

Positive deviance

An asset-based approach to improve malaria outcomes



Learning paper series

Since starting operations in 2003, Malaria Consortium has gained a great deal of experience and knowledge through technical and operational programmes and activities relating to the control of malaria and other infectious childhood and neglected tropical diseases. Organisationally, we are dedicated to ensuring our work remains grounded in the lessons we learn through implementation. We explore beyond current practice, to try out innovative ways – through research, implementation and policy development – to achieve effective and sustainable

disease management and control. Collaboration and cooperation with others through our work has been paramount and much of what we have learned has been achieved through our partnerships.

This series of learning papers aims to capture and collate some of the knowledge, learning and, where possible, the evidence around the focus and effectiveness of our work. By sharing this learning, we hope to provide new knowledge on public health development that will help influence and advance both policy and practice.

Community members in Sampov Luon District gather for a positive deviance meeting



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Introduction

This learning paper describes a pilot project in north-west Cambodia that used positive deviance as a method of behaviour change communication for malaria control

Positive deviance is a behaviour and social change approach that helps identify existing model behaviours within a community that can be shared and amplified by the rest of the community.

It rests on the observation that in every community, there are certain individuals whose uncommon behaviours enable them to find better solutions to problems than their neighbours who have access to the same resources¹⁻³.

The project discussed in this learning paper focused on mobile and migrant workers and resident communities in three villages in Sampov Luon, north-west Cambodia. This work was carried out by Cambodia's National Centre for Parasitology, Entomology and Malaria Control (CNM), with the technical support of Malaria Consortium and funding from the Bill & Melinda Gates Foundation.

The positive deviance project involved selecting role models from within the community who practised uncommon but positive behaviour with regards to malaria prevention and control. These role models then worked within the community to show other individuals and families how they could act in similar ways, in order to improve malaria prevention and enhance malaria treatment. The project ended with a large advocacy event that symbolically handed the project over to the community.

This paper looks closely at what this project involved, discusses what worked well, what lessons were learned and the challenges met during the period it was running. At the end of this paper are recommendations for future malaria control work using positive deviance.

“Positive deviance identifies the solutions of the problems today. It identifies the role models who, despite all odds, living in similar conditions, sharing similar resources, have managed to have better health outcomes than their neighbours. Positive deviance can be a very effective interpersonal communication tool for hard to reach populations, such as mobile and migrant workers, to better understand and reach out to them.”

*Muhammed Shafique,
Malaria Consortium*

The positive deviance project targeted the local community and migrant populations





What is positive deviance?

The term 'positive deviance'* means uncommon but positive behaviours within a community that could be used more widely for the benefit of others.

Positive deviance individuals and their families have more effective solutions to health problems than do their neighbours, with whom they share similar resources¹⁻³. In positive deviance, these individuals are used to model behaviours for other members of the community.

Positive deviance is a behaviour change approach that builds on the existing strengths of communities. The positive deviance approach starts with a community dialogue; it respects local wisdom and provides social proof by identifying positive practices from within the community that ensures acceptance and speeds up the process of behaviour change. It allows community members to be active beneficiaries, engaged as full partners to play a role in their own health and protection from malaria.

Positive deviance has also been used to identify positive behaviours associated with maternal and newborn health, family planning, female genital mutilation, preventing trafficking of women and HIV/AIDS^{3,7-10}. The project detailed here is the first time positive deviance has been used for malaria prevention and control.

As the phrase 'positive deviance' has some negative connotations in the areas of Cambodia where the programme run, the term 'role model' was often used instead in this programme in order for it to remain culturally appropriate.

“After learning from the positive deviance role model, we follow her behaviour. We wear long-sleeved clothes and sleep under the mosquito net every night to protect ourselves from malaria.”
Female community member

*The term 'positive deviance' first appeared in nutrition research in 1970s^{4,5}. The positive deviance concept was first operationalised in the field by Jerry and Monique Sternin on nutrition in Vietnam in 1990s^{6,7}.



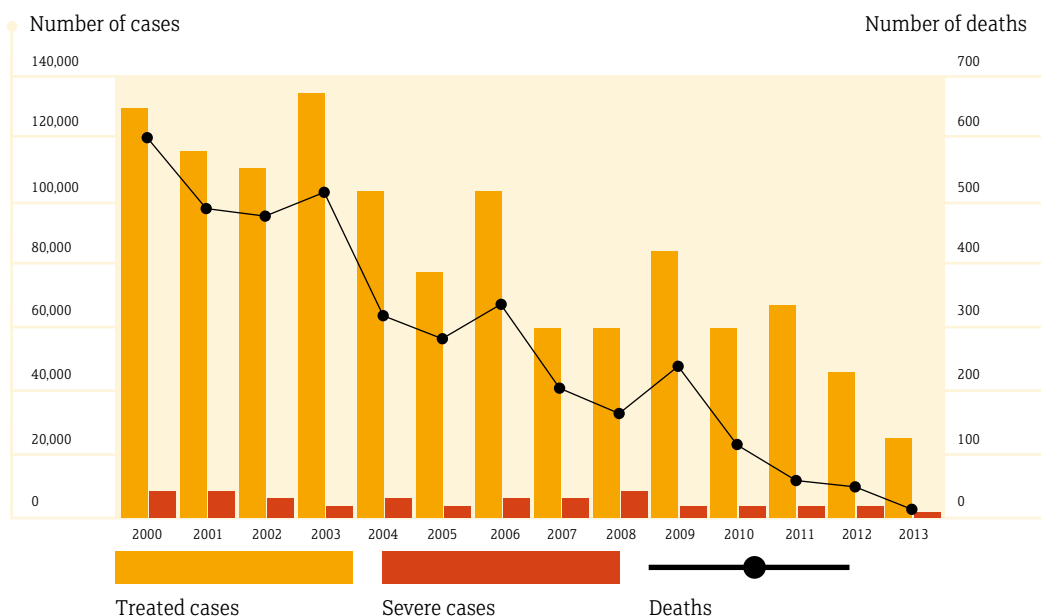
Background

Cambodia, which lies in the centre of the Indo-China peninsula in Southeast Asia, has a population of 13,386,910* consisting of 2.2 million households, in 13,406 villages in 24 provinces. Malaria remains a public health concern in Cambodia.

Cambodia has witnessed a steady reduction in the total number of malaria cases and deaths. According to the latest CNM annual report 2013, a total of 24,135 malaria episodes were treated by the public health services during 2013, a dramatic decrease of more than 81 percent of the cases reported in 2000 (when 129,167

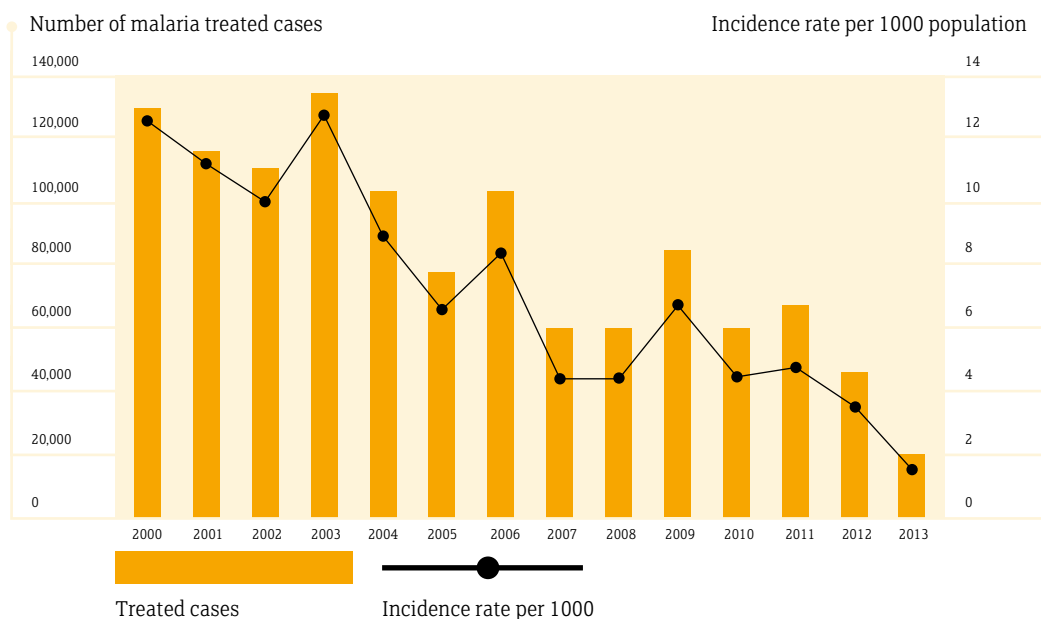
cases were recorded). As seen in the figure below, similar incidence trends were observed during the same period. At the same time, an even more dramatic decrease of around 95 percent of the malaria deaths reported in 2000 was observed during the last 13 years (from 608 to 12 deaths in 2013).

Number of malaria treated cases, severe cases and deaths, Cambodia 2000 to 2013



Source: National Centre for Parasitology, Entomology and Malaria Control

Incidence rate of malaria treated cases per 1000 population, Cambodia 2000 to 2013



Source: National Centre for Parasitology, Entomology and Malaria Control

*Cambodia Census, 2008

A migrant worker packing corn. Many migrant workers seek temporary work during planting or harvesting season



Farming and forest areas

Despite the decrease in malaria as a whole, there is growing evidence for the emergence of artemisinin resistance along the Cambodia-Thailand border area. Recent evidence has suggested that artemisinin resistant *Plasmodium falciparum* parasites are present on the Cambodia-Thailand border. The spread of artemisinin resistance, if confirmed, through Asia to Africa, would be a major setback to global efforts to control malaria. As an emergency project, the Bill & Melinda Gates Foundation supported the *Strategy to contain artemisinin resistant malaria parasites in Southeast Asia* (the containment project) through the World Health Organization, the National Malaria Control Programmes, and other relevant partners. Malaria Consortium was one of the key partners responsible for monitoring and evaluation, surveillance and behaviour change communication strategy in the project.

One of the key target audiences of the containment project was mobile and migrant populations. It was very important to target this population effectively through innovative ways. Positive deviance was considered to be the appropriate approach to be piloted to better understand and reach out to these populations. This pilot positive deviance project – led by the CNM and Malaria Consortium – was developed as a result.

The positive deviance project was set up to encompass both local populations and the area's mobile and migrant workers. The three communities where this project was carried out were in Sampov Luon District, Battambang province. The total population in that area is around 6,000, including migrant workers and a resident community. This area was in zone 1 of the containment project – which is the highest risk area.

This area has many migrant workers coming to work in the villages during the planting or harvesting season to find temporary work. The majority come from Siem Reap, Battambang, Takeo, Pursat, Kampot and Kampong Speu provinces. Most of the landowners use the same migrant workers who go from farm to farm in the village.

Some of the migrant workers stay for 15 to 30 days, others for three to four months, before returning to their home towns. Some come with their families, others in groups. During the period they are working there, they usually stay with landlords in the village. On average, a landowner needs 20 to 30 workers for planting or harvesting per season. These workers are male and female, and are aged between 15 and 50. Men often do manual labour, such as digging, spraying insecticide, planting and harvesting, and catching grasshoppers. Women plant beans, harvest and pick the corn, plant rice and cassava, and pack the corn for transport.

Men are more likely than women to work at night, and in the forest – packing bags of corn, and catching grasshoppers – leading to increased vulnerability to mosquito bites.

Planning the project

Based on the recommendations of the cross-border behaviour change communication workshop held in August 2009 in Siem Reap, it was decided to carry out a pilot project for positive deviance on malaria in the selected communities to measure the effectiveness of this approach on mobile and migrant workers on malaria.

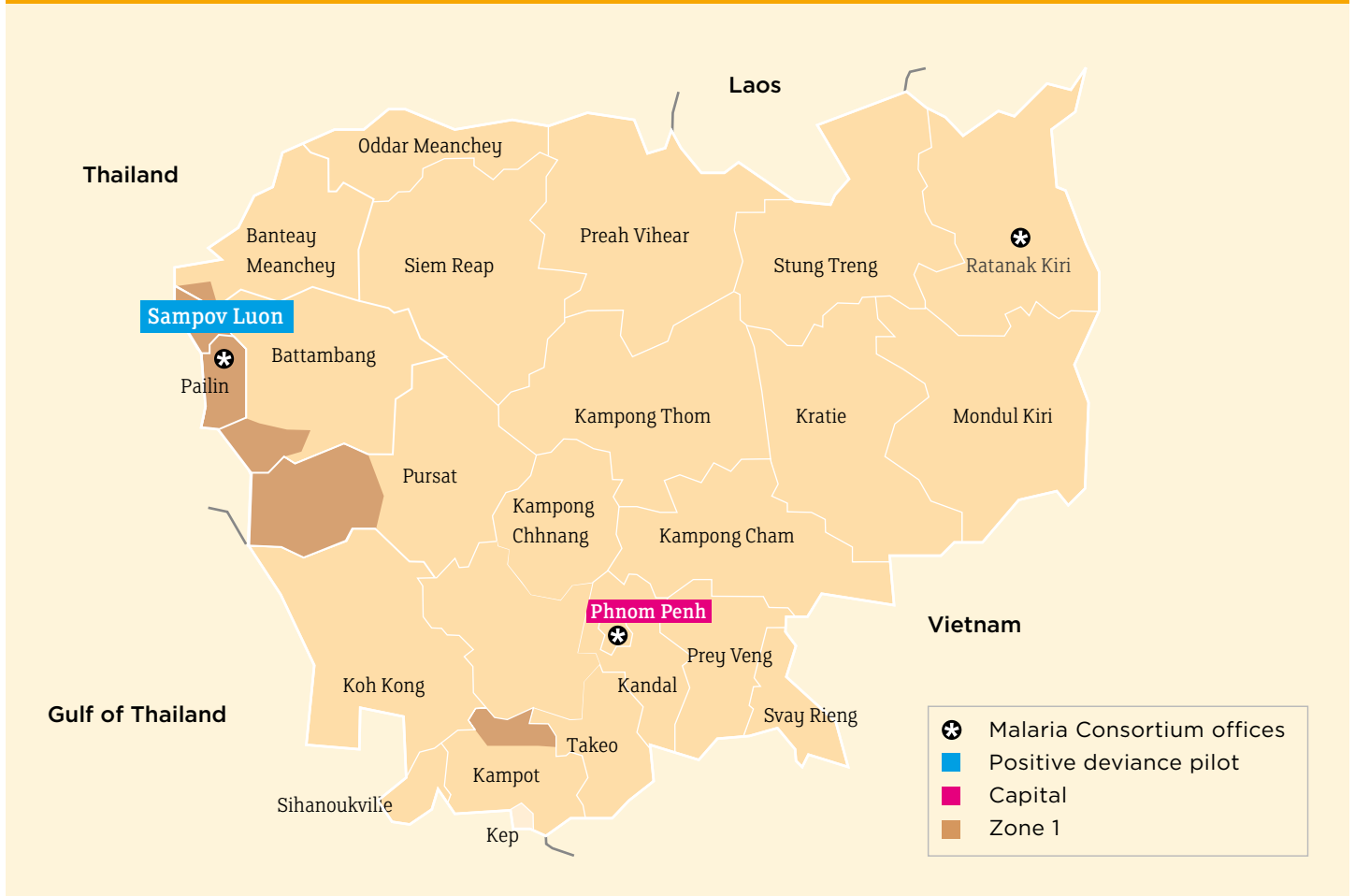
The proposed pilot set out to:

- Mobilise and sensitise the community for malaria prevention and control through the positive deviance process
- Create a robust communications strategy to disseminate the success stories of community members (positive deviants) to maximise their role model effect
- Enable at-risk community members to practise these key behaviours identified from the same community

- Assess the extent to which the identification of positive deviants and the diffusion of their ideas, beliefs and strategies have influenced norms and behavior in the targeted community
- Galvanise appropriate staff and partners to the potential of the approach
- Document the process and lessons learned to share with the broader audience

A baseline survey took place in August 2010, to assess the levels of knowledge about malaria prevention, transmission, treatment and control. This took place through questionnaires, and involved information on the levels of knowledge and behaviour around many aspects of malaria transmission, prevention and treatment. The information gathered in this survey was fed into the pilot project design.

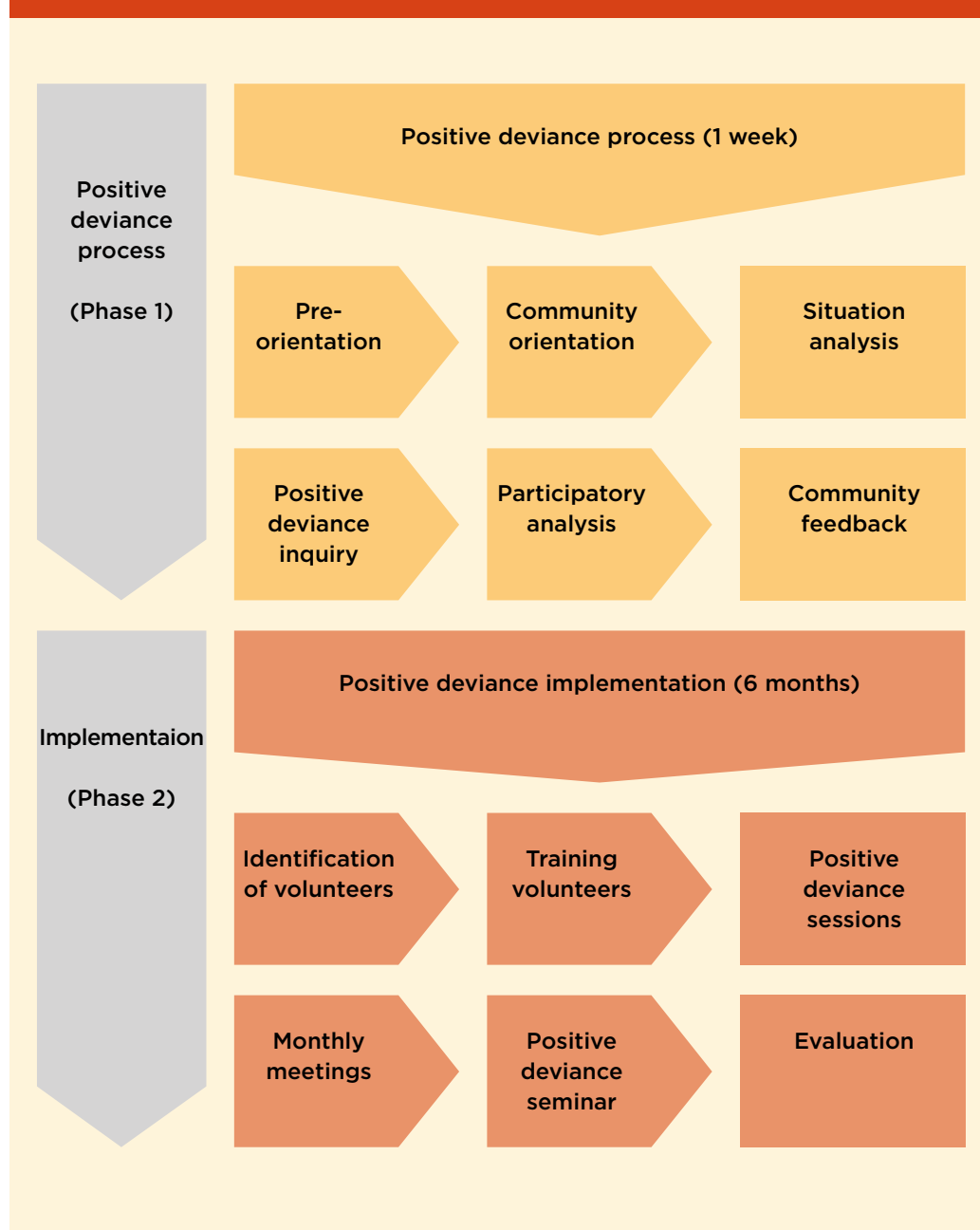
Location of the positive deviance pilot in Cambodia



The positive deviance project

The positive deviance approach was conducted in two phases. In the first phase, which was carried out in one week, community dialogues were established and qualitative methods were used to understand the normative behaviours around malaria prevention and control. Positive deviant individuals (role models) from the community were identified during this phase. In the second phase, which was completed in six months, interactive ways were implemented to share the role models' behaviours with other community members.

Positive deviance process and positive deviance-informed implementation



A community orientation meeting in Sampov Luon District



Phase 1

Phase 1 of this project was a one-week positive deviance process, which took place from 3-8 August 2010. The field team to gather the qualitative data comprised four experienced members from the CNM, University Co., LLC Committee and Malaria Consortium, all of whom had relevant experience and skills in community mobilisation and qualitative methods.

The process began with large community-based meetings to familiarise various stakeholders with the project and its aims and objectives, through both discussion and activities. This pre-orientation meeting involved key community members, district and provincial level stakeholders. The Provincial Malaria Supervisor, operation district staff, health centre staff, CNM team and village chiefs participated. The main purpose of this meeting was to inform the key community leaders to ensure their support in the planned positive deviance activities.

Next, the positive deviance team organised a large community orientation meeting with the key stakeholders, village leaders, volunteers, teachers, and the mobile and migrant population. The main purpose behind this was to introduce the positive deviance concept through different activities. During the meeting, the positive deviance team talked about malaria and, using interactive games, explained how this approach helps identify solutions from within the community.

The positive deviance team planned the situation analysis and identified volunteers who came to participate or help. In order to gather the information for this, various qualitative methods were used. These included in-depth interviews and focus group discussions, as well as a 'transact walk' through the villages to observe and confirm the information gathered. This was used to establish the ways in which the communities normally behaved with regards to malaria prevention and treatment, and to identify the positive deviance role models. A separate quantitative survey was conducted to establish the baseline of knowledge and behaviours of the communities to evaluate the outcome of the project.

Topic guides were developed in English, and subsequently Khmer. The team conducted in-depth interviews and focus group discussions with men and women aged over 18, which were carried out separately to understand the gender perspective of malaria. Men and women have different risks as they are involved in different work – for example, men often work in the farm or forest while women mostly stay at home or work in farms nearby their homes. Comprehensive notes were taken during the in-depth interviews and focus group discussions; they were also recorded and transcribed.

Six focus group discussions and 13 in-depth interviews were carried out with community members, farmers/landlords and mobile and migrant workers. Mosquito nets and hammock nets were used to animate the focus group discussions and in-depth interviews.



In-depth interview with a positive deviance role model

Situation analysis

The focus group discussions and in-depth interviews were analysed to demonstrate the patterns of migration, knowledge of malaria symptoms, beliefs about who was more likely to get malaria, and health-seeking behaviours.

All groups showed a lack of understanding about malaria transmission. While most knew that mosquito bites cause malaria, many also believed one or more of a range of other causes. These included not eating enough, drinking lime water, lack of sleep, changing areas, or curses from forest spirits. But many also mentioned that malaria is more widespread during the rainy season, and knew that mosquitoes breed in ponds, stagnant water and ditches. They also knew that men were more likely to contract malaria as they worked at night on the farm or in the forest.

When it came to seeking treatment for suspected malaria, both community members and migrant workers adopted a wait-and-see approach. The majority of the community members and migrant workers mentioned that when they got a fever, they consulted a shopkeeper or drug seller and purchase medicines based on their knowledge. If the symptoms persisted or got worse after this, they visited the health centre for proper diagnosis and treatment. The usual delay was one or two days.

Both community members and migrant workers preferred to visit the health centre rather than use the private sector when they had malaria. This was for reasons of cost, as the health centre is much cheaper. Many mentioned that they went to the village malaria worker (VMW) for a blood test, but some preferred not to do so as the VMWs were sometimes busy with their domestic chores, and had no treatment to offer if malaria was not the cause of the fever. The landowners,

however, did use the private sector rather than the local health centre due to its distance, lack of drug availability, and few staff during the weekend. They advised their workers to go to the VMWs for the free blood tests.

For the prevention of malaria, insecticide treated nets were commonly used by both migrants and community members. The community members had been given long lasting insecticide treated nets (LLINs) from the national malaria programme. There were some issues with the lack of distribution of LLINs to migrant workers. Other interviewees considered that the holes in the LLINs were too large to prevent the mosquitoes from entering. Many interviewees also pointed out that they wore long sleeved clothes, burned coils, clean the surrounding environment, burn rubbish and cleaned the bed before going to sleep. All of these activities lowered the chances of them being bitten by mosquitoes.

With regards to malaria messages, many respondents mentioned hearing them on the radio and television; health centre staff, volunteers and billboards were also mentioned.

“Men get malaria more often than women. They often go to the forest and sometimes they become careless, taking off their shirts because they are too hot. That’s why they get bitten and get malaria.”

Male community member

Role models

The positive deviance inquiry helped identify those community members and migrants who, despite sharing the same resources and living or working in the same community, showed healthy behaviours and outcomes. During the focus group discussions, the team identified potential role models whose behaviour was further explored through in-depth interviews. On the discovery of uncommon positive practices, the teams explored the strategies which enabled them to practise these behaviours. The team conducted six in-depth interviews with mobile and migrant workers, two in-depth interviews with the landlords and five in-depth interviews with community members to identify the potential role models.

The positive deviance findings were analysed with the help of community stakeholders, in order to identify positive deviance behaviours and confirm them with community members. A community feedback and action planning session then shared the findings and mobilised and motivated the community. Around 50 participants from all parts of the community, and including health professionals, attended.

Some positive deviance behaviours were shared with the audience, asking three couples from the community to do the role plays on identified behaviours. The community members said they enjoyed the role plays and promised to follow the behaviours highlighted in the role plays. In another activity, the positive deviance behaviours were written, by topic, on flip chart and were placed in a cardboard box decorated as a positive deviance house. Participants were asked to take out a flip chart paper through the door and read the behaviour. Each behaviour led to a general discussion among the participants. At the end, an action plan was prepared to explore ways to enable more families to adopt these behaviours.

“A young female migrant worker, has been visiting this area for the past five years. She had never fallen ill with malaria, unlike many of her fellow farm workers. She knows that only mosquito bites cause malaria, and always sleeps under an insecticide-treated net, which she strongly believes will protect her from malaria. She tries to go to bed early to avoid mosquito bites and when she watches TV after dark she covers her arms and legs. Whenever she gets fever and suspects malaria, she goes to the village malaria worker immediately for a blood test. She said, ‘if you all follow these practices you will never get malaria’.”

A role model migrant worker

Choosing the role models

The positive deviance (role model) individuals and families were those who already demonstrated good preventive and treatment seeking behaviours such as the correct use of mosquito nets and getting prompt diagnosis and treatment if malaria was suspected. Five role models were selected – two female migrants, one male and one female community members, and one male landowner.

It was not easy to find role models for the insecticide-treated mosquito net use as it was already a norm in the community. However, through demonstration of use of insecticide treated mosquito nets during the interviews, it was found that proper mosquito net use (cleaning the bed, warding off mosquitoes from the net especially from conventional nets and properly tucking the net in the bed sheet/mat to avoid mosquito entrance) was quite uncommon. Therefore, the people who demonstrated a proper use of insecticide treated mosquito net were considered role models. The use of insecticide treated mosquito nets or hammock nets in the farm or forest was also quite uncommon and was consequently considered model behaviour. As delayed treatment was a norm, people who sought prompt diagnosis and treatment from VMWs or the health centre and completed the course of treatment were also considered role models.

Volunteers were then selected to carry out positive deviance work during the six-month follow-on programme for behaviour change. This process encouraged community participation, established a community dialogue, identifying the positive strategies used by members of the community. It led the way for acceptance and ownership by the community.

It was difficult to find individuals who modelled all the positive malaria prevention and health-seeking practices. As a result, different people were chosen to model different behaviours.

Malaria prevention role model behaviours

- A female migrant worker, who never got malaria, always slept under an insecticide treated net. In the evening, she always covered her arms and legs with a *krama* (local scarf) when watching TV or cooking meals to avoid mosquito bites.
- A migrant mother bought a mosquito net, treated it with insecticide and gave it to her migrant daughter. She emphasised to her daughter that she should sleep under the net every day to stay healthy from malaria.
- A community member slept under the properly prepared insecticide treated mosquito net every day. He cleaned and properly prepared the bed sheet and net by tucking it under the sheet. He did this every day, even if he was exhausted after work. He never left a way for a mosquito to enter his net.
- A farm owner kept 10 extra insecticide treated mosquito nets in his farm house. He lent these nets to the migrant workers who came to work on his farm. He ensured that his workers slept under the insecticide treated mosquito nets to avoid malaria. He considered that it was his responsibility to take care of the workers. He thought that if the workers were healthy, they would work well and earn well.

Malaria treatment role model behaviours

- A farm owner gave money to his sick migrant worker (who had malaria) for transport to go to the health centre. This enabled the patient to receive early diagnosis and quick treatment for malaria. He believed that malaria was dangerous, and that if individuals were late in seeking treatment, the malaria could get worse and become complicated.
- A community member had malaria three years ago. He went to the health centre on the same day to seek treatment. He completed the malaria treatment as prescribed by the doctors. Afterwards, he always used the LLIN and has never had malaria again.
- A migrant worker who never got malaria, as whenever she got fever or suspected malaria, she always rushed to the VMW to get blood test. She never bought any medicines without having a blood test first. After the blood test result was negative, she went to the health centre to get proper alternative diagnosis.



A role model sharing her story during a community meeting

Phase 2

The next stage was a six-month positive deviance implementation. Initially, positive deviance was not planned in the containment project; it was later incorporated into the work plan due to interest of the National Malaria Control Programme. As such, there were limited resources to pilot the project in the selected communities for six months. After this period, the project was handed over to the community to continue the activities without any external support.

The end-line survey was planned one year after the intervention to ensure the seasonality factor of malaria in the survey, but due to a lack of resources, it was conducted in March 2012 – one year after the six-month positive deviance implementation. However, the interest the project generated paved way for a one-year pilot project in Kyun Su Township in Southern Myanmar, which is in its final stages of evaluation in 2014.

During the six-month positive deviance implementation, a total of 11 volunteers, including three role models of various backgrounds, were trained, and they subsequently carried out a range of activities at the monthly interactive positive deviance sessions. Each volunteer conducted two positive deviance sessions per month in their respected areas. The sessions were conducted in the evening to ensure participation of mobile and migrant workers and community members in the sessions. The aim was to share the identified positive deviance practices with other community members. Interactive and participatory methods were used to share the positive deviance behaviours with other community members during the sessions:

- active participation in the positive deviance sessions
- the participation of volunteers in the monthly meetings held at the health centre
- active participation in the community based competitions, such as poster competitions, and malaria song competitions

Access to participation in these sessions was maximised by organising them in places that were easily accessible both socially and physically – such as pagodas, school buildings, positive deviance volunteers' or landowners' houses and other commonly used social spaces. The appropriate scheduling of positive deviance sessions was ensured to maximise the participation of community members and migrant workers, especially women.

“We regularly participated in the positive deviance sessions that were very interesting and different from the routine health education sessions. The real positive deviance individuals shared their personal experiences and practices which were very useful and simple to practise.” Female community member

These activities included

- role plays
- story telling
- interactive discussions

Community participation in the project increased as time went on. Community volunteers, village chiefs, migrant workers and positive deviance individuals took a leadership role in the planning and implementation of the project. The community expressed a strong sense of ownership in it with, for instance:

Sharing identified positive deviance practices with community members at Sampov Luon District



Advocacy event

At the end of Phase 2 in March 2011, a large positive deviance seminar was held. This was a community seminar involving more than 300 people. The seminar was a major advocacy event involving key decision makers from the community, national programmes and the community members to celebrate the project's achievements. The event symbolically handed over the project to the community.

Positive deviance community seminar to hand over the project to the community at Sampov Luon District

“The community seminar was the most engaging and interesting activity of the project. The question and answer session was very interesting. It not only engaged the community members but also assessed and corrected their understanding on the key malaria messages.”
Chief of health centre

“The community members really enjoyed the colourful event of the community seminar. They enjoyed the song and malaria poster competitions. We never witnessed such interesting activities before this project.”
Positive deviance volunteer



Results

In 2012, qualitative and quantitative surveys were carried out to assess the community's views of the project, and to see the extent to which there had been lasting behaviour change with regards to malaria control in the area.

The qualitative evaluation looked at:

- the community's understanding of the project
- the community's perception of behaviour changes regarding malaria prevention and control at the household level
- the role of the positive deviance approach in both mobilising communities and promoting behaviour changes
- the prospects for sustainability of behaviour and social change

These were all broadly successful and are addressed in this learning paper. Findings from the evaluation showed some evidence of a trend in social and behavioural changes towards role model behaviours as a result of this project. For instance, a network of volunteers was successfully built with individuals from all parts of the community continuing to demonstrate the positive deviance behaviours. The sustainability of the programme now seems sure, due to the levels of community ownership. Positive deviance informal sessions were still taking place a year after the project had formally ended.

The quantitative survey showed:

- An increase in knowledge of malaria prevention methods
- An increase in knowledge of transmission modes, especially knowledge of vulnerable groups, ie. forest-goers

The project also strengthened key delivery mechanisms such as village health volunteers which resulted in an increase in the uptake of services and advice by volunteers. However, there remain some misconceptions that have not been addressed, and this pilot project has not been able to show evidence of the effectiveness of the intervention. A succeeding one-year positive pilot project in Kyun Su, Myanmar, which is at its evaluation stage in 2014, will provide more understanding about the effectiveness of the positive deviance approach.

“The positive deviance project has increased knowledge and improved the behaviours of the community members and migrants regarding malaria.

We want to continue this project to bring further improvements in our knowledge and behaviour.”

Village chief

“There is not much malaria this year which helped us save some money. We kept this aside for malaria treatment.”

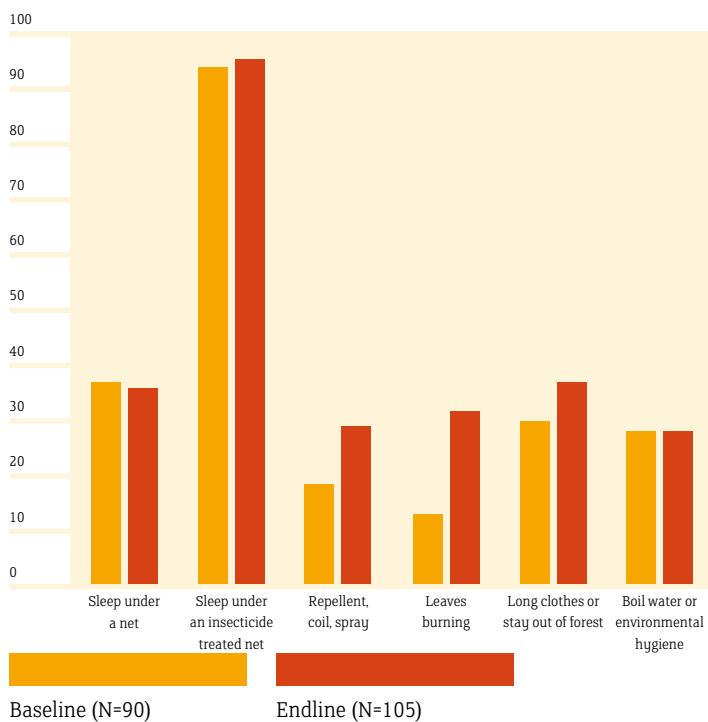
Female migrant worker

“The number of malaria cases has decreased from 48 cases in 2010 to 24 cases in 2011 in the catchment area of [this] health centre. Only six malaria cases were found in the three positive deviance villages for the whole year, which may be attributed to the successful positive deviance project.”

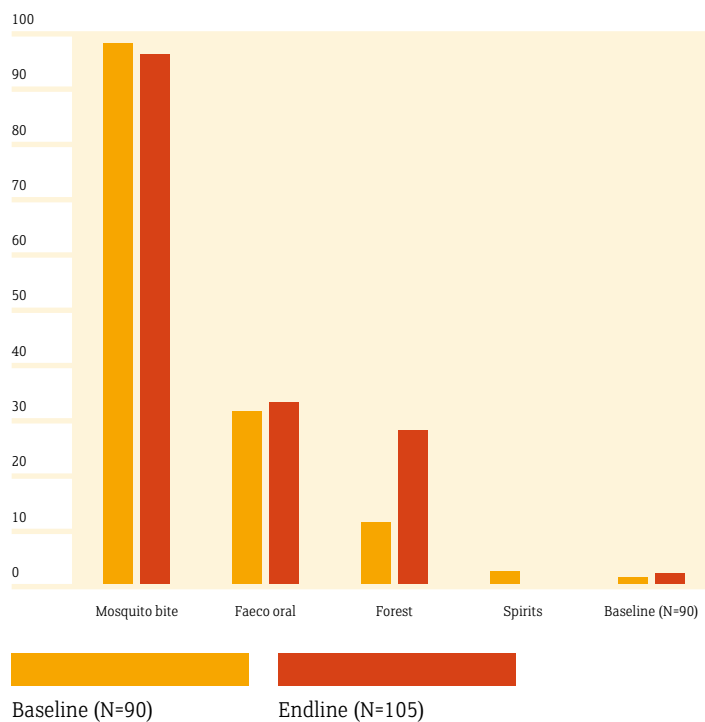
Mr Se, Chief of Health Centre, Takrey

Some of these results can be seen in the graphs below:

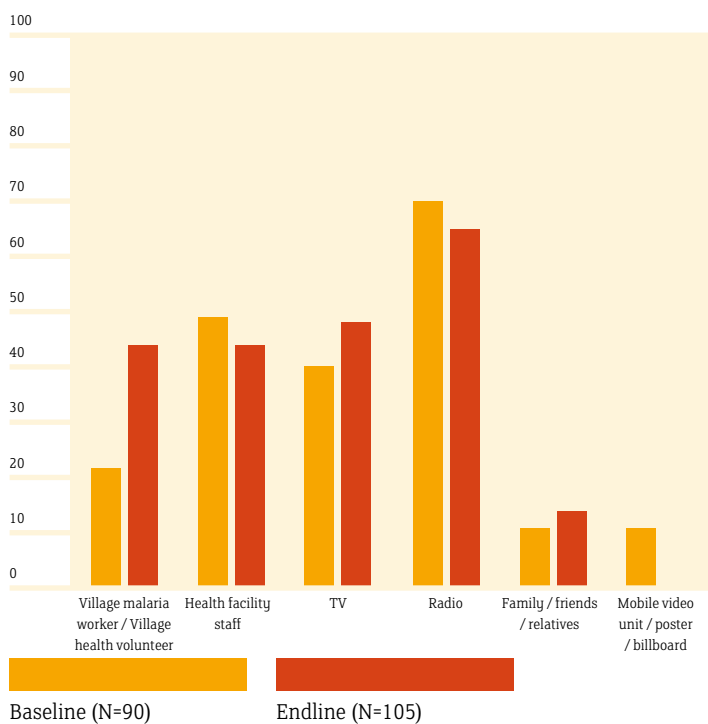
Knowledge of prevention methods (multiple answers possible)



Knowledge of transmission modes (multiple answers possible)



Sources of information (multiple answers possible)



What worked well

The positive deviance project was considered to be a success. Most of the intended beneficiaries said they were aware of the project and acted on the information they learned through it.

The majority of the community members and migrant workers mentioned that they participated in the positive deviance project activities. They expressed that they liked these activities, especially the role plays during the positive deviance sessions and the community seminar which took place at the end.

The positive deviance approach in malaria prevention and control has demonstrated its ability to harness the community's capacity to find solutions within, and to act upon them. The project has been effective in increasing knowledge about malaria and improving health-seeking behaviour such as consulting VMWs or visiting the health centre for malaria diagnosis and treatment.

Specific areas of success were:*

The emergence of new leadership

The project developed a new and effective leadership for malaria prevention and treatment. It strengthened the capacity of 11 positive deviance volunteers to manage the project.

The degree and equity of participation

All sectors of the community were equally engaged in the project. This was due to convenient positive deviance session timings, accessible and neutral venues for sessions to maximise participation, especially from female community members.

Information equity

Ensuring that each part of the villages received similar levels of information and, developing a map to mark the areas that had been covered.

Sense of ownership

There was community engagement at each step of the positive deviance process, to ensure that everyone felt involved in the project.

Cost effective

Positive deviance is a cost effective approach if it is implemented by the trained provincial or local health facility staff and volunteers.

Sustainability

The community had a high sense of ownership over this programme. Positive deviance sessions were still carrying on a year after the project officially ended.

*To measure the social change aspects of the project, the social change indicators of the Communication for Social Change Model by John Hopkins University and Rockefeller Foundation was used.

“The interesting thing was that we identified the positive deviance role models from our own community. We adopted their behaviour which was very easy to follow. We feel proud that these are our own people doing something positive and different.”
Male community member

“We learned from the real role model; he lives with us, sits with us and tells us what exactly he did to prevent malaria. We can easily understand and follow his behaviour.”
Female Community member

Sharing positive deviance behaviours through role plays during a feedback session



Lessons learned and challenges

Lessons learned

1.

The positive deviance concept is most effective in resident communities, collectivist societies, ethnic groups, or similar occupational groups. When people are linked together and have a strong sense of belonging, they can easily share with and adopt the uncommon practices of other group members: “If he/she can do, why can't I?”.

2.

The positive deviance approach is very effective in targeting specific groups such as mobile workers and migrants, or other hard-to-reach populations. It provides an opportunity to understand their context which helps develop well-informed communication strategies to target the groups.

3.

Community involvement is a key in the success of the project. The community should be involved at every step to establish a successful community dialogue and strong community ownership in malaria prevention and control activities.

4.

Positive deviance can be used as an interpersonal communication method to malaria prevention and control/elimination, alongside other methods.

5.

As positive deviance behaviours and strategies are local, they are easily accepted by the communities which expedite the process of behaviour change.

6.

The positive deviance approach provides on-the-job training opportunities to volunteers, which boost their confidence, increase their motivation and ensure their retention.

7.

The positive deviance approach is more effective when applied in a community where the problem is already felt.

Challenges

1.

The evaluation of the positive deviance project on mobile and migrant populations was challenging because at the end-line survey, most of the mobile and migrant population had already left the villages. This made the baseline and end-line comparison difficult.

2.

Positive deviance is a human- and time-intensive approach, and requires close and regular supportive supervision to the volunteers.

3.

The positive deviance implementers require some basic facilitation and qualitative skills to conduct the positive deviance process and focus group discussions.

Conclusions and recommendations

The final evaluation of this pilot project was completed in March 2012. A range of recommendations, covering many different aspects of positive deviance and malaria, has come out of this project. Some of these specifically apply to this particular community; others refer to work that could be replicated elsewhere.

1.

The positive deviance approach could be applied in other areas such as public health facilities, private clinics and private health providers to improve the use of malaria services.

2.

The positive deviance approach can be applied on the village volunteers to improve their performance, motivation and retention.

3.

Positive deviance role models and their behaviours can be leveraged through electronic media, such as provincial

and national radio and TV. This will help scale-up the approach and reinforce the messages given by the positive deviance volunteers at community level.

4.

The provincial and local health facility staff should be trained to replicate or scale-up the positive deviance approach at provincial or district level.

5.

Community and community-based individuals such as village health volunteers and health centre staff should be given a lead role when positive deviance is implemented at community level.

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Malaria Consortium

Malaria Consortium is one of the world's leading non-profit organisations specialising in the comprehensive control of malaria and other communicable diseases – particularly those affecting children under five.

Malaria Consortium works in Africa and Asia with communities, government and non-government agencies, academic institutions, and local and international organisations, to ensure good evidence supports delivery of effective services.

Areas of expertise include disease prevention, diagnosis and treatment; disease control and elimination; health systems strengthening, research, monitoring and evaluation, behaviour change communication, and national and international advocacy.

An area of particular focus for the organisation is community level healthcare delivery, particularly through integrated case management. This is a community based child survival strategy which aims to deliver life-saving interventions for common childhood diseases where access to health facilities and services are limited or non-existent. It involves building capacity and support for community level health workers to be able to recognise, diagnose, treat and refer children under five suffering from the three most common childhood killers: pneumonia, diarrhoea and malaria. In South Sudan, this also involves programmes to manage malnutrition.

Malaria Consortium also supports efforts to combat neglected tropical diseases and is seeking to integrate NTD management with initiatives for malaria and other infectious diseases.

With 95 percent of Malaria Consortium staff working in malaria endemic areas, the organisation's local insight and practical tools gives it the agility to respond to critical challenges quickly and effectively. Supporters include international donors, national governments and foundations. In terms of its work, Malaria Consortium focuses on areas with a high incidence of malaria and communicable diseases for high impact among those people most vulnerable to these diseases.

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Malaria Consortium is committed to a practical approach that integrates engagement between the community and health services, and national and global policy makers. It is an approach that is underpinned by a strong evidence base and driven by shared learning within and between countries

A malaria art community competition in the positive deviance community seminar in Sampov Luon District



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