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“Interactions between populations, health workers and health programmes for prevention of malaria: teachings of an analysis «from below».”

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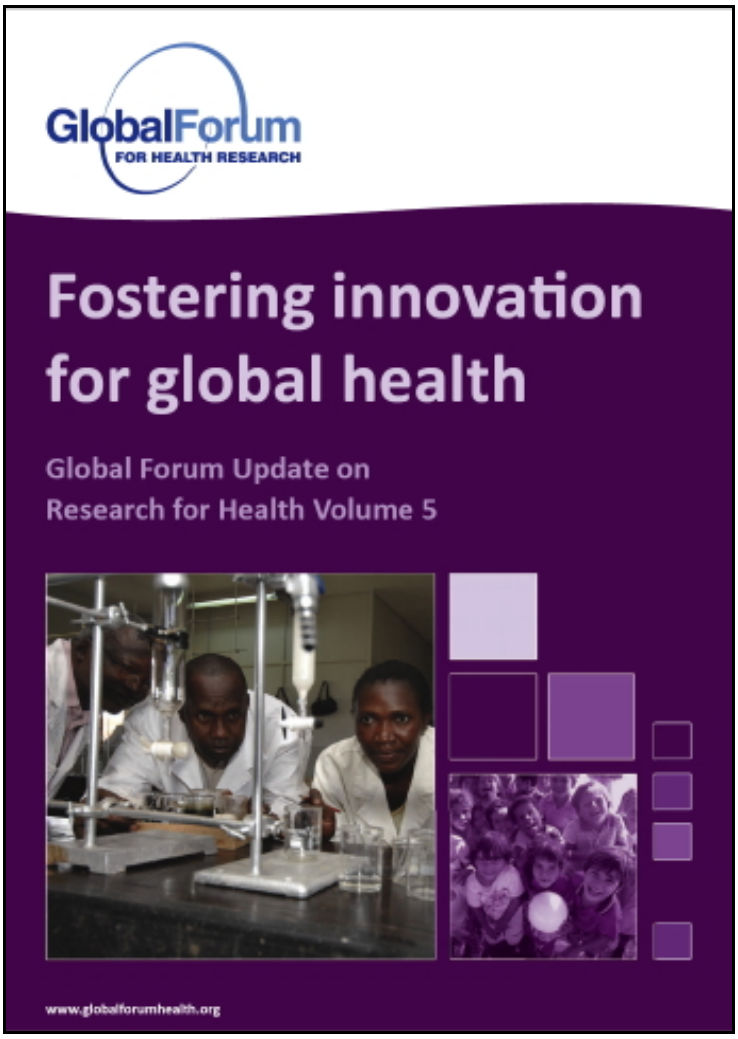

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One of the most accurate ways of qualitatively evaluating a health situation consists of analysing it from the point of view of diverse social groups who are supposed to benefit from the development programmes and who also physically feel the difficulties of their situation each day.

Of course, one must beware of succumbing to a "populist" approach or confusing the "actors oriented" position with a naive approval of what could be considered as "traditional" or unanimously shared homogeneous "communitarian" opinions. Populations everywhere are pluralist and always manifest economic inequalities, contradictory cultural options and political conflicts [1]. To put it simply, nothing is ever "communitary" or "traditional" : everything is always "political" and "historical".

Besides, if various "laymen" behaviours are socially explicable, this cannot mean that they are coherent and commonplace from the health angle. Having reasons for acting in a certain way cannot be synonymous to right action, and a good number of causes of infantile and maternal mortality find their explanation in harmful popular behaviours. But once these precautions are taken, the approach "from below" is indispensable because it permits the shift from "global" to "local" and allows the study in situ of how big strategies conceived by interna-

[1] Olivier de Sardan JP. *Anthropology and development. Understanding contemporary social change*. London, Zed Press, 2005.

tional institutions come to install themselves in the ordinary course of lives and in social practices that impact on health.

These ordinary dimensions of daily life are often ignored by research or development programmes. And if the technical goals of "projects" benefit from a lot of attention, these social dimensions are evoked only very erratically under the term "context". The error here is obvious, since this term in fact designates a set of essential variables: how one eats, lives, sleeps or washes… in short, the "context" that we have not yet taken the time to study is simply "all that is social", and that nevertheless determines and explains the essentials of the actors' behaviours.

Methodologically, this qualitative approach "from below" corresponds to several theoretical models that emphasize the links between "sociological reasoning" and its socio-historical environment [2]. It is sufficient here to mention "thick description" that aims at describing and analysing the links between actions and the meanings given to them by their authors [3] or micro-history that identifies invisible structures according to which the actors' experiences are articulated [4].

Concretely, in the framework of the application of health programmes, this position enables two vital processes. It first permits the comparison of words used by "developers" and the realities they are supposed to designate. In short, it permits us to know if the notions used to define health strategies have a "real" reference or if they are mere "paper words" designating only the rhetorical universe of "projects" and "seminars" [5]. Consequently, this position permits us to analyse the applicability of theoretically conceived health measures in real situations – more precisely, in their "contexts".

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2 Passeron JC. *Le raisonnement sociologique*. Paris, Albin Michel, 2006.

3 Geertz C. *La description dense. Vers une théorie interprétative de la culture*. EHESS/Eds Parenthèses, 1998, Enquête N°6, 73-105.

4 Lévi G. *Le pouvoir au village. Histoire d'un exorciste dans le Piémont du XVIIe siècle*. Paris, Gallimard NRF, 1989 (1st edition 1985).

5 Jaffré Y. Quand la santé fait l'article. Presse, connivences élitaires et globalisation sanitaire à Bamako, Mali. *Revue de Pathologie Exotique*, 2007, 100 (3), 207-215.

Proposals and difficulties of malaria prevention programmes

Let us briefly recapitulate the situation. Globally, various preventive strategies for limiting the morbid effects of malaria – besides vaccine research – have three objectives that imply broad fields of activities, with unfortunately as many specific difficulties [6].

(1) To begin with, establishing an early diagnosis can permit a rapid and satisfactory management of the disease and the necessary observation of the treatment. However, forms of resistance to antimalarial measures that have been observed give the impression that the treatment is not always appropriate to the complaint as would be desired.

Questions of quality of health offer and mutual understanding between populations and health personnel are essential here.

The exchange of health information always implies a translation of the doctor's technical medical vocabulary into the laymen's representations of the illness. This difference between reference systems explains the great number of difficulties of mutual understanding between health teams and populations. This is accentuated by the fact that in a number of countries, the scientific language used (most often English or French) is different from the language ordinarily employed by people to express themselves. In this case, when local languages do not possess a true scientific lexicon and medical terms, the health dialogue requires multiple interpretations and adaptations of the terms used. Health dialogue can then be described as a confrontation between two semantic systems bringing about different classifications of the pathologies.

Several "distortions" will then result. Some diseases like malaria, distinguished by the medical discourse, can be conceived by populations as constituting a single morbid unit ("diseases of fever") and hence interpreted wrongly as be-

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6 Jaffré Y. Contributions of social anthropology to malaria control. In: Tibayrenc M (ed.). *Encyclopedia of Infectious Diseases: Modern Methodologies*, New York, Wiley, 2008, 591-602.

nign. Reciprocally, several clinical signals defining a single medical syndrome can be distinguished by populations as many different illnesses.

Lack of scientific analysis of these laymen interpretations of the disease and its treatments have made confusions between health teams and populations more of a norm than an exception. Yet, populations can only adhere to the prevention of what they can label and understand. Very broadly, these constant divergences prevent the establishment of a true health dialogue and encourage populations to have recourse to popular remedies or "informal chemists" [7] – economically more costly than judicious medical treatments, but culturally closer to the populations.

To put it plainly, following the treatment and resistance to new molecules is largely a matter of communication and quality of the health offer.

(2) Preventive measures must then be planned and implemented particularly for "risk" groups, such as pregnant women. Bednets and insecticide-treated curtains used for some years seem to constitute an effective means. However, they are still little used in Africa outside "pilot" programmes. This is simply because "bed manners" defined according to kinship, the status of the child or ill-adapted architecture, gradually deconstruct and dilute the theoretical coherence of health "messages".

Thus, preventive proposals are remodelled by the ordinary course of things: bednets are torn during children's games, intense heat prevents people from sleeping under the net, sexual intimacy leads to children being kept at a distance, mosquitoes breed in beds with boards, the status of elders reserves bednets for seniors.

These ordinary norms and daily actions construct references for a way of living. This is why impregnated bednets are used in the frame of restricted programmes – when "the project" plays the role of a reminder for the new norms proposed. But their effectiveness diminishes when new actions imposed by this innovation are eroded or demolished by the routines of daily behaviours.

(3) Finally, from an administrative point of view, the multiplicity and "verticalization" of programmes makes their harmonization difficult. It often leads to

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[7] Jaffré Y. Farmacie cittadine, farmacie "per terra". *Africa e Mediterraneo*, 1999, 1, 31-36.

confusion among populations and provokes iatrogenic effects like the constant transfer of health personnel towards more "profitable" programmes.

An economy of "projects" is in evidence everywhere (bonus, daily allowance, transport) along with a misappropriation of health personnel towards public health that is considered more advantageous [8].

Thanks to various health education campaigns, there has been a real improvement of knowledge about the role of the mosquito in particular and the advantage of bednets. But this new knowledge does not "automatically" lead to new practices. Unfortunately, it must be admitted that little change has been noted in the presence of malaria in the zones of highest transmission. This is particularly so in Africa where the appearance of new resistances and new "urban" forms of the disease has been noted [9].

New trails?

Naturally, programmes once begun must be continued and attempts made to diffuse these health proposals that are really new body practices [10]. But, if one agrees with what has been affirmed here, three other broader paths that can only be briefly mentioned here must also be considered.

(1) A political ecology: between public and private spaces: constructing a healthy city

Several dimensions are interlinked and must therefore be treated together. The rapid growth of urban population [11], the transformation of malaria features,

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8 Jaffré Y and Olivier de Sardan JP. *La construction sociale des maladies*. Paris, PUF, 1999.

9 Gonzalez JP et al. Fundamentals, domains, and diffusion of disease emergence: tools and stategies for a new paradigm. In: Tibayrenc M (ed.), *Encyclopedia of Infectious Diseases: Modern Methodologies*. New York, Wiley, 2008, 525-568.

10 Corbin A, Courtine JL and Vigarello G. *Histoire du corps*. Vol. 2. Paris, Seuil, 2005.

11 Antoine P. *L'urbanisation en Afrique et ses perspectives. Archives des documents de la FAO*. 1997, p. 21.

the great social inequalities as well as the common presence of other pathologies (dengue, chikungunya, schistosomiasis, trachoma, etc.) give a global dimension to parasitical and infectious risks in new urban spaces.

In other words, although the rural world cannot be abandoned, a large number of new health questions are linked to the specificities of contemporary mégapoles [12] where 72% of the population of Africa lives in unsanitary conditions [13].

In short, it is obvious that no progress in malaria prevention will occur without conducting a solid reflection involving urbanists, architects, doctors and specialists in social sciences on the various ways of constructing "healthy cities" rather than "pathogeneous complexes". Several fields need to be examined here.

Public spaces must be analysed and their general management improved [14] [15] [16] [17]. It is necessary to understand the various ways in which public policies and occupation of "lived spaces" are articulated depending on the territories [18] [19] [20]. Once again, to put it simply: it is ridiculous to ask the poor and destitute to protect themselves when open drains run across the cities.

Simultaneously, in private spaces, more adapted architectures could be developed. Indeed, the diffusion of architectural models – use of tin and cement – particularly unsuited to the extreme heat of tropical climates, besides being an ecological absurdity, renders the regular use of bednets illusory.

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12 Harpham T. Urban health in developing countries: a review. *Progress in Development Studies*, 2001, Vol. 1, No. 2, Sage Publications, 113-137.

13 Davis M. *Le pire des mondes possibles. De l'explosion urbaine au bidonville global*, Paris, La Découverte, 2006, p. 205.

14 Onibokun AG (dir.). *La gestion des déchets urbains. Des solutions pour l'Afrique*. Paris, CRDI/Éditions Karthala, 2002.

15 Enten F. L'hygiène et les pratiques populaires de propreté. Le cas de la collecte des déchets à Thiès (Sénégal). In: Bonnet D and Jaffré Y (sous la direction). *Les maladies de passage*. Paris, Karthala, 2003, 375-402.

16 Blundo G. La question des déchets et de l'assainissement à Dogondoutchi. Niamey, Lasdel. *Etudes et Travaux*, N°10, 2003.

17 Hahounou E. La question des déchets et de l'assainissement à Tillabéri. Niamey, Lasdel. *Etudes et Travaux*, N°9, 2003.

18 Frémont A. *La région, espace vécu*, Paris, Flammarion, 1999.

19 Ingold T. *The perception of the environment. Essays in livelihood, dwelling and skill*, Routeledge, London, 2000.

20 Choay F. *Pour une anthropologie de l'espace*, Paris, Seuil, 2006.

As was the case for tuberculosis or all water-borne diseases, the struggle against malaria is thus linked to a policy of habitat. Although this cannot be detailed here, two essential points must be mentioned that encourage populations to take care of their environment.

First of all, access to property must be developed. This alone can guarantee the time required for planning and impart a desire to improve one's environment.

History also teaches us that transformations of space owe more to aesthetic reasons than to health guidelines. Therefore, new norms combining beauty and function must be diffused [21] [22].

Globally, these multiple dimensions, mainly economic, sanitary and urban, must orient a real reflection on the political ecology of the disease [23].

(2) University and continuing education concerned with contexts of healing practices

More specifically, the dialogue between health personnel and populations must be improved. But if this dimension is recognized as essential in the texts, practically no teaching – initial training – dealing with the complex links between languages and popular behaviours versus sanitary proposals is proposed in faculties of medicine or paramedical schools.

Ehnolinguistic works on the body and on disease [24] [25] should be used – not as a "curiosity" or a social "plus" – but in order to initiate a real reflection on conditions of future healing practices in a specific environment. Let us put this even more simply: is good medical advice if not understood or applicable by patients "good advice"?

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21 Vigarello G. *Le propre et le sale. L'hygiène du corps depuis le moyenâge*. Paris, Seuil, 1985, p.286.

22 Goubert, 1986.

23 Baer HA. Toward a political ecology of health in medical anthropology. *Medical Anthropology Quarterly*, 1996, New Series, Vol. 10, No. 4, Critical and Biocultural Approaches in Medical Anthropology: A Dialogue, 451-454.

24 Jaffré Y. *Une médecine inhospitalière*. Paris, Karthala, 2003.

25 Tourneux H et al. *Dictionnaire peul du corps et de la santé* (Diamaré, Cameroun), Paris, Karthala, 2007.

The most common practices refute the precepts taught, thus reducing teaching to a purely rhetorical exercise. For example, practically no hospital in sub-Saharan Africa uses bednets despite recommending their use. If requirement levels shouldn't be lowered, nonetheless concrete questions must be raised about the suitability of "basic material" for local conditions of practice (linguistic uses, specific forms of organization of work, etc.).

(3) Intitate better coordination of development policies and help clinicians remain at their posts

The following three observations counteract the "verticalization" of health programmes and would thwart iatrogenic effects of health development projects.

First of all, it is culturally of little relevance to treat "nuisances felt" requiring similar "defensive barriers" (malaria, dengue, chikungunya) separately.

Next, work on the causes of parasitic infections would permit action on common initial causes largely linked to water and hygiene.

Finally, clinicians could be helped to remain in their departments rather than encouraged to join different, more or less temporary, specific programmes of "public health".

The struggle against malaria depends largely on how aid and development policies are conducted. A better coordination of programmes, the pooling of means, enhancing actions and grants of research subsidies granted to practitioners who despite their low salaries and difficulties continue to work with sick people, would be an essential aid.

To conclude, at different levels all authorities interact with various health programmes. Consequently, helping local authorities comes down largely to thinking about ways of promoting an offer of quality health.

Yannick Jaffré *worked as an anthropologist in West Africa for 20 years. He collaborated with public health teams, conducted many anthropological research projects focused on health priority and taught in many African and French medical faculties.*

He is now Research Director at the French National Centre for Scientific Research (CNRS – UMR 6578) and responsible for PhD teaching in health anthropology in SHADYC (Sociology, History and Anthropology of Cultural Dynamics) in a French social sciences high school (EHESS). Yannick Jaffré has written many books and articles about disease in West Africa and the relationships between health-care providers and users.

Fin du texte