Parents and communities' assets to control under five child malaria in rural Benin.

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Summary

Introduction: Malaria is the biggest threat in terms of morbidity and mortality in sub-Saharan Africa (SSA) and one of the main factor contributing to poverty in the region. One of its target populations are children under five years. Despite the fact that several actions are being put in place for already many decades, the Malaria issue has never had a little change and continues to challenge the whole of the actors engaged in the process of its control. It is in this context that we initiated an experiment to show the node of the failure of the various actions undertaken to date.

Context: At the time when we carried out the present experiment, Abuja Declaration to control Malaria had already failed. Countries in the region are struggling actually to control Malaria through the Millennium Development Goals (MDGs) n° 6. But as one said, "*Globally, we are not doing a better job of reducing child mortality now than we were three decades ago*…" So one can say, when considering the way health systems in the region are working, that there is no possibility to control Malaria.

In fact, according to many authors, Malaria in SSA is characterized by a particular context anchoring in a culture, socio-economic, and environment. Fever in Malaria is the main sign which entails particular perceptions and social representations from individuals in communities depending on each sub-region of SSA. So there is a need for a strong participation of the people in order to be able to control Malaria in SSA basing interventions on their assets.

Methods and results:

How assets based policy has worked to improve Malaria control and reduce inequalities? Within a rural community in Benin (West Africa), we chose to plan to control Malaria by putting all the process in the hands of the members of that community. All the process lasted for 27 months. As health professionals, we were their referent, giving them the needed skills and knowledge to accomplish their mission. The community planned six activities to control Malaria: (1). Early home treatment of the child fever by mothers; (2). Use of impregnated mosquito nets (IMN); (3). Parents' income improvement; (4). Setting up of a micro-insurance for health. (5). Environment cleanliness and creation of mosquito-free habitat; (6). Systematic schooling of children and adult literacy.

As the results, there were significant changes in terms of knowledge of Malaria transmission and prevention in children, parents practices of recourse to health centre in the case of child fever, community participation, competence to treat child fever adequately, skills to establish partnership with stakeholders, and communication through a positive interaction, expression from divergent point of view anchored in confidence. The prevalence of fever and other signs of malaria were significantly reduced, the recourse to the health facilities in the case of fever increased, but especially an early and adequate home treatment of fever. Consequently, there is reduction in severe cases of fever compare to the year before the intervention. Deaths caused by malaria were statistically significantly reduced.

The critical conditions required to ensure the effective implementation of assets based in malaria control policy at a community level are: (1). No action was taken without considering the local context of the intervention community; (2). The issue approached has priority for the intervention community; (3). Participation, giving really capacity to the community to take all the possible and suitable actions, according to the members community's assets, for the fever control; (4). We (professionals), played a role of guiding the process mainly at the beginning

and the resource persons, enlightened actions under consideration by the community. We acted as a referent; (5). The use of several types and strategies of action concerns various aspects of the community's life, without limiting ourselves to the health sector as the causes go beyond this sector alone; (6). Confidence in the community (their assets) had played a role of "motivator" that contributed to the development/increase of their self-esteem, implying an important motivation to make their own suggested actions successful. We call this process "*The principle of the Crank*"

New methodologies for constructing the evidence base on assets approaches to health and development. Speaking about interventions which ensure people's health and wellbeing, and based on population's assets, health professional must: (1). Take care 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. (2). Support the initiatives of community development which contribute to the improvement of the quality of life of the partner populations. (3). Take care of the development of the community competences and skills.
This process reorients the role of health professionals and shows the importance of the multisectoral work that is centered on specific contexts with their own 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.

Conclusion: We showed through this community approach that it is possible to control Malaria basing programs on population's assets. With this approach helps awakening its critical conscience, not only child fever, but to also contribute to the resolution of other problems and to the community development. Such an action would deserve to be taken back on a larger scale to examine more of the various methodological and operational outlines. Building capacities in health promotion in the region should come as a main priority for health systems in order for them to consider the bio-psychosocial vision of health instead of the one being used, the biomedical when planning health action.