapt messaging based on community feedback. Preservation of participatory communication practices that can inform future outbreak preparedness and response.

Case Evidence

Vignettes # 3 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 – 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

Sierra Leone – Water Insecurity – Social learning

Ethiopia – Covid19 – Multisectoral Collaboration