Chapter 14
Parents and Communities' Assets to Control Under-Five Child Malaria in Rural Benin, West Africa

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Keywords Sub-Saharan Africa • Child malaria • Benin • Community • Fever • Millennium Development Goals

14.1 Introduction

Malaria continues to be the principal cause of morbidity and mortality in sub-Saharan Africa (SSA) countries (Breman et al. 2004; Hay et al. 2009) (Fig. 14.1). Each year, 350–500 million people suffer from it in the world, generally in its severe form (WHO 2005). Nearly three million children and adults continue to die of this disease in the world each year in spite of the existence of effective preventive and curative measures (Greenwood et al. 2005). Approximately 94% of these deaths due to malaria in the world occur in SSA (Bryce et al. 2003, 2005). The victims are mainly children under 5 years of which at least one dies every 30 s (WHO 2003a). This large prevalence of malaria translates to a situation of poverty and the health services inadequacy (Barat et al. 2004; Keiser et al. 2004; Malaney et al. 2004; Panosian-Dunavan 2006). Furthermore, the consequences of malaria contributes to maintaining the populations in a state of poverty, generating for the SSA countries a total loss of more than 12 billion dollars US each year through the loss of incomes, foreign investments and resources related to tourism (Greenwood et al. 2005; Panosian-Dunavan 2006). At households' level for instance, Malaria decreases the resources intended for the expenditure of first needs (food, expenses of schooling, etc) and supports the multiplication of the births because of the logic which is often evoked: "*it is necessary to make some sufficiently in forecast on behalf of death*" (Panosian-Dunavan 2006).

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A. Morgan et al. (eds.), *Health Assets in a Global Context: Theory, Methods, Action*,
DOI 10.1007/978-1-4419-5921-8_14,

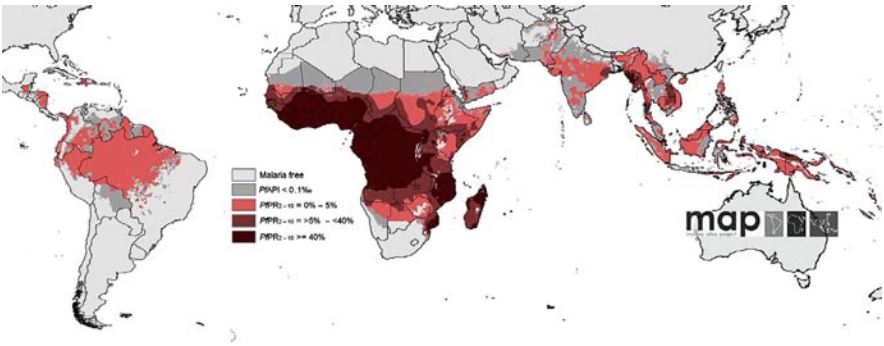

Fig. 14.1 (Hay et al. 2009). The spatial distribution of P. Falciparum Malaria PfPR2_10 predictions stratified by endemicity class. They are categorized as low risk PfPR2_10 – 5%, light red; intermediate risk PfPR2_10 – 5–40%, medium red; and high risk PfPR2_10 – 40%, dark red. The map shows the class to which PfPR2_10 has the highest predicted probability of membership. The rest of the land area was defined as unstable risk (medium grey areas, where PfAPI, 0.1 per 1,000 pa) or no risk (light grey).

Vis-a-vis malaria, several uncoordinated actions have been undertaken for already several decades with the support of several development partners. However, this known situation of malaria has little change in terms of prevalence (Houéto 2007) and continues to challenge the whole of the actors engaged in the process of its control (Greenwood et al. 2005; Panosian-Dunavan 2006). It is in this context that we initiated an experiment to show the node of the failure of the various actions undertaken to date. We evoke some actions undertaken and/or in progress at the time of our study.

14.2 International and National Context at the Time of the Study

At the time of carrying out the present study, Heads of State and Government of the SSA, on many occasions, have paid attention on the malaria issue and have worked with the adoption of many declarations for its better control. Among these declarations we mention that of Abuja and the Millennium Development Goals (MDGs).

14.2.1 The Heads of State and Government Summit in Abuja on Malaria

Being aware of the malaria issue, SSA Governments gave a priority to the fight against this disease in interventions aiming at the people's wellbeing in the region (WHO 2000). A particular emphasis is put on child malaria; children constitute one of the vulnerable

populations to Plasmodium falciparum, the principal pathogenic agent in the region (Greenwood et al. 2005). This concern of the African leaders had led them to meet in Abuja (Nigeria) in 2000 when it was expected that at the end of the year 2005:

- At least 60% of those suffering from malaria have prompt access to, and are able to correctly use affordable and appropriate treatment within 24 h of the onset of symptoms;
- At least 60% of those at risk of malaria, particularly children under 5 years of age and pregnant women, benefit from the most suitable combination of personal and community protective measures such as insecticide treated mosquito nets and other interventions which are accessible to prevent infection and suffering (WHO 2000).

To achieve these goals, Governments of the SSA region initiated, within many other actions, the strengthening of the community base interventions with mainly the Home Malaria Management initiative (HMM) (WHO 2003b), the Integrated Management of Childhood Illness (IMCI) (Breman et al. 2004), and the generalized use of the impregnated mosquito nets (Abdulla et al. 2005; Lengeler 2005; WHO 2004). Several studies were conducted with encouraging results in communities in many countries of the region, such as Kenya (Marsh et al. 2004), Ethiopia (Kidane and Morrow 2000), and Burkina Faso (Sirima et al. 2003). Some of these experiments are only locally realized, while others cover whole regions of the countries concerned, but none are replicated to across an entire country (Yamey 2004; Ahorlu et al. 2006). It is thus not surprizing that at the end of the year 2005, the commitments of Abuja Declaration are not reached (Ahorlu et al. 2006; Butler 2007; Molyneux and Nantulya 2004; Yamey 2004).

However, one can wonder, if the generalization of these studies had taken place, would it have made them possible to achieve the goals of Abuja? If one considers the analysis of Adongo et al. (2005), Baume (2002a, b), Jones (2006), Jones and Williams (2004) and Williams and Jones (2004), one should anticipate the failure of the Abuja Declaration even with the implementation of the HMM initiative and alike. According to these authors, malaria care requires the intrinsic consideration of factors such as those socioeconomic, cultural, environmental and others factors which underlie this disease. Beyond these factors, there is the whole health system in SSA countries which constitutes a potential barrier to the attainment of these goals (Panosian-Dunavan 2006; WHO 2004). In other words, several factors are to be considered simultaneously for an effective malaria control in general, and child malaria in particular, which imply a comprehensive approach and perfect community participation (Jones 2006; Jones and Williams 2004). Interventions implemented in order to attain Abuja goals did not take into account these intrinsic aspects of broad determinants of malaria prevalence (Panosian-Dunavan 2006; Molyneux and Nantulya 2004; Yamey 2004). At the international level, the persistence of the malaria prevalence is acknowledged through its inclusion in the MDGs. Although the MDGs include at the same time some social aspects e.g. poverty reduction, primary education for all etc, with the principal diseases that are causing more deaths worldwide, they are not conceived in the way it should be with the health promotion concept.

14.3 The Millennium Development Goals

Beyond the African continent, the malaria issue is a concern at the international level expressed through the MDGs. MDGs are expressions of the international community recognizing the importance of malaria on the poor economic level of SSA countries (Lapeyre 2006; Panosian-Dunavan 2006). In other words, MDGs are making the link between certain diseases including malaria and the development of victim communities. However, MDGs as goals, targeting some particular diseases without considering them in the specific contexts which generate them, seems to put the resolution of the malaria issue under the biomedical vision of health (Lapeyre 2006). The link that is supposed to exist through the MDGs between specific diseases and the development status is not obvious within these goals. According to Lapeyre (2006), this form of resolution regarding these issues is far from supportive to the attainment of the MDGs. Murray et al. (2007) affirm, by examining the MDG 4: "*Globally, we are not doing a better job of reducing child mortality now than we were three decades ago…*" If therefore nothing is done in order to take correct actions adapted to the malaria reality such as the one experimented by communities in SSA region, "*MDGs should fail certainly*", said many authors (Bryce et al. 2006; Campbell 2007). African children under five will continue dying from malaria (Werner and Sanders 2006). In other words, malaria control programs should consider the perceptions and representations of communities that are suffering from Malaria. To do so it is to put into their hands the development of these programs, what we shall call "people-centered malaria control programs". This is completely different from the way the MDGs are approaching the disease issue.

14.4 Approaches Used in Benin to Control Malaria

In Benin (West Africa), malaria is the main cause of under-five children morbidity and mortality. In 2005, 49% of under-five children consultations and 50% of hospitalizations were due to malaria. Malaria is a major priority of action for the country leaders through the Ministry of health (MS/Benin 2006). Several actions have been initiated in link with the policies that are progressing at the regional and international levels to control malaria, including: use of impregnated mosquito nets (IMN) and malaria cases management using Artemisinin Combined Therapy (ACT) (MS/Benin 2006). The Malaria Program has a lot of resources (human, material and financial) and is dealing with the equity issue by providing free IMN to all vulnerable populations. In spite of all these efforts, when one considers for instance the decade from 1996 to 2005, one can notice that malaria remained the first cause of morbidity and mortality in Benin, with a trend of increased prevalence (MS/Benin 1997–2006). The persistence of the malaria situation despite the many efforts and resources, has led some health actors in Benin to say that "*Malaria is feeding more than it kills*".

14.5 How to Deal with the Persistence of Malaria?

Is malaria an invincible disease in spite of the existence of effective curative and preventive measures? One can say that these measures have to be delivered with the right access, equity, coverage and quality. But we know that in possession of these, people continue to not use them properly or refuse to use them because of their social and/or cultural conditions (Houéto et al. 2007b). It is also possible to imagine that the vaccine is the ideal solution. Yet the recent events as regards immunization on the continent recall that the vaccine is not always the best solution for populations that are not convinced of the biomedical logic on the same basis as the health professionals (Helman 2007). The malaria issue invites, according to us, a revisit to the traditional strategies to control diseases. For Alilio et al. (2004), Jones (2006), Jones and Williams (2004), strategies currently used against malaria are not adapted. According to them, malaria in SSA is characterized by its anchoring in a cultural, socioeconomic, environmental particular context. Also, with malaria and more precisely with fever which is the main sign, there are particular perceptions and representations from individuals in communities depending on each sub-region of SSA (Adongo et al. 2005; Baume 2002a; Helman 2007, p. 412; Jones and Williams 2004; Kamat 2006). All this has led communities in the region to get an "indigenous knowledge" in the field of malaria in particular and that for fever in general. Thus, because there is no link established between fever and child malaria, parents have recourse to some therapeutic practices to control fever using e.g. antipyretic and/or anti-malarial drugs, but with inadequate dosage and duration of the treatment (Baume 2002a; Helman 2007, p. 412; Kamat 2006; Marsh et al. 2004). The majority of the campaigns against malaria have often little or no aspects which deal truly with these various factors (Houéto et al. 2007a; Baume 2002b; Helman 2007). One of the possible reasons is that medicine manages disease with a biomedical vision which leads health professionals to bring solutions to the populations without seeking a true collaboration of these populations in order to systematically identify the various above-mentioned factors and to work with them (Alilio et al. 2004; Baume 2002b; Helman 2007; Jones and Williams 2004; Kamat 2006). Dealing with the malaria issue by taking into account populations' perceptions and representations would be a way of empowering them. This is because taking into account their "indigenous knowledge", their assets, would shift an amount of power that was previously with the health professionals. This approach also conforms to the Primary Health Care declaration (WHO 1978) which stated: "*A strong participation of the people is essential and social autonomy and conscience are key factors of the human development*". This has nothing to do with the Information, Education and Communication (IEC) method some health professionals try to use, thinking that by adding to this a kind of participation (that is not empowering), people can take responsibility for prevention and treatment of disease in general and malaria in particular.

In other words, when it comes to strategies that lead to more positive results within the framework of the fight against malaria, to work with the populations'

characteristics, knowledge and practices (good and bad according to the biomedical vision of disease) could play an important part in their empowerment to control malaria. To improve this, communities must be put at the centre of the intervention for they are the ones who know their conditions more than the external people such as health professionals. That is what we call a "people-centered malaria control program". When health professionals can acknowledge that public health programs such as the malaria program do not work this way, it is time to reorient the basic strategies in this field so that health action becomes more effective. In other words, there is a need to come back to the new public health that is health promotion (Kickbusch 2007).

We have, on the basis of this principle of populations' assets and especially because the characteristics of malaria seem to us to depend on it, initiated the intervention about which we are going to report in this chapter for an effective fight against under-five child malaria in Benin. We will discuss:

- How assets based policy has worked to improve malaria control and reduce inequalities;
- The critical conditions required to ensure the effective implementation of assets based policy at a community level;
- New methodologies for constructing the evidence base on assets approaches to health and development; and
- How assets based policy has worked to improve malaria control and reduce inequalities.

14.6 Intervention (Houéto and Deccache 2008)

The intervention took place in Benin (West Africa) in a rural area. It lasted 27 months, and involved a village of around 1,000 inhabitants in developing a program to control under-five children malaria based on their assets through participation and empowerment. The process is reported here after.

1. *Identification and description of the health priority problem*: With the community, we did a baseline study after several contacts and discussions with the village leaders, notables and the whole community in a general assembly.
2. *Expressed problem*: A feedback session of the baseline study results was organized. Its aim was to establish a general community understanding of the cause of fever in children. The various health or non-health factors of fever, in connection with the realities of the village, were identified. The problems to be resolved for the organization of the fight against fever were identified.
3. *Reformulation of problems*: The main problems identified were reformulated after their validation, according to the community's understanding and based on locally available means.
4. *Prioritisation*: The problems identified were ranked according to the importance placed on them by the community members.

5. *Resources inventory*: The community discussed the issues around the resources needed for the resolution of the identified problems as well as the potential collaborations with health professionals and other professionals according to the needs identified.
6. *Desirable and feasible changes*: The community identified various actions to be taken. They identified the need for, and set up a steering committee, which decided on several main lines of action.

Here are the actions implemented by the steering committee:

- *Early home treatment of the child fever by mothers*. On the community initiative, training was organized for mothers in different hamlets of the village. This was ensured by the principal investigator, in collaboration with the departmental management of health, which gave a material support to this activity and the entire process. At the end of each training session, mothers established their criteria and unanimously chose a community health worker (CHW). Mothers proposed to add vermifuge, because according to them, intestinal worms worsen child fever. The doses of treatment were pre-packaged in reconditioning sachets. Supply of medicines and prices are managed by the steering committee.
- *Use of impregnated mosquito nets (IMN)*. The steering committee, after discussion with the community, decided to use IMN. They estimated that 300 IMNs were required, which the Ministry of Health provided within one week.
- *Parents' income improvement*. Two very important income-generating activities came into force. There was the installation of two grain mills for processing corn, beans and other cereals, and also cassava. For the farming activities, contacts were made with the International Institute of Tropical Agriculture (IITA) in order to improve agricultural practices. This was made possible via the former Director of IITA who is naturalized Benin citizen and an inhabitant of the village.
- *Setting up of a micro-insurance for health*. The community agreed upon some methods of the micro-insurance: 100F CFA ($US0.2)* as membership fees and a monthly contribution of 200F CFA ($US0.4) by household ($US4.8 per year). The contribution covers 100% of care at the CHW level and at the district health centre. The steering committee committed itself to supervise a regular (quarterly) deworming programme through the micro-finance scheme, in order to reduce children "susceptibility" to fever according to the belief in the village. [*$US1 = 500F CFA]
- *Environment cleanliness and creation of mosquito-free habitat*. According to the understanding of the community after discussions, there is a model of habitat in the village which provides protection from mosquitoes' bites. Community members adopted a new model of habitat with regards to this understanding with appropriate measures to maintain and clean their environment.
- *Systematic schooling of children and adult literacy*. The process of discussion in order to understand under-five children fever led the community to the conclusion that literacy was related with a better health attitude and behaviour. They decided to ensure the schooling of all the children of the village. Mobilization of children

for school started from the following academic year, while the elimination of adults' illiteracy was also planned in order to help the rest of the village.

- *Implementation*: The steering committee played the leading role during the implementation of the identified activities. It created and maintained informal relations with the community mainly through the community leaders, the notables, and periodic village meetings.
- *Assessment*: An evaluation of the intervention was done after 27 months. It involved the steering committee and community members as well as the principal investigator. At this evaluation, the results below were noted as the fruits of this intervention based on the community's assets.

14.7 Results

Many changes were noted from before and after the intervention regarding cognitive information:

14.7.1 At the Individual Level

- *Causal attributions of under-five child fever*: Correct attributions before and after intervention were respectively 6 and 15 among 18 households interviewed. Incorrect attributions were respectively 12 and 3 among 18 households. One of the interviewees stated before intervention: "natural fever never worsens, but when caused by the witchcraft, always becomes complicated". After intervention, he said: "mosquitoes and houses insalubrities" cause child fever.
- *Knowledge of prevention methods*: Before intervention, 8 amongst 18 households knew malaria prevention practices. After intervention, 16 amongst 18 households knew adequate methods for malaria prevention and practised them.
- *Parents' practices of recourse to health centre in the case of child fever*: Table 14.1 presents practices of recourse to adequate health care in the intervention village before and after the intervention ($\chi^2 = 48.07$, $P = 0.000000$). One of

Table 14.1 Recourse to adequate health care in the intervention village before and after intervention

Recourse to adequate health care	Intervention village			
	Before intervention		After intervention	
	n (%)	*N*	*n* (%)	*N*
Active screening of malaria	6 (12)	52	19 (66)	29
In-depth interviews	2 (11)	18	16 (89)	18
Total	8 (11) [5–21]	70	35 (75) [60–86]	47

N number of households interviewed, *n* frequencies of adequate recourse to health care, *[ ]* 95% confidence interval.

the households interviewed was asked "does child fever require recourse to modern care?" They answered: before intervention: "yes, but after at least three days, because if it is natural, it will give up with the house remedies." After intervention: "Yes, because not treated by them (health professionals), fever can lead to anaemia and even the loss of the child. It will be without conditions. The ideal to be reached will be that parents contribute in advance in order to have recourse to health centre without worrying about the price to pay".

Community participation and actions implemented: According to in-depth and group interviews, about 80% of the community members participated in the intervention through the different actions implemented. The interviewees confirmed that the high level of participation was due to the fact that community members were the authors of the proposed interventions.

14.7.2 At the Community Level

- Community behaviours, through participation in meetings, gradually developed informed decision making and readiness to be engaged in the project activities;
- Competence to treat child fever adequately is developed very quickly (see details in Houéto 2007; Houéto and Deccache, 2008), contributing to the development of people's self-esteem;
- Skills to establish partnerships were also developed;
- Communication through a positive interaction, and the confidence to express divergent points of view was developed during the intervention;
- Development of a critical conscience through the manifestation of collective, social, political conscience, engagement towards the other members of the community, and the acceptance of a personal liability for change were noted.

14.7.3 Health Data

We have, for active screening of malaria as well as the registers analysis, obtained modifications of the health data.

- The prevalence of fever and other signs of malaria were significantly reduced (before: 34% [27–42], after: 20% [14–28], $P=0.008$);
- The recourse to the health facilities in the case of fever increased, in particular an early and adequate home treatment of fever as showed on Table 14.1;
- Consequently, there is reduction in severe cases of fever compared to the year before the intervention (13% [7–22] in 2003–2004, and 7% [3–15] in 2005–2006, $P=0.18$, this reduction is not statistically significant); and
- A statistically significant reduction in the deaths caused by malaria (4 in 27 months of intervention versus 15 in 2004, the year just before our intervention, $P=0.001$).

These successes require certain conditions that are indispensable for a successful community-led development based on their assets.

14.8 The Critical Conditions Required to Ensure the Effective Implementation of Assets Based Policy at a Community Level

The very strong support obtained from the community seemed to be related to the process which we followed in this intervention, summarized below:

- No action was taken without considering the local context of the intervention community;
- The issue approached has priority for the intervention community;
- Participation, giving real capacity to the community to take all the possible and suitable actions, according to the members community's assets, for the fever control;
- We (professionals) acted as a referent, guiding the process and contributing to actions under consideration by the community;
- Expanded beyond the health sector to use several types and strategies of action against malaria concerning various aspects of the community's life; and
- Confidence in the community (their assets) contributed to the development/increase of their self-esteem, in turn acting as motivation to make their own suggested actions successful.

We summarise all these aspects in Fig. 14.2 and name it "The principle of the crank" in order to figure out the roles of the community and of the professionals, the former being at the centre of the process using its assets and the latter just

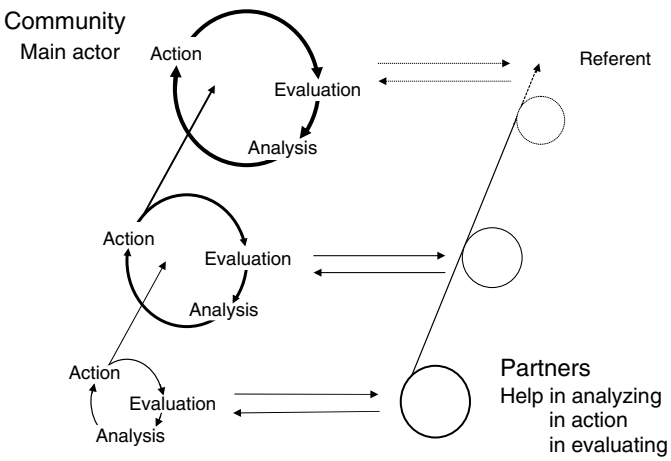

Fig. 14.2 Representation of the community roles and the external partners in the action process based on community's assets (principle of the crank) (Houéto 2007)

accompanying the process (mainly at its beginning), being confident in the community's assets and progressively taking distance and becoming a "referent". This role of referent will disappear with time according to the characteristics of each community as stated by Boyte (1989). According to McFarlane and Fehir (1994), it will take two to 5 years for the community to get control of the whole process. We think, as far as we are concerned, that this time will also depend on the initial level of powerlessness of each community or the quality of its assets and its will to change its health status and quality of life. The time required will also depend on the strength of the role the professionals have played at the beginning of the intervention process (the force of the crank) by really giving power to the community (Raeburn and Corbett 2001). According to Arole et al. (2004) from whom we have drawn this "principle of the crank", and Raeburn and Rootman (1998), the role of the professionals in achieving this goal, will have to be located in the logic of a guide and an adviser which supports community control through three lines of action, namely:

1) To take care that health interventions/programs lie within the framework of health and wellbeing of the populations concerned, while aiming at a community control from the very beginning;
2) To support community's development initiatives which contribute to the improvement of the quality of life of the partner populations;
3) To nuture the community competences and skills development, i.e. the development of their assets.

Through the "principle of the crank" we are acknowledging some new methodologies to construct sustainable results in community interventions that lead to community development. Here after we are attempting to present the new methodologies as we perceived them in our malaria control experience in a rural area.

14.9 New Methodologies for Constructing the Evidence Base on Assets Approaches to Health and Development

To construct evidence base on assets approaches, we found through this intervention that community participation is central. There is evidence as stated by Raeburn (2005) that community participation, as experienced within this intervention, is the core process of using and developing people's assets. This kind of participation is compared to the crank as it's important at the beginning of a health/development action where professionals help start the reflexion and the enlightenment of the issue in a specific community. By doing so, professionals are not the principal actors for they are not going to replace the community, but just help them solve the problem. It is for the community to continue doing things with new resolutions. Through community participation based on community assets, it was possible to the community in our intervention to discover the biomedical reality of child fever and to adopt behaviours favourable to its control. This form of participation is possible, only when programmes focus on the local contextual factors and not on some

generic actions, as it is the case in many national malaria control programs in SSA (Houéto et al. 2007b). Community involvement is necessary for ensuring equity in health care, as well as the sustainability of the health action (Raeburn 2005; Ridde et al. 2007). Without doing so, how can one assume to control successful child malaria in SSA where communities have many assets by living for many decades in their environment knowing some other cultural aspects of their life related to malaria, for instance, that health professionals do not know? It is to say in other words that health systems in SSA cannot "roll back malaria" without a health promotion approach which values people's assets through participation, empowerment, and contextualism (WHO 1998). The role of researchers/actors appears to us as the major factor in such an approach, for its capacity to be both "present and not", for the benefit of "indigenous knowledge", by keeping only a status of a guide/mentor and resource persons. Why professionals would like to be "gods" for communities when they have also knowledge, and are the ones living in their own context? One can imagine what we should gain in this particular intervention if we go beyond 27 months, as it was the case in the community empowerment projects reported by Raeburn (2005).

Speaking generally way, for the national health system, regarding interventions which ensure people's health and wellbeing, it seems necessary to us to mention essential attributions that professionals must have. We have drawn these attributes from the role that we played as health professional and researcher in this particular study based on population's assets. Care must be taken that health interventions/programs lie within the framework of health and the global wellbeing of the populations concerned while aiming at the community control from the early beginning of their development. Professionals take a role of:

- Guides for the establishment of the process of the intervention while aiming at the empowerment of the partner communities; and
- Advisers who are solicited according to the needs identified by the community itself within the framework for the program, neither imposing their points of view nor giving particular instructions.

Support the initiatives of community development which contribute to the improvement of the quality of life of the partner populations. The professionals are then:

- Guides of the communities in the development of social cohesion, mutual support, networking, cooperation, friendship, and the improvement of their quality of life; and
- Facilitators for the establishment of partnerships and other links between communities and the other potential actors.

Take care of the development of the community competences and skills. The professionals contribute to:

- The reinforcement of community competences through trainings and explanations on topics identified by the community itself in the course of the action,
- The development of the self-esteem and critical conscience at individual level, bringing them to more participation in the community action,

- The valorization of the positive community practices for health and wellbeing and encouragement of the community initiatives,
- Advocacy and negotiation with regard to the community's harmful practices.

The whole of these attributions shows the importance of the multisectoral work that is centered on specific contexts with its related realities. These realities are not sufficiently perceived without the full participation of the members of community, using in consequence various strategies. All this leads to the sustainability of the action through the process of implementation and evaluation and contributes to the resolution of specific health problems and to the reduction of the social inequalities of health (Fig. 14.3).

The example of malaria in SSA is a real case which shows the inefficiency in the traditional way of solving health and development problems of the populations. To base intervention on the populations' assets is certainly the best way to "roll back malaria" because of the multiple cultural and socioeconomic implications which rather make it an issue of community development. Indeed, it is known that malaria is not prevalent in the environments whose standing is average or top-of-the-range in terms of urbanization, healthiness and thus of a minimum of wealth within the populations. That implies that this work is made beyond the health system since the causes of malaria are associated with sectors outside of the health system and the community in particular. To work with the populations' assets, is to give them the possibility of putting forward all their competences and improving them in order to be able to continue implementing effectively the necessary steps for a sustainable fight against malaria. In other words, in the current situation of malaria in the SSA countries, the national malaria control program, in a global vision based on the

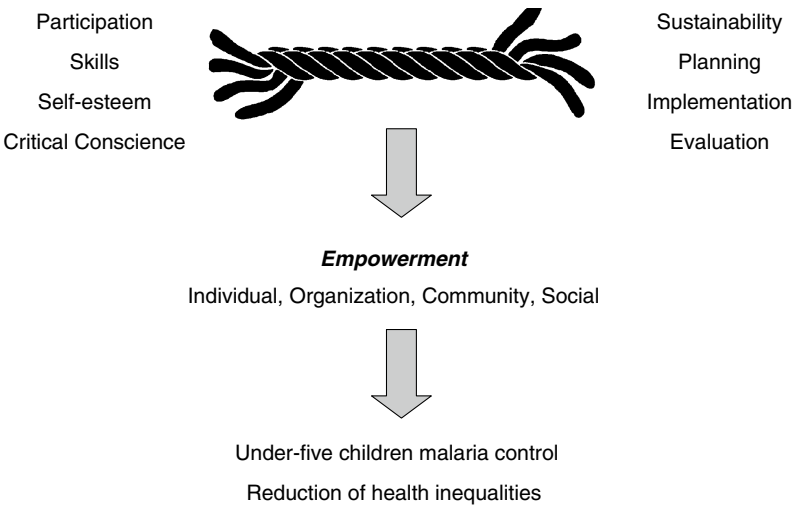

Fig. 14.3 Illustration of the process, effects and impacts of malaria control intervention based on population's assets (Adapted from Ridde et al. 2007)

populations' assets, should be sheltered by any other department rather than the Ministry of Health. Indeed, the curative aspect of malaria program will remain on the hands of the Ministry of Health because health professionals are experts in this field. This needs to be organized in the health promotion perspective in order to avoid the problems raised by a similar approach in HIV/AIDS prevention. The department to steward the malaria program could be the Presidency of the Republic or the Prime Minister in order to be able to influence the various factors that underlie malaria by giving power to those who really need it for their control. Alternatively make the Ministry of Health a Ministry delegated to the President of the Republic, as the majority of the health problems need a strategy which goes beyond the biomedical approach of disease. There is a need for the reorientation of the health system even of the system of government in the region's countries in order to be able to contribute to the improvement of health and wellbeing of the populations which suffer too much from misery and disease. Endorsing this is to work from the health promotion perspective which recognizes the important role of the individual and the community in the resolution of their health and development issues.

14.10 Conclusion

Our experience underscores the importance of using an assets based approach in the fight against child malaria. Many health problems, like malaria, are rooted in several other sectors, whose involvement is necessarily in order to reach a solution. The community in many cases also has to play an important role. So it is worth basing interventions on what the community has as resources. This has the advantage of entailing the community to be managed by the awakening of its critical conscience, but to also contribute to the resolution of other problems and to its own development. Such action deserves to be taken on a larger scale to examine more of the various methodological and operational outlines. At the current stage of health promotion status in the SSA region, the issues could be situated at the level of the availability of competent human resources, as well as the capacity of the current health systems to bring about a successful conclusion. Such an action would nevertheless turn out to be indispensable if we want to achieve the Millennium Development Goals and targets for the Health for All policy.

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