Sierra Leone Supporting Evidence for Malaria-CHWs case studies

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Case study manuscripts

Three manuscripts are in preparation based on each of the case studies summarised in this (and accompanying) document(s).

Data Collected

Primary data from 15 key informant interviews, 12 in-depth interviews and 16 focus group discussions.

Identified mechanisms by which community engagement & involvement can build resilience

Case Study 1: Sierra Leone – Malaria-CHWs – Trusted and legitimate leaders and intermediaries

Embedding CHW-led malaria services within trusted local leadership structures enhances health system resilience by leveraging social legitimacy, community trust, and collective accountability, thereby ensuring sustained service utilization, adaptive community response, and continuity of malaria care during periods of health system disruption.
Vignette #1

Case Study 2: Sierra Leone – Malaria-CHWs – Social Capital

Social capital is provided in the form of volunteer/minimally remunerated community-based health roles. Community-driven selection of community health workers (CHW) and their training and deployment locally creates trust and strengthens community-based Malaria service delivery.
Vignette #2

Case Study 3: Sierra Leone – Malaria-CHWs – Resource Mobilisation

Decentralised CHW-led malaria services in Kailahun district facilitated the development of a cost recovery scheme which led to better and timely access to malaria drugs and commodities.
Vignette #3

Vignettes Case Evidence

Vignette #1: Sierra Leone – Malaria-CHWs – Trusted and legitimate leaders and intermediaries

In several rural and hard-to-reach communities of Kailahun District, the success of Community Health Worker (CHW)-led malaria case management is deeply intertwined with the influence of trusted local leadership structures. These leaders—village chiefs, section chiefs, elders, Village Health Committee (VHC) members, and Facility Management Committee (FMC) representatives—play a central and indispensable role in mediating the relationship between the formal health system and community-based healthcare delivery. Their involvement shapes community perceptions, influences behavior, and ensures sustained engagement with malaria prevention, diagnosis, and treatment services.

Across these communities, traditional leadership is not merely symbolic but represents a deeply embedded system of governance and social organization. Leaders are custodians of cultural norms, arbiters of disputes, and key decision-makers in matters affecting community welfare. As such, their endorsement of CHWs carries significant weight and serves as a critical entry point for the acceptance of community-based health interventions.

During a Focus Group Discussion with adult men in one remote village, participants described the centrality of leadership authority in shaping their health decisions: "*In our village, nothing works without the chief's approval. When the CHW was brought, we did not just accept him because he was trained. We accepted him because the chief stood in front of us and said this person is chosen to help us. That is why we trust him*."

This sentiment reflects the legitimacy endorsement mechanism, whereby CHWs derive credibility not only from formal training but also from the social validation provided by trusted leaders. Without such endorsement, CHWs might be perceived as external actors, potentially leading to resistance or low utilization of their services.

Women caregivers, who are often responsible for seeking care for children, echoed similar perspectives. In a Focus Group Discussion with mothers, one

participant explained:"When my child has fever, I go to the CHW because our leaders told us he is someone we can trust. If the chief and elders did not support him, I would be afraid to give my child the medicine." – mother of an under five in FGD in Gooh

Another caregiver added: "*Before the CHW came, we used to rely on herbs or wait until the sickness became serious. But now, the leaders always remind us that malaria is dangerous and we should go early. That is why we go quickly*."

These narratives illustrate how trusted leaders function as social mobilizers, reinforcing key health messages and promoting timely health-seeking behaviour. Their influence extends beyond formal meetings into everyday interactions, where they continuously encourage adherence to recommended practices such as early testing, treatment completion, and use of insecticide-treated nets.

From the perspective of CHWs, the role of trusted leaders is both enabling and sustaining. Many CHWs described how their initial acceptance within the community was largely facilitated by leadership endorsement. "*When I was selected, the chief called a community meeting and introduced me. He explained that I was trained to test and treat malaria. From that day, people started coming to me without fear*," said a CHW during an in-depth interview. (CHW in IDI in Madina). Another CHW elaborated on how leaders continue to support their work: "*Sometimes people doubt the test results or delay coming for treatment. When that happens, the chief or VHC members talk to them and explain why it is important. That makes my work easier*." – CHW in an KII in Mobai. CHWs also highlighted how leaders help address misconceptions and cultural beliefs that may hinder malaria service uptake: "*Some people still believe in traditional medicine, but when the leaders talk to them and explain that malaria needs proper treatment, they listen. The leaders help us change these beliefs*."- CHW in KII in Niahun

Healthcare workers at Peripheral Health Units (PHUs) further emphasized the critical intermediary role played by trusted leaders. A PHU In-charge described the importance of community leadership in supporting CHW programs: "*We can train CHWs and give them supplies, but without the support of community leaders, their work will not be effective. The chiefs and VHCs help us communicate with the*

community. When they speak, people pay attention." PHU In – Charge in KII at Levuma.

Another healthcare worker noted: "*The leaders act as a bridge between us and the community. They help us understand community concerns and also help the community understand our services.*" This bridging function highlights how trusted leaders facilitate bidirectional communication, ensuring that both the health system and the community remain aligned in their expectations and actions.

In addition to mobilization and communication, trusted leaders play a crucial role as mediators and accountability agents. They ensure that CHWs remain accountable to the community while also protecting the integrity of the program. During a Focus Group Discussion with adult men, one participant explained: "*If the CHW does something wrong, we don't just ignore it. We report to the chief or the VHC. They will call the CHW and discuss the issue. This helps us trust the system*." Male caregiver in FGD in Niahun

A VHC member elaborated on this oversight role: "*We monitor the work of the CHW. If there are complaints, we investigate and resolve them. The community must trust the CHW, and the CHW must also respect the community*." VHC Member in a KII in Gooh. CHWs acknowledged this accountability structure as both supportive and motivating: "*Knowing that the leaders and the community are watching my work makes me more careful. I want to maintain their trust because without it, I cannot do my job*."

Healthcare workers also recognized the complementary nature of community-level and facility-level supervision: "*At the facility, we supervise CHWs periodically, but the leaders provide daily oversight. This helps ensure that CHWs are always accountable*." – PHU In – charge in Levuma

Another important dimension of this pathway is the development of collective trust through social networks and shared experiences. Trust in CHWs is not only built through leadership endorsement but also reinforced through community interactions and observed outcomes.

In a Focus Group Discussion with youth, participants described how trust spreads within the community: "*When we see other people going to the CHW and getting better, we also go. The chief also encourages us, so we feel confident*." Youth Chairman in FGD in Mobai

Similarly, a caregiver shared: "*At first, I was not sure about the CHW, but when my neighbour's child was treated and recovered, and the chief kept talking about it, I started trusting him*." Lactating Mother in FGD in Gooh

This reflects a social proof mechanism, where individuals' behaviors are influenced by observing others within their social network. Trusted leaders amplify this effect by endorsing CHWs and reinforcing positive experiences.

The role of trusted leaders becomes even more critical during periods of health system disruption, such as stock-outs of malaria commodities or reduced service capacity at PHUs. In these situations, leaders help maintain community confidence and ensure continuity of care. A PHU in-charge explained: "*During stock-outs, the community becomes worried, but the leaders help to calm the situation. They explain what is happening and encourage people to continue using CHW services where possible*."

Community members confirmed this adaptive response: "*When the facility does not have medicine, we don't panic. The chief and CHW explain what to do. We still rely on the CHW because we trust him*." Lactating mother in a FGD in Madina
CHWs also highlighted how community support, facilitated by leaders, enables them to continue their work: "*The community supports me with food and transport during outreach. This support comes because the leaders remind them that my work is important*." – CHW in a KII in Mobai

Through these narratives, it becomes evident that trusted leaders are not passive actors but active intermediaries who shape the success of CHW-led malaria interventions. Their roles encompass endorsement, mobilization, mediation, accountability, communication, and reinforcement of social norms.

Vignette #2: Sierra Leone – Malaria-CHWs – Social Capital

Evidence from Key Informant Interviews with community leaders and members of Village Health Committees (VHCs) further demonstrated how CHW programs strengthened cooperation and collective problem-solving within communities – helping to generate and mobilise social capital. One VHC member explained how the program improved community engagement in health matters. *"When the CHWs were trained and deployed, it helped the community become more involved in health activities. People attend meetings, ask questions, and support the work of the CHWs."(KII, Village Health Committee member in Baiima Mandu)*. Similarly, a local chief described how CHWs helped mobilize the community to respond to health challenges collectively. *"The CHWs are the link between the community and the health facility. When they tell us there is a problem, we call the community together and decide what we should do." (KII, community chief in Niahun)*

Another community leader emphasized the sense of shared responsibility that emerged through the CHW program. *"People now see malaria control as something we must work on together. The CHW cannot do everything alone, so the community supports the activities." (KII, community leader in Levuma)*. In-depth interviews with CHWs themselves revealed how their roles strengthened relationships with community members and improved trust in local health services. One CHW described how regular household visits built stronger connections with families. *"When I go from house to house to test children and give treatment, people begin to trust me more. They see that I am helping them."(IDI, CHW in Niahun)* CHWs also described how collaboration with community structures strengthened collective action. *"When there is a health problem, we work together with the Village Health Committee. We meet and discuss how to help the community." (IDI, CHW)*

Across these interviews and discussions, respondents consistently described how the CHW program strengthened bonding, bridging, and linking social capital within communities. Bonding social capital was reflected in the strong trust between CHWs and community members, bridging social capital emerged through collaboration between community groups and committees, and linking social capital developed through stronger relationships between communities and the formal health system.

Vignette #3: Sierra Leone – Malaria-CHWs – Resource Mobilisation

In Kailahun District, malaria service delivery periodically faced system shocks, most notably stockouts of RDTs and antimalarial medicines at Peripheral Health Units (PHUs). These disruptions were often linked to delayed supply chains, seasonal spikes in malaria cases, or broader national health system constraints. During such periods, formal facilities reduced services, referred patients elsewhere, or advised households to wait until supplies were replenished.

Within this unstable service environment, CHWs continued to operate at the community level, positioned at the interface between households and a strained health system. "*Sometimes the clinic will say there is no test and no drugs. People come back confused and frustrated*." (Caregiver in Baaima Mandu). Even though trust and legitimacy were undermined during stockouts, CHWs communicated transparently with households, explained the reasons for shortages, and guided families on alternative actions, including referrals, symptom monitoring, or delayed treatment where appropriate. "*He did not hide anything from us. He told us clearly that the drugs were finished and showed us his empty box*" – (Community member in a FGD in Garama)

This openness signalled honesty and accountability, reinforcing perceptions that CHWs were acting in the community's interest rather than withholding care. The CHWs also adapted by maintaining presence and support, even when they could not provide testing or treatment. Their continued engagement in checking on sick children, advising on danger signs, and facilitating referrals to the health centres demonstrated commitment beyond commodity availability. "*Even when he had no medicine, he still came to see the child and told us when to rush to the clinic."* (Mother of an under-five child at FGD in Levuma)

Such behaviours activated a mechanism of relational reliability, where trust was sustained not by the ability to dispense commodities but by consistency, honesty, and care.

During stockouts, community expectations shifted from immediate treatment to guidance and navigation of uncertainty. Because CHWs were socially embedded and accountable to local leaders, they were expected to explain system failures and advocate informally on behalf of the community. "*People will ask him first before going anywhere else because he understands what is happening in the system*."

(Section Chief at a KII in Gooh)

During periods of persistent stockouts of malaria drugs, Community leaders, Village Health Committee members, and health facility in–charges called a meeting to discuss community-led actions to address stockouts. In those meetings, all agreed to the formation of a cost recovery scheme to address stock issues. The VHCs and community leaders signed a Memorandum of Understanding with the pharmacy owners for the supply of malaria drugs and commodities for community members to buy on a cost-recovery basis. This necessitated the availability of the malaria drugs, thereby reinstating trust in the CHWs and continuity of care. Community members were so appreciative of the scheme and continued to seek care from the CHWs. In Communities where this scheme was not formed, their CHWs coordinated with nearby villages, PHUs, or supervisors to locate available commodities or fast-track referrals, reinforcing their role as problem-solvers within the system. "*When there was no drug here, he called another CHW and asked where medicine was available*."- (Male caregiver - FGD in Gooh). This adaptive coordination enhanced legitimacy by positioning CHWs as connectors rather than passive victims of system failure. As a result of these adaptive responses, community trust in CHWs was maintained or even strengthened during stockouts. Households continued to seek advice from CHWs, complied with referral guidance, and did not attribute system failures to CHW incompetence or neglect. "*Even when there was no medicine, we did not blame him. We know he is trying*." (Community elder in KII in Mobai)

Importantly, results from the study indicated that CHWs absorbed the relational burden of health system shocks, preventing frustration from escalating into disengagement or mistrust of malaria services more broadly. "*If he was not there, people would lose hope. But because he explains and follows up, we still trust the programme*."(Community Leader at KII in Garama)