Community leaders' engagement to prepare and respond to shocks, increase inclusivity, accountability and trust, and support health system resilience: lessons from Sierra Leone

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ReBUILD FOR RESILIENCE

UKaid from the British people

Background – Community Engagement (CE)

- Dialogue at local level
- Accountability and Trust
- Inclusive

Aim and Objectives

Aim - to provide insights into the current CE strategies in response to PH emergencies and HSS interventions in Sierra Leone through an inclusivity and accountability lens and test approaches to support and improve engagement, to develop resilience capacities of the health system.

Specific objectives

- To (participatorily) **map** and understand who the community leaders and their role in relation to (formal) health are actors and to the health system:
- To **co-develop** an action agenda and plan for system strengthening with local stakeholders and community leaders:
- To observe and assess the **implementation of the action agenda** and **reflect** on challenges and achievement:

Methodology – Participatory Action Research

Phase	Workshop	Data collection
Phase 0	DR	
Phase 1	Workshop 1	Power mapping - formal
	Workshop 2	Power mapping - informal
	Workshop 3	Power mapping - community
Phase 2	Workshop 1	Problem tree
	Workshop 2	Venn Diagram
	Workshop 3	Action agenda
	Workshop 4	Pathway to change
Phase 3		Implementation phase; documentation reflection and learning

Preliminary findings

Key lessons to inform future strategies

Category	Lessons learned
Cross learning	Covid vs EVD
Gender and inclusivity	Gender core to CE; barriers to women's involvement in CE and as SM to be addressed (links back to prior evidence from ReBUILD); inclusion of marginalised and vulnerable groups
Regular update, feedback and adaptation of the approach	Continuous follow-up visits to the communities paramount; two way dialogue platform needed – communication and coordination; Communication channels need to have a mix of 'one-way' and 'two-way' approaches
Programme Integration	Multi sectoral approach; CE structures should go beyond pandemic preparedness and/response
SM - selection, training and supervision	Community involvement; peer learning; enabling environment
Define clear protocols and collect adequate	CE scale up requires clearly defined protocol to facilitate sustained relationship between response activities, frontline HWs and the communities; promote real time data collection and analysis to inform response decision making
Sufficient funding	Essential to ensure the sustainability of community engagement; cost?
System thinking approach	Designing CE strategies as part of community health systems; CE and SM should be recognised as having different processes, methods, and approaches
Health System Resilience	CE approaches and the role of community leaders should respond to the need to build communities' resilience to health emergencies but more broadly
Political economy analysis	Critical lens should be integrated into community engagement and leaders' study and research; The source of authority of traditional political institutions remains not fully understood

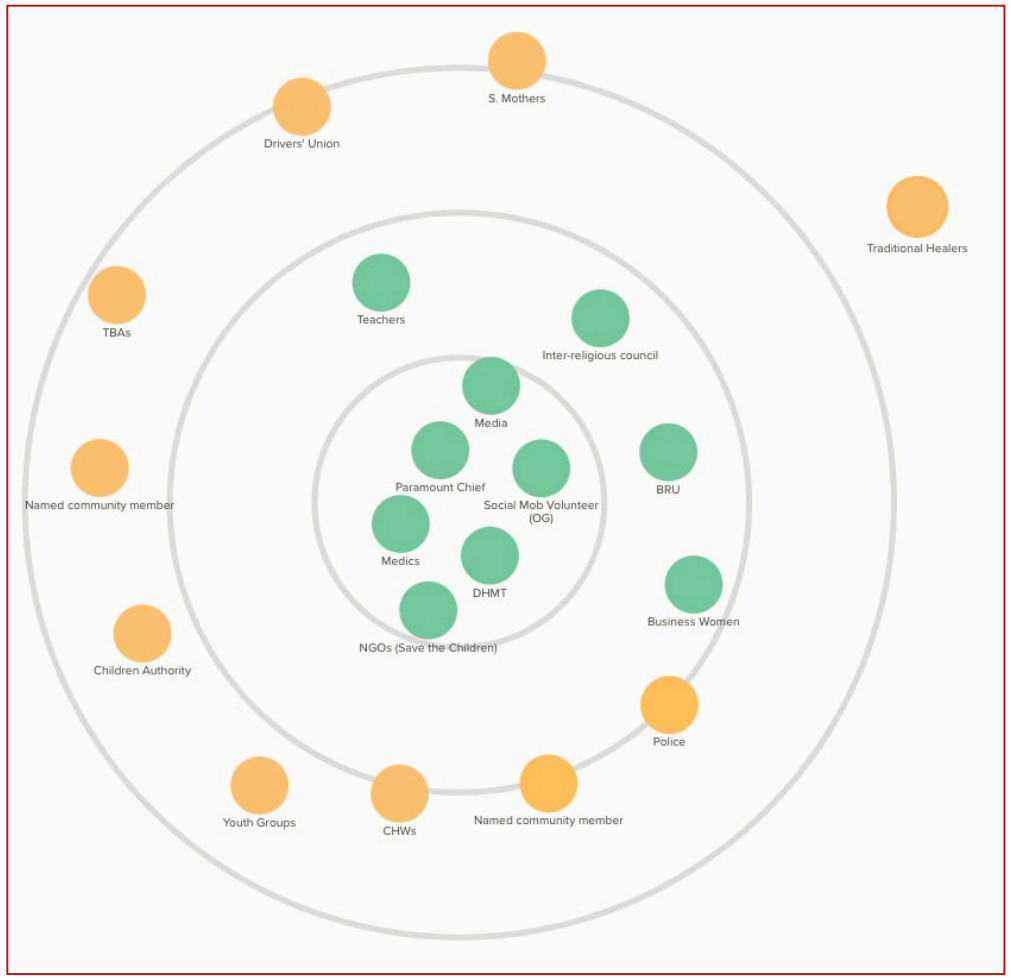
Phase 1 – Power mapping

- Identify the most representative and influential leaders at community level, their power relations,
- Understand their power, and roles in relation to health and the health system, the relationship between power and trust and how power changes over time
- Inform decisions on who to involve or engage during phase 3 for sustainable impact

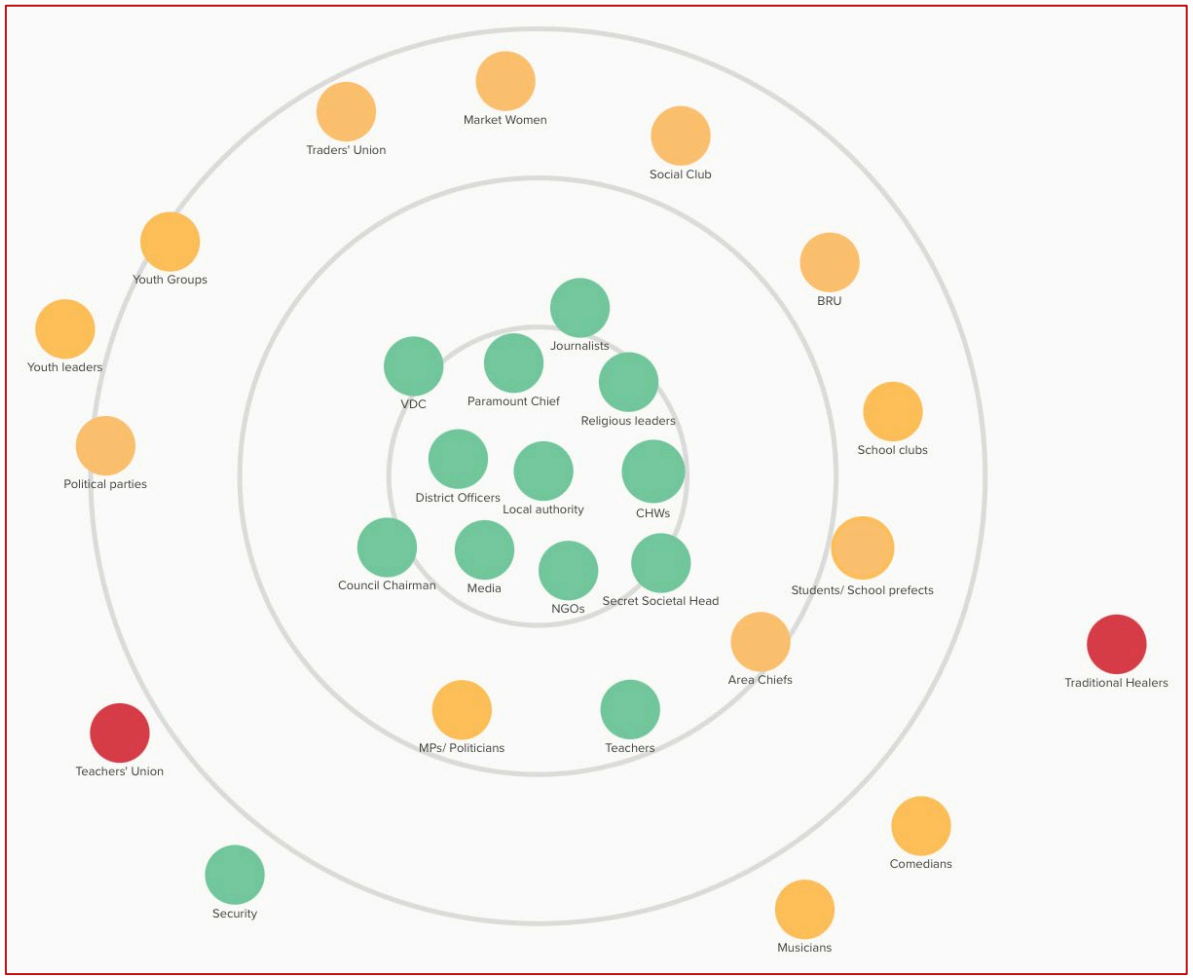
Community Leaders

Green=high trust
Yellow=medium trust
Red=low trust

Kailahun



Moyamba

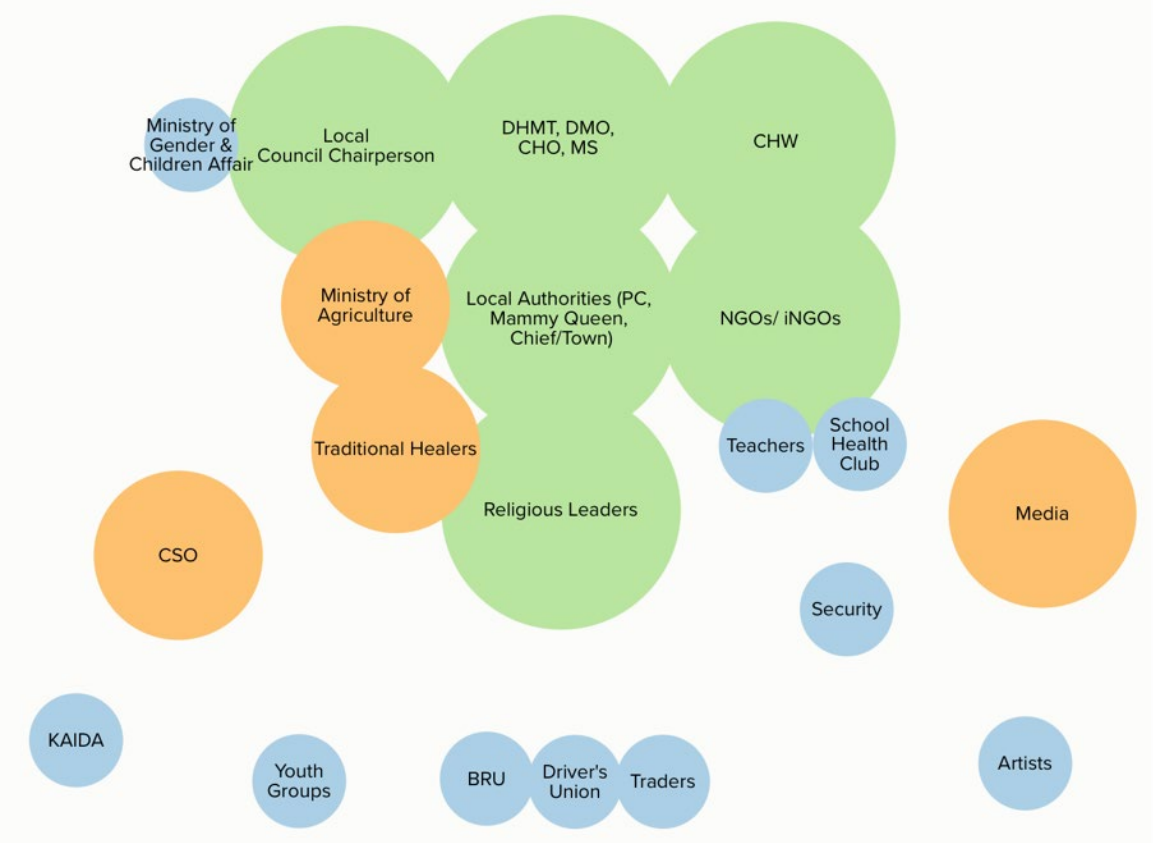


Phase 2 – Problem tree/key barriers

Reference point – MCH (Kailahun) and Infectious Diseases (Moyamba)

- Political affliation
- Traditional beliefs
- Media
- Poor community engagement
- Absence of focal person at community level
- Reduction in the number of CHWs
- Shifting trust in the system
- Gender norms
- Terrain and environmental factors

Phase 2: Kailahun - Venn Diagram of Actors/Organizations/institutions

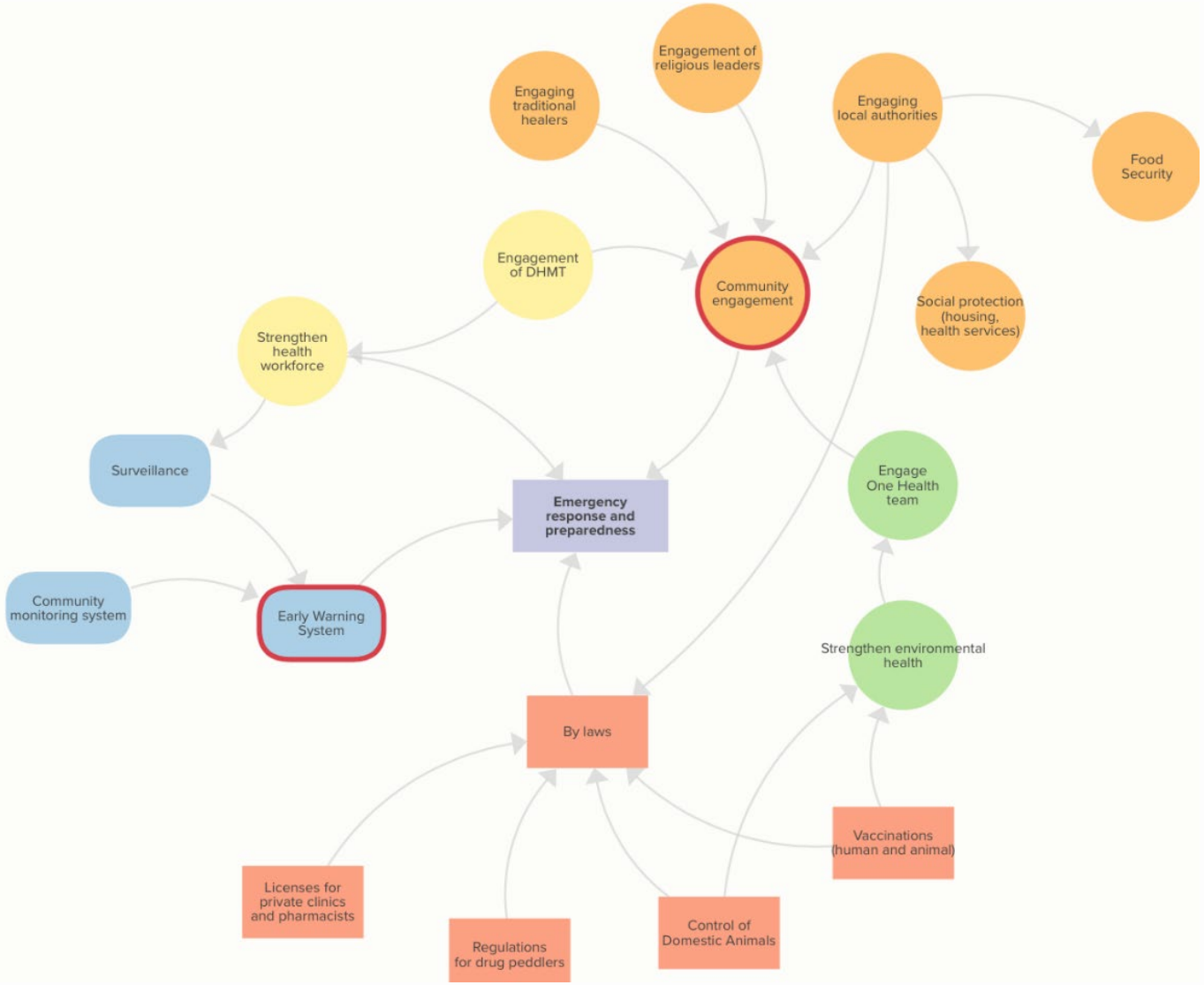


- *Traditional healers are essential in community engagement…they can engage communities to refer cases to the formal health system…so they are paramount in outbreak response*
  (Workshop participant, Kailahun)

- *NGOs are always closer to the DHMT… whether in community engagement or not… A clear example has to do with project implementation… They don't do it without working directly with the DHMT*
  (Workshop participant, Kailahun)

(Green:most important; Yellow: important; Blue: less important)

Kailahun – Pathway to change



Next steps and linkages

- Identify linkages
  - Kailahun – PIH (qehssp) FOCUS 1000 (Kombra Network)
  - EWS - Kailahun
- TWGs – CE and HSE
- Phase 3 planning
  - Planing meeting with the DHMT and relevant partners
  - Implement and monitor (tools)
  - KIIs

Learning so far

- Ownership and leadership - sustainability
- Advocacy in budget allocation at the district level
  - Decentralisation
- Do they have the capacity to respond?
  - Capacity building – DHMT and volunteers
  - Unintended consequences
- Managing expectations
  - Are we fuelling a culture of dependency?
- Social mobilisation vs CE
- Power dynamics vs bias
  - Will this change post phase 3?
- Context is key

Thank you

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