Malaria Consortium and the Sustainable Development Goals
At Malaria Consortium, we strive to ensure our work contributes to achieving the Global Goals for Sustainable Development (SDGs) by 2030. Whether it be providing intermittent preventive treatment for malaria in pregnancy (IPTp) at antenatal check-ups or training community health workers (CHWs) to diagnose and treat malnutrition, we support the countries in which we operate to ensure their citizens are free from the burden of disease.

Our efforts to address key health issues in Africa and Asia reflect the interconnected nature of the SDGs. While our activities focus primarily on goal three (good health and wellbeing), they also support the attainment of 10 others. For instance, our dengue control programmes encourage communities to adopt safe water storage and sanitation practices in order to reduce transmission rates. This helps make progress towards realising goals three and six (clean water and sanitation).

In addition to implementing cross-cutting and integrated programmes, Malaria Consortium seeks to improve equity and ensure appropriate power relations; this is crucial if we are to improve health for all. To this end, we have helped establish village health clubs and the community dialogue approach to enable community members to discuss and find solutions to their own healthcare concerns.

We are guided by the SDGs’ principle of leaving no one behind. We are developing, trialling and scaling up novel approaches, including digital health strategies and new tools such as insecticide-treated clothing that protect night-time forest workers in the greater Mekong sub-region from malaria during their working hours. We are actively supporting governments to deliver health services to hard-to-reach and underserved communities.

This brochure highlights some of the key ways Malaria Consortium is contributing to the SDGs and, in particular, illustrates the importance of using a multifaceted approach to improve health outcomes globally.
Fewer working hours are lost and economic productivity improves when less money is spent travelling to health facilities and treating illness. Therefore, many of our programmes seek to improve access to affordable healthcare for poor and remote communities. For instance, in Nigeria we trained CHWs to diagnose and treat life-threatening illnesses in some of the country’s most impoverished and isolated villages.

In communities affected by malaria and other infectious diseases, frequent bouts of illness adversely impact children’s education. Our programmes help keep children in school and build health-related knowledge. For example, by incorporating health into primary schools’ curricula, our malaria awareness classes and net distributions in Mozambique increased teachers’ and pupils’ understanding of how to spot, treat and prevent malaria and reduced school absenteeism.

Malnutrition – the cause of half of all child deaths globally – is a significant problem in a number of the countries in which we operate. To tackle this, we have trained CHWs in Nigeria and South Sudan to rapidly identify and refer malnourished children to feeding centres, integrating nutrition checks into pre-existing community case management programmes where possible.

Achieving goal three is at the heart of our work. To help improve maternal and child health, we distribute long lasting insecticidal nets that protect against malaria throughout Africa, and develop community case management systems to ensure common childhood illnesses are treated quickly and efficiently in remote communities. We also deliver seasonal malaria chemoprevention (SMC) to under-fives in the Sahel to prevent and control the spread of malaria in the rainy season, and have provided Ugandan health facilities with incubators and guidance on implementing cost-effective and high-impact neonatal care techniques.

Gender norms and relations impact on access to, and uptake of, health services and also affect individuals’ opportunities to work within the healthcare system. We promote a gender-sensitive workforce, advocating for equal opportunities for health workers at community and facility levels as part of our programmes across Africa and Asia. Our health messaging is also gender-aware and avoids reinforcing gender-based health inequalities. For instance, knowing that Nigerian women tend to be less literate than men, our SMC promotional materials are designed to be accessible to individuals with all levels of literacy.

As an evidence-led organisation, we regularly trial innovative approaches and embed research and lessons learnt into the design of our programmes. For example, we tested a mobile health platform to support CHWs in Mozambique and carried out cross-border malaria surveillance to address malaria and artemisinin resistance in the greater Mekong sub-region.
It is well known that unequal access to health services further exacerbates the impact of poor health, especially on those in low-income settings who are already at higher risk of poor health and often face being driven further into poverty when seeking care. Therefore, we aim to promote and support universal health coverage in the countries in which we work. For instance, our community-based primary healthcare programme in Myanmar is improving access to quality health services among marginalised and remote communities. Likewise, in addition to supporting the Nigerian government’s mass net distribution campaigns, we also helped to build a sustainable culture of net use and provision in the country, which included strengthening local private-sector manufacturing.
Cognisant of the growing threat posed by antimicrobial resistance (AMR), we endeavour to reduce the misdiagnosis and unnecessary prescribing of medicines. For example, we are trialling innovative automated respiratory rate timing devices in Ethiopia and Nepal to improve the accuracy of pneumonia diagnosis. We are also using a One Health approach to identify the drivers and map the prevalence of AMR in rural Cambodia, and to develop training guides to improve health, agricultural, and veterinary personnel’s use of antibiotics. We have additionally used community dialogues in Bangladesh to engage towns and villages around antibiotic resistance.

Climate change and variability can impact the transmission of vector-borne diseases through effects on the life cycles of vectors, as well as the pathogens that they carry. This, in turn, can lead to increases in disease incidence and even outbreaks in areas with previously low or no transmission. We are, thus, trialling health interventions that help countries adapt to the potential impacts of climatic changes. For example, we have introduced the use of guppy fish to control Aedes aegypti mosquitos in areas of Cambodia where ecological and other changes may cause an increase in vector breeding. We are also working in countries such as Mozambique and Myanmar to strengthen their disease surveillance systems so that they detect and respond to outbreaks in a timely manner.

Strong, cross-sectoral partnerships and policies are essential to achieving the SDGs. To this end, we facilitate partnerships between the private and public sectors and support governments to develop coherent national health policies and strategies. For instance, findings from our formative research in Uganda influenced national decision makers to adopt a World Health Organization policy recommendation on IPTp for malaria, increasing coverage and improving quality of care.
References
7. Whiting, A. Doctors must check weather forecasts to stop epidemics in their tracks. Reuters. 7 April 2017. [Cited September 2018].

About Malaria Consortium
Malaria Consortium is one of the world’s leading specialist non-profit organisations. Our mission is to improve lives in Africa and Asia through sustainable, evidence-based programmes that combat targeted disease and promote child and maternal health.

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