malaria consortium

CAPACITY STATEMENT

Social and behaviour change

Since 2003, Malaria Consortium has pioneered best practices for innovative evidence-informed social and behaviour change (SBC) approaches for malaria and related health challenges. Effective health interventions do not achieve impact through availability alone. People practise behaviours within complex social, cultural and economic realities. Our SBC work helps bridge the gap between available interventions and their appropriate use. By working alongside communities and those most at risk, we develop, implement and embed responsive, equitable and effective health programmes grounded in local realities.

Our community engagement approaches drive impact by combining social mobilisation and communication strategies to improve health outcomes, while strengthening longer-term community resilience. We partner with communities, governments, local organisations and the private sector to co-design and adapt behaviour change strategies that reflect how people live, make decisions and access care. Through dialogue, shared learning and mutual accountability, our work strengthens local ownership over health and amplifies voices that are often excluded.

As a frontrunner in inclusive malaria SBC programming, Malaria Consortium's work has influenced social norms, knowledge, attitudes and behaviours, and informed policy at national and international levels. By embedding research within ministry of health structures and engaging closely with stakeholders, we support the use of evidence in ways that translate into meaningful, real-world impact.

Children learn about health through play, Cambodia

Our approach and scope

We view SBC as a systematic, inclusive process that identifies the factors influencing automatic and reflexive decision-making. Strong partnerships with governments, implementation partners and community members are the driving force behind our approach. We innovate and co-develop approaches and technologies most likely to be effective in supporting individuals, communities and societies to understand, adopt and sustain positive behaviours. Grounded in recognised SBC theories, models and frameworks,[1-4] we take a systems approach, focusing on how behaviours are shaped and reinforced through interactions between communities, service delivery, social norms and policy environments, and adapting interventions as these dynamics change over time. This means combining community engagement and social mobilisation, behaviour change communication, advocacy for supportive policies, applied behavioural and social science, and improvements in service delivery.

Our expertise

We draw on our SBC expertise to:

- understand the barriers to access and use of health services
- build trust and demand for prevention, diagnosis, treatment and care
- support communities, health workers and local partners to shape solutions
- adapt interventions using evidence, learning and community feedback
- improve the reach, quality and sustainability of health programmes.

Our strategy

SBC cuts across all of the strategic pillars that guide Malaria Consortium's actions as an organisation, ensuring that our technical expertise, research and on-the-ground presence translate into proven health outcomes for communities impacted by malaria.

1. Implementation
We focus on identifying solutions that can be scaled, optimised and implemented by locally-led teams to ensure programmes are both efficient and effective.

2. Research
Our research aims to clearly show how our programmes improve community health outcomes, helping us adapt and scale solutions for greater impact, and identify new ways to create value for communities.

3. Policy and practice
We provide national and global decision-makers with timely, evidence-based data on health solutions to help shape health policy, practice and outcomes.

4. Partnerships
We work with diverse local and global partners, including governments and innovation stakeholders, to drive systemic change, address malaria-related health challenges and improve access to healthcare for communities.

5. Organisational development
We strategically strengthen our internal capacity, systems and processes to enhance efficiency and foster a healthy, collaborative workplace culture, ensuring we can deliver maximum impact and continuously adapt to evolving global health challenges.

Implementation

By working closely with local governments and communities, we ensure that community engagement is locally led and locally owned, enhancing long-term sustainability of SBC interventions.

Embedding behaviour change through locally led approaches to community engagement

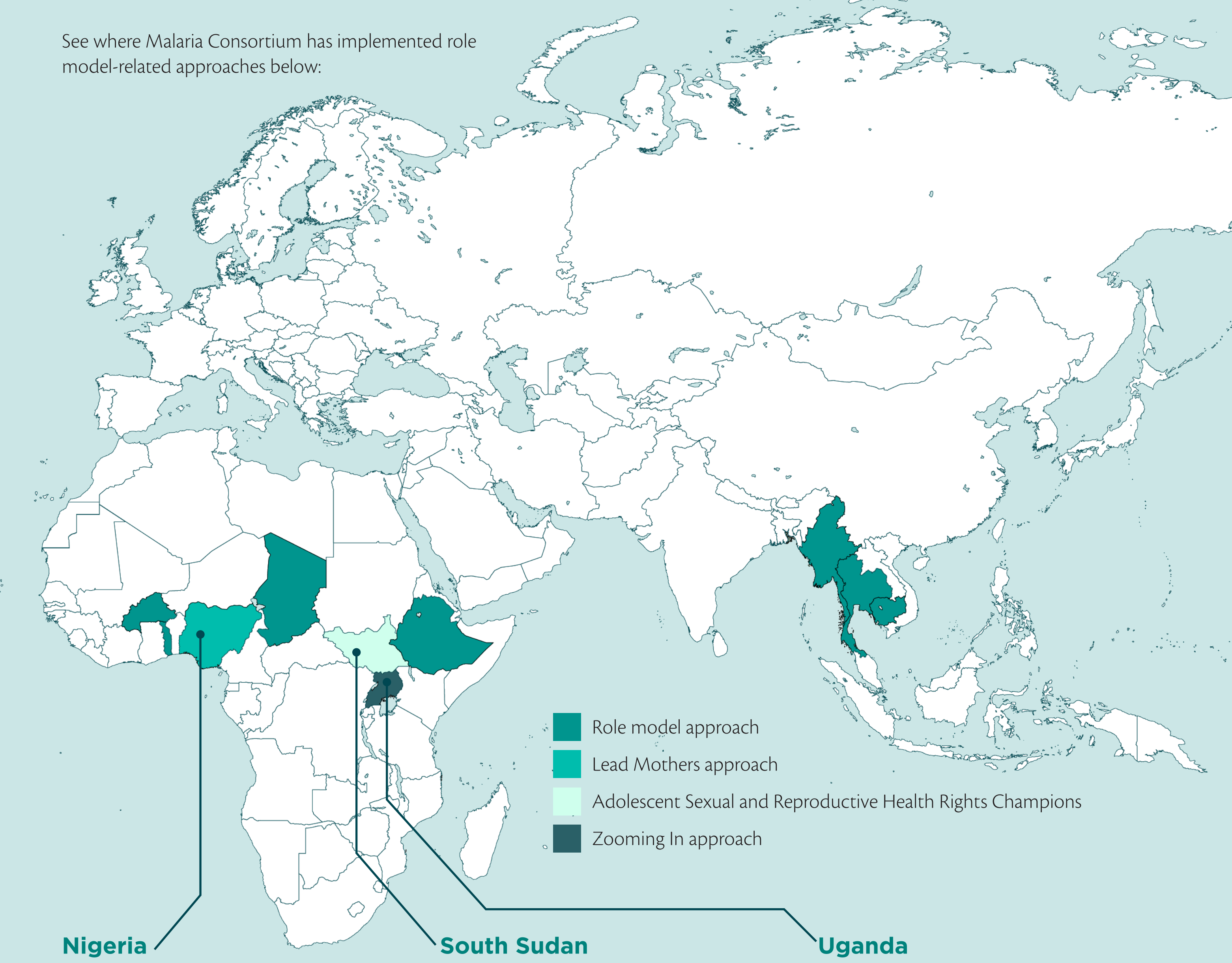
We support trusted community members to promote behaviour change in their communities through several related but context-specific approaches.

In malaria elimination settings, Malaria Consortium was the first organisation to apply the Role Model approach (previously known as Positive Deviance).[1,5] This involves identifying and training community members who practice uncommon but positive behaviours, and supporting them to promote behaviour change within their communities. Introducing the Role Model approach to mobile and migrant workers and high-risk communities in Myanmar, Cambodia and Thailand **increased net use, improved care seeking and malaria knowledge, and enhanced leadership skills among volunteers.**[1,6] Community volunteers in Myanmar took the approach a step further, developing village malaria maps to record malaria cases, track role model session coverage and plan future activities. This contributed to a cost-effective and sustainable model with high levels of community ownership.

Building on its success in Asia, we took the Role Model approach to several African countries to engage caregivers with seasonal malaria chemoprevention (SMC) activities, reminding them to administer antimalarial medications to their children.[7] Role model activities encouraged communities to mobilise and cooperate with stakeholders and each other, leading to **reduced malaria caseloads at health facilities in Ethiopia.**

Role model approach activities, Ethiopia

See where Malaria Consortium has implemented role model-related approaches below:



Nigeria

In settings where patriarchal norms can limit women's access to care, Lead Mothers have played an important role in improving engagement, trust and access to interventions. These women community health volunteers conduct health promotion activities, including supporting caregivers to administer medicines during SMC campaigns. Through their strong connections to communities and unique relationships with caregivers, **Lead Mothers influenced caregivers to adopt healthy behaviours during the SMC campaign and supported them to administer Day 2 and Day 3 doses of antimalarial medicines to their children.**[8]

South Sudan

Through a gender equality and social inclusion programme, we supported influential women and religious leaders to engage marginalised women and girls to become role models among their peers. By holding health talks and debates, these Sexual and Reproductive Health Rights Champions have helped to reduce the stigma surrounding sexual health so that girls, including young mothers, can access essential sexual health and family planning services with less fear.

Uganda

The Zooming In approach targets high-risk individuals identified through health facility data and health worker support. Trained 'key influencers' visited households with high rates of positive malaria tests to identify the challenges they experienced in accessing malaria services. They worked with the families to develop household-specific action plans. By carrying out follow-up visits, they could ensure the plans were being implemented. This approach had a positive impact on a range of malaria-related indicators including **13 percent fewer uncomplicated malaria cases, eight percent fewer cases of malaria in pregnancy and nine percent fewer positive malaria tests** among people in the intervention group compared with a control group.

Caregiver administers SMC medication to her child, Federal Capital Territory, Nigeria

Catalysing demand by adapting communication methods to enhance social reach

Targeted SBC communication (SBCC), delivered through intensive, multichannel interpersonal and group communication, strengthens protective norms, increases use of prevention tools and early care-seeking for malaria and other health issues, and is associated with reductions in malaria incidence and prevalence when combined with core malaria tools.[9] We implement tailored community-led SBCC strategies using the most appropriate and impactful channels for a given context to ensure sustainable health outcomes.

In Cambodia, we are leveraging our long-standing malaria elimination experience in reaching communities where health services are not well established to address preventable deaths from cervical cancer among women. We identified the contextual barriers limiting access to cervical cancer prevention and treatment services in northern Cambodia. Working with community health workers (CHWs), local leaders, women's representatives, healthcare professionals and educators, we co-designed health promotion plans that raise awareness of a preventive vaccine among schoolgirls and screening for women aged 30–49 years. Schoolchildren have become powerful agents for change within their communities.

In Uganda, as part of the Malaria Action Programme for Districts (MAPD), we collaborated with partners to develop a qualitative study to identify how gender- and youth-related norms might be hindering effective malaria control. This gender analysis revealed that men and male youths are often overlooked in malaria programming.[10] In response, we targeted men through an edutainment campaign that promoted malaria messaging at World Cup football match screenings, reaching almost two million people.

Case study

Integrating online messaging with traditional approaches in urban areas

Challenge: Obstacles to SMC distribution in urban areas of Nigeria include restricted access to gated communities, and young children being away from home in day nurseries during the working day, or being cared for by childminders who are unable to give consent for SMC.

Approach: We used social media to promote SMC rapidly to large and diverse audiences. In Abuja, churches shared notifications of SMC dates, as well as stakeholder and caregiver testimonials, via their social media platforms. Online messaging was integrated with broader community engagement approaches, such as letters and radio and television announcements to ensure caregivers who were less connected could also be reached.

Change: Proactive messaging, use of trusted voices and rapid response to misinformation has helped to overcome some of the common challenges around online approaches to SBC communication.

Research

We inform and refine our SBC approaches with evidence from high-quality research. By testing and refining new concepts in real-world settings, we can ensure that they are contextually relevant, feasible and effective.

Overcoming barriers to net use with insights from behavioural science

In Uganda and Nigeria, where insecticide-treated net (ITN) use remains consistently low, we are applying a behavioural science lens to increase the use of ITNs in households that already own nets. We explored the factors that encourage and inhibit net use and then supported local community members to co-create, evaluate and select interventions through focus group discussions and interviews. This enhanced the acceptability of the chosen interventions: distribution of the preferred soft nets paired with behaviourally informed messaging and a Net Champion social signalling intervention.[11] **Overall, 83 percent of respondents in Nigeria and 97 percent in Uganda were familiar with the Net Champion programme, and 53 percent and 78 percent, respectively, had discussed it with other community members — indicating a positive response to social signalling.**[11]

We are working with national governments and partners to explore the potential integration of this low-cost approach to increasing ITN use into future net distribution campaigns.

Measuring impact through participatory monitoring and evaluation

We adapt and develop participatory monitoring and evaluation approaches and tools to address the complexity of measuring the success of SBC programmes.

In Uganda, we conducted a qualitative evaluation of the integrated community case management (iCCM) project to improve care-seeking behaviour, using rapid appraisal activities (visualisation tools) to generate group discussions. We conducted participatory historical matrices; iCCM delivery and uptake matrices; a problem-ranking matrix; and an intervention ranking matrix with village health teams, community members, leaders and health staff to map information and inform future iCCM implementation.

During the Breaking Barriers project co-creation workshop in Cameroon, service users, civil society and Ministry of Health representatives developed indicators and a scoring mechanism that have been used to assess and analyse the quality, accessibility and acceptability of the community engagement intervention.[12]

Policy and practice

We develop and test innovative SBC approaches that can be embedded within local health systems and taken to scale. Working closely with policy makers we can ensure long-term stewardship by integrating these approaches into national policy and practice.

Evolving approaches from inception to scale and sustainability

In 2009, we pioneered the Community Dialogue Approach (CDA) for interventions where health-related behaviours are strongly influenced by social norms and community dynamics. The cornerstone of CDA is supporting community volunteers to facilitate regular dialogues to increase understanding of key issues, build cooperation and generate collective action within their communities.

In 2012–2013 we tested the approach for iCCM projects in Mozambique, Uganda and Zambia.[13] We later applied it to mass drug administration for neglected tropical diseases in Mozambique.[14]

Building on this work, we supported the design, implementation and evaluation of a similar intervention in Bangladesh and Nepal, using a gender intersectional lens to explore and address the contextual drivers of antimicrobial resistance (AMR).[15,16] Taking a One Health approach, we integrated context-specific storytelling into a co-designed intervention. This engaged local communities in the complex subject matter and promoted community-led solutions. The intervention was embedded into existing health systems and community structures to optimise its potential for scalability and sustainability. The CDA helped to shift gender norms.

It had a positive impact on community knowledge of AMR[17] and subsequently influenced government policy, being adopted into the Bangladesh National Adaptation Plan in 2023. **Knowledge of antibiotics, resistance and use for human health increased by 16 percent by the end of the intervention**.[17]

EVOLUTION AND APPLICATIONS OF THE COMMUNITY DIALOGUE APPROACH (CDA)

- 2009
  CDA designed
- 2012–2013
  Pilot — Mozambique, Uganda and Zambia — integrated community case management
- 2014–2016 and 2017–2019
  Mozambique — mass drug administration for neglected tropical diseases
- 2017–2018
  Bangladesh — antibiotic resistance (AMR) and Mozambique — mobile health
- 2020–2023
  Cameroon — Community Health Participatory Action approach
- 2021–2023
  Bangladesh and Nepal — AMR
- 2023
  National policy — adopted into Bangladesh National Adaptation Plan

Supporting government stewardship by incorporating SBC strategies into the national health system

In Mozambique, with our focus on both demand side and service provider behaviour change, grounded in behavioural theory and formative research, we launched the inSCALE mobile phone app to strengthen the capacity of CHWs to deliver care to communities who are far from health facilities. The inSCALE study influenced policy and practice, particularly for the government-led scale-up of iCCM in Mozambique and Uganda,[18] and in Nigeria.[19]

In 2016, inSCALE became a complete digital health platform renamed upSCALE, which is used to engage rural communities on key disease prevention and control messages. During the COVID-19 pandemic a CHW survey delivered via upSCALE informed the development of COVID-19 education materials.

upSCALE has since been expanded nationwide and integrated into the national community health system to enhance local ownership and sustainability.

In 2024, CHWs reached more than 17,000 people with health promotion activities using the upSCALE app.[20]

Modules have now been added to assist with tracking of under-vaccinated children, and to support the supervision process at all levels.

Community dialogue, Cameroon

Case study

Reaching everyone by adapting our approaches for communities in complex contexts

Cameroon

Challenge: In conflicted-affected areas of Cameroon, displaced people, host communities and returnees face challenges accessing malaria prevention and treatment services.

Approach: We adapted the Community Dialogue Approach (CDA) to identify and overcome barriers to access and increase demand for services, holding regular community-driven meetings supervised by community health workers (CHWs).

Change: Meetings improved community knowledge and practice of malaria prevention, and increased treatment-seeking behaviour and trust in CHWs. Lack of money and transport were pinpointed as key barriers to healthcare use. We provided treatment vouchers and transport to health facilities, improving community engagement in areas with functioning health services.[12] **Malaria prevalence among under-fives fell from 54.5 percent to 20.7 percent.**

Karamoja, Uganda

Challenge: Children under five living in nomadic and semi-nomadic communities in Karamoja experienced some of the highest rates of malaria in Uganda due to low community engagement and difficulties locating households during the SMC campaign.

Approach: We adapted malaria outreach for nomadic and semi-nomadic households, aligning SMC campaign timing with migratory patterns and coordinating with local herders to map their locations. Religious leaders and community elders helped reach children at grazing sites in isolated areas, using simple talking points and culturally adapted storytelling in local languages to engage caregivers with malaria prevention messages.

Change: This approach strengthened the SMC campaign,[21] contributing to reduced malaria incidence among children under five.[22] Village health teams are building on the success of these door-to-door SMC visits, using them to identify children who have missed vaccinations or who need additional health services, and refer them to fixed point outreaches for treatment. **Malaria prevalence among under-fives fell by 31 percent following the introduction of SMC to Karamoja.**[22]

Community health workers engage a caregiver in a home-based consultation to strengthen malaria prevention practices, Karamoja, Uganda

SMC Project

Lead Mother, Helen Oluwafunke, speaks with caregivers at their home in Gwagwalada, Federal Capital Territory, Nigeria. Credit: Light Oriye

Partnerships

To work effectively, SBC relies on a broad ecosystem of actors and partnerships across all levels of society, with the right mix varying by context, audience and behaviour. This may include governments and health authorities, civil society and community-based organisations, health workers, media and communications partners, researchers, technology and innovation partners, private sector actors and funders.

Strengthening the connections between different stakeholder groups deepens understanding of the barriers to equitable healthcare, builds trust and enhances impact. We support communities to engage with government institutions for accountability in the provision of health services and to strengthen social accountability structures and actions.

Connecting communities with governments to influence change

The SuNMaP2 project combined SBCC and implementation of social accountability mechanisms by carrying out operational research; advocating for increased malaria funding through town hall meetings and state policy dialogues; and establishing community feedback loops on SBCC. To complement engagement with state and local government officials with strong conventional and social media engagement, community coalitions were formed, comprising existing and potential social accountability structures.

In response to the concerns raised by communities at town hall meetings, local stakeholders committed to environmental education workshops, door-to-door campaigns and awareness campaigns in schools. Based on feedback and active dialogue with communities, we closed SBCC feedback loops by changing radio broadcast times, messages, radio stations used to broadcast malaria prevention messages and presenters delivering messages on air. We tracked progress and commitments, ensuring that lessons learnt informed the project evolution. This enabled continuous learning, reflection and adaptive management, which increased the trust and quality of relationships with stakeholders for greater programme impact. **More than 90 percent of children under five with confirmed malaria were treated with ACTs.**

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Malaria Consortium is a leading non-profit organisation dedicated to improving health and saving lives in communities affected by malaria and associated health inequities.

Our work is rooted in providing responsive, contextualised solutions within communities, enabling them to thrive. Grounded in research and implementation science, and working closely with governments and partners, we drive innovation to narrow the gap in health outcomes and create tangible, scalable and sustainable impact.

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Cover image: Fatema, a community dialogue facilitator, raises awareness of antimicrobial resistance, Cumilla district, Bangladesh

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