ENVIRONMENTAL HEALTH PROJECT

Activity Report 113

End of Project Report

Environmental Health Project
CESH Benin Activity

Gestion Communautaire de Santé Environnementale II (GESCOME II)

by

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Executive Summary

The Environmental Health Project (EHP) Community-based Environmental Sanitation and Hygiene (CESH) Benin Activity, originally conceived by USAID/Benin as a one-year activity, began on the ground in September 1999 and was completed on May 31, 2001. The goals were to: (1) prevent diarrheal disease in young children and (2) support the Mission's efforts to strengthen ties between municipal and departmental levels of government. The activity was developed as a joint programming activity by the USAID/Benin Family Health Team and the Democracy and Governance Office. The activity was known in Benin as *Gestion Communautaire de la Santé Envirronmentale II* or GESCOME II (Community Management of Environmental Health). The Mission conceptualized the activity as a bridge to a planned, larger democracy and governance project. GESCOME II was to extend the GESCOME approach to new neighborhoods in GESCOME I towns and to an entirely new town.

The Activity was specifically designed to contribute to the achievement of USAID/Benin's Family Health Strategic Objective 2, Intermediate Result 4 (IR 4), "*increased demand for, and practices supporting use of, family health services, products & prevention measures."* The purpose of the project was to extend GESCOME I to new neighborhoods and a new town, paving the way for the implementation of the Mission's upcoming decentralization activity by supporting increased community dialogue and collaboration with local government structures in the identification of local problems and their solutions.

The expected results of the activity included:

Result 1: EMEs (Expanded Municipal Teams) actively participate in CESH/CIMEP (Community Involvement in the Management of Environmental Pollution).

Indicators:

- Community representatives for the EME in the new target intervention area of Sinendé will be selected within three months of activity start date
- EMEs in all target municipalities will develop and implement a work plan
- EMEs in all target municipalities will plan meetings and meet on a regular basis

Result 2: Round Table meetings will continue, with the support of the Préfet, and will involve municipal support for environmental health issues.

Indicators:

- Round Table meetings will be attended by regional officials from various sectors

- Departmental and municipal decision makers will implement action items identified at Round Table meetings

Result 3: In each target intervention area/neighborhood, measurable changes will occur in behavior and environmental conditions directly related to diarrheal disease transmission.

Indicators:

- In each target area, high-risk behaviors contributing to transmission of diarrheal disease will be identified

- Participatory methods will be used to develop and implement strategies for addressing the high-risk behaviors identified.

- Neighborhood concerned citizens groups in neighborhoods will monitor behaviors on a regular basis

- High-risk behaviors contributing to transmission of diarrheal disease decrease, as measured through qualitative studies

Result 4: In target intervention areas, stakeholders (local elected officials, NGOs and community members) will collaborate to address community problems.

Indicators:

- Mechanisms will be established and used for regular interaction between EMEs and communities

- Mechanisms will be established and used for soliciting community input in local decision making

- Communities will contribute financially to micro-projects, contributing at least 15% of budget

- Revolving funds will be established to support maintenance costs for micro-projects

GESCOME II continued and enhanced the GESCOME I implementation structure. In this structure, the Departmental Environmental Health Committee (*Comité Départemental de la Santé Environnementale* or CDSE) was the body that guided the project and made strategic and policy decisions. The CDSE supervised the municipal-level teams. Membership included heads of relevant ministries at the departmental level, coordinators of the municipal teams, the *sous-préfets* or mayors of the municipalities, and the *Préfet*, who chaired the CDSE. CDSE membership linked department-level government to municipal-level government. In addition, since the Préfet and all ministry heads at the departmental level report to the national government, the CDSE had the potential to link to the national level as well. The

CDSE's responsibilities tied the department-level to both the municipal and community (neighborhood) levels. At CDSE meetings, municipal team coordinators reported about neighborhood issues and concerns.

Each town had one Enlarged Municipal Team *(Équipe Municipale Élargie* or EME). The EME was responsible for mobilizing all the GESCOME neighborhoods in the town, helping the community to conduct participatory rapid appraisal (PRA) to identify, analyze, and find solutions for environmental health problems, propose micro-projects, and conduct participatory community health communication (PCHC) with the neighborhoods. In addition, they supervised the micro-project management committees (CGMP). Each EME had a representative who attended CDSE meetings. It was the job of the representative to be the advocate for the communities in his town, representing both community views and the EME perspectives to the CDSE, and also keeping the CDSE apprised of his town's activities and progress made. EME members generally participated in other civil society organizations and activities as well.

The Micro-project Management Committee (*Comité de Gestion des Micro-projets or* CGMP) was elected by the neighborhood. Its members were generally well- respected people who were believed to be honest and dedicated. The CGMP's job was to manage the micro-project. This encompassed opening a bank account to manage project funds, contracting with masons and other workmen or with the national water company to build the necessary infrastructure, collecting and managing the community's contributions and user fees, and maintaining the micro-project once completed. In the case of micro-projects that supply potable water, the Water Users Committee fulfills some of these responsibilities. Neighbors of a GESCOME II water point source elected members of the Water Users Committee from among themselves. While.the majority of the members of latrine CGMPs were men, the majority of members of water point source CGMPs and Water Users Committees were women since a prime household responsibility for women is obtaining and storing water for the family.

GESCOME II worked in three rural towns in Borgou Department: Banikoara, Sinendé, and Bembéréké/Beroubouay. Beroubouay is actually another town located 37 km from Bembéréké, but is part of Bembéréké sub-prefecture and considered a part of "metropolitan" Bembéréké. GESCOME I had focused on three neighborhoods each in Banikoara and Bembéréké. GESCOME II added two neighborhoods in Beroubouay, one neighborhood in Bembéréké proper, and three neighborhoods each in Sinendé and greater Banikoara. GESCOME I had also operated in Parakou, the capital of Borgou. In GESCOME II, that town's involvement consisted of having a representative on the CDSE.

GESCOME II activities fell into six categories:

1. Training

2. Participatory rapid appraisal (PRA) (using the same basic approach and tools as GESCOME I)

3. Community implementation of micro-projects

4. Social mobilization and participatory community health communication (PCHC)

5. Round Tables

6. Policy dialogue

Training: EME members were the primary participants in training, since they carried out a major portion of the activities with communities. CGMP members also received training, in financial management and contracting, but were instructed on-the-job rather than through formal workshops. GESCOME II conducted training in the following topics:

- Diarrheal disease
- Problem identification (through PRA)
- Problem analysis (using PRA tools)
- Solution finding (using PRA tools)
- Community mobilization (during two workshops)
- Gender awareness
- PCHC, including development of community-based communication materials

Immediately after each training, the EME would use the skills it had learned to conduct the activity in the community.

Participatory rapid appraisal: These techniques (e.g., community transect, hope trees, decision trees, etc.) were used in the problem identification, problem analysis, and solution finding steps of the project. The community was involved in actually conducting the PRA with the EME, and it was the community that made all the decisions.

Community implementation of micro-projects: Each neighborhood identified, using PRA tools and techniques, their own local environmental health problems relating to transmission of diarrheal disease. Using other PRA tools during community meetings, neighborhoods prioritized these problems and decided how best to address them, including deciding which micro-projects they would like to build. The EME then developed the micro-project proposal, with community help, and submitted it to the CDSE. EHP II contributed 85% of the cost of building each micro-project, with the community contributing the remaining 15%. The CGMPs managed the funds and

contracted out the work. Micro-projects were self-sustaining through user fees. CGMPs collected the fees and maintained the infrastructure after the micro-project was complete. One neighborhood in Bembéréké was unable to contribute 15%. Consequently, it did not participate in micro-project implementation.

Social mobilization and participatory community health communication: EME members learned these skills through two workshops and used them to successfully invite people to and facilitate community meetings and to conduct participatory community health communication (PCHC) with "natural groups" in the community that they had identified. "Natural groups" are defined as socially meaningful groups that arise from within the community, rather than being imposed from the outside (i.e., a project-organized group is not a natural group). Natural groups may be formal (e.g., an age grade) or informal (e.g., neighboring women who have children under five years old). EMEs also learned that natural groups can be brought together to form coalitions. EMEs concentrated on natural groups that also had some epidemiologic relationship to preventing or transmitting diarrheal disease in young children.

Round Tables: The CDSE met in Round Tables six times during GESCOME II in order to supervise EME work and make policy decisions. The Round Table served to link the communities, the municipalities (through EME representation) and the departmental level. Perhaps the best example of this linkage is the urgent request, by all communities, to build grey water micro-projects, which EHP II did not have a mandate to fund. The CDSE, in a Round Table, learned of this local need and voted to seek funding elsewhere in order to respond to community needs.

Policy dialogue: GESCOME II worked with the Préfet and CDSE on institutionalizing the GESCOME structure so that the community environmental health activities and organization around environmental health could continue, even after the end of GESCOME II. In fact, the CDSE voted to request that the Préfet institutionalize the GESCOME structure, which the Préfet did by issuing a decree.

Results:

Result 1: EMEs actively participate in CESH/CIMEP

Indicators:

- *Community representatives for the EME in the new target intervention area of Sinendé will be selected within three months of activity start date*.GESCOME II began in September 1999. Sinendé had already begun selecting its EME members before the close of GESCOME I. By December 1999, all EME members from all new neighborhoods had been selected.

- *EMEs in all target municipalities will develop and implement a workplan. Throughout GESCOME II, EMEs prepared workplans to cover six-week periods.* All work plans were implemented and seldom required much amendment.

- ∉ *EMEs in all target municipalities will plan meetings and meet on a regular basis.* Throughout GESCOME II, EMEs met at least once a week and held at least two community meetings per week.

Result 2: Round Table meetings will continue, with the support of the Prefet, and will involve municipal support for environmental health issues.

Indicators:

- ∉ *Round Table meetings will be attended by regional officials from various sectors. All Round Table meetings were chaired by the Préfet.*

- ∉ *Departmental and municipal decision makers will implement action items identified at Round Table meetings.* The members of the CDSE definitely took ownership of the Round Table meetings. Their decisions included:

    1. The CDSE decided to add four community representatives to each neighborhood. This was implemented by all GESCOME II neighborhoods.

    2. The CDSE decided not to drop GESCOME I neighborhoods from GESCOME II. GESCOME I neighborhoods (except for Parakou) participated in the identification of risk factors/behaviors and environmental health needs for GESCOME II. They also participated in the participatory community health communication meetings.

    3. The CDSE decided to drop Parakou from all GESCOME II activities except for the Round Table after the third neighborhood did not attend meetings or training and the two-neighborhood EME was not able to complete the first step of discussion of problem identification and analysis. Parakou municipal leaders accepted the decision.

    4. The CDSE voted to institutionalize the GESCOME structure in departmental government (CGMPs, EMEs, CDSE, and Round Table). The Préfet subsequently issued a decree institutionalizing the structure.

Result 3: In each target intervention area/neighborhood, measurable changes will occur in behavior and environmental conditions directly related to diarrheal disease transmission.

Indicators:

- ∉ *In each target area, high-risk behaviors contributing to transmission of diarrheal disease will be identified.* EME members were trained to understand the transmission and prevention of diarrheal disease. Therefore, when EMEs and communities began their GESCOME II PRA activities, they were able to identify factors that placed children at risk of contracting diarrheal disease. Each EME, with the community, drew up a list of factors specific to their neighborhoods that contributed to diarrheal disease transmission.

- *Participatory methods will be used to develop and implement strategies for addressing the high-risk behaviors identified.* The community and EME used PRA methods to identify all types of factors that place children at risk for diarrheal disease. These factors were addressed through a PCHC. The assumptions upon which this method was based are the same as those in GESCOME II (see Section 1.3).

- *Neighborhood concerned citizens groups will monitor behaviors on a regular basis.* This indicator was not completed during GESCOME II because there was no time to monitor latrine use and concomitant hand washing because of the lateness of micro-project completion. However, EHP II will follow GESCOME II with a Lessons Learned exercise during which this indicator is expected to be achieved.

- *High-risk behaviors contributing to transmission of diarrheal disease decrease, as measured through qualitative studies.* Anecdotal evidence (i.e., Mr. Yallou's cursory examination of latrines upon his visits to the towns and in his discussions with EME members), suggests that latrine use--even in GESCOME I neighborhoods--has increased. Part of the Lessons Learned exercise will include focus group discussions held with members of the key natural groups identified by the EMEs, as well as individual interviews with latrine custodians and those who live in the vicinity of a GESCOME I or II latrine. This exercise should provide qualitative evidence of changes in actions that contribute to the transmission of diarrheal disease.

Result 4: In target intervention areas, stakeholders (local elected officials, NGOs and community members) will collaborate to address community problems.

Indicators:

- *Mechanisms will be established and used for regular interaction between EMEs and communities.* EMEs held twice weekly community meetings during GESCOME II. While a mechanism of regular community meetings was established during GESCOME I, at that time, everyone in the community was invited to attend by the town crier. This appeared to be an inclusive approach, but in fact, led to inefficient meetings in which those of lower status did not feel able to speak. GESCOME II training addressed issues of exclusion, gender role and status, and segmenting the community, as well as how to most effectively issue invitations to the community.

- *Mechanisms will be established and used for soliciting community input in local decision making.* Community meetings served as an effective mechanism for transmitting community perspectives to local governments, since representatives of several municipal-level ministries served on each EME and EME members facilitated the meetings. The EME representatives on the CDSE effectively advocated for their communities, giving community members a voice, albeit indirect, in local decision making. During GESCOME II's original design phase,

it was anticipated that decentralization of governance and decision making would have progressed much further than was in fact the case by the end of GESCOME II. Therefore, the ability of GESCOME II to help communities gain a voice in local decisions is limited simply because local decision making is still limited. However, both the CDSE and Préfet believe that the GESCOME structure will be an invaluable aid to local elected officials once the decentralization laws that have already been enacted are fully implemented..

- *Communities will contribute financially to micro-projects, contributing at least 15% of budget.* This indicator was met in all but one neighborhood (see section 3.4, *Financing*).

- *Revolving funds will be established to support maintenance costs for micro-projects.* GESCOME II did not meet this indicator. Neither Mr. Yallou nor Dr. Krieger had any experience with revolving funds. During Dr. Krieger's trip to Benin, in January-February 2000, she and Mr. Yallou asked all the USAID partners engaged in micro-finance whether they could provide assistance to implement revolving funds. Unfortunately, these projects also did not have the requisite expertise to help. GESCOME located a Beninois consulting firm specializing in micro-finance that was prepared to assist GESCOME. However, their proposed fees would have consumed a large share of the GESCOME budget.

Problems Encountered:

GESCOME II was able to resolve almost all the problems it encountered. However, several issues remained unresolved at the end of GESCOME II.

- **EMEs and CGMPs wished to be given some compensation for their work.** GESCOME I and II were designed as completely voluntary activities in order to be more easily sustainable after the end of the project and to encourage greater participation. Therefore, members of the EMEs and CGMP received no monetary compensation.

- **EME members complained about how much of their time was devoted to GESCOME II work.** Throughout the project, EME members met twice weekly with the community. Once micro-projects were initiated, they also supervised the CGMPs. EME members said that PCHC meetings took longer than simply messages. However, they did find that segmenting the community into natural groups greatly reduced the number of these meetings.

- **Occasionally, an EME member did not pull his or her weight and other EME members were saddled with more work.** When a member consistently did not attend EME meetings and did not assume his/her fair share of community work, the member was voted off the EME.

- **Since participation by EME, CGMP, and community members was completely voluntary, farming and politics sometimes came first; this meant**

that many project activities took longer than planned. This finding seems to be widely shared by other highly participatory community projects.

- **The inception of the project took longer than expected on the Washington side.** On the EHP II side, GESCOME II was not a continuation of GESCOME I; it was a new activity. Therefore, the CESH Benin Activity, GESCOME II, was part of the new project called EHP II. The EHP II implementation began slowly, as CESH and other components of the project had to first determine their focus and direction.

- **Some community members started negative rumors about CGMP members.** GESCOME II and the Préfet attempted to address this. To avoid such rumors in the future, steps should be taken to ensure even more financial transparency (e.g., periodic neighborhood meetings to update neighbors on exactly how the micro-project construction and maintenance funds are being spent, perhaps with special meetings immediately after particularly large expenditures).

- **It was very difficult to find consultants who were not government employees and NGO partners with the skills necessary to assist GESCOME.** U.S. government regulations prohibit government employees from being compensated for outside work. This rule resulted in EHP II being unable to find a suitable trainer in gender awareness and social mobilization. A workshop for NGOs held early in GESCOME II might have assisted both GESCOME II and NGOs to better fulfill partnership needs (see Section 5.3).

- **The pool of interested, able EME members with no financial constraints to participation in training of training was very restricted.** This led to a situation where the there were six fewer trained trainers than required (the project in fact only trained four trainers and they were trained during the first GESCOME II workshop in Sinendé, which was held during GESCOME I).

- **The distance of Beroubouay from Bembéréké proper led to adaptation of GESCOME regulations and their subsequent violation since there was sometimes a lack of communication between the Bembéréké portion of the EME (which included the coordinator) and Beroubouay.** As a result, Bembéréké/Beroubouay did not finish the first round of micro-projects during GESCOME II. However, by the end of the project, Bembéréké's latrines were at least 2/3 complete and were fully completed during the course of the Lessons Learned period.

- **Communities were upset about the narrow focus on diarrheal disease, which was not necessarily their priority.** This finding is related to a concern that is a major conundrum of in all development. Development projects must have very specific goals and indicators. In this case, EHP II intended to focus on diarrheal disease in order to make a public health impact. In the trade off between complete participation, in which communities would choose what public health or wider development problem they wanted to work on, and a completely top-down project

with targets (e.g., diarrheal disease reduced by 15% in children under five), GESCOME II took an intermediate ground. It focused on diarrheal disease with no targets or behavior identified by outsiders that communities must adopt in order for the project to be successful. In the future, a longer project time period and funds for an additional micro-project round would enable towns to complete a third micro-project on any environmental problem they wished (e.g., construction of gray water pits).

- **The labor demands of the agricultural season limited both community and EME involvement for weeks at a time.** During the design phase, the start-up time for GESCOME II was underestimated. Therefore steps for implementation, which had originally been synchronized with the demands of the agricultural calendar, no longer remained in sync with farming schedules, causing additional delays. GESCOME II has provided valuable lessons about the time that start up and each step actually takes.

Selected lessons learned:

Following is a partial list of lessons learned to date through GESCOME II. EHP II anticipates that the Lessons Learned exercise will reveal additional lessons.

1. A grass-roots participatory project can provide infrastructure to relatively large numbers of people in rural African towns.

2. Even with a participatory process, building infrastructure does not guarantee its use; in latrine construction, for example, the community's attention needs to be focused on the latrines through publicity and community discussion (PCHC).

3. A pay-per-use financing mechanism for potable water works., Pay-per-use water point sources are used extensively, as demonstrated by their ability to generate enough fees to cover the water bills and maintain the water point.

4. The GESCOME structure and CIMEP process effectively link the community/neighborhood with the municipal and departmental levels to support governmental decentralization.

5. The participatory process and structure of GESCOME, with decision making localized at the neighborhood and departmental levels, lent flexibility to the structure; communities were able to adapt the GESCOME structure to meet their local needs.

6. In using the GESCOME structure as a mechanism to support decentralization, care should be taken avoid giving EME members additional activities without removing some of the environmental health activities for which they are responsible.

7. EME members clearly believed that GESCOME II activities were important because while they were also involved in a number of other civil society activities

and development projects that compensated them for their time, they were willing to spend 14-24 hours per week on GESCOME II activities.

8. The means for collecting community contributions must be clearly spelled out and community members responsible for collecting and disbursing community funds must operate in a completely transparent manner.

9. A participatory project design with voluntary community implementors must be planned over a longer project period with a more relaxed pace than more directive designs.

10. A workshop for NGOs in proposal preparation and GESCOME II training needs and orientation might have helped GESCOME to more easily identify and incorporate NGOs and their skills to meet GESCOME's administrative and technical needs.

11. For the GESCOME process to succeed, there must be political will at the municipal level, strong political support at the departmental level, and community members willing to participate as EME members, CGMP members, and community contributors.

12. The cost of maintaining one EME's routine activities (i.e., community meetings, EME meetings, and correspondence) is equivalent to US$ 50 per month. The cost per year to maintain all three GESCOME II EMEs is US$ 1,800.

13. The CDSE will continue to require some funding in order to meet in Round Tables.

14. Training will be important to support the EMEs after the end of the project. EME members viewed training as a major benefit and as a kind of compensation for their work. In addition, new members will inevitably join the EMEs due to natural attrition. These new members will require training.

15. The cost of each three-day training workshop averages about US$ 3,000 per town or US$ 9,000 for one round of training in all three towns. With the expanded EME size, only one town may be trained at a time.

16. Two additional trips by the Activity Manager to Borgou/Alibori were needed during the project, especially during the final training of GESCOME II, and to follow up on decisions made during the trip of Drs. Borrazzo and Krieger. These trips would also have helped identify and resolve areas of miscommunication.

17. EHP country directors/activity coordinators need periodic face-to-face contact with EHP II activity managers to provide technical assistance and useful communication and feedback.

18. In the future, entire towns should be included in the GESCOME process, rather than incorporating towns in groups of three neighborhoods at a time. This would ensure parity in each town and save costs in training.

19. A larger, more inclusive EME worked well.

20. Mechanisms should be formally agreed upon by the CDSE and EMEs to handle situations where one or more EME members does not pull his/her weight.

21. USAID/Benin's flexibility in overseeing the project and its recognition that a truly participatory process takes time enabled GESCOME II to support USAID/Benin's 1999 Democracy and Governance Special Objective: "Improved Governance and Reinforced Democracy" and IR3.1: "Increased local community access to financial and technology resources to support local initiatives." However, GESCOME II may not have been expected to contribute to this indicator. At the time of this writing, communities had the technology, via micro-projects, as a result of a local initiative and the resources, via local usage payments, to maintain the resources. Continuing PCHC meetings may help maintain local interest in continuing these interventions.

22. USAID/Benin's wisdom in refraining from requiring targets for reduction of diarrheal disease enabled the project to attempt new strategies in health communication for diarrheal disease prevention. Such strategies may be more time consuming than more directive models, but they may, in the end, ensure community-wide, enduring changes in behavior.

Next Steps:

The planned Lessons Learned activity, to begin immediately after the conclusion of GESCOME II, will seek to assess the sustainability of GESCOME and garner lessons for future projects. In addition, continued implementation and bridging to the new USAID project suggest several next steps:

1. To maintain the link between community/neighborhood, municipal, and departmental levels, the CDSE should continue meeting in Round Tables in the various towns and include discussions with CGMPs and other EME members in their meetings.

2. To better bridge between GESCOME II and the new USAID democracy and governance project, Mr. Yallou should be retained through EHP II or another mechanism. This will help ensure that GESCOME structures and communities are prepared for upcoming USAID project activities.

3. EMEs are scheduled to resume participatory health communication meetings after the latrine monitoring is completed during the Lessons Learned period. If possible, Mr. Yallou should follow up on these meetings after the Lessons Learned exercise to maintain project momentum.

4. Someone experienced in GESCOME should be given responsibility for ensuring that GESCOME continues even after the end of the project. S/he should have the ability to devote a significant amount of time to coordinating GESCOME in Borgou and Alibori Departments. This person might be designated by the Préfet and be part of the Department administration or could be a contractor hired through a donor. S/he could also assist the Préfet in scaling-up GESCOME to the other towns in the two Departments, something the Préfet has already indicated he would like to do.

5. If community latrine monitoring appears to be useful and viable, communities may wish to undertake this monitoring for two to three weeks twice a year, especially during a drier season. In that way they could better determine whether and how community members wash their hands after defecation in order to better monitor the use and utility of their latrine micro-projects.

6. Eventually, communities may wish to track cases of diarrhea in young children to understand the outcome of latrine use, handwashing, and safer food storage and water handling. If EME members find that caregivers take young children with diarrhea to health facilities, EME members could be trained in collecting and tabulating health facility statistics. They would share the results in community meetings. If caregivers frequently resort to traditional healers for children's diarrhea, perhaps it would be possible to collect statistics on the number of cases from the most popular healers

7. The GESCOME process seems to work well in Banikoara, Bembéréké, and Sinendé. By incorporating all the neighborhoods in each town simultaneously, the project design, process, and GESCOME structures, could be extended, perhaps in two or more waves, to all of Borgou/Alibori and beyond.

8. A survey should be undertaken to evaluate the epidemiologic impact of GESCOME. The survey should be accompanied by brief ethnographic research in order to understand the processes that led to any epidemiologic changes.

9. At or shortly before the inception of the next project, training of trainers workshops should be held to train those already trained, as well as additional trainers.

MAP OF BENIN


BENIN
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0 70 mi
0 70 km
BURKINA FASO
NIGER
Malanville
Banikoara
Kandi
Tanguiéta
Béroubouay
Natitingou
Bembéréké
Nikki
Djougou
Ndali
Parakou
Kainji Reservoir
NIGERIA
Niger R.
Bassila
Tchaourou
TOGO
Kilibo
Pira
CÔTE D'IVOIRE
Savalou
Savé
GHANA
Dassa
Kétou
Abomey
Bohicon
Pobé
Allada
Sakété
Athiémé
Lake Volta
Cotonou
Porto-Novo
Volta R.
Gulf of Guinea
10° N
8° N
6° N
2° W
0°
2° E
4° E
6° E

Abbreviations

AGEFIB	*Agence de Gestion et de Financement à la Base* (Agency for Grass-roots Financial Management)
Alibori	The new department (or prefecture) formed when Borgou Department was divided in two as part of decentralization effort; it currently exists only on paper
Borgou	The department (or prefecture) in northern Benin in which GESCOME I and II were located
Chef de Quartier	The elected Head of the Quarter or neighborhood, a traditional administrative office with responsibilities to the government
Conseil Consultatif	Consultative Council, to be elected under decentralization plans
CDSE	*Comité Départemental de la Santé Environnementale* (Departmental Environmental Health Committee)
CESH	Community-based Environmental Sanitation and Hygiene. GESCOME II was the initial project activity under EHP II's CESH program. The strategy of CESH is to focus on diarrheal disease reduction through community-based interventions.
CGMP	*Comité de Gestion des Microprojets* (Micro-project Management Committee)
CIMEP	Community Involvement in the Management of Environmental Pollution
COGEC	*Comité de Gestion du Centre de Santé Communautaire* (Community Health Center Management Committee)
CREPA	*Centre de Reseau pour l'Eau Potable et L'Assainissement à Faible Coût* (Center for Potable Water and Low-Cost Sanitation)
DDS	*Directeur Départemental de la Santé Publique* (Departemental Director of Public Health)
DHAB	*Direction Nationale de l'Hygiène et de l'Assainissement de Base of the Ministry of Health* (National Hygiene and Community Sanitation Directorate)
DHS	Demographic and Health Survey (in this report, refers to the 1996 Benin survey)
EHP	Environmental Health Project
EME	*Équipe Municipale Élargie* (Expanded Municipal Team)
FHT	Family Health Team

GDP	Gross domestic product
GESCOME	*Gestion Communautaire de la Santé Environnementale* (Community Management of Environmental Health)
Groupement	Village Agricultural Cooperative
Villageois Agricole	
GTZ	*Deutsche Gesellschaft für Technische Zusammenarbeit* (German Agency for Technical Cooperation)
Maire	Mayor
MCDI	Medical Care Development, Inc.
MOU	Memo of Understanding
NGO	Non-governmental organization
PADEB	*Projet D'appui au Développement de L'Elevage dans le Borgou* (Support Project in Animal Husbandry in the Borgou)
PAMR	*Projet D'appui au Monde Rural* (Support Project for the Rural World)
PCHC	Participatory community health communication
PHAST	Participatory Hygiene and Sanitation Transformation (a participatory, community-based approach to water, sanitation, and hygiene developed by the World Health Organization)
PRA	Participatory rapid appraisal
Préfet	Prefect
PROSAF	*Programme Integrée pour la Promotion de la Santé Familiale au Borgou* (Integrated Program for the Promotion of Family Health in Borgou)
quartier	Quarter or neighborhood
SBEE	*Société Béninoise d'Electricité et l'Eau*, the national, state-owned water company
SNV	Netherlands Development Organization governance project that recently began working with local associations, employing a similar experiential learning and participatory methodology
Sous-préfet	Sub-prefect
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

1. Background and History

Introduction

The purpose of this report is to describe the background, history, goals, implementation, problems, lessons learned, and next steps of the Environmental Health Project II (EHP II) Community-based Environmental Sanitation and Hygiene (CESH) Benin Activity. The Environmental Health Project (EHP) is a United States Agency for International Development (USAID) funded global health project. This report will provide a sufficient level of detail so that others in Benin or in EHP II can replicate this activity in whole or in part, while at the same time, avoiding some of the pitfalls encountered. A second goal of the report is to provide a context for the decisions, actions, and timing of GESCOME II.

Chapter 1 contains a short background section followed by a brief history of the activity. The history includes information of the earlier activity under GESCOME I and the key assumptions underlying GESCOME II implementation. Chapter 2 places GESCOME II in the context of USAID/Benin's strategic objectives at the time the project was designed, as well in the context of the portion of EHP II, Community-Based Environmental Sanitation and Hygiene (CESH), whose goals GESCOME II elaborates upon and helps to achieve. Chapter 3 presents GESCOME II activities. The first four sections and the sixth section of Chapter 3 present activities by activity category. The fifth section addresses community-level activities in some detail by town. Readers whose interests are better served by a less detailed examination of the activities may wish to skip Sections 3.5.1–Sections 3.5.6. Chapter 4 addresses how GESCOME II met the results and indicators required under the USAID scope of work (see Annex 1 for USAID Scope of Work). In addition to the indicators, USAID requested that EHP II carry out certain tasks. These are also addressed in Chapter 4. In addition, Chapter 4 explores results achieved by GESCOME II (including some that were not anticipated) that are not included in the indicators. The chapter also discusses problems encountered and how these were addressed. Finally, Chapter 5 looks at lessons learned and next steps with the conclusion of GESCOME II.[1]

1.1. Country Background

Benin, formerly Dahomey, is bordered by Nigeria to the east, Togo and Burkina Faso to the west, Niger to the north, and the Atlantic Ocean to the south. The population of

[1] Although the Benin CESH Activity is properly an activity under EHP II, those involved in the activity in Benin and the United States referred to it as a project. Therefore, the words "project" and "activity" will be used interchangeably in this report to refer to the CESH Benin Activity.

the country was estimated at 6,395,919 in July 2000, with an estimated growth rate of 3.3%. In 2000, the crude birth rate was estimated at 44.81/1,000 and the crude death rate at 14.51/1,000. Life expectancy at birth was estimated at 51.16 years for females and 49.24 years for males, yielding a total population life expectancy of 50.18 years. The total fertility rate was estimated at 6.32, which, while high, is by no means the world's highest. Literacy was estimated at 25.8% for women and 48.7% for men.[2]

The 1996 Demographic and Health Survey (DHS) reported that 50% of the population had access to biomedical health services, but only about 20% of the population actually used them. The DHS asked mothers to recall whether their children of 0–3 years of age had had diarrhea during the previous two weeks. In Borgou, 28.1% of the mothers reported a diarrheal episode.[3] It is estimated that only about 19% of Beninois households have a latrine and only 56% have access to clean water.

Table 1. The Projected Populations of the Towns in Which Gescome Worked[4]:

Banikoara	23,000
Bembereke + Beroubouay (GESCOME II treated these as one town)	33,000
Sinende	22,000
Parakou:	
Oueze	3,000
Zongo-Zenon	5,000
Banikani (estimated**)**	4,000
Total	**90,000**

Economic development in Benin depends largely upon services and agriculture. The 1999 GDP per capita was estimated by the United States government at US$ 1,300. Services accounted for 51% of the GDP in 1997, agriculture 34%, and industry 14%. Agricultural products include corn, sorghum, cassava, yams, beans, rice, cotton, palm oil, peanuts, poultry, and livestock.

When last measured in 1997, electronic communication was relatively scarce. Less than one percent of the population owned televisions with an estimated 60,000

[2] All population and economic information is based on the CIA World Fact Book 2000, unless otherwise indicated.

[3] It is unclear whether the concept of diarrhea was understood similarly by those who designed the DHS and those who answered its questions.

[4] These figures were calculated by Dr. Eckhard Kleinau, EHP II Technical Director, based on a population growth rate derived from the difference between the *Deuxieme Recensement Général de la Population et de l'Habitation Février 1992* 1993:13-16) and the 1979 census. The formula used was supplied by the United States Bureau of the Census.

televisions in Benin. Less than 10% of the population owned radios with an estimated 620,000 radios in Benin. These statistics, taken in the context of Benin's low literacy rate, makes mass communication difficult. However, Benin's high fertility rate means that much of the population is under the age of 15 and possibly too young to own a television or radio, which may make television and especially radio ownership appear to be less prevalent than these figures might indicate. Figures for access to radio or television were not readily available.

At the initiation of the Environmental Health Project II CESH Benin activity (GESCOME II or *Gestion Communautaire de la Santé Environnementale:* Community Management of Environmental Health), Benin was divided into six departments, or prefectures. Benin is in the process of decentralizing its government structure, with concomitant shifts in power. There are now officially 12 departments, the number doubled by dividing each department in two. Each department is still headed by a prefect (*préfet*) appointed by the national government. Departments are divided into sub-prefectures headed by a sub-prefect (*sous-préfet*) appointed by the national government. Each sub-prefecture is centered around a town or city and includes the surrounding rural areas. Towns are further divided into quarters (*quartiers*), which are similar to neighborhoods and which are headed by an elected head of the quarter (*Chef de quartier).*

Borgou, where EHP has worked, is a large department in the north of the country (see map, p.xvii) divided into 14 sub-prefectures. Borgou was chosen in 1998 as the primary locus of USAID development assistance to Benin. During the course of the project, Borgou Department was officially divided into Borgou and Alibori Departments. This official division does seem to have been implemented.

Decentralization will eventually result in much more power for elected municipal officials and much less power for *préfets*. Each municipality, whether town/city or village, will elect its own mayor (*maire*); financial control and governing powers will be largely in the hands of the *maire*. Currently, mayors are elected but have relatively little power. Under the new system, mayors will not be elected by direct plebiscite. A *conseil consultatif* (consultative council) will be elected by the citizens of each *quartier*. The *conseils consultatifs* will, in turn, elect the mayor from among one of their own members. The office of *sous-préfet* will be abolished. The *préfet'*s responsibilities will lie primarily in coordination among the municipalities and liaison between the municipalities in the department and the national government. *Préfets* will continue to be appointed by the national government, but will control far fewer financial and human resources.

At the conclusion of GESCOME II, it remained unclear when the planned decentralization would be implemented, even though the necessary legislation had been enacted and elections were scheduled for December 2002.

1.2. Gestion Communautaire de la Santé Environnementale I (GESCOME I)

Both GESCOME I and II were USAID bilaterally-funded activities. GESCOME I began in March 1997, when May Yacoob, Ph.D., EHP I Technical Director, Community Participation, toured Benin to choose appropriate sites for EHP I participatory interventions to prevent diarrheal disease. In August 1997, EHP I staff along with a consultant, Habib Khanfir, selected three towns in the Department of Borgou for participatory interventions. The criteria for town selection were: presence of environmental risk factors; potential for mobilizing human and financial resources; prevalence of specific diseases; and socio-economic factors, such as community cohesiveness and homogeneity.

The towns chosen for EHP I were Banikoara, Bembéréké, and Parakou. The first two are rural towns, while Parakou is a more cosmopolitan town and the seat of government of the department. Three neighborhoods (*quartiers*) were selected in each town. At the end of GESCOME I, a fourth town, Sinendé, was selected for future work and three neighborhoods were chosen for inclusion in GESCOME II.

In October 1997, GESCOME was officially launched by the signing of a protocol between the United States Agency for International Development (USAID)/Benin and the Department of Borgou. Representatives of all the stakeholder groups—communities, NGOs, other projects, donors, and local, departmental, and national levels of public administration—attended the start-up workshop.

GESCOME I was based on an approach, Community Involvement in the Management of Environmental Pollution (CIMEP), developed by Dr. Yacoob under EHP I (see The Environmental Health Project's brochure, "Building Community Partnerships for Change: The CIMEP Approach"). This participatory approach unites three levels of political and social structure: community members; members of the sub-prefecture government, and NGO members; and members of the departmental (prefecture) government. The objective of its application in Benin was two-fold:

- To improve environmental health, particularly through prevention of diarrheal disease in children.

- To facilitate decentralization—by increasing government participation and awareness of community affairs and by establishing linkages between neighborhoods, municipalities, and prefecture levels of government.

A meeting was held during the course of GESCOME I to link CIMEP to national government structures. However, GESCOME I was never able to forge a strong link between national and local levels (Yacoob et al. 1999).

The CIMEP approach used in GESCOME I was based on the formation in each municipality of an EME (*Équipe Municipale Élargie,* or Extended Municipal Team).

At the departmental level, the activity worked with the government to create the CDSE (*Comité Départmental de Santé Environnemental,* or Departmental Environmental Health Committee). A CGMP (*Comité de Gestion des Microprojets* or Micro-project Management Committee) was elected by each project *quartier*. GESCOME II continued and built upon this approach.

The CDSE was a policy-making group at the departmental (prefecture) level, and also advised, monitored, supervised, and supported the EMEs. It was chaired by the *préfet* and contained department heads of Health, Environment, Planning, and Social Affairs, as well as the *sous-préfets* of GESCOME sub-prefectures, *maire*s (mayors) of the municipalities in which the project worked, and the elected leader of each EME. CDSE meetings were called "Round Tables" and were supported through GESCOME funds. The CDSE structure, membership, and financing arrangement were, at the outset, maintained in GESCOME II.

The membership of the CDSE linked the departmental-level government to the municipal-level government. Since the Préfet and all the ministry heads at the departmental level report to the national government, the CDSE also had the opportunity to connect the department to the national level. The CDSE, at the same time, tied the department-level to both the municipal and community (neighborhood) levels because municipal team activities ultimately occurred at the neighborhood level, and the EME team coordinators reported about neighborhood issues and concerns to the CDSE.

Under EHP I, each EME was composed of seven members: three elected neighborhood representatives—one from each participating *quartier* (neighborhood*)* in the town; one representative from an NGO working in the town; and one representative from each of the sub-prefecture government departments of health, environment, and administration. The *sous-préfet* served as the non-voting chair, but the EME also elected a leader from among its members. The membership was expanded under GESCOME II (see Section 3.1).

In the CIMEP approach, the task of each EME was to learn about and then help the community use techniques of participatory rapid appraisal to assist in identifying their environmental health problems, prioritize them and determine how to solve them including developing micro-projects proposals. EMEs supervised neighborhood micro-project management committees and represented their neighborhood concerns to the departmental committee.

Each CGMP consisted of thee members elected by the residents of their neighborhood or *quartier,* with the help of the EME representatives of the neighborhood. The CGMP function was to oversee and manage the implementation of micro-projects. Under GESCOME I and II, a single "micro-project" was defined as the infrastructure built in a single neighborhood during one specific funding and construction round to address a single community-identified environmental health problem. For example, the three latrines constructed in a neighborhood (*quartier)* of Sinendé to address open-air defecation during the first micro-project round are

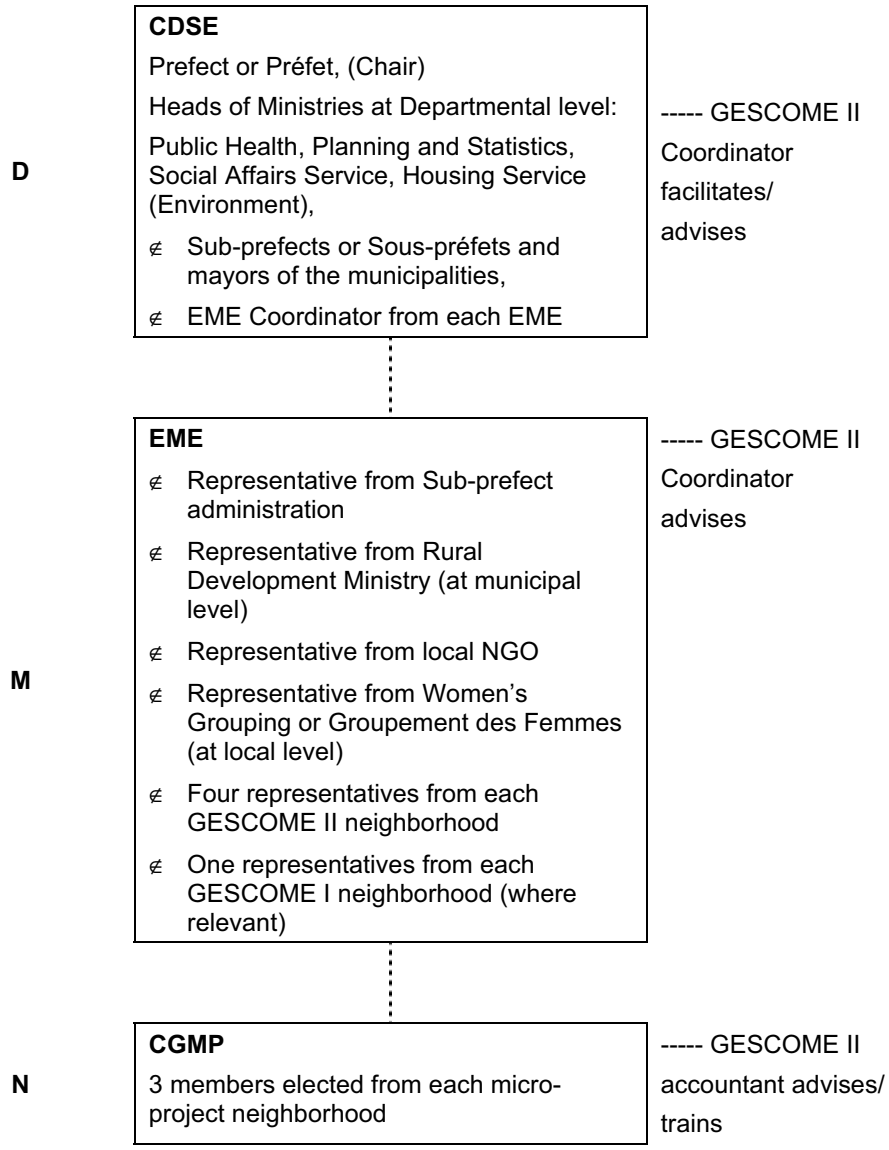
considered a single micro-project. GESCOME I micro-projects included infrastructure such as latrines, gray water pits, cement culverts for drainage, and a market shelter.

The CGMP selected the workers to build the infrastructure, oversaw the work, and managed the micro-project grant funds from GESCOME and community contributions (communities paid 15% of the cost; USAID, through EHP II, paid the remaining 85%). CGMPs were also responsible for seeing that the infrastructure was maintained and managing the funds for its operation. CGMP members received on-the-job training in financial management from the GESCOME I consulting accountant.

The CGMP structure, its function, responsibilities, and training content and mechanisms were maintained under GESCOME II (see GESCOME II Organogram on the following page).

GESCOME I had six phases: (1) problem identification; (2) problem analysis; (3) solution development; (4) micro-project planning; (5) micro-project implementation; and (6) evaluation. EME members were trained in participatory methods of problem identification, problem analysis, and solution finding with the community. The project was evaluated by an outside evaluator, as well as by the CDSE (for further details on GESCOME I and the final evaluation, see Yacoob et al. 1999; for a general version upon which the GESCOME I EME training curricula was based and used in slightly modified form in GESCOME II, see Frelick et al. 1999). GESCOME II included nearly all these steps, as well as additional phases.

By the end of GESCOME I, its six phases had been completed by three neighborhoods each in Parakou, Banikoara, and Bembéréké. All neighborhoods had completed two rounds of micro-projects, except for one neighborhood in Parakou that was only able to complete one round of micro-projects (Yacoob et al. 1999:28-32). In addition, GESCOME I completed an epidemiologic baseline survey in those neighborhoods in the three towns where it operated. An additional result was the establishment of the GESCOME I structure (CDSE, EMEs, CGMPs) to facilitate decentralization. However, by the end of GESCOME I, the structure had not yet been formalized by the departmental government.



GESCOME II Organogram

D=department level

M=municipality, or town, level

N=neighborhood level

GESCOME I made the assumption that

> Disease prevention best comes from local knowledge that is integrated with a baseline assessment of behavioral and environmental risk factors [*through participatory rapid appraisal (PRA)*]. Achieving disease prevention is the responsibility of many different ministries working in partnership with community stakeholders. It requires policymakers from health, public works, environment and local governments working in partnership with the private sector, traditional leaders, and local NGOs to address identified risk factors and then provide the appropriate infrastructure improvements and behavior change interventions. (Yacoob et al. 1999:7).

GESCOME I did not seem to incorporate behavior change interventions. Its underlying, unstated assumption seemed to be that presenting communities with information derived from PRA and an epidemiological survey would induce social change, resulting in decreased incidence of disease.

1.3. Inception of GESCOME II

GESCOME II was designed by USAID/Benin to extend GESCOME I interventions to the rest of the neighborhoods of Banikoara, which has six *quartiers*, and Bembéréké, which has four *quartiers*, to three additional neighborhoods in Parakou, and to three neighborhoods in Sinendé, a town that was not included in GESCOME I (see map). Sinendé has five *quartiers.* Since GESCOME I had already worked in three of Bembéréké's four neighborhoods, the CDSE and EME decided to choose a suburb of Bembéréké, Beroubouay, located about 37 km from Bembéréké and to include its two *quartiers* as part of Bembéréké. The division, at least on paper, of Borgou Department meant that Banikoara became technically part of Alibori Department. However, since the departmental division has not yet been implemented, this had no effect on the project.

From the inception of GESCOME II, there were problems with Parakou's participation (see Chapter 4). About mid-way through the activity, after many unsuccessful attempts to encourage interest and support in Parakou, the CDSE decided that Parakou would probably never adhere to the activity guidelines and could no longer meet the activity schedule. The CDSE, therefore, voted Parakou out of the activity, but retained a representative from Parakou on the CDSE. GESCOME II worked in the three remaining towns. All three towns had existing EMEs from GESCOME I because Mr. Yallou was able to start GESCOME II activities in Sinendé before the close of EHP I.

Responding to the desires of the EMEs, the CDSE voted at the start of GESCOME II to enlarge community representation on the EMEs to four members per neighborhood and to allow representatives of GESCOME I neighborhoods to remain on the EME in order to help to sustain interest in community participation in environmental health in the GESCOME I neighborhoods. Four representatives for each new neighborhood were selected by December 1999. Each GESCOME II EME contained about 20 members. With no "old" neighborhoods, Sinendé's EME had only 12 members.

At the close of GESCOME I, the CDSE and EMEs carried out an assessment of the project and identified some weaknesses. In January–February 2000, John Borrazzo, USAID Chief Technical Officer (CTO) for EHP II and USAID Population, Health and Nutrition liaison for Benin, and Laurie Krieger, Activity Manager for GESCOME II, and at the time also CESH Coordinator, traveled to Benin. They met with members of the USAID Family Health Team, as well as members of EMEs and CGMPs. After Dr. Borrazzo's departure, Dr. Krieger met with the CDSE (on January 27). Mr. Yallou, Drs. Borrazzo and Krieger, and EME, CGMP, and CDSE members identified additional weaknesses in GESCOME I. The CDSE also commented on the GESCOME II work plan and suggested ways to remedy any weaknesses.

Identified GESCOME I weaknesses included:

1. Insufficient focus on prevention of diarrheal disease

2. Insufficient emphasis on community mobilization skills

3. Lack of community health communication for hygiene

4. GESCOME structures not institutionalized (i.e., not formalized within the departmental government structure)

5. Insufficient links to community groups

6. EME members not able to continue training after the end of GESCOME I

7. Confusion regarding documentation of community contributions to micro-projects

The GESCOME II work plan was then revised to address these issues:

1. Diarrheal disease

    - Training for EME members in diarrheal disease transmission and prevention (see Annex 2 for diarrheal disease training module)

    - A community health communication component on prevention of diarrheal disease

    - Administrative decision to fund only those micro-projects that could reasonably be expected to have an impact on diarrheal disease transmission to young children.

2. Community mobilization

    - Training for EMEs in community mobilization skills (e.g., inviting the community to meetings (see Annex 3, *Centre de Reseau pour l'Eau Potable et L'Assainissement à Faible Coût*—Center for Potable Water and Low-Cost

Sanitation—curriculum), coalition building, segmenting the community into natural groups—curriculum not available)

- ∉ Follow up to training with supervision and on-the-job training by Mr. Yallou

- ∉ CDSE decision that each EME have at least two female members

3. Hygiene education

   - ∉ Training of EMEs in participatory community health education for diarrheal disease prevention (curriculum not available)

   - ∉ Training of EMEs in community-based materials development (curriculum not available)

   - ∉ Use of materials in participatory health communication with appropriate natural groups in the community (curriculum not available)

4. Institutionalization of GESCOME structure

   - ∉ Policy dialogue with CDSE and Préfet

5. Links to community groups

   - ∉ Inclusion of at least one representative of the local *groupement des femmes* in each EME and encouragement of COGEC members to join EME or attend training and activities

6. Training of trainers

   - ∉ Train at least one member of each EME to be a trainer.

The key assumptions underlying GESCOME II were similar in many ways to those of GESCOME I. GESCOME II activities and strategy were based on additional assumptions that do not appear in GESCOME I documents:

- ∉ Many of the actions that reduce diarrheal disease transmission are social actions (praxis); praxis resulting in reduced diarrheal disease transmission should be encouraged through insights derived from the social sciences, rather than individual behavioral psychology. For example, in Borgou, handwashing is easily observable, and hence public, at latrines and houses (people wash their hands outside their houses because there is no running water or sewerage in their homes). In addition, anyone near the community latrine or the route to the latrine can observe who uses the facility.

- ∉ Groups influence social behavior through shared meanings, understandings, expectations, ideal and behavioral norms (i.e., rules for what *ought* to be done and

rules for what *is* usually done, respectively), and coercion; meanings, understandings, and norms are not shared similarly by all group members.

- ∉ Traditionally, cultures in Borgou contained the possibility of many natural groups (e.g., age grades) accustomed to taking collective action.

- ∉ Community members, especially women, already know quite a bit about diarrhea in young children.

- ∉ Community member's knowledge may not necessarily correspond to public health knowledge.

- ∉ Assumed preeminence of the public health diarrheal disease model neither allows for community participation nor is likely to be very effective if people disagree with aspects of it—including the underlying assumptions of the biomedical model.

- ∉ Understandings can be negotiated between community members and EME members presenting the biomedical model to the community, especially since EME members may have been raised with the same or similar community models or knowledge of diarrheal disease.

- ∉ Social change that results in changes in what groups of people do collectively or on their own to prevent disease requires a carefully thought out strategy and series of deliberate actions.

- ∉ Abandonment of messages in favor of negotiated understandings, facilitated by photographs of community situations and actions, could stimulate both EME members and members of the community to explore more fully their understanding and actions regarding diarrheal disease transmission.

- ∉ In a truly participatory fashion, community groups would be able to decide whether or what they wished to do about preventing diarrheal disease.

- ∉ A group decision based on common understandings would be more likely to be implemented and would be more participatory than prescriptive messages aimed at a groups of individuals.

- ∉ Community groups would be likely to spread their understanding and decisions regarding action to members of other community groups, resulting in well recognized and sustainable processes of community/social change.

- ∉ Community change can lead to reduced transmission of diarrheal disease to young children.

2. The Place of GESCOME II in the Strategic Plan of USAID/Benin and CESH

2.1. The Place of GESCOME in the Program of USAID

The USAID mission in Cotonou designated Borgou prefecture as the focus of its programming efforts in 1998. By then, GESCOME I had already been working in Borgou for about a year. In 1999, USAID funded a large bilateral health project, PROSAF (*Programme Integrée pour la Promotion de la Santé Familiale en Borgou* or Integrated Program for the Promotion of Family Health in Borgou), to work on all aspects of family health throughout Borgou. PROSAF was also tasked with coordinating efforts among all the USAID-funded projects in Borgou. Another USAID-funded organization, MCDI, has been working in diarrheal disease prevention through school-based hygiene education and construction of latrines in schools.

Although primarily health projects, both GESCOME I and II also had democracy and governance objectives. GESCOME, with its focus on uniting different levels of government with the community, served as a mechanism for USAID to collaborate with the government and people of Benin on decentralization. The project elaborated mechanisms for participatory, democratic governance and encouraged intersectoral collaboration.

USAID expected to finalize a new democracy and governance results package in 2001 or early 2002 that would result in a new bilateral democracy and governance project, which would also have a health component. The USAID FHT envisioned that after the end of GESCOME II, its work would be folded into the new project.

GESCOME II was designed to contribute to the achievement of USAID/Benin's Family Health Strategic Objective Two: *"Increase the use of FP/MCH/STD/HIV services and prevention measures within a supportive policy environment"* as well as Intermediate Result 2.1 (IR 2.1): "*Improved Policy Environment."*

The 1999 Benin Results Review and Resource Request (R4) explained GESCOME's place in the Mission's strategic framework[5]:

> In addition to our more traditional policy-related activities, CIMEP, implemented by the Environmental Health Project, has focused on developing an enabling environment to address major public health problems that are associated with childhood diarrhea. The process to date has included building a departmental level administrative crosscutting team in Borgou, and community level teams in three towns in the region. These teams have identified community-based and household risk factors for diarrheal disease and developed and implemented intervention plans in the form of micro-projects. IEC linked the micro-projects to public health goals through the production and presentation of a video about transmission of diarrheal pathogens to children through improper hygiene, water and sanitation. The most impressive results achieved to date through this activity are actually related to its successful application of a community-based, participatory approach to problem solving. (USAID/Benin 1999)

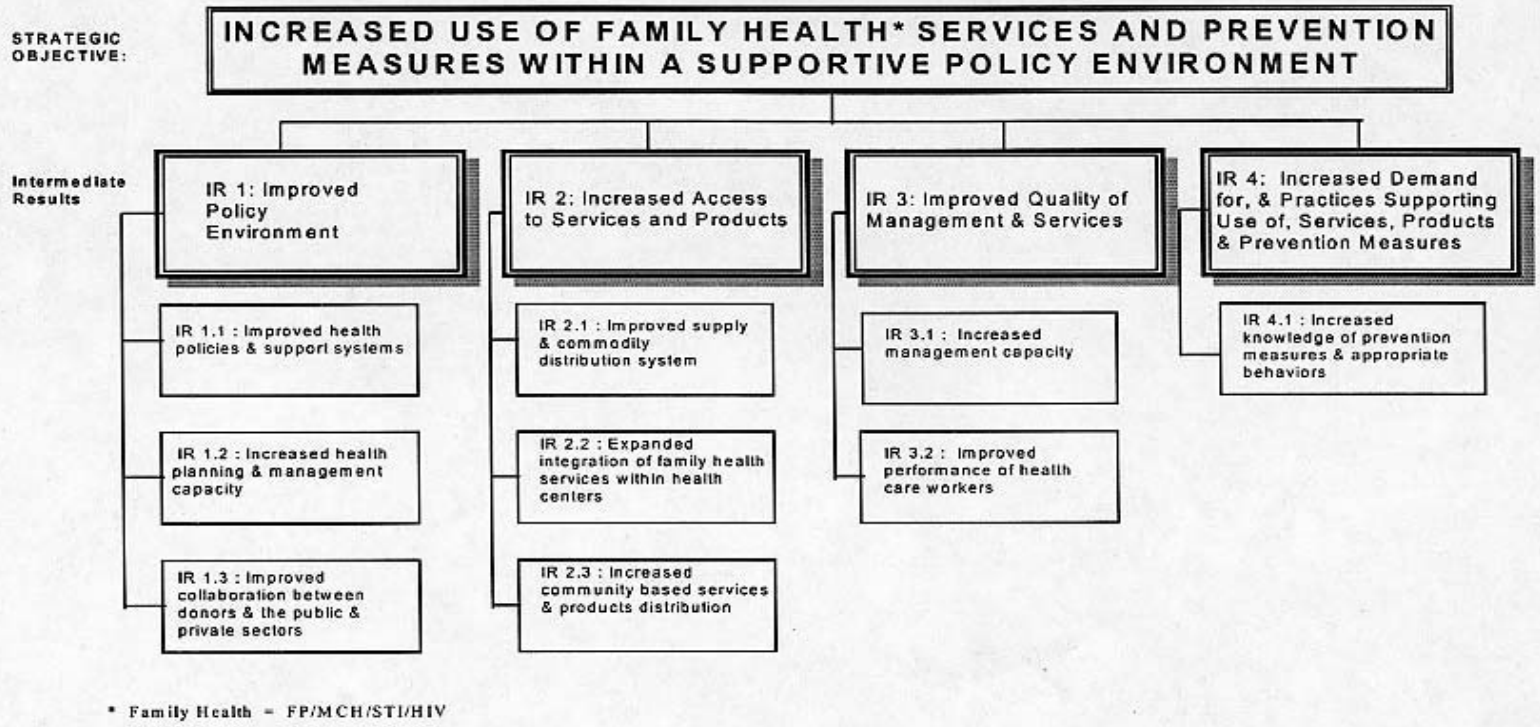
Although not mentioned in the R4, GESCOME II may also contribute to SO 2, IR 4: "*Increased demand for, and practices supporting use of, family health services, products, and prevention measures,*" since GESCOME II aims to provide communities with the means to prevent diarrheal disease in children under five years old. Similarly, the R4 does not explicitly mention the place of GESCOME II in the democracy and governance special objective: *"Improved governance and reinforce democracy."* However, GESCOME aims to contribute to IR 3: *"Improved environment for decentralized private and local initiatives,"* through locally managed and maintained micro-projects that are decided upon by the communities themselves, through a process that institutionalizes a structure linking neighborhoods to municipalities to departmental governments and through building capacity in communities for the production of community-based health materials.

In 1999, USAID/Benin had three strategic objectives, addressing family health, democracy and governance, and girls' education. Only the first two applied to GESCOME II. The 1999 USAID/Benin results frameworks for the family health and improved democracy and governance objectives follow.

[5] GESCOME II was known in English in Benin by the EHP I GESCOME I acronym CIMEP or Community Integrated Management of Environmental Pollution.

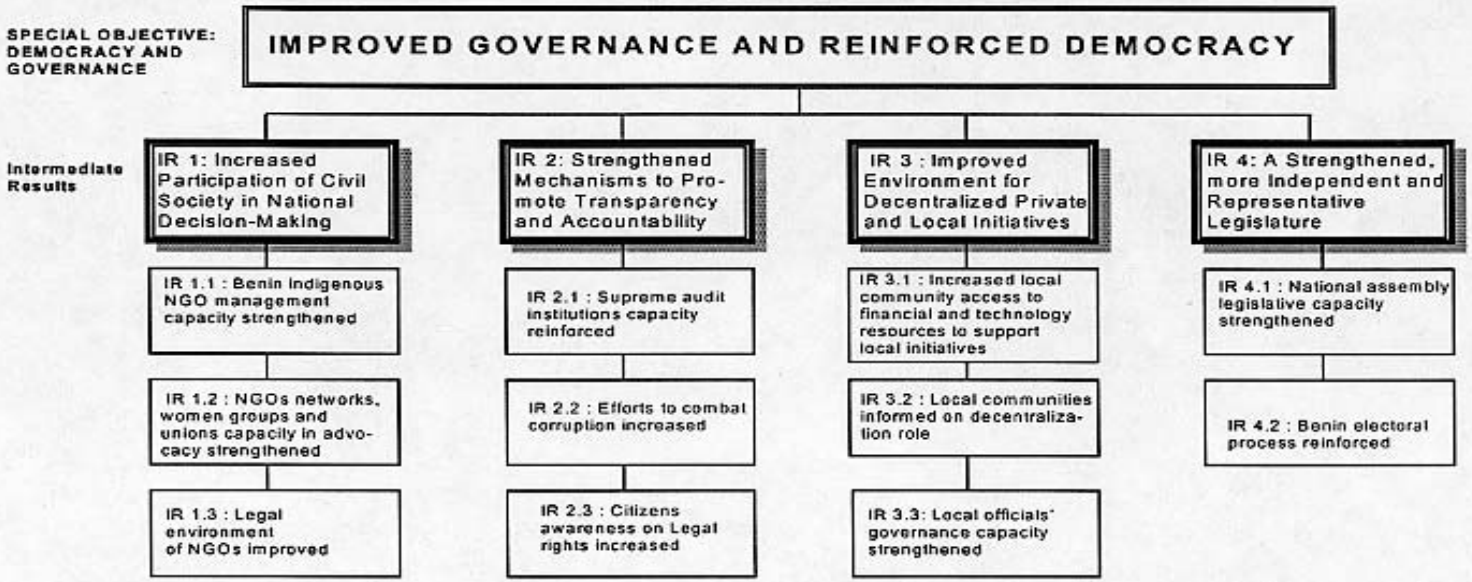
February 25, 1999

RESULTS FRAMEWORK FOR USAID/BENIN'S FAMILY HEALTH STRATEGIC OBJECTIVE



* Family Health = FP/MCH/STI/HIV

RESULTS FRAMEWORK FOR USAID/BENIN'S DEMOCRACY & GOVERNANCE SPECIAL OBJECTIVE



In addition, GESCOME II mainstreamed a gender aware approach, through gender training, integration of women's grouping into the project structure, and insistence on the inclusion of other community women in EMEs. Promotion of gender equity is part of an agency-wide USAID official guidance and is included in the Automated Directive System or ADS (USAID's official written guidance to employees on policies, operating procedures, and delegation of authority for conducting agency business). For example, ADS, dated November 29, 2000, (Chapter 303.5.5B), states, " … USAID policy requires that gender issues be addressed as appropriate; in all USAID-funded activities (see Mandatory Reference, USAID Policy Paper, 'Women in Development,' dated October 1982."

2.2. Community-based Environmental Sanitation and Hygiene (CESH)

EHP II officially began on June 21, 1999. However, the project was not fully staffed until the following September. Most importantly for GESCOME II, the CESH Coordinator, who was also the Activity Manager for GESCOME II, did not join the staff until September 1, 1999.

At the inception of EHP II, the project was divided into three task orders. Task Order One contained the great majority of project work. It was divided into two components: CESH and ECHO (Environmental Change and Health Outcomes). GESCOME II, officially "the Benin CESH Activity," was the initial country activity under CESH.

The strategy of CESH is to focus on diarrheal disease reduction through community-based interventions. The mechanisms to prevent diarrheal disease include improved access to hardware, together with hygiene promotion and the creation of enabling environments (see Annex 4 for a fuller discussion of GESCOME II's contribution to CESH).

GESCOME II supports CESH by creating field-tested training materials, tools (e.g., further refinement of the CIMEP process), community-based evaluation methods through the follow-on Lessons Learned activity, social mobilization skills for community organizing for environmental health, and participatory community health communication. In addition, GESCOME II has mainstreamed a gendered perspective and added assistance in attaining women's strategic needs through environmental health activities. However, no democracy and governance indicators were added for this component of the activity. [6]

[6] The first curriculum on social mobilization, developed by the local branch of a regional NGO *Centre de Reseau pour l'Eau Potable et L'Assainissement à Faible Coût (*Center for Potable Water and Low-Cost Sanitation), may be found in Annex 3. The second social mobilization curriculum includes gender awareness, segmentation of the community into natural groups, an introduction to coalition building, participatory community health communication, and developing community-based participatory health communication materials. It is described in section 3.5.6.

When GESCOME II was approximately 95% complete, a new CESH approach was approved. Annex 4 discusses how GESCOME II fits into this new CESH approach.

GESCOME II developed the following processes/tools to support CESH:

- A half-day diarrheal disease training module for use with EME members, also suitable for other audiences who are literate but have no medical backgrounds (e.g., it could be used to brief media representatives in a sensitization workshop)

- A modified diarrheal disease training module for use with community members

- A participatory process for presenting biomedical environmental health knowledge to the community, eliciting local knowledge and responses, and then community negotiation between the two perspectives to encourage social change in order to reduce diarrheal disease transmission (see Lessons Learned report)

- A tool to maximize the effectiveness and efficiency of community meetings, including:

  - A process for segmenting the community into socially meaningful groups that also have epidemiological relevance to the transmission of diarrheal disease (see Section 3.5.6)

  - A process for announcing and inviting community members to meetings (see Annex 3).

- A test of the CESH approach using a highly participatory EHP II activity concentrating exclusively on prevention of diarrheal disease in children, resulting in lessons learned (see Section 4.3 in this report and Lessons Learned report).

3. GESCOME II Activities

3.1. Focus and Activity Categories

The scope of work and indicators for GESCOME II reflect its design as a joint family health and democracy and governance project (see Section 4.1 and Annex 1, Scope of Work). GESCOME II attempted not only to fulfill the scope of work, but also to scale up the CIMEP approach and test additional CESH elements.

GESCOME II added the following additional elements to the GESCOME I (CIMEP) approach:

- Focused more narrowly on prevention of diarrheal disease in children
- Broadened membership of EMEs. Each included two additional community representatives from each quartier (i.e., four community representatives per neighborhood), as well as a member of the *Groupement des Femmes* (a national women's organization represented at the local level that was originally created by the state under a previous government, similar to a women's union and now functioning at the local level usually like economic self-help group), retained membership of the GESCOME I EMEs, and insisted that at least two members of each EME must be women
- Included participatory community health communication
- Focused on transmitting social mobilization skills to EME members
- Included gender awareness and mainstreaming gender in GESCOME II activities
- Emphasized policy dialogue at the local level to encourage sustainability

Activities fell into six categories:

1. Training
2. Participatory rapid appraisal (PRA) (using the same basic approach and tools as GESCOME I)
3. Community implementation of micro-projects
4. Social mobilization and participatory community health communication (PCHC)
5. Round Tables

6. Policy dialogue.

3.2. Training

During GESCOME II, each participating EME participated in six training workshops:

1. Diarrheal disease transmission and prevention (appended as an extension to the first participatory rapid appraisal workshops for each EME) (see curriculum in Annex 2)

2. Problem identification (Sinendé's EME had already participated in the workshop during GESCOME I, so this was not repeated for them)

3. Problem analysis

4. Solution finding and micro-project development

5. Community mobilization: inviting the community to attend and holding community meetings (provided through a subcontract with CREPA) (see Annex 3)

6. Gender awareness, social/community mobilization, participatory community health communication, development of community-based health communication materials (curriculum not available).

In GESCOME I, EME members from all three towns traveled to Parakou for training. Under GESCOME II, each EME received training in their own town in order to save money and time and to make the training and practice in the community more relevant.

Under GESCOME I, the EME members received training in the participatory rapid appraisal (PRA) techniques and community participatory decision making that are part of the EHP I CIMEP approach (see the EHP publication, "Building Community Partnerships for Change: the CIMEP Approach"). GESCOME II provided similar training. GESCOME II training in PRA techniques and the community decision-making approach served as a refresher for EME members who had been part of GESCOME I, allowing them to help the new neighborhood representatives and other new EME members. This mixture of experienced and neophyte trainees actually seemed to help rather than hinder training. As in GESCOME I, all training was highly participatory and skill-based. EME members learned skills immediately before they needed to use them so they could put their skills to use without any time lag between training and implementation.

During the morning, EME members participated in classroom training sessions. Then, each afternoon, EME members went into their community under the supervision of trainers and practiced the skills they had just learned that day. As part of the training

workshops, EME members developed six-week plans for implementing the activity that they were being trained to carry out.

Diarrheal Disease Transmission and Prevention: Under GESCOME I, EME members did not receive training in diarrheal disease. The EHP II CESH Benin Activity Manager perceived this as a weakness. EHP II, therefore, contracted with a consultant experienced in both Benin and diarrheal disease to design a curriculum to train EME members in diarrheal disease transmission and prevention. EHP consultant Sarah Fry developed a half-day training curriculum conducted in English. Salifou Yallou translated the curriculum into Bariba, a local language spoken by virtually all members of the EMEs, and Mr. Yallou also served as lead trainer. This curriculum was incorporated into each EME's initial training workshop during GESCOME II.

GESCOME (PRA) Training: In the GESCOME process, EME members participate in five-day training workshops in problem identification, problem analysis, and solution finding. These continued under GESCOME II (see Frelick et al. 1999 for curricula adapted from GESCOME I).

Problem identification:

Problem identification training included the following skills:

- Community walk, coupled with a discussion of the observed environmental health issues
- Community mapping
- Venn Diagram
- Detailed observations in specific areas
- Focus group discussions
- Listing and prioritizing the community's environmental health problems.

After the problem identification training, EMEs conducted eight weeks of problem identification with the community, through a series of community meetings to which all community members were invited. After helping communities identify the problems, EMEs were ready for problem analysis training.

All the members of the EME in Sinendé had participated in problem identification training and had conducted the problem identification phase (see Chapter 1, Section 1.2) near the end of GESCOME I in anticipation of GESCOME II. GESCOME II training in Sinendé, therefore, began with problem analysis. In Banikoara and Bembéréké, as well as Parakou, GESCOME II training began with problem identification.

Problem analysis: Training lasted five days and included the following topics:

- Diarrheal disease problem analysis using the "F-diagram" (see Section 3.5.2) community maps.

- Causality trees

- Hope (solution) trees

- Impacts of solutions on health and environmental issues.

After the workshop, EME members held a series of community meetings over the course of eight weeks during which they facilitated analysis of the problems by community members, using the techniques that they learned in the workshop.

This was the first workshop that the Sinendé EME attended, during which they also received the half-day training in diarrheal disease. The Sinendé EME was trained in problem identification during the same month as the other EMEs.

Solution finding and micro-project development: The five-day solution finding and micro-project elaboration workshop provided training and practice in the following topics:

- Objective tree development

- Expected outcomes

- Identification of activities to be undertaken for each outcome

- Resources necessary for each activity

- Planning of activities

- Micro-project budget

- Writing the plan of the micro-project.

Parakou did not receive this training, since the CDSE had voted Parakou out of the activity before the training took place.

After the workshop, the EMEs facilitated community solution finding, as well as listing and prioritizing micro-projects. This process also lasted eight weeks.

Community organizing: The *Centre de Réseau pour l'Eau Potable et L'Assainissement à Faible Coût* (CREPA), the local branch of a regional NGO, conducted a half-day training on community facilitation skills. They emphasized community meeting planning and how to successfully issue invitations to community members. They also provided on-the-job supervision of EME members in the use of their newly acquired competency. This half-day training was included as part of the solution finding and micro-project development workshop for Banikoara and

Bembéréké. It was given separately to Sinendé, which had already finished PRA process training well before the other towns (see Annex 3).

Gender awareness, social mobilization/community organizing, participatory community health communication, community-based materials development: This three-day training was designed to address the weaknesses in GESCOME I that became apparent during the participatory evaluation at its conclusion and the assessment made of the earlier activity at the beginning of GESCOME II. Training topics included:

- Gender awareness and its applicability to EME work with communities and within EMEs
- Segmenting the community for social mobilization, including identifying natural groups (i.e., socially meaningful groups indigenous to the community that are also epidemiologically meaningful for diarrheal disease transmission and prevention)
- Work planning for social mobilization
- Introduction to building community coalitions
- Participatory community health communication techniques
- Development and testing of community-based participatory communication materials.[7]

EME members had already worked in some of these areas—the training expanded upon and further honed their skills. Since EME members already had the PRA skills necessary to test materials with community members, the time necessary for that workshop was reduced.

Training of trainers: The scope of work for GESCOME II includes a training of trainers workshop near the end of the activity. It was anticipated by USAID/Benin that GESCOME II would serve as a bridging activity to a large democracy and governance/health project being developed by the Mission. However, at the end of GESCOME II, the RFA had not yet been released, so holding a training would have been appropriate. Since training should occur in close proximity to the time the newly acquired skills are used and since it is best to allow for a period of supervised practice before trainees are on their own, GESCOME II and the CTO at that time, Mr. Zinzindohoue, agreed that training of trainers could be accomplished differently.

[7] The curriculum is not available.

3.3. Participatory Rapid Appraisal and Community Meetings

EMEs conducted six weeks of problem identification in the community through a series of community meetings to which all community members were invited. During these meetings, the community learned and applied techniques of PRA to help them to identify their neighborhood's environmental health problems, particularly those relating to diarrheal disease.

Each round of meetings covered one of the topics. Each meeting led to the final goal of this stage: to identify and prioritize the neighborhood's environmental health problems, particularly those relating to the transmission of diarrheal disease to young children. Each step in the problem identification process formed the content of a round of community meetings. The steps in the problem identification process reflected the topics covered in training. The EME:

1. Operationalized the diarrheal disease module in the community, working with the community in meetings to identify the modes of transmission of diarrheal disease at both the community and household levels.

2. Conducted a community transect (neighborhood walk) with community members to identify the places and behavior that favor the transmission of diarrheal diseases in the community.

3. Together with community members, drew a neighborhood map, marking all the problem areas they observed.

4. Discussed the problem in greater depth with the people living in the most seriously affected problem areas and observed those areas more closely through a participant observation visit.

5. Facilitated the writing of the diarrheal disease history of the neighborhood by the community members themselves. The objective was to elicit from the senior community members and other resource people what had happened over time in the community/town relative to this health problem, including responses from the community, the administration, etc.. Community members learned for example when "modern" water sources were introduced and by whom.

6. Individually interviewed resource persons, e.g., nurses, the health administration or environmental municipal officers, to better understand some of the health problems.

7. Convened group discussions with community members affected by a problem and those who were believed to have caused it. The objective was to promote an atmosphere of problem solving and to seek, if possible, reach a community solution.

8. Through the CDSE's EME representative, used a Round Table to present the community's prioritized list of the problems that they had identified to the CDSE.

Environmental health problems identified using this method included:

Banikoara:

Open air defecation

Garbage management

Gray water management

Potable water shortage particularly in dry season

Bembéréké:

Open air defecation

Market hygiene

Garbage management

Water shortage in the dry season

Sinendé:

Open-air defecation

Children's practice of defecating behind their houses

Sharing living space with animals

Household garbage management

Garbage disposal areas

Gray water management

Although problems varied by town and perceived importance, open-air defecation, garbage management, and gray water disposal were problems shared by all three towns. Both men and women attended the meetings to help pinpoint the problems. However men spoke out much more frequently than women and more men attended.

All the PRA steps were carried out by community members who chose to attend community meetings called by the EME. All decisions made were by those community members. The EME's role was to train community members in the PRA tools and help in their use, facilitate meetings and discussion, and guide the process.

Conflict Resolution and GESCOME II Community Meetings

In one community meeting in Sinendé, residents of a neighborhood where garbage was being thrown into a common area in front of houses spoke out and confronted the offending neighbor garbage dumping. He was astonished, as he had no idea that his garbage was bothering anyone. The EME facilitated a positive discussion, resulting in the neighbor choosing a more appropriate site to dispose of his garbage.

Most neighborhoods initially did not choose latrines as their first priority micro-project. Most chose the construction of gray water pits (holding tanks for used water) because these (and the channels that lead to them) benefit the neighborhood in two specific ways; First, the dirt streets do not remain perpetually muddy and second, they diminish the amount of standing dirty water that is a breeding ground for nuisance mosquitoes, which may result in fewer mosquito bites.

So while the construction of gray water pits makes living more pleasant, and may possibly lead to a reduction in breeding grounds for mosquitoes that transmit filariasis and encephalitis, the pits probably do not contribute to the reduction of diarrheal disease in young children. Therefore, EHP II informed the neighborhoods that the project could not fund the pits as a first round micro-project. Initially, three rounds of micro-projects were planned, although the USAID GESCOME II SOW budget only included funds for the first round—12 micro-projects (i.e., four towns with three neighborhoods each). The CDSE dropped Parakou from eligibility for micro-project development and implementation (see Section 3.5.1). Two rounds of micro-projects were constructed in Banikoara and Sinendé and one round in Bembéréké. Bembéréké had not yet finished construction of its first round micro-project before the end of GESCOME II, so it did not qualify for funds for a second round of micro-projects.

3.4. Community Implementation of Micro-projects

Financing: After prioritizing their micro-project ideas using the hope trees generated during solution finding in community meetings, neighborhoods decided how they wanted to finance the micro-project. Each neighborhood was required to contribute 15% of the total cost of the micro-project. However, neighborhoods were free to choose the most appropriate way to raise the funds. GESCOME I allowed households to make in-kind contributions—for example, labor or construction materials—instead of paying in cash. However, GESCOME II insisted that in-kind contributions be calculated according to their cash equivalents and that the in-kind contributions be easily "visible." If for example, 14 hours of labor were agreed to be equivalent to a household's cash contribution, then the labor had to occur when the micro-project management team could verify the time worked. These two criteria responded to problems that arose during GESCOME I—i.e., in-kind contributions were not calculated according to their cash equivalents, and disputes arose over whether community members had actually fulfilled their in-kind contributions. GESCOME II neighborhoods themselves decided that in-kind contributions were a management nightmare and chose instead to limit contributions to cash only. Financing schemes were ultimately determined by discussion during the community meetings. The

following table summarizes the financing mechanisms chosen by GESCOME II neighborhoods.

Table 2. Mechanisms Chosen for Raising Neighborhood Contributions to Micro-project Construction

TOWN Neighborhood	Door-to-door + after cotton harvest	Only after cotton harvest
SINENDÉ		
Danrigourou	x	
Niaro Bariba	x	
Lemanou	x	
BANIKOARA		
Orou Gnonrou		x
Demanou		x
Gomparou		x
BEMBÉRÉKÉ/BEROUBOUAY		
Beroubouay Est	x	
Beroubouay Ouest	x	

CGMPs, mayors, and chef de quartiers, assisted by EME members, collected funds for all three rounds of micro-projects. One neighborhood in Bembéréké proper decided that they could not make the 15% contribution. The EME held numerous community meetings in the neighborhood, with the Sous-Préfet chairing one of these community meetings in order to put his weight behind GESCOME II. Finally, the development association of the town approached the neighborhood to try to convince the residents to participate. However, the neighborhood insisted that it could not afford the contribution, although the community very much wanted micro-projects. Ultimately, the neighborhood opted out of the micro-project but continued to participate fully in other portions of GESCOME II (e.g., community participatory health communication).

Micro-project Proposals: Once the community had identified its desired micro-projects and the requisite 15% contribution was made, the EME wrote a proposal to the CDSE describing the micro-project and its cost, requesting funds for its implementation. The CDSE then met in a Round Table to review the proposal.[8] It

[8] Round Tables were a feature of GESCOME I that was continued in GESCOME II. Round Tables were held when decisions had to be made or when it was necessary to oversee some aspect or issue surrounding the project. The Prefet always chaired the Round Tables. The CDSE took ownership of these meetings and included representatives of the departmental levels of the Ministries of Public Health, Planning and Statistics, Social Affaires Service, and Housing Service, sous-préfets and mayors of the municipalities, and the EME Coordinator from each EME. Salifou Yallou always attended Round Tables and assisted in their facilitation. However, the Round Tables ultimately were the responsibility of the Department and the Department maintained the list of participants.

could accept the proposal, reject it, or ask the EME to go back to the community and rework it. During the first round of micro-projects, the CDSE accepted five proposals as written and asked for modifications in three other proposals.

The CDSE chose to accept, without need for revision, all the second round micro-projects, with the exception of Bembéréké because it had not yet finished its first round micro-project. All the accepted second round micro-projects connected neighborhoods to the water company's connections and provided community multi-faucet water points, supplying potable water on a pay-per-use basis. The pay-per-use covered the cost of water, water use, maintenance of the multi-faucet water point, and connection rather than the cost of construction. In addition, one neighborhood renovated a well to reduce pollution and avoid possible catastrophes (i.e., put a cover on the well and built retaining walls so that animals and children could not wander into the well—see pictures in this section of renovated and unrenovated wells).

Table 3. CDSE Decisions on GESCOME II Micro-projects

TOWN	NEIGHBORHOOD	First Micro-Project[9]	Decision	Second Micro-Project[10]	Decision
Bembéréké	Beroubouay Est	3 blocs of latrine with 3 doors	Accepted	Not allowed to Submit proposal	NA
	Beroubouay West	3 blocs of latrines with 3 doors	Accepted	Not allowed to Submit proposal	NA
Banikoara	Orou Gnonrou	3 blocs of latrines with 2 doors	Add one door for children		Accepted
	Demanou	3 blocs of latrines with 2 doors	Add one door for children	Well renovation	Accepted
	Gomparou	3 blocs of with 2 doors	Add one door for children		Accepted
Sinendé	Danrigourou	3 blocs of latrines with 3 doors.	Accepted		Accepted
	Lemanou	3 blocs of latrines with 3 doors.	Accepted		Accepted
	Niaro Bariba	3 blocs of latrines with 3 doors.	Accepted		Accepted

[9] A description and illustrative photograph of the latrines follow in this section.

[10] A description of the second round micro-projects and illustrative photographs follow in this section.

Figure 1. Gescome II well renovation, Demanou, Banikoara

CGMPs: Prior to a proposal being written, each neighborhood chose the members of its three-person Comité de Gestion des Micro-projets (Micro-project Management Committee, or CGMP). The EME convened a neighborhood meeting where they explained the CGMP and asked for nominations from the community. At such neighborhood meetings, neighbors elected members of the CGMP. In both GESCOME I and II, members of all CGMPs were nominated and elected by the neighborhoods. The majority of CGMP members for latrine projects were men. However, water micro-project CGMPs were mostly women. While nearly all those elected to CGMPs had never held any official post previously, were illiterate and most had never been inside a bank, much less controlled a bank account, all were considered respected members of their communities.[11]

GESCOME hired an accountant to review the books of each CGMP at least twice monthly and to provide the CGMPs with on-the-job training. Once the micro-project proposal was accepted, the GESCOME consultant accountant visited all the neighborhoods and trained the CGMPs in financial management, contracting, and how to open and manage a bank account. CGMPs received additional assistance from EME members.

The responsibility of CGMPs did not end with the successful construction of the micro-projects. CGMPs were also responsible for management of the micro-project, seeing that micro-projects were maintained and continuing to collect and manage funds collected from users.

Water Users Committees: The neighborhood CGMP arranged for the election of a water users committee for each GESCOME II water source point. The electorate consisted of the adults of all the houses surrounding the new tap; water users committee members were chosen from among these neighbors. Literacy was not a criterion for committee membership. Water Users Committees have three duties: (1) pay the water bill; (2) ensure that the water source is always clean; and (3) collect users' fees on a pay-per-use basis (fees range from 10-25 CFA, depending on the size of the container the woman has used to collect her water.)

The CGMP and EME supervise Water Users' Committees. No committee had been elected during GESCOME II because construction of the water source points had not

[11] Most CGMP members were farmers. Other occupations represented by CGMP members included: welder, driver, goldsmiths, cattle trader, and a mechanic.

yet been completed. However, such elections were planned for the Lessons Learned period. Water Users Committees had been elected for GESCOME I water source points, as well as for those of other projects—although other projects did not use the CGMP mechanism for holding elections. Since other water projects have worked with the same model, many women have been trained in basic accounting. Those with accounting skills were being encouraged to take the lead in the Water Users Committees. Like the CGMP, Water Users Committees will continue to function regardless of whether GESCOME is still operational.

Construction of Micro-projects:

Latrines

The Direction Nationale l'Hygiène et de l'Assainissement de Base of the Ministry of Health (DHAB) designed GESCOME latrines after the models developed by UNICEF. Every project, including GESCOME, is required to comply with this latrine design. The latrine design chosen by DHAB is a double-pit, vented model. There are three doors: one each for women, men, and children. All stalls have child-sized holes so that children are not in danger of falling into the latrine in any of the stalls. All three holes lead to the same pit. When this pit is full, the other pit is opened. Either plastic or concrete vent pipes are used in GESCOME II latrines with an average diameter of about 20 cm. The pipes rise an average of one to two meters above the roofs of the latrines. DHAB trained at least five masons in each sub-prefecture throughout the country in the construction of these latrines. Thus, DHAB ensured that skills would be available to follow the design. Eight neighborhoods constructed a total of 24 three-door micro-project latrines during GESCOME II.

Table 4. Cost of Each Micro-project

TOWN Neighborhood	1st Round Micro-project: Latrines	Cost in FCFA 1st Round	2nd Round Micro-project: Potable Water	Cost in FCFA 2nd Round
Sinendé				
Danrigourou	3 blocks	1,925,870	5 water source points	1,309,195
Niaro Bariba	3 blocks	2,013,000	5 water source points	1,151,695
Lemanou	3 blocks	1,885,000	6 water source points	1,196,845
Banikoara				
Orou Gnonrou	2 blocks	1,638,700	3 water source points	1,523,222
Demanou	2 blocks	1,634,000	2 renovated wells, & 6 water source points	1,520,091
Gomparou	2 blocks	1,638,500	4 water source points	1,462,652
Bembéréké				
Beroubouay East	3 blocks	1,402,000	None	N.A.
Beroubouay West	3 blocks	1,402,000	None	N.A.

Water Distribution

In Benin, a state-owned water company, *Société Béninoise d'Electricité et l'Eau* (SBEE), distributes water. Connection requires paying the installation fees, which differ from area to area depending upon the difficulty of access. Each neighborhood micro-project built four to six single or double faucet water points scattered throughout the neighborhood. Banikoara constructed 15 new water point resources during GESCOME II, and Sinendé constructed 16 new water point resources. Banikoara also renovated one well. Each water point resource has one tap in Banikoara, with the exception of one two-tap water point resource. In Sinendé, each water point resource was built with two taps. Those who use the water pay per use. The revenues pay the water bills and maintain the multi-faucet water point areas.

Figure 2. Unrenovated well, Banikoara

Maintenance of Micro-projects:

Finances: CGMPs are responsible for collecting user fees and maintaining micro-projects. During the course of GESCOME I, methods for collecting user fees varied. At first, all latrines from GESCOME I were pay-per-use. During GESCOME II, some neighborhoods decided to shift to an annual assessment per household, paid out of the household's proceeds from the cotton harvest. The Village Agricultural Cooperative (*Groupement Villageois Agricole)* subtracts the sum from each household's share of the harvest proceeds before the families receive any money. Thus, the maintenance fees represent a sort of community tax. During the course of GESCOME II, a few neighborhoods also instituted this method of collection for GESCOME II latrines. Latrine monitoring data from the Lessons Learned exercise following GESCOME II may reveal whether latrine use is associated with any particular payment mechanism. In both GESCOME I and II, for those neighborhoods using a fee-per-use payment scheme, the cost per use is CFA 25 for an adult, with the exception of one neighborhood that charges 15 CFA per use. Use of the GESCOME latrine is always free for children: a rule instituted by EHP during GESCOME I and continued during GESCOME II.

Figure 3. A GESCOME I CGMP in front of their GESCOME I latrine

A CGMP-appointed custodian cares for latrines (see below). The custodian receives a salary, which may be paid as a percentage of user fees per month or per week. The custodian subtracts his payment from the user fees he receives and gives the CGMP the remaining funds to pay for the water fees (since all latrines are supposed to have a connection to the water source or get water from one of the micro-project multi-faucet water points), cleaning supplies, and soap for latrine users to wash their hands. No latrine supplies clean towels. During GESCOME II, Sinendé latrines were not yet connected to the water supply. Some neighborhoods arranged to buy water for the latrines. Other latrines went completely without water. However, all Sinendé water connections for latrines were completed during the Lessons Learned period.

Potable Water

Users pay 10-25 CFA per use of water, depending upon the volume of the water container. Either a neighbor, a member of the Water User Committee, or a CGMP member living next to the water source point collects the money. The funds are used to pay the water bill from SBEE; any funds that remain are used to maintain the water source point. Renovated well users pay no fees.

Table 5. Financing of GESCOME II Latrine Micro-project Recurring Costs

Location	Pay per Use	Date Initiated	Pay per year	Date Initiated
Bembéréké				
Beroubouay Est		October 2001		
Beroubouay West		October 2001		
Banikokara				
Orou Gnonrou	25 CFA	July 2001		
Demanou	25 CFA	July 2001		
Gomparou			500 CFA/household	2001
Sinendé				
Danrigourou	25 CFA	July 2001		
Lemanou			300 CFA/person	2001
Niaro Bariba	15 CFA	July 2001		

Responsibility: CGMP members ensure that all micro-projects are in working order and are kept clean. This is especially important for the latrines. The CGMP usually hires a neighborhood boy or young man who either needs the money or lives nearby to act as custodian and keeper of the latrine key and to clean the latrine at least once a day. For GESCOME I latrines, the custodian was often a disabled man, affording the community an opportunity to perform tow social services at the same time. The CGMP supervises the custodian and handles any problems.

Management Issues

During GESCOME II, CGMPs and EMEs held, on an as needed basis, frequent problem-solving sessions with Salifou Yallou, EHP II Benin Country Director. Sometimes Mr. Yallou called the meeting, but more often the meeting was called by the CGMP or EME. At CGMP problem-solving sessions, the EME and Mr. Yallou would help think through solutions to issues raised. The problem-solving meetings were highly participatory, informal brainstorming sessions. Mr. Yallou used the meetings not only to help solve problems, but also to gather the perspectives of EME and CGMP members, which he then relayed to the Activity Manager in Washington. In Sinendé, the CGMPs formalized the brainstorming session by agreeing to meet monthly as a group to exchange information, solve problems, take joint decisions, and provide mutual support.

Latrines are usually locked. Either the custodian sits near the latrine and keeps the key or the CGMP asks a neighbor to keep the key, in which case, users must ask for the key to use the latrine. By the rules of GESCOME II, which were instituted by EHP during GESCOME I, the doors to the children's latrines are kept unlocked at all times. In the case of one neighborhood, latrines are kept unlocked—some all the time, some only at night.

Figure 4. Gescome II Latrine, Gomparou, Banikoara

Repair of Micro-projects: An Integrated Learning Experience

During the early part of GESCOME II, a CGMP of Bembéréké had to make major repairs to a GESCOME I micro-project: a water point resource with several multi-faucet water points. The taps, located near the ground, were embedded in a concrete wall that was quite high. All the taps had been broken because women who collected water rested their full water containers on the taps as they sought to more easily raise the heavy containers from the ground onto their heads. The EME facilitated the collection of contributions, through a community-wide assessment, to repair the micro-project. In contracting for repairs, the CGMP practiced the contracting and supervision skills learned during the construction of the micro-project.

While the all-male CGMP and nearly all male EME blamed the ignorance of the women for the new micro-project's problems, it was clear that the women didn't know they shouldn't rest their water containers on the taps. EHP saw this as a learning opportunity, observing that this was a clear sign that community women were not fully integrated into GESCOME I decision making. Presumably, if women had more fully participated, they would have commented on the impracticality of the micro-project design in advance of its construction and subsequent problems. This indicated to EHP that GESCOME I community meetings had not been participatory enough.

Later in the project, GESCOME II responded by introducing gender awareness and community and social mobilization training. The Bembéréké EME came to understand that they had erred in their initial assessment of this GESCOME I micro-project usage problem and that the CGMP had in fact compounded the problem by fixing the taps, but not the basic design. The EME shared these new observations with the CGMP.

During their social mobilization training, this EME decided that mothers of young children were a natural group within the community, but one that did not feel empowered to speak out during general community meetings. Since the training, the EME has organized separate community meetings for various natural groupings of women and men. Such meetings allow women to speak their minds in community settings where only their peers and the EME are present. The meetings permit each group to openly discuss sanitation and hygiene issues that are most appropriate for them. Subsequently, all GESCOME II water source points were constructed with structures placed lower in the design suitable for resting water containers.

Figure 5. Latrine from an earlier development project that fell into disrepair and disuse, but was renovated by GESCOME.

Sustainability of CGMPs and GESCOME

In Parakou, which did not organize a functioning EME in GESCOME II, Mr. Yallou nevertheless observed that CGMPs from GESCOME I continue to function. All Parkakou GESCOME I micro-project latrines employ a pay-per-use scheme. CGMPs manage user fees, pay the latrine custodians, buy soap and cleaning supplies, pay for water and any other needs, and manage any surplus. All latrines are self-sustaining (i.e., all custodians are paid every month, there is no shortage of cleaning supplies, and water bills are paid monthly—all from the proceeds of the micro-project). The micro-project latrines appear to be well-used. One latrine is so popular that it has a sizeable budget surplus. The CGMP is using the surplus to construct a shelter for the latrine custodian. During GESCOME I solution finding, the community had identified this as a need, but ranked it just below a latrine, so it was not constructed during the life of the GESCOME I project.

Social Mobilization and Participatory Health Communication

The processes of participatory rapid appraisal (PRA) and decision making, community cost-sharing and micro-project construction form the backbone of GESCOME I and II at the community level. GESCOME II added another element to the community-focused effort, participatory health communication or PCHC. All of these activities take place in a framework of neighborhood, municipality and departmental collaboration. Both community members and members of government at the municipal level take part in community/social mobilization, primarily through

regular community meetings with the political support of community and municipal leaders. In both GESCOME I and II, EME members were trained in a number of PRA techniques (see "Training" section). This section presents, by town, GESCOME II in more detail, to provide a flavor of the social mobilization and community participation. It also provides the context for decisions, actions, and timing of community activities in GESCOME II.

3.4.1. Start Up

At the beginning of GESCOME II, the CDSE met in a Round Table (see Section 3.6) and, at the urging of EMEs, voted to raise the number of neighborhood representatives on each EME from two to four per neighborhood. This meant that all GESCOME II towns had 12 **new** community representatives (see Annex 5, EME Membership; for CDSE membership, see Annex 6). Of the four neighborhood representatives, two were women, who might also be members of the *Groupement des Femmes* (e.g., in Bembéréké and Sinendé).[12] In addition to the neighborhood representatives, each EME had one member of a local NGO. The remaining EME members were civil servants employed by ministries at the municipal level. GESCOME I EME members from ministries could remain on the EMEs if they wished, and all opted to stay.

EME representatives on the CDSE successfully lobbied the CDSE to continue to include the community representatives of GESCOME I neighborhoods (one per GESCOME I neighborhood, with three GESCOME I neighborhoods each in Banikoara, Parakou, and Bembéréké). This meant that each EME, except for Sinendé, now had 15 community representatives, two local community leaders, and generally, three representatives of government ministries. Sinendé had no GESCOME I neighborhoods, so it had only six community representatives, in addition to the two local leaders and the civil servants.

Once the CDSE had met, the GESCOME I EMEs and Mr. Yallou approached the *Chef de Quartier* (elected neighborhood head—a traditional leader with responsibilities to the government) about GESCOME II. GESCOME II held a meeting for residents of each new neighborhood with the *Chef de Quartier* to introduce the project. An election was supposed to be held to elect the community representatives, but sometimes the *Chef de Quartier* simply appointed four literate representatives. Since GESCOME was dependent upon the political support of the *Chef de Quartier*, there was little the project could do. In all cases, the *Sous-Préfet* (Sub-Prefect, the highest ranking government administrative official at the municipal level) was involved in start-up activities and in virtually all cases, was extremely supportive.

Parakou, which is much larger and more urban than the other towns (see Section 1.1), also followed this process. However, the *Chefs de Quartier* in the new neighborhoods

[12] The EHP II GESCOME II Activity Director made an administrative decision to include at least one representative from the *Groupement des Femmes* on each EME.

did not hold elections nor make appointments for neighborhood representatives. Mr. Yallou met repeatedly with the *Chefs de Quartier*, EME members representing ministries, and local government leaders but remained unable to spur the selection of neighborhood representatives. The neighborhoods of all the other towns had selected their representatives and these had been approved by the CDSE in December 1999. The other towns waited for Parakou so that all could begin their training at about the same time in order to finish the whole process together. Eventually, however, even with the Préfet's intervention in Parakou on behalf of GESCOME, the towns had to proceed without Parakou.

Parakou was ready to begin training in April 2000. Banikoara and Bembéréké, at that point, already were being trained in problem analysis. Mr. Yallou held the initial training for Parakou in April 2000. However, Parakou *chefs de quartiers* had selected far fewer than the full complement of EME representatives.

In the next Round Table, the CDSE, when faced with the timetable of GESCOME II and the certainty that at that point (December 2000) there was no way that Parakou could complete the PRA, community decision-making process, and micro-projects in time, the CDSE voted to drop Parakou, but to maintain its representation on the CDSE.

3.4.2. Problem Identification

Members of the Sinendé EME were trained in and conducted problem identification during the last weeks of GESCOME I. Banikoara, Bembéréké, and eventually Parakou EMEs received problem identification training.

Each town followed this sequence for the problem identification phase:

a. Diarrheal Disease Module 1: Diarrheal disease causes and effects on children and adults from the community point of view. Treatments and prevention means from the community point of view.

b. Diarrheal Disease Module 2: Diarrheal disease transmission from the public health perspective. Identification by community members of means of diarrheal disease transmission in each neighborhood. Drawing of the F-diagram (see following page) adapted to their neighborhood's circumstances by community members during group meetings.

c. Community walk to identify diarrheal disease transmission sites and behaviors that supported transmission in the neighborhood.

d. Drawing three or four community maps by different groups (men, women, young and older people) showing the most important places in the community that favored diarrheal disease transmission.

e. Community members drew a Venn diagram for diarrheal disease transmission. This included a list of institutions—traditional or official—where the community could transmit or increase the risk for contracting diarrhea. The diagram also included institutions responsible for health, hygiene and sanitation, and showed relations between them and community members.

f. Community members drew a histogram showing all facts or events related to or affecting diarrheal disease, health or sanitation in their neighborhood.

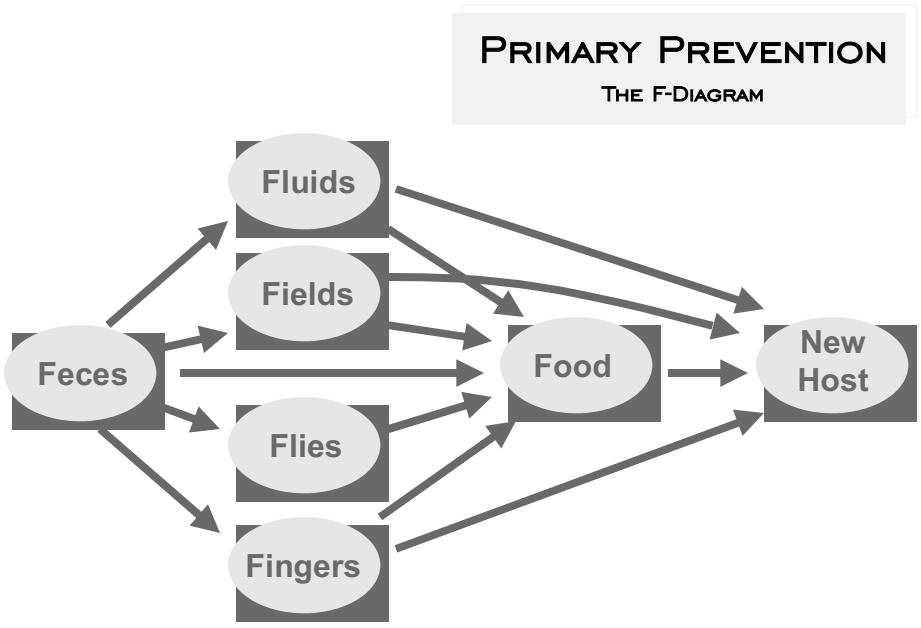
g. Community members paid a participant observation visit to specific sites or compounds seriously affecting community health, especially diarrheal disease in children.

h. If necessary (if there were specific questions or the need for more information became clear), community members interviewed specialists like health caregivers, hygiene, sanitation or local administration officials to better understand some of the issues raised in the identification phase.

i. Sometimes other issues were easier to understand just by meeting with the so-called "authors" of the problem and the "affected" ones, the EME facilitated a community-led group discussion.

j. At the end of this process, community members prioritized their problems with diarrheal disease transmission.

EMEs decided to adapt the diarrheal disease training curriculum for use with community members. They had been instructed by Mr. Yallou always to first elicit the knowledge that community members already had about the problem, next present current public health knowledge about the problem, and then to facilitate negotiation between the various realities. Figure 4 illustrates a well known diarrheal disease transmission model used by the project.



Source: Wagner and Lanois, 1958

Figure 6. Primary Prevention: The F-Diagram

The dates of problem identification for each town are summarized in the following table.

Table 6. Problem Identification Workshops in GESCOME II Towns

	Banikoara	Bembéréké	Sinendé
Problem Identification workshop	April 3–7, 2000	April 17–21, 2000	GESCOME II
Community problem identification activities	April 7–June12, 2000	April 21–July 3, 2000	GESCOME II

Banikoara

In GESCOME I and II, each EME drew up its work plan at the end of each training workshop and organized themselves to implement it. Banikoara's EME, at 19 members, is the largest, but size did not interfere with the group's efficiency. Banikoara's EME divided itself into three groups led by three GESCOME I EME members to encourage a good mix of GESCOME I and II skills and to more efficiently conduct activities in the new neighborhoods. They succeeded in carrying out ten community activities in six weeks, exactly as outlined in their work plan. Other towns did not meet their deadlines with such precision.

The community diarrheal disease modules described above were used in all six neighborhoods of Banikoara (both GESCOME I and GESCOME II neighborhoods). All other GESCOME II activities, with the exception of community participatory health communication, in which all neighborhoods participated, were carried out only in the three GESCOME II neighborhoods.

Diarrheal Disease Concepts and Cures in Banikoara

Use of the community diarrheal disease module in Banikoara revealed common conceptions throughout the town. Causes and treatments were seen as similar in all neighborhoods. Some of the treatments diverged greatly from accepted biomedical practices. For example, adults drank water in which grey mud had been dissolved, a common cure that a large number of community members claimed helped them when they suffered from diarrhea. Children's diarrhea was treated differently: they were given teas made from certain plants. Oral rehydration solution did not figure prominently in statements about treatment of diarrhea.

As revealed by the community diarrheal disease history and Venn diagram, other than GESCOME I and II, there have not been many attempts to prevent diarrhea in Banikoara. The town already had a reputation as an epicenter of measles epidemics. The Direction Nationale de l'Hygiène et de l'Assainissement (DHAB) built a few family latrines in Demanou in order to promote cheap family latrine platforms. Family heads could purchase latrine platforms for as little as 5000 CFA, provided that the family drilled the hole and assured that it could build the protecting wall. At the time of this writing, few of these latrines had been sold. Moreover, the sub-prefecture bought platforms to be given without charge to any family that agreed to dig the hole. This arrangement also failed. Community members reported that soon after construction, the pits filled and the latrines smelled bad.

Community-identified Risk Factors for Diarrheal Disease in Banikoara

The community walk and neighborhood maps revealed a large number of sites favoring transmission of diarrheal disease. For example, an empty plot in Orou Gnonrou had been transformed into a popular defecation place. As a result, the community requested that the owner, who works in Cotonou, build a brick fence around his land and the sous-préfet was asked to help communicate this to the owner. In Demanou, an old cemetery serves as a public defecation place. The community asked people to clean the cemetery out of respect for the dead and to avoid defecating there. Other transmission places were market places (contaminated food), unprotected wells, and water ponds (containing contaminated water in which children play).

An example of problems identified in one Banikoaran neighborhood is cited in the following table:

Table 6. List of Problems Identified by Demanou Neighborhood, Banikoara

PROBLEMS	SITE
∉ Dirty Latrines that were built by DHAB (Ministry of Hygiene)	One is situated in Mr. Sanni Sounon's empty plot. The second is built in Mr. SABI Kadakéri's empty plot The third one is built in Mr. Agbenga Luc's empty plot.
∉ Open air defecation ∉ Garbage area	Old cemetery
∉ Used water ∉ Gray water ∉ Animal excreta	On the roads and in certain compounds, like El-Hadj SABI Nonrou
Human cohabitation with animals	In the compound of the ex-chef du quartier

Bembéréké

Geography posed the greatest challenge in Bembéréké. Two of the three new neighborhoods (Beroubouay East and Beroubouay West) are suburbs that are part of greater Bembéréké, but situated 37 km from the main settlement of Bembéréké. The EME was divided in two as a result of these distances. This increased the cost of activities and resulted in other problems because transportation is difficult. Anyone traveling to Beroubouay in the morning must wait until the evening before returning back to Bembéréké: a loss of one day of work. Despite these conditions, GESCOME I EME members from the beginning agreed to share their experience with the new EME members of Beroubouay. But because of their inexperience, the Beroubouay EME members could not mobilize people before the arrival of their colleagues from Bembéréké. Consequently, activities were postponed, discouraging EME members commuting from Bembéréké proper to Beroubouay.

Use of Community Diarrheal Disease Module in Bembéréké

The diarrheal disease modules provided a good eye opener to the community members in Bembéréké/Beroubouay. In Bembéréké's GESCOME I neighborhoods, people deepened their understanding of the necessity to use community latrines built during the previous project. The problems identified by communities in Bembéréké and Beroubouay included all the transmission routes of the F-diagram (see Section 3.5.2).

Sinendé

Sinendé conducted the problem identification phase during GESCOME I. However, the EME did not receive training in diarrheal disease until GESCOME II and did not integrate this knowledge into their problem identification with the community. Therefore, problems the community had identified were not specifically diarrhea related. When the diarrheal disease problem identification community learning was implemented in Sinendé, the Sinendé EME, as well as community members, appreciated learning the potential of communities to prevent diarrheal disease. However, this newly gained understanding came into some conflict with the community's prioritization of problems identified in GESCOME I. One of the top priorities of all Sinendé's neighborhoods had been gray water pit construction. The other two priorities identified by Sinendé were retained: open-air defecation and unprotected water sources.

3.4.3. Problem Analysis Phase

Community members analyze the three priority problems selected by each neighborhood. The sequence of problem analysis activities was:

1. Barriers to diarrheal disease transmission:

    a. For each problem identified, the community identifies the barriers to stopping transmission of diarrheal disease. Since there are many problems and routes of transmission, this activity was split into two parts to allow in-depth participation by the community. When community members seemed to be tired of discussions, the meeting was stopped and the remaining barriers were discussed during a second round of meetings

2. Barriers to diarrheal disease transmissions, Part 2:

    a. Problem prioritization: After identifying the main barriers to diarrheal disease, community members decide whether to redefine their priorities for the problems.

    b. Problem tree: For each problem selected, community members create a problem tree, defining the causes (or roots) and the effects (or branches).

c. Hope maps: Community members draw their hope map opposite to the community problem maps drawn during the problem identification phase.

d. Hope trees: These trees are aimed at transforming the weak roots (causes of diarrheal disease transmission) into strong roots (actions to be taken, resolutions) to address the problem. Thus the sick branches (the effects) will be changed into fruitful ones (the impacts of actions).

e. Alternative solutions: The community selects the best resolutions/actions and implements them.

The following table summarizes the timing of this step.

Table 8. Problem Analysis Timing

	Banikoara	Bembéréké	Sinendé
Problem analysis training workshop	June 12–16, 2000	July 3–7, 2000	April 10–14, 2000
Community problem analysis activities	June 13–Sept. 4, 2000	July 4–Sept. 11, 2000	April 15–June 6, 2000

Communities began problem analysis enthusiastically. However, farming season intervened, making community mobilization increasingly difficult. June and July is the start of the rainy season and thus the beginning of intensive farming activities, when residents usually stay on their farms. Sinendé was less affected because it began problem analysis well before the rainy season, having already completed the first phase under GESCOME I.

Banikoara

The composition of the EME during this phase changed. Two people dropped out: the representative of the health directorate, and one of the Weterou neighborhood representatives. Both were very busy and therefore could not attend GESCOME II activities.

Community members did not find it difficult to identify barriers to diarrheal disease transmission or design interventions, e.g., washing hands after defecation or refraining from selling food on leaves. Community members also encouraged the use of potties for children and more hygienic ways to clean potties after defecation.[13] However, the problem and hope trees were vaguer, perhaps because at that point few community members were available for meetings.

[13] In Borgou, as in many other countries, potties consist of a little plastic basin that the toddler sits on to defecate and which s/he can carry with him/her to use anywhere.

Bembéréké/Beroubouay

Despite a seeming rivalry between its Bembéréké and Beroubouay halves, the EME carried out activities with community members in all three GESCOME II neighborhoods (two in Beroubouay and one in Bembéréké). Community members determined barriers to diarrheal disease transmission in detail and met on their own to discuss household and community level barriers and make decisions to address them. At the time of this writing, it was not clear whether all the decisions/resolutions taken had been implemented.

Problem and hope trees were developed in both neighborhoods of Beroubouay. However, Beroubouay EME members concluded that since the problems were the same in both neighborhoods, the two neighborhoods could analyze the problems together. This hindered expression of the more locally relevant aspects of the problems as well as development of solutions tailored more closely to the particular circumstances of each neighborhood.

Bembéréké/Beroubouay: Competing Interests Within an EME

The issue of the distance between Bembéréké and Beroubouay continued to create some gaps between the two halves of the EME. Workshops organized in Bembéréké tended to be more useful for EME members from Beroubouay, who could learn more because all the experienced EME members were from Bembéréké. This created a feeling that Bembéréké was working for Beroubouay. In addition, there was no compensation for Bembéréké EME members to take an entire day off from work to go to Beroubouay to help their colleagues there. Travel (taxi) expenses were reimbursed only when EME members submitted documentation to the GESCOME II office. On the other hand, Beroubouay EME members who came to Bembéréké to attend training workshops received the USAID authorized per diem, which Bembéréké members were not entitled to in their own town. As a result, some Bembéréké EME members simply stopped going to Beroubouay to assist their colleagues.

Sinendé

Sinendé performed the problem analysis step at the end of GESCOME I. However, Sinendé subsequently had to adjust to the GESCOME II focus on preventing diarrheal disease in children under 5.[14] This adjustment initially created some frustration for community members of the three neighborhoods, who had already decided to address used water spillage and gray water along the streets, neither of which contributes greatly to transmitting diarrheal disease. Community interest in the diarrheal disease focus increased after community members learned more about diarrheal disease, especially the ways communities can prevent its transmission.

[14] GESCOME I did not have as clear a public health focus and goal as GESCOME II.

Community members identified the barriers to stopping transmission to children. At the end of the sessions on diarrheal disease, Sinendé neighborhoods chose to address the problem of open air defecation, indiscriminate garbage areas and unprotected water sources. The Sinendé neighborhoods completed the problem trees, actions to be taken, and anticipated impacts. As in the other two towns, Sinendé residents also found hope trees difficult to understand and use. Consequently, unlike the other towns, they were not able to complete the hope trees.[15] EME members addressed this problem by going over the same information orally, without using the tree diagram.

3.4.4. Solution Finding

After completing problem analysis, community members meet to find an integrated solution for each problem. However, it is the EME that does the actual writing because most community members are not literate. The EME therefore works with them to develop, in writing, a micro-project proposal to address the top problem. The sequence of community solution finding for each problem follows:

a. A community meeting was held to elect the micro-project management committee (CGMP). Prior to the election, the EME thoroughly described the roles and responsibilities of committee members.

b. The community met to draw an objective tree of the top-ranked problem. Evolving from the hope tree, community members drew the problem, where the specific objectives would be the roots and the expected results, the branches.

c. Community members decided on activities that would lead to each expected result. These were activities that would be integrated into a micro-project. Based on the previous step, each result was discussed separately so that the activities and means to accomplish them could be determined. The community and EME next summarized the activities for all expected results in order to avoid duplication. It is important to note that the resolution could be related to infrastructure, i.e., a micro-project, or social, e.g., a community action like health communication.

c. The community identified the resources needed to carry out the activities to achieve the results. Only locally available resources and technologies were selected for implementation of the micro-projects. Both GESCOME I and II required a 15% contribution from the community toward the cost of the micro-project. This usually came to 640,000 CFA per neighborhood for three micro-projects (about US$ 880) or 213,333 CFA per micro-project round (about US$ 293).

d. With the list of activities and required resources prepared, the community participated in planning the micro-project. The maximum duration of each micro-

[15] The hope tree, as were all the PRA tools, was adapted and incorporated into the GESCOME PRA process in GESCOME I. Although hope trees are a common PRA tool, they may rely on different ways of categorizing the world than is common in these Borgou towns.

project construction was initially fixed at ten weeks; if unforeseen problems arose, the time might be extended.

e. The community estimated the cost of the micro-project based on the resources needed. Before submitting the micro-project proposal to the CDSE, the community contribution of 15% of the cost had to be placed in a special micro-project bank account, which the GESCOME II office helped to establish for each neighborhood.

f. The EME further developed the micro-project proposal. Each micro-project proposal had to include the following items: (1) a brief presentation of the problem; (2) objectives; (3) expected results; (4) the number of people affected; (5) causes of the problem; (6) consequences of the problem; (7) actions to be undertaken; (8) activities to be implemented; (9) resources needed; (10) the work plan; and (11) a cost estimate. Community maps, as well as problem, hope and objective trees were required to be attached to the document to certify that the community had participated fully.

The seven activities in this phase must be accomplished within six weeks. At the same time, community members must complete their contribution for the construction of three micro-projects per neighborhood. [16]

Table 7. Solution Finding Training and Implementation

	Banikoara	Bembéréké	Sinendé
Solution finding workshop	Sept. 4–8, 2000	Sept. 11–15, 2000	June 6–10, 2000
Community solution finding activities	Sept.–Nov. 2000	Sept–Dec. 2000	June–Dec. 2000

Community members found the tools for solution finding to be the most demanding. These included tools for project planning and implementation, which few community members had previously had to use in such a standardized manner. To effectively use these tools, the community must anticipate micro-project resource needs, consequences, and outcomes, as well conceptualize them visually. Even many EME members initially found the solution finding tools difficult to use (e.g., problem trees and hope trees). Once EME and community members began to understand the logic behind the tools, they became excited about them and said that they could use the tools for many problems they might encounter in their own lives.

September is the beginning of the last part of the rainy season. Community members rush to finish their farming activities before the rains end. Consequently, community participation is generally not widespread. GESOME II addressed this issue by holding a September EME training workshop in social mobilization. The workshop, as well as

[16] GESCOME II initially planned to have three, rather than two, rounds of micro-projects.

the follow-up supervision activities, were designed and implemented by CREPA, a local NGO. Based on this workshop, EME members sent a meeting invitation card, signed by the sous-préfet, to each household. The novelty of receiving a printed invitation from an important person greatly increased community participation, despite the difficulties in using the solution finding tools. In the end, novel ideas for collecting community contributions for micro-projects resulted and were implemented (e.g., collaboration with the village agricultural cooperative to assess and collect the early payment per child).

Banikoara

Banikoara initially collected more funds toward the required 15% community micro-project contribution than the other towns. Each neighborhood had to complete the collection of its contribution while carrying on GESCOME II activities. This funding issue diverted the attention of some community members, who did not seem to want to participate in identifying micro-projects at the same time that they were paying for the micro-projects. This period was very difficult for EME members, who reminded community members of their financial responsibility to the community, while, at the same time, they were trying to assist community members in using the PRA tools to identify the micro-projects that the community wanted to build. Despite all these difficulties, Banikoara was the first town to submit its micro-project proposal.

Bembéréké/Beroubouay

As in Banikoara, the Bembéréké EME became unpopular during the micro-project development period, since they had to remind everyone of the community contribution during every community meeting. As a result, people began to avoid community meetings. The Bembéréké East neighborhood said it found contributing 15% to the micro-projects just too burdensome, despite the EME's best attempts at encouraging collection. The Groupement Villageois de Producteurs (Village Agricultural Cooperative or GV) was unable to lend funds to the community to build the micro-project (something GVs had done in many other neighborhoods in different towns). The EME held community meetings attended by the GESCOME coordinator and sous-préfet to try to resolve this. Ultimately, Bembéréké East never collected the required contribution and did not participate in micro-project construction. However, the neighborhood continued to participate enthusiastically in other GESCOME II activities.

Beroubouay, in contrast, had no problem collecting the community contribution in its two neighborhoods. The CDSE noted a certain vagueness in both neighborhoods' micro-project proposals, but approved them nevertheless.

Sinendé

Due to Sinendé's head start during GESCOME I, the town had much more time than the other two to complete the solution finding step. However, a two month lead was eroded because the EME found it difficult to collect the community contribution for

the micro-projects. EME members found it especially difficult to collect contributions in one particular neighborhood, Niaro Bariba. To resolve this, the EME organized several meetings among the sous-préfet, GESCOME Coordinator, Chef de Quartier and his aides, and leaders of the local GV.

The neighborhood of Niaro Bariba differed from other neighborhoods participating in GESCOME II in its diversity. The different groups living in Niaro Bariba, although speaking the same language, come from different parts of the country and this may have affected the community's desire to contribute. It was difficult to build a coalition for GESCOME II among this diversity, perhaps because there was no conscious sense of community in this collection of groups and GESCOME depends heavily on such "community" participation. Collecting community contributions and conducting activities were much less problematic in the other neighborhoods of Sinendé: Lemanou and Danrigourou.

Another reason for Sinendé's lag in finishing the solution finding step was that the EME coordinator is very public-spirited and consequently is involved in many other civic activities and responsibilities. He was working with UNICEF's EDUCOM project, with PAMR (Projet D'appui au Monde Rural), the Conseil Consultatif (consultative council), with PADEB, (Projet D'appui au Développement de L'Elevage dans le Borgou) as well as with GESCOME. He also had a full-time job in the municipal administration. To address this problem, the EME elected a deputy coordinator. However, the deputy did not feel that he had the authority that the EME coordinator enjoyed. Nevertheless, on December 29, 2001, all three neighborhoods were able to submit their micro-projects to the CDSE.

3.4.5. Micro-project Implementation

GESCOME operated under strict rules to ensure financial accountability. Once the micro-project proposal was approved by the CDSE, the CGMP opened a bank account in which it placed the community contribution. Three signatures were necessary to access the account: two members of the CGMP and the sous-préfet. The account number was communicated to the GESCOME Coordinator, who deposited an initial 50% of the project contribution.

The CGMP then met to decide the items or services to be purchased. They listed their estimated costs on a purchase order and checked the costs with different local suppliers, comparing and then selecting the most favorable estimate. With the purchase order ready, the CGMP met with the sous-préfet to decide on the amount to be withdrawn in order to meet the expenses. After reaching an agreement, the money was withdrawn. The CGMP could keep the funds for a maximum of two days before disbursing them to pay the expenses. Receipts were presented to the sous-préfet within 48 hours after disbursement to document payment. The CGMP collected and stored the construction material and equipment. Anyone who took any equipment or material was required to sign each time materials were used.

When the community contribution and half of the project contribution was exhausted, an accountant closely examined the records. The project accountant consultant was crucial at this stage. He verified the receipts and justifications of expenditures. Only after the accountant's approval was the project coordinator able to add an additional 40% of the project contribution to the micro-project account. If the accountant did not approve the receipts and justifications, the micro-project would be stopped until the justifications were correct. Only the CDSE could decide to override the accountant's decision. After completion of the micro-project, the project coordinator transferred the remaining 10% of the project contribution to the account, again only if the accountant approved all the micro-project financial transactions.

Although GESCOME I had hired an excellent consultant accountant, GESCOME II was not as fortunate. Its first accountant was dismissed for poor service and the second accountant did not live up to the terms of his contract. As a result, the communities, CDSE, and GESCOME II did not receive the accountant's reports in a timely manner (e.g., April's reports were submitted at the end of July). The poor accounting service did a disservice both to the communities and the project. On-the-job training and supervision by the accountant at the community level also suffered. The delay in receiving the accountant's verification held up the disbursement process, creating frustration both at the community and GESCOME II project office levels. In order to overcome this difficulty, Mr. Yallou provided on-the-job training in financial management to CGMPs himself. In addition, he held training meetings where GESCOME I CGMP members answered questions and provided some training to GESCOME II CGMP members. Mr. Yallou's search for a more appropriate accounting consultant was unsuccessful.

Banikoara

Micro-project Round # 1, Latrine Building

In Banikoara, all three neighborhoods submitted micro-projects to the CDSE for three sanitation facilities, each equipped with one stall for females and one for males. The CDSE amended the proposals to increase the number of stalls in each sanitation facility to three, to include one stall for children so that this stall could be kept open at all times for children to use without charge. This decision had the effect of not only expanding the size of the infrastructures, but their cost as well. Since the corresponding community contribution also had to be increased as result, the three neighborhoods decided to reduce the number of sanitary facilities to two per neighborhood but with three stalls each. This responded to the CDSE's expectations while maintaining the original community contribution.

In January 2001, the micro-project contracts were signed by each CGMP as well as the sous-préfet and the Préfet. The bank account was then opened. In February 2001, the initial 50% of the project contribution was deposited in each neighborhood's bank account. Banikoara experienced a cement shortage that slowed down construction projects in general, including the GESCOME II community sanitation facilities. Banikoara shared a second problem with the other two towns: the latrine holes had to

be drilled in the dry season. This was both more difficult and costly. Therefore, construction and completion of the sanitation facilities took three months in Banikoara.

Micro-project Round #2: Potable Water Sources

The process for deposits and withdrawals of funds was accelerated for the second round of micro-projects in order to begin implementation of these micro-projects before the end of GESCOME II. GESCOME II managers were concerned about sustainability, timely completion of micro-projects, and wanted to learn whether finances would still be transparent if funds were dispersed at one time instead of in tranches. Therefore, once the micro-project accounts were established and the community contributions deposited, GESCOME II deposited 100% of its contribution. There was relatively little risk in this tactic because more than 80% of the second round micro-project funds were paid to a state owned company, *Société Béninoise d'Electricité et l'Eau (*Beninois Society of Electricity and Water, or SBEE), to install and hook up water resource points. SBEE only begins work after receipt of full payment.

However, after the CGMPs contracted with SBEE and paid the funds required, SBEE informed the CDSE that there was a country-wide shortage of taps to operate the water resource points and consequently the company could not meet the CDSE deadline. Mr. Yallou traveled to Cotonou and elsewhere in Benin to locate the taps but to no avail. The taps were finally purchased by SBEE in Niamey (Niger) at an additional cost of 25,000 F per tap for the communities. In all, there were 15 outlets installed in Banikoara at an average of five per neighborhood.

Bembereke/Beroubouay

Beroubouay East and Beroubouay West constructed three sanitary facilities, each with three doors. The beginning of micro-project construction in these two neighborhoods was not auspicious. CGMP members had learned about the financial and construction process during their training in January of 2001, e.g., a withdrawal requires two signatures from the CGMP as well as the signature of the sous-préfet. Unfortunately, the first withdrawal (560,000 CFA) was made by an entrepreneur to buy all the goods and materials for both neighborhoods. The CGMP were astonished and concerned by this action since they neither knew the entrepreneur nor who had engaged him. The GESCOME Coordinator immediately stopped the process until the CGMP got the situation under control. An initial meeting with the entrepreneur was arranged for February 13, 2001. After that date, the entrepreneur could not be contacted. The Préfet intervened and, with the assistance of the sous-préfet, the entrepreneur was summoned and required to reimburse the communities. The entrepreneur agreed to withdraw from the project but said that he could pay his debts to the CGMP only with in-kind services. On March 3, 2001, the CGMPs and entrepreneur reached an agreement and work on the Beroubouay micro-projects resumed, but with different workers.

The CGMP hired new masons, who complained about a shortage of funds. Despite this shortage, the sanitary facilities were completed on August 28, 2001, after the end of GESCOME II but during the Lessons Learned period. Because of its slow pace in finishing the first round of micro-projects, the town could not apply for a second round of micro-projects.

Sinende

Micro-project Round #1: Sanitary Facilities

Sinendé initially gave a portion of its funds to an entrepreneur to manage. Fortunately, the CGMPs were able to quickly reverse that decision. The CGMPs hired other masons, and work resumed without delay. This allowed Sinendé to finish the first round of micro-projects in enough time to submit the second round micro-project proposal.

Micro-project Round #2: Potable Water Source Points

Potable water is an extremely important issue for Sinendé because the town is surrounded by mountains, and it is extremely difficult to drill for water in the mountain rock. Sinendé completed installation of 16 water source points (including all three neighborhoods). The water user committees had been elected by the time of this writing, and the water source points were opened to the public.

3.4.6. Participatory Community Health Communication

EMEs tried, on their own, to conduct "hygiene educaion" at some community meetings, based on what they had learned in their diarrheal disease training. The GESCOME II approach was to elicit local knowledge, interpretations, and meanings first before presenting established public health knowledge, interpretations, and meanings and then negotiating among these realities (see Section 3.5.2). This was different from the prescriptive health messages EMEs were accustomed to in approaches to behavior change often used in other development work. EME members had initially told the community how diarrheal diseases are transmitted and what actions would prevent diarrheal disease. They would then ask questions, and ask for questions. EMEs found that this did not encourage a great deal of discussion. In contrast, the participatory community health communication approach of GESCOME II relied on extensive discussion among community members as well as dialogue between the community and EME.

The three-day training in gender awareness, social mobilization, community health communication, and community-based materials development was the final training module in GESCOME II. Gender training was incorporated into the social mobilization training in order to mainstream gender, rather than have it be a separate activity that EMEs "did." In the training, EME members learned that "natural groups" refer to groups that have not been established for the purpose of a project. The groups are established by members of the community or are groups into which members of

the community may be born (e.g., females born between 1982 and 2002). EME members also learned that some natural groups may not be conscious of being a group. For example, women who usually come to collect their water at about the same time every day and chat with each other may not see themselves as a group, yet they may be seen to be a natural group. Natural groups are *socially* meaningful. In addition, some natural groups are meaningful epidemiologically (e.g., mothers of small children who normally talk with each other while getting water). During the training EME members identified which relevant natural groups in their communities were most influential in transmission or prevention of diarrheal disease.[17] Each EME developed a somewhat different list of these natural groups.

As part of the first phases of the GESCOME II PRA, EMEs worked with communities to identify a list of risk factors (activities, situations, and occurrences) influencing transmission of diarrheal disease to young children in their communities (see Sections 3.2 and 3.5.2). This knowledge helped EME members decide which natural groups, identified during the final training, might influence transmission of diarrheal disease. EMEs referred to the diarrheal disease risk factors on their lists as "themes." For example, one risk factor or theme in Bembéréké/Beroubouay was the market women's preparation and handling of the food they sold. Consequently, one of the natural groups the Bembéréké/Beroubouay EME identified during training were market women, who are organized into a formal natural group (market women's organization). Since this group coincided with one of the environmental health issues community members and the EME had identified through the PRA during training, EME members decided to conduct a PCHC with this natural group.

Development of participatory health communication materials served multiple purposes in the training (as well as in the project). As part of the PCHC training, each EME received two instant Polaroid cameras and film. The trainer, Mr. Yallou, divided the EME by sex. One camera was given to the female EME members and one to the males. Both groups were instructed to go out into the communities and photograph situations, circumstances, or actions that documented their "themes" and that would be the basis of health communication materials for use with the natural groups that the EME had identified. The men's and the women's groups were to separate and find their own pictures. Then, the two groups would meet together to discuss similarities and differences of the role of gender in people's perspectives, their views about diarrheal disease transmission and prevention, the community, and the project. The pictures were not to be posed, but to be situations and activities occurring naturally in the community.

[17] Natural groups may be formal (e.g., a lineage) or informal (e.g., women who collect their water at about the same time and socialize with each other at that time).

Figure 7. A photograph by the Sinendé men's group

Figure 8. A photograph by the Sinendé women's group

After each group had taken 20 photographs, EME members held one focus group to pretest the pictures with members of each of the natural groups they had identified.[18] Since all community members were familiar with photographs and these were pictures of familiar actions and/or places, one round of focus group discussions was sufficient to select pictures for use in community meetings for participatory health

[18] All EME members had been trained in focus group methodology early in GESCOME II and had previously worked with the community to conduct many focus groups (see section 3.2).

communication. The EME returned to the training room and discussed the pictures along with the pre-test focus group results. Based on the pre-test results, they selected the pictures to use or recommended other subjects to photograph for the community-based health communication materials.

Dr. Krieger had envisioned that EMEs would use the photographs to fashion posters, flip charts or other materials for community meetings, and therefore she included skills to develop such materials in the training. However, EME members found that simply passing around the photographs to group members during the focus group discussions generated so much intense interest and depth of discussion that EMEs decided to use the photographs as stimulus cards. They thus spontaneously reinvented Paolo Freire's concept of empowering low-literate community members through facilitated discussions using pictorial stimulus cards to spark discussion (see Freire 1986).

After the training, during April and May 2001, EME members in all neighborhoods of all towns (GESCOME I, as well as GESCOME II neighborhoods, including the Bembéréké neighborhood that did not participate in micro-project construction) held community meetings with natural groups to discuss diarrheal disease among young children.

EME members told Mr. Yallou that concentrating on natural groups allowed them to cover all the groups much more rapidly than inviting the entire community to every meeting (as they had previously done) and helped enable young women to speak more freely in a group of their peers. The EMEs had categorized young mothers of children under five living near each other as a natural group and held meetings just for them.

The activities held in each town, as reported to the CDSE in the final Round Table, follow:

Banikoara

The community representatives and other EME members identified at least seven natural groups in each neighborhood. The EME facilitated at least four participatory health communication meetings with each natural group. The EME coordinator praised this new method of communication because it encouraged much more interaction with community members. He said that people understood diarrheal disease much better by sharing the photos and discussing them than through a more traditional community gathering. However, he admitted that the process took longer.

Sinendé

The EME held participatory health communication meetings with the community, but both EME members and male community members were involved in activities that competed for their time during this period. Many EME members were very involved in workshops and vaccination campaigns, and male community members were busy

hunting in the bush during the day. EME members therefore met with the men at night. The EME coordinator reported that women were eager to come and were active participants in the PCHC meetings. The EME coordinator did not report how many such sessions were held. "Themes" included open-air defecation, children's practice of defecating behind houses, sharing living space with animals, consumption of surface water, uncovered wells, garbage areas, and household garbage handling.

Bembéréké/Beroubouay

The EME coordinator lives in Bembéréké and had not visited Beroubouay to observe their activities in PCHC. He therefore reported only on the Bembéréké neighborhoods, which include the GESCOME I neighborhoods. PCHC meetings were held with identified natural groups in all GESCOME I and II neighborhoods of the town. The coordinator listed themes covered in the meetings. However, the specific photos used, and the themes discussed, very much depended upon their interest and relevance to the specific natural group that was meeting. Themes included: open air defecation, water contamination, handling children's feces, and what to do after using the latrine.

The next step in the participatory health communication process was to help negotiate steps that groups in the community would agree to take to decrease the likelihood of transmitting diarrheal disease to young children. However, after two months of meetings, the EMEs reported that they needed a little more time to negotiate these community responses. It is expected that these meetings will continue during the Lessons Learned period following GESCOME II.

Figure 9. Picture of hand-washing that can stimulate discussion on a number of themes (e.g., child feces handling, what to do after using a latrine, cooking and purity/cleanliness, women's work schedules and the practicality of public health's beliefs about hygiene)

Sustaining the EME's participatory health communication work in all GESCOME neighborhoods in all towns cost US$ 150 per month. These funds, US$ 50 per month

per town, were used for photocopying, stationery supplies, and refreshments at community meetings. Eventually, additional film will have to be purchased.

3.5. Round Tables

CDSE meetings, called Round Tables, were convened six times during GESCOME II. Under GESCOME I and II ground rules, the CDSE must approve micro-project proposals and any changes to the structure of GESCOME (e.g., dropping Parakou or adding additional community representatives). Round Tables were convened only when there was a reason for the CDSE to meet. The CDSE first met to determine selection criteria for which neighborhoods could be included in GESCOME II, since there were to be three new neighborhoods per town. The CDSE also met to review/supervise and support the PRA and community decision-making process (problem identification, problem analysis, solution finding, micro-project implementation), as well as to plan for sustainability of the project after its close.

In GESCOME I, the location of Round Tables varied, rotating through each GESCOME II town. This provided CDSE members, who are all high level policy makers, with an opportunity to visit the communities, observe the EMEs and CGMPs at work, view the progress of micro-projects, acquaint themselves better with the communities and see the PRA, community decision making, and micro-project construction and management first-hand. However, in GESCOME II, USAID regulations prohibited payment for any transportation costs for government employees by this project. Since all the CDSE members are government employees who lacked the budget to cover the expenses of traveling several hours or more to another town, almost all meetings in GESCOME II were held in Parakou.

The generic agenda of a Round Table follows:

- Welcome address by the sous-préfet hosting the Round Table
- Opening address by the Préfet, as chair of the CDSE
- Review of activities performed by each EME during the previous period, followed by questions and answers
- Review of each EME's proposed work plan, followed by questions and answers
- Other issues related to the project, e.g., the role of CDSE members in the work plans proposed
- Site visits to neighborhoods by the CDSE members, as applicable
- Conclusions and resolutions, facilitated by the Prefecture's Chief of Housing and Environmental Affairs.

Review and evaluation of micro-projects generally required two additional topics to be covered:

- Review of each EME micro-project, followed by questions and answers
- Evaluation of the progress of micro-projects being implemented and the inputs required from the CDSE to advance the projects

Figure 10. Round Table meeting

Table 8. Dates and Locations of Round Tables

Round Table	Month/Year	Location	Purpose
Round Table #1	October 1999	Parakou	Briefing on GESCOME II, decide criteria for selecting new neighborhoods, vote on # of community reps
Round Table #2	December 1999	Parakou	Choose new neighborhoods
Round Table #3	January 2000	Parakou	Meet with CESH Coordinator/Activity Manager, review GESCOME work plan
Round Table #4	August 2000	Bembéréké	Review EME progress, meet with USAID Mission Director, FHT[19]
Round Table #5	December 2000	Parakou	Review proposals for first round of micro-projects
Round Table #6	May 2001	Parakou	Discuss sustainability, lessons learned, evaluate micro-projects

[19] Family Health Team

The Préfet serves as Round Table facilitator. He also assigns responsibilities, usually to each sous-préfet, for remedying problems or addressing issues. The CDSE sets deadlines for the implementation of the agreed upon resolutions. These are followed up at the next Round Table, or by the Préfet between Round Tables to ensure accountability. Each CDSE member, including the EME coordinators, is free to ask questions, make proposals and point out problems. The discussions were uniformly polite and usually friendly.

The CDSE also makes recommendations to the Préfet. In 2000, the CDSE voted to recommend to the Préfet that he institutionalize the GESCOME structure by creating a formal GESCOME structure in the Department. The Préfet subsequently issued a decree formalizing the structure. The GESCOME coordinator provided guidance to the CDSE members, reminding them of agreed-upon rules, activity deadlines, expected results, and USAID regulations.

The Sixth Round Table

This Round Table, chaired by the Préfet, convened in the Prefecture conference room in May 2001. All but two heads of departmental services were present, as were the sous-préfets and EME coordinators from all three towns. Parakou was represented by the Mayor of Commune #5.

The Préfet welcomed the group and spoke about the importance of participatory community health communication. He said that micro-projects are only one part of what needs to be done. Without a change in behavior at the community level, health will not improve. He reminded the CDSE that the project was drawing to a close and any remaining micro-projects must be finished quickly. Then the Préfet invited each EME coordinator to present his activities.

Each EME coordinator updated the CDSE on implementation of the first round of micro-projects. The Banikoara Coordinator proudly reported that all six blocks of latrines (two per neighborhood) were finished. His EME had used the Polaroid cameras provided by EHP to photograph the latrines. He passed around photos of the micro-projects

The Sinendé Coordinator discussed the effect of the cement shortage on latrine completion in his town.

The Bembéréké Coordinator reported much less progress and related the story of the entrepreneur who had not built latrines to the right plans. He told the CDSE that his EME foresaw a shortfall of 310,000 CFA per neighborhood.

The Bembéréké EME Coordinator faced many questions. For example, why hadn't the CGMPs used one of the DHAB-trained masons? He replied that in order to save time, they wanted to use a single contractor for all their needs. The Sinendé Coordinator added that his town, too, had made the same mistake for the same reason, but had rectified it quickly and completely.

Each EME coordinator reported on participatory health communication in their communities (see Section 3.5.6). The topic elicited fewer questions, but many statements of interest.

A lengthy discussion of the second round of micro-project proposals included presentation of the proposals (Banikoara's and Sinendé's neighborhoods requested connections to the national water company's potable water; one neighborhood also wanted to renovate two of its wells. Bembéréké/Beroubouay's neighborhoods each wanted to construct a public dining room). CDSE members posed questions about the significant differences in cost for the same intervention, from neighborhood to neighborhood, even within the same town. They also asked questions about Bembéréké's request to begin a second micro-project. An EME coordinator answered the question about variation in cost: the cost of the connection is determined by a number of factors, including whether pipes need to be first laid or whether pipes to the neighborhood already exist (a connection vs. an extension) and the geological formation of the area (a rocky area or an area in which the pipes must cross a road is more expensive). Mr. Yallou explained the problems with beginning a second round before completing the first round micro-projects. The Préfet requested that Bembéréké/Beroubouay sign an agreement to finish the first round in 15 days or forfeit the opportunity for a second round of micro-projects.

Mr. Yallou reported on the shortage of taps in Benin for the public water source points and received feedback. Finally, the CDSE reviewed the next steps in the project (i.e., Lessons Learned activity, etc.).

4. GESCOME II Results

Introduction

USAID's scope of work for GESCOME II included indicators of success, tasks, and scope of work (see Annex 1). When Dr. Krieger visited Benin in January–February 2000, the Family Health Team (FHT) requested that EHP add additional indicators, particularly related to democracy and governance. Upon Dr. Krieger's return, EHP II discussed the issue and suggested additional indicators, which were accepted by USAID/Benin.

Originally, the scope of work called for collecting epidemiological data on diarrheal disease in young children through a PROSAF survey. However, the EHP II epidemiologist advised that for the sample to contain enough cases of diarrheal disease in children under five, it would have to be extremely large. Since PROSAF was sampling primarily for reproductive health, this would have enlarged their sample to impractical dimensions. After much discussion at EHP II, and a great deal of budget work, EHP II realized that it would not be able to pay for its own epidemiological survey to assess rates of diarrheal disease to compare with GESCOME I neighborhoods. Therefore, the indicators pertaining to diarrheal disease rates were not included. Instead, the Lessons Learned activity following GESCOME II will include observation of types of behavior that can prevent or transmit diarrheal disease and qualitative assessments of changes in diarrheal disease patterns, as well as collection of health statistics on diarrheal disease before and after GESCOME II.

4.1. Results and Indicators

Result 1: EMEs actively participate in CESH/CIMEP

Indicators:

Community representatives for the EME in the new target intervention area of Sinendé will be selected within three months of activity start date. GESCOME II began in September, 1999. Sinendé had already begun selecting its EME members before the close of GESCOME I. By December 1999, all EME members from all new neighborhoods had been selected.

- *EMEs in all target municipalities will develop and implement a work plan.* Throughout GESCOME II, EMEs prepared work plans to cover six-week periods. This ensured that work plans always reflected current realities (e.g., preparations for elections, planting season, etc.) and was the decision of the EMEs. Due to the

brief period that they covered, all work plans were implemented and seldom required much amendment.

- *EMEs in all target municipalities will plan meetings and meet on a regular basis.* Throughout GESCOME II, EMEs met at least once a week and held at least two community meetings per week.

Result 2: Round Table meetings will continue, with the support of the Prefet, and will involve municipal support for environmental health issues.

Indicators:

- *Round Table meetings will be attended by regional officials from various sectors.* All Round Table meetings were chaired by the Préfet. Mr. Yallou also attended all the meetings. An attendance sheet was circulated during each meeting, with everyone signing. The Department considered the Round Table their activity rather than GESCOME's. Therefore, the CDSE representative from the prefecture collected and kept the completed attendance sheets; consequently they were not available for GESCOME II to copy (see section 3.6 for attendance at the last Round Table).

During the first part of GESCOME II, the Departmental Director of Health (DDS) was often absent from meetings. The Préfet intervened and made certain that the DDS attended. The attendance sheets reveal that departmental representatives of the following ministries generally attended the meetings: Environment, Planning, Hygiene and Sanitation, Rural Development, as well as the Sous-Préfet of each GESCOME II town, and one EME representative from each town.

- *Departmental and municipal decision makers will implement action items identified at Round Table meetings*. As mentioned in the previous indicator, the members of the CDSE took ownership of the Round Table meetings. They have been eager to listen to EME members and hear the view of community members and took seriously all CDSE decisions. The following are illustrative of decisions taken and implemented at the departmental or municipal levels:

    1. The CDSE decided to add three community representatives to each neighborhood. This was implemented by all GESCOME II neighborhoods.

    2. The CDSE decided that at least two of the four neighborhood representatives must be women.

    3. The CDSE decided not to drop GESCOME I neighborhoods from GESCOME II. GESCOME I neighborhoods (except for Parakou) participated in the identification of risk factors/behaviors and environmental health needs for GESCOME II. They also participated in the participatory community health communication meetings.

4. The CDSE decided to drop Parakou from all GESCOME II activities except for the Round Table after the third neighborhood did not attend meetings or training and the two-neighborhood EME was not able to complete the first step of discussions surrounding problem identification and analysis (even when these were based on problems and analysis identified during GESCOME I from Parakou neighborhoods rather than attempting a new problem identification/analysis). Parakou municipal leaders accepted the decision.

5. The CDSE voted to institutionalize the GESCOME structure in departmental government (CGMPs, EMEs, CDSE, and Round Table). The Préfet subsequently issued a decree institutionalizing the structure.

Result 3: In each target intervention area/neighborhood, measurable changes will occur in behavior and environmental conditions directly related to diarrheal disease transmission.

Indicators:

- *In each target area, high-risk behaviors contributing to transmission of diarrheal disease will be identified.* During the problem identification training, EME members (except those in Sinendé) were trained to understand the transmission and prevention of diarrheal disease. Sinendé EME members received diarrheal disease training in a separate workshop. Therefore, when EMEs and communities began their GESCOME II PRA activities, they were able to identify factors that placed children at risk of contracting diarrheal disease. Each community, with the EME facilitating, developed a list of factors specific to their neighborhoods that contributed to diarrheal disease transmission. Factors were not limited to behavior. They might have included lack of infrastructure, such as an easily accessible latrine, as contributing factor to the transmission of diarrheal disease.

- *Participatory methods will be used to develop and implement strategies for addressing the high-risk behaviors identified.* The community and EME used PRA methods to identify many factors including behavioral (e.g., defecating in the bush, and no handwashing on occasions when public health guidance promotes handwashing) in transmission of diarrheal disease. These factors were addressed through a novel form of participatory community health communication (PCHC) that was developed in this project (see Section 3.5.6). The assumptions upon which this method was based are the same as those in GESCOME II (see Section 1.3). [20]

- *Neighborhood concerned citizens groups will monitor behaviors on a regular basis.* This indicator was not completed during GESCOME II because there was

[20] Save the Children (STC) developed a similar intervention that seems to be based on several similar assumptions. However, STC has not used their approach for environmental health (Lisa Howard-Grabman, personal communication).

no time to monitor latrine use and concomitant handwashing due to the late date of micro-project completion. However, EHP II will follow GESCOME II with a Lessons Learned exercise during which this indicator is expected to be achieved. The EME will select male and female community latrine monitors to conduct behavior observations at latrines constructed during GESCOME II and to note, by sex and age category, who uses the latrine and whether and how they wash their hands. The latrine monitors will conduct their observations over a period of eight weeks.

Latrine monitors will be high school students from the neighborhoods where the latrines for which they will be responsible are located. The students will be trained and begin conducting the monitoring as soon as the school year is over. Students normally spend their summers as paid field laborers. Therefore, EHP II will pay the monitors the same rate they would earn as field laborers. Students will be trained in diarrheal disease transmission and prevention, as well as the ethics and methodology of latrine monitoring. EME members will donate their time to serve as the students' supervisors, attending the students' training and also receiving training in supervision of latrine monitoring. Results of this community behavior observation will be available in the Lessons Learned report, upon completion of the Lessons Learned exercise.

- *High-risk behaviors contributing to transmission of diarrheal disease decrease, as measured through qualitative studies.* Anecdotal evidence (i.e., Mr. Yallou's cursory examination of latrines upon his visits to the towns and in his discussions with EME members), suggests that latrine use—even in GESCOME I neighborhoods—has increased. Part of the Lessons Learned exercise will include focus group discussions held with members of the key natural groups identified by the EMEs, as well as individual interviews with latrine custodians and those who live in the vicinity of a GESCOME I or II latrine. This exercise should provide qualitative evidence of changes in actions that may contribute to or prevent transmission of diarrheal disease.

Result 4: In target intervention areas, stakeholders (local elected officials, NGOs and community members) will collaborate to address community problems.

Indicators:

- *Mechanisms will be established and used for regular interaction between EMEs and communities.* EMEs held twice weekly community meetings during all of GESCOME II. While a mechanism of regular community meetings was established during GESCOME I, at that time, everyone in the community was invited to attend by the town crier. This appeared to be an inclusive approach, but in fact, led to inefficient meetings where those of lower status did not feel empowered to speak. A training curriculum that addressed issues of exclusion, gender role and status, and segmenting the community was developed to address that issue.

- After training in these topics and participatory health communication, EME members focused community meetings on members of groups they identified could be instrumental in preventing the transmission of diarrheal disease to young children. EME members also increased the number of community meetings they held. EHP II anticipates that such meetings may continue after the end of GESCOME II and the Lessons Learned exercise for the several reasons: First, EME members are not compensated so there is no financial disincentive to discontinue GESCOME activities. Second, the GESCOME II structure has been institutionalized by the Préfet's decree. Third, the Préfet wants the community meetings to continue. And fourth, EME members have told Mr. Yallou how much they enjoy the PCHC.

- It is important to note that periodic training, which EME members do not receive in any other way, as well as the desire to serve, form a large part of the reason that EME members are willing to devote so much of their time to GESCOME. After the Lessons Learned period, EME training will stop. Financial reimbursement to EMEs for the costs of stationery and photocopying necessary for community activities, and the light refreshments offered at community meetings, also will end. EHP II has provided each EME with US$ 50 per month as reimbursement for these costs. Some EMEs are willing to pay these costs from their own pockets, but cannot do so indefinitely.

- *Mechanisms will be established and used for soliciting community input in local decision making.* Community meetings, even before the last GESCOME II training, served as an effective mechanism for transmitting community perspectives to local governments, since representatives of several municipal-level ministries serve on each EME and EME members facilitated the meetings. The EME representatives on the CDSE effectively advocated for their communities, giving community members a voice, albeit indirect, in local decision making. For example, many communities had not originally chosen latrines as their first round micro-project. Instead they chose to build gray water pits. However, the EHP II Activity Manager specified from the inception of GESCOME II that all micro-projects should contribute to the reduction of diarrheal disease transmission. EME representatives shared their communities' reactions with the CDSE. As a result, the Préfet and CDSE decided that if communities truly wanted to build gray water pits so much, the CDSE would commit to raising the funds to help them do so using the GESCOME structure, but outside of the GESCOME project.

During GESCOME II's original design phase, it was anticipated that decentralization of governance and decision making would have progressed much further than was in fact the case by the end of GESCOME II. Decentralization would have resulted in local governments gaining more power than they currently enjoy. Therefore, the ability of GESCOME to help communities gain a greater voice in local decisions is limited simply because local decision making is still limited. However, both the CDSE and Préfet believe that the GESCOME structure will be an invaluable aid to

local elected officials once the decentralization laws that have already been enacted are implemented.

- *Communities will contribute financially to micro-projects, contributing at least 15% of budget.* This indicator was met in all but one neighborhood (see Section 3.4, Financing).

- *Revolving funds will be established to support maintenance costs for micro-projects. GESCOME II did not meet this indicator.* Neither Mr. Yallou nor Dr. Krieger had any experience with revolving funds. During Dr. Krieger's trip to Benin, in January-February 2000, she and Mr. Yallou asked all of USAID partners engaged in micro-finance whether they could provide assistance with implementing revolving funds. Unfortunately, these projects did not have the requisite expertise to help GESCOME establish such a mechanism. Eventually, GESCOME located a Beninois consulting firm specializing in micro-finance that was prepared to assist GESCOME. However, the proposed fees for their technical assistance would have consumed a large share of the GESCOME budget.

By the end of GESCOME II, it was still too early to tell whether the GESCOME II micro-projects were being maintained through users fees. Interestingly, at the end of GESCOME II, GESCOME I micro-projects, were being maintained adequately through these fees (Salifou Yallou, personal communication). "Adequate" in the context of latrines meant that they were kept clean, water and soap were supplied to users, the custodian was easily available with a key when needed, and funds were sufficient to cover these needs as well as the custodian's compensation. In the context of water source points, "adequate" meant that users fees were sufficient to cover the SBEE bills for water used, as well as to maintain the cleanliness of the water source point and cover minor repairs.

Indicator Agreed Upon Later

Number of micro-projects resulting from joint EME, community member, and local government decisions per community.

A total of six micro-projects were completed during GESCOME II. An additional eight micro-projects, begun under GESCOME II, would be completed during the Lessons Learned period (all had been completed at the time of this writing). The 14 micro-projects were completed through GESCOME II funding and PRA activities undertaken during GESCOME II. They represented 40 new completed infrastructures (including the two well renovations), because each micro-project encompassed all the infrastructure initiated in one neighborhood during one round of construction and funding to address an environmental health risk.

All community micro-projects resulted from joint EME, community member, CDSE (departmental), and local government decisions. The EMEs facilitated the community meetings during which communities selected the micro-projects they wanted to build to address the environmental health problems that they had identified with the EME.

The EME intervened to ensure that all micro-project suggestions that reached the proposal stage would address a cause of diarrheal disease transmission that they and the community had identified in the community. The CDSE decided upon the merits of the micro-project proposals.

4.2. Tasks Requested in Scope of Work

USAID/Benin requested that EHP II, through CESH, perform the following tasks to achieve the results:

Table 11: Tasks Required Under USAID/BENIN Scope of Work

TASK	OUTCOME	COMMENTS
Build on CIMEP accomplishments by continuing to strengthen community-based structures such as municipal teams, EMEs, and the CDSE in order to maintain dialogue between communities and local officials	EMEs and CDSE continued to work together; CDSE developed commitment to communities (e.g., pledged to find funds for micro-projects not fundable under GESCOME II); EME reported community sentiment to CDSE	Build on CIMEP
In collaboration with the Préfet and local elected officials from the target municipalities of Bembéréké, Banikoara, Parakou and Sinendé, identify criteria and select three new target intervention areas/neighborhoods in each of the target municipalities	New neighborhoods identified in Sinendé before close of GESCOME I; new neighborhoods approved in other towns by December 1999	
In collaboration with local elected officials in each municipality, select EME and CDSE participants at community, municipal and regional levels and establish a dialogue and mechanisms for communication between the municipal teams and decision makers at the various levels	Chefs de quartier (local elected traditional neighborhood leaders) helped select EME members. Local elected officials (mayors) served on the CDSE. Decision makers collaborate, through the Round Tables. EMEs brief chefs de quartiers on progress.	The slower than expected pace of decentralization meant that there were fewer elected decision makers than anticipated
Form and train a municipal team (EME) in the new target intervention municipality of Sinendé	Completed under GESCOME I	
Form and train concerned citizens groups in each new target intervention area/neighborhood	Completed (see Training, section 3.2)	

TASK	OUTCOME	COMMENTS
In each target municipality, organize five skill-building workshops covering institutional arrangements, identification of community high-risk behaviors, community monitoring, development of interventions and establishment of a revolving fund mechanism	Six skill-building workshops conducted during GESCOME II covered all required topics except for establishment of a revolving fund mechanism	EHP II did not have the expertise, nor could it identify a USAID project with the appropriate skills to provide technical assistance (TA); the Beninois firm that could have provided TA was too costly; EME members were concerned that even the current load of work could be onerous
Participate in a behavior change baseline study in each target intervention area, in collaboration with the University Research Corporation (Benin Integrated Family Health Program, PROSAF)	Did not complete	GESCOME II met with the PROSAF team but was unable to work out an agreement. PROSAF and GESCOME II collaborated in other ways. EHP II epidemiologist had advised that sample needed for diarrheal disease baseline would add enormously to PROSAF's reproductive health sample.
Establish baselines for selected key indicators in each target intervention area/neighborhood	No quantitative indicators established; qualitative baselines established by each neighborhood	No baseline survey conducted
In collaboration with local elected officials from each target municipality, identify priority environmental health risks and behaviors at the community level that contribute to the transmission of diarrheal disease	Completed during participatory rapid appraisal phase of GESCOME II, in which local elected officials participated	There were fewer elected officials than anticipated during project design because of the slow pace of decentralization
Implement three micro-projects per target intervention area/neighborhood that address the environmental problems/risks identified in that area. The micro-projects will involve infrastructure development and will be oriented to improving knowledge, attitudes and practices of communities toward preventing disease transmission	Banikoara and Sinendé neighborhoods implemented two micro-projects per neighborhood. Two Bembéréké/Beroubouay neighborhoods implemented one micro-project each. All micro-projects were oriented toward preventing diarrheal disease transmission.	

TASK	OUTCOME	COMMENTS
For each micro-project, identify key indicators related to changes in health behaviors and environment that should result from the intervention	Indicators for individual micro-projects were not established, but they were established for rounds of micro-projects	Indicators for latrines: handwashing after defecation, usage of latrines, use of latrines by children under 5. Indicator for water points: usage
Set guidelines for community revolving funds, taking into account seasonal conditions which influence communities' ability to make financial contributions to micro-projects	Guidelines for handling micro-project funds were established; no revolving funds were developed	The village agricultural cooperative was involved in collecting micro-project construction and user fees, as a kind of community tax deducted from cotton harvest proceeds
Organize five Round Table meetings to continue support for the departmental mechanism which encourages dialogue among various levels of government officials and community representatives, and allows participants to identify factors that impede collaboration among partners and implementation of planned activities	Six Round Tables were held. These facilitated communication among various levels of government officials and community members, allowing participants to delve into barriers to collaboration and implementation (see section 3.6, especially, "The Sixth Round Table"	
Monitor and evaluate community-level behavior change and environmental health risk factors for selected indicators	Monitoring occurred after the end of GESCOME II, during the Lessons Learned phase	Community latrine monitoring monitored indicators; fees collected for water source point usage (all are pay-per-use; renovated well use was gratis)
Collaborate closely with URC to facilitate coordinating efforts and with other partners such as BASICS, MCDI, etc., in the area of behavior change	Salifou Yallou, GESCOME II Country Director collaborated closely with URC and other partners, attending all partners' meetings and any other meetings called by PROSAF	Mr. Yallou presented updates of GESCOME II at partners' and other meetings
Within two months before the project PACD, organize a training of trainers workshop to transfer skills and knowledge gained through the activity to a wider audience	Not completed	Training is undertaken immediately before skills are used; since new project was not ready, it was unclear whom to train and no opportunity existed to use skills
Within one month before the project PACD, evaluate the CESH/CIMEP process in Benin	CDSE evaluated GESCOME process during last Round Table, within final month of project	Lessons Learned team scheduled to examine GESCOME process in early 2002

4.3. Results Not Covered by Indicators

Participatory health communication on diarrheal disease transmission and prevention provided to GESCOME I and II neighborhoods in Banikoara, Sinendé, and Bembéréké/ Beroubouay. The Lessons Learned exercise explored the approximate numbers of people covered by PCHC in these towns.

Gender Equity. At the beginning of GESCOME II, there were no or at most, only one female member per EME. The majority of women on the EMEs did not speak much or at all during meetings. Attempts by male EME members to encourage women to speak out seemed to embarrass the women and were not particularly supportive. In addition, members of a GESCOME I EME and CGMP had accepted a design for a water point delivery source that was inappropriate to the way women collect water—and collecting water traditionally is a female task. This resulted in broken taps because taps were the only places women could rest their full water containers between transferring them from the ground to their heads, where they carry the containers. EME and CGMP members blamed women for the broken taps and planned to sensitize women to the consequences of their actions.

Two steps were taken to respond to this gender inequity: First, more women were required to be incorporated into the EMEs, although how this happened was up to the CDSE. Second, gender training was designed with three objectives: (1) to promote a gender aware atmosphere within the EMEs to encourage and support female members' full participation; (2) to promote gender awareness in the EME's community work so that the EME could realistically segment the community into natural groups that affect transmission and prevention of diarrheal diseases among young children; and (3) to ensure that female community members have at least an equal voice in community meetings and decisions.

During the training, most of the natural groups that EME members identified were females because it is women who cook, feed and clean children and dispose of their feces. Some of the groups identified included women working in a cooperative garden, women meeting at the same water source, and market women. The PCHC meetings were limited to the members of identified natural groups. This gave female community members a new presence in the community/EME dialogue about child diarrhea and ensured that they would feel comfortable speaking out in meetings because they were among their same-sex peers.

Departmental links to the community. Evidence that strong links were forged between the community and departmental levels include: the CDSE's repeated request that the members receive the same training as the EME members so that they could supervise the work of EME's more closely and get to know the communities better; the CDSE's decision to find funding for gray water pits, since this was a priority of the communities; and the Préfet's repeated interventions to provide advocacy and political support at the community level.

EME's involvement in elections. While the national elections slowed down GESCOME II, they also provided an opportunity to view the degree of support by the communities for the EME. In every GESCOME II town, every EME member who ran for election was successful in his bid to serve as an overseer of the election process. Mr. Yallou asked EME members whether they felt that GESCOME had played a role in their election. They responded that facilitating community meetings certainly gave them visibility. And since the meetings are participatory, they reinforced EME members' public image of commitment to democracy and the community.

Multiplier effect of EME participation. Many EME members were also involved in other projects and other community activities, even before agreeing to serve on the EME. In fact, this is the reason that some of the members were recruited, i.e., in order to stimulate a multiplier effect. On every EME there was at least one active member of the *Comité de Gestion de Centre de Santé* or Health Center Management Committee (COGEC). The Sinendé EME boasted three COGEC members. Two EME members used skills acquired during GESCOME to play important roles in facilitating the design of the Banikoara Community Urban Development plan by a SNV (Netherlands Development) project. Civic activities of EME members are summarized in the following table:

Table 9. Civil Society Activities of EME Members (in addition to GESCOME)

Bembéréké/Beroubouay	Banikoara	Sinendé
Caisse Locale de Crédit Agricole (Local Agricultural Credit Fund)	Composant Sanitaire—Société Beninoise d'Eau et Electricité (COSA-SBEE) (Sanitary Component of the Beninois Society of Water and Electricity)	APE
Groupement Villageouis de Producteurs (Village [Agricultural] Producers Grouping or Cooperative)	Red Cross	Caisse Locale de Crédit Agricole et Mutuelle (CLCAM) (Local Fund of Agricultural and Mutual Credit)
Association du Développement (Development Association)	Groupement Villageois de Producteurs	Comité de Santé de Zone Sanitaire (CSZS) (Sanitary Zone Health Committee)
Projet EDUCOM (UNICEF) (Education Communautaire—Community Education)	Association Sportive (Sporting Association)	COGEC
Association des Parents des Élèves (APE, the Parent-Teachers Association)	Office National pour la Sécurité Alimentaire (ONASA) (National Food Security Office)	Groupement des Femmes
PROMIC Fonds de Developpement Agricole (FIDA/PROMIC) (Agricultural Development Funds)	Association pour les Services Financiers (ASF-PROMIC) (Association for Financial Services)	
Comité de Décentralisation (Decentralization Committee)	APE	
Conseiller de la Village (Village Counselor)	COGEC	
Comité de Gestion du Centre de Santé de Commune (COGEC)	Groupement des Femmes	
Groupement des Femmes (Women's Group)		

Two EME members served as facilitators in the design of Banikoara Community Urban Development plan, as part of a SNV project, having learned facilitation skills through GESCOME. This means that other projects and community roles gain the benefit of GESCOME II EME training and experience, while GESCOME II benefited from capacity building by other projects and groups.

Other organizations/projects working in diarrheal disease prevention and GESCOME seemed to create synergistic effects.

Empowerment of community natural leaders (CGMPs). Elections of community representatives for the EMEs were, in reality, often appointments by the *Chef de Quartier* (Head of the Quarter or neighborhood leader). Literacy is relatively low in Benin, and literacy was a requirement for EME membership. However, all CGMP members were actually elected by their neighbors. Many were illiterate and, as mentioned earlier in this report, most had never been inside a bank. None had previously contracted for work. CGMPs responsible for latrines tended to be respected male elders (natural leaders), whereas CGMPs responsible for water point

sources tended to be women, both young married and older women whom their neighbors felt were responsible, honest, and qualified (natural leaders). Some of these women had previous experience with other projects where they had learned the basics of accounting, although almost all were illiterate. GESCOME II provided the opportunity to showcase and use skills learned in previous development efforts by women who may not have otherwise been particularly powerful in the community, so that the multiplier effect worked both ways.

4.4. Problems Encountered

GESCOME II was able to resolve almost all the problems it encountered. However, several issues remained unresolved at the end of GESCOME II.

EMEs and CGMPs wished to be given some compensation for their work. GESCOME I and II were designed as completely voluntary activities in order to be more easily sustainable after the end of the project and to encourage greater participation. Therefore, members of the EMEs and CGMP received no monetary compensation at all. EME members continually complained about the amount of work involved in GESCOME I and II. They felt that in return they did receive training and the sense of serving their community, but no money (see Lessons Learned report for further details on EME opinions). They at least wanted tee shirts that they could wear to show that they were EME members. Mr. Yallou felt strongly that, during the life of GESCOME, tee shirts would differentiate EME members from the community and make the whole project less participatory. However, at the end of the Lessons Learned exercise, EHP II does plan to give EME and CGMP members tee shirts as a "parting thank you gift" and to publicize hygiene.

EME members complained about how much of their time was devoted to GESCOME II work. Throughout the project, EME members met twice weekly with the community. Once micro-projects were initiated, they also supervised the CGMPs. While EME members enjoyed their work, they also sometimes found the time burden onerous, particularly since they had many other commitments (see table in Section 4.2; see Lessons Learned report for estimated average and range of amount of time per week spent by EME members). The PRA portion of the EME's duties and micro-project development took much more time than some of the other activities, e.g., supervising CGMPs. EME members said that PCHC meetings took longer and involved more than simply relaying messages. However, segmenting the community into natural groups greatly reduced the number of community meetings held, so that overall, the amount of time devoted to this activity was less than for more time consuming activities.

Occasionally, an EME member did not pull his or her weight and other EME members were saddled with more work. Although Mr. Yallou heard some grumbling about members whom other EME members felt often did not pull their weight, the great majority of members worked hard. When a member consistently did not attend EME meetings and did not assume his/her fair share of community work,

the member was voted off the EME. This happened in at least one case during GESCOME II.

Since participation by EME, CGMP, and community members was completely voluntary, farming and politics sometimes came first; this meant that many project activities took longer than planned. Given the voluntary nature of participation, it is not surprising that activities often were delayed. CAN MOVE, a Washington-based group formed by members of USAID-funded projects and private voluntary organizations and other U.S. government agencies, encourages community participation. It has taken on an advocacy role for project designers and donors. The group advocates the need to plan for very long roll out and implementation periods for truly participatory activities. This point is also emphasized repeatedly in Meredith Minkler's edited volume, Community Organizing and Community Building for Health (1999). Fortunately, both USAID/Benin and EHP II were responsive, within limits, to the need for flexibility in timing.

The inception of the project took longer than expected on the Washington side. Although some of the staff members of EHP II remained from EHP I, most were new and EHP II was a new project with somewhat different goals. The Task and Activity Manager for GESCOME II was also new both to the activity and the project. On the EHP II side, GESCOME II was not a continuation of GESCOME I; it was a new activity. The CESH Benin Activity, GESCOME II, was part of the new project, EHP II, and EHP II implementation began slowly, as CESH and other components of the project had to first determine their focus and direction. Although GESCOME II was initially designed to focus most of the energy required during periods of less intensive agricultural work, the delay meant that the project was out of sync with the agricultural schedule at certain points, resulting in additional delays. With the permission of USAID/Benin, GESCOME II work plan revisions reflected the new schedule.

Some community members started negative rumors about CGMP members. Some members of the community told neighbors, relatives, and friends that EME and CGMP members benefited financially from their GESCOME work. Since EMEs and CGMPs collected money from the community, such gossip caused hostility within the community toward EME and CGMP members. Mr. Yallou notes that this was also the case during GESCOME I. In the beginning of both GESCOME I and II, community meetings were held in each neighborhood to explain GESCOME and its structure. Mr. Yallou and political leaders explicitly stated that no one would be compensated for their work—which was the case. Later, in response to the rumors during GESCOME II, Mr. Yallou, as well as the Préfet, attended a number of community meetings to seek to correct any false impressions, but Mr. Yallou felt that this did not help as much as he had hoped.

While truly participatory community activities are more democratic and more sustainable than top-down projects, communities are formed by a congeries of often competing interests and personalities. Unless the project included an ethnographic community study by social scientists that identified how community processes

worked in project neighborhoods, it is unclear how this gossip could have been avoided. The CGMP members themselves, however, did their best to investigate the sources of the negative rumors and to use their social allies and networks to deflect any harm that might result. During the Lessons Learned exercise, a team of expatriates, including Dr. Krieger, will meet with communities to again try to change the views of community members in this regard. In addition, (see section 5.1, Lessons Learned), steps should be taken in the future to ensure even greater financial transparency (e.g., periodic neighborhood meetings to update neighbors on exactly how the micro-project construction and maintenance funds are being spent, perhaps with special meetings immediately after any large expenditures).

Miscommunication between the EHP II Country Director and Activity Manager. On rare occasions, miscommunication occurred between these two managers. For example, one would think he or she had relayed clear information in an email or telephone conversation, but subsequently found that it had been interpreted completely differently by the other person. Fortunately, this occurrence was the exception rather than the rule. However, it would sometimes cause some frustration until both parties realized what had happened. Miscommunication seriously affected only one activity during GESCOME II: the initiation of radio broadcasts. These did not occur under the direct auspices of GESCOME. The few cases of other miscommunication were easily rectified shortly after they had occurred.

It was very difficult to find local consultants who were not government employees and NGO partners with the skills necessary to assist GESCOME. U.S. government regulations prohibit government employees from being compensated for outside work. This resulted in EHP II not being able to find a suitable trainer in gender awareness and social mobilization. Dr. Krieger, who was not budgeted for curriculum development, developed the gender awareness, social mobilization, and participatory community health communication curriculum on her own time (the reason it is not included in the annexes).

EHP II was delighted to have identified CREPA to conduct social mobilization and health communication training. As a local NGO, GESCOME II anticipated that CREPA's involvement in training and supervision might aid in the sustainability of the process. However, even with a great deal of help from Mr. Yallou, CREPA took much longer than anticipated to develop an acceptable proposal. CREPA provided assistance for one workshop in social mobilization, which EME members appreciated. However, providing payment to CREPA was a problem until the NGO was able to supply EHP II with a bank account number. At the same time, CREPA understandably did not wish to engage in any additional work with GESCOME II until they had been paid. Since training had to be implemented at certain times, this meant that GESCOME II could not further avail itself of CREPA's assistance. Mr. Yallou followed up repeatedly with CREPA about providing an invoice and bank account number, so it is unclear what GESCOME II could have done differently to facilitate this process. However, a workshop for NGOs early in GESCOME II might have assisted both GESCOME II and NGOs to better fulfill partnership needs (see Section 5.3).

The distance of Beroubouay from Bembéréké proper led to adaptation of GESCOME regulations and their subsequent violation. As a result, Bembéréké/Beroubouay did not finish even the first round of micro-projects during GESCOME II. However, by the end of the project, Bembéréké's latrines were at least 2/3 complete and were fully completed during the course of the Lessons Learned period. The signatures of two CGMP members and the sous-préfet were necessary to disburse funds; funds could only be disbursed for immediate use; and receipts had to be submitted to the sous-préfet within 48 hours after disbursement. However, the sous-préfet did not live in Beroubouay. Therefore, the mayor of Beroubouay was deputized to substitute for the sous-préfet. The mayor decided independently to disburse a large amount of community contribution funds to an entrepreneur, without the required two CGMP signatures. When the CGMP discovered this, they were upset and immediately informed Mr. Yallou, who froze the bank account and did not make any further EHP deposits. The entrepreneur chosen had not been trained in building to the specs used in all GESCOME communities and desired by the national government. Therefore, he started building latrines that were not environmentally sound. The CGMPs, EME, and Mr. Yallou prevailed upon the Préfet to intervene. Unfortunately, the entrepreneur was unable to return the funds he had been given and said that he could only contribute in kind services. Needless to say, this greatly slowed the implementation process. There was no longer sufficient money available to pay the new, trained mason hired by the community to complete the work. Consequently, the latrines were not finished during GESCOME II.

In hindsight, to avoid this kind of situation, EHP might have insisted on an inspection of the signature card at the bank to ensure that all three required signatures were on the card in order for funds to be disbursed. EHP might also have required community meetings to be held after each major withdrawal and disbursement of funds to apprise the community of where the funds had gone. In this community, the mayor, together with the CGMPs, might have been required to report to the community (see Section 5.1). However, the failure to hire a trained mason was in part due to a breakdown in communication between the Bembéréké and Beroubouay halves of the EME. It may be that the Beroubouay members never learned of the CDSE requirement to use a trained mason (a requirement that complied with the Beninois government request).

Communities were upset about the narrow focus on diarrheal disease, which was not necessarily their priority. This finding reflects a concern that remains a major conundrum in development work. Development projects, must have specific goals and indicators. In this case, EHP II intended to focus on diarrheal disease in order to make a public health impact. But public health perspective is seldom shared by communities. In the trade off between complete participation, in which communities get to choose what public health or wider development problem they want to work on, and a completely top-down project with specific quantitative targets (e.g., diarrheal disease reduced by 15% in children under 5), GESCOME II took the intermediate ground of focusing on diarrheal disease but without targets or specified behavior as identified by outsiders that communities must adopt in order for the project to be successful. In the future, a longer project time period and funds for an

additional micro-project round would enable towns to complete a third micro-project on any environmental problem they wished (e.g., construction of gray water pits).

Parakou was to be a test of a streamlined process for scaling up GESCOME, but never participated enough to truly test the process. Parakou was able to find some but not all the requisite number of community representatives for two of its three neighborhoods. The town was to be a test of streamlining the GESCOME process in the scale-up of the GESCOME process in Benin or other countries. The project managers proposed, with the permission of the CDSE, to combine the problem identification and problem analysis training to sensitize new Parakou EME members to GESCOME and the GESCOME process. The EME would not collect any new data, but would share the data from the three Parakou GESCOME I neighborhoods with residents of the new neighborhoods. The GESCOME I data would serve as the basis for the solution finding process in the GESCOME II neighborhoods. Parakou received training in diarrheal disease transmission, problem identification and analysis, but never completed any work with the community (see Section 3.5.1). There was continued interest in GESCOME, but it was insufficient to support a community program. Therefore, Parakou's involvement in GESCOME II was limited to representation in the CDSE and the continued operation and use of GESCOME I micro-projects, as observed by Drs. Borrazzo and Krieger during their January-February 2000 visit (see Section 5.1 for lessons learned from this experience).

5. Lessons Learned and Next Steps

5.1. Lessons Learned

The following is a list of lessons learned to date through GESCOME II. EHP II anticipates that the Lessons Learned exercise will reveal additional points.

1. A grass-roots participatory project can provide infrastructure to relatively large numbers of people in rural African towns.

2. Even with a participatory process, building infrastructure does not guarantee its use; in latrine construction, for example, the community's attention needs to be focused on the latrines through publicity and community discussion (PCHC).

3. A pay-per-use financing mechanism for potable water works. Pay-per-use water point sources are used extensively, as demonstrated by their ability to generate enough fees to cover the water bills and maintain the water point.

4. A pay-per-use financing mechanism for community latrines does not work as well as an annual levy per household.

5. The GESCOME structure and CIMEP process effectively link the community/neighborhood with the municipal and departmental levels to support initiatives aimed at governmental decentralization.

6. The participatory process and structure of GESCOME, with decision making localized at the neighborhood and departmental levels, leant flexibility to the structure; communities were able to adapt the GESCOME structure to meet their local needs

7. In using the GESCOME structure as a mechanism to support decentralization, care should be taken to avoid giving EME members additional activities without removing some of the environmental health activities for which they are responsible because EME members are already overloaded and almost all have other civic responsibilities and involvements. The temptation to use this effective mechanism for multiple activities should be avoided unless some EME members specialize in certain activities, so that not everyone carries out all activities in all areas.

8. EME members clearly believed that GESCOME II activities were important because they were also involved in a number of other civil society activities and

development projects that compensated them for their time, but they were willing to spend 14–24 hours per week on GESCOME II activities

9. The means for collecting community contributions must be clearly spelled out and community members responsible for collecting and disbursing community funds must operate in a completely transparent manner, perhaps holding neighborhood meetings after the collection to explain how much was collected and again after each major disbursement to explain how the funds are being spent.

10. A very participatory project design with voluntary community implementors must be planned over a longer project period with a more relaxed pace than more directive designs.

11. A workshop for NGOs in proposal preparation and GESCOME II training needs and orientation might have helped GESCOME to more easily identify and incorporate NGOs and their skills to fulfill GESCOME's administrative and technical needs.

12. A computerized consultant database available to all donor projects, NGOs, and other development organizations would facilitate identification of consultants well in advance of when they are needed so that government employees could take leaves of absence in order to assist in non-governmental development work.

13. For the GESCOME process to succeed, there must be political will at the municipal level, strong political support at the departmental level, and community members willing to participate as EME members, CGMP members, and community contributors.

14. The presence of other actors in environmental health, particularly diarrheal disease prevention, was welcomed by GESCOME II and created a synergy with GESCOME's and others' efforts.

15. A case study of Parakou by a consultant should be undertaken in order to gather further lessons learned, focusing on the reasons Parakou's involvement was so limited, to avoid the same situation in the future.

16. The cost of maintaining one EME's routine activities (i.e., community meetings, EME meetings, and correspondence), is equivalent to US$ 50 per month. The cost per year to maintain all three GESCOME II EMEs is US$ 1,800.

17. The CDSE will continue to require some funding in order to meet in Round Tables. Since many members must travel significant distances to attend the meetings, meals or per diems are provided following USAID regulations. In addition, if the Prefecture conference room is not vacant, a hall must be rented. This can cost approximately US$ 60 to US$ 180 per Round Table meeting.

18. Training will be important to support the EMEs after the end the project. EME members viewed training as a major benefit and as a kind of compensation for

their work. In addition, new members will inevitably join the EMEs due to natural attrition. These new members will require training.

19. The areas in which EME members could valuably use additional training include: social mobilization, coalition building, training, other technical areas of environmental health, treatment of diarrhea, additional participatory evaluation skills, and data analysis (to completely take over the community latrine monitoring activities to be undertaken during the Lessons Learned exercise).

20. The cost of each three-day training workshop averages about US$ 3,000 per town or US$ 9,000 for one round of training in all three towns. With the expanded EME size, only one town may be trained at a time. However, there would be an economy of scale if GESCOME were introduced to an entire town at the same time instead of only to selected neighborhoods

21. Two additional trips by the Activity Manager to Borgou/Alibori were needed during the project, especially during the final training of GESCOME II, and to follow up on decisions made during the trip of Drs. Borrazzo and Krieger. These trips would also have helped identify and resolve areas of miscommunication.

22. EHP country directors/activity coordinators need periodic face-to-face contact with EHP II activity managers to provide technical assistance and useful communication and feedback. The extent of the contract needed will depend upon the project, but face-to-face contact on a quarterly basis would be ideal.

23. In the future, entire towns should be included in the GESCOME process, rather than incorporating towns in groups of three neighborhoods at a time. This would ensure parity in each town and save costs in training. Since many activities occur at the municipal level, the additional work that would result would probably not be overly burdensome.

24. An alternative to the hope tree should be designed and pretested with communities in order to avoid some of the confusion experienced by one of the towns.

25. A larger, more inclusive EME worked well—no problems arose in GESCOME II EMEs that were not seen during the smaller EMEs of GESCOME I. The only problems that arose related to members who did not pull their weight or, rarely, an autocratic EME coordinator.

26. The work schedule should be carefully timed to coincide with less intensive parts of the agricultural schedule, recognizing that participatory community work often takes longer than expected.

27. Mechanisms should be formally agreed upon by the CDSE and EMEs to handle situations where one or more EME members fails to pull his/her weight.

28. USAID/Benin's flexibility in overseeing the project and its recognition that a truly participatory process takes time enabled GESCOME II to support USAID/Benin's 1999 Democracy and Governance Special Objective: "Improved Governance and Reinforced Democracy" and IR3.1: "Increased local community access to financial and technology resources to support local initiatives," although GESCOME II may not have been expected to contribute to this indicator. At the time of this writing, communities had the technology, via micro-projects, as a result of a local initiative and the resources, via local usage payments, to maintain the resources. Continuing PCHC meetings may help to maintain local interest in continuing with these interventions.

29. USAID/Benin's wisdom in refraining from requiring targets for reduction of diarrheal disease enabled the project to attempt new strategies in health communication for diarrheal disease prevention. Such strategies may be more time consuming than more directive models, but they may, in the end, ensure community-wide, enduring changes in behavior.

5.2. Next Steps

EHP II is undertaking a Lessons Learned activity as a follow up to GESCOME II. The activity will undertake the following tasks:

1. Mr. Yallou follows up EME and CGMP financial management for how EMEs and CGMPs manage financially without benefit of technical assistance.

2. Mr. Yallou trains selected high school students to conduct latrine monitoring and trains EME members to conduct latrine monitoring, develop latrine monitoring work plans, and supervise latrine monitors.

3. Community conducts latrine monitoring (i.e., behavior observations) by high school students, hired by EHP II and supervised by EME members.

4. Latrine monitoring data are analyzed using the Statistical Package for the Social Sciences (SPSS).

5. CGMPs finish the first round of micro-projects in Bembéréké.

6. CGMPs complete the second round of micro-projects in Sinendé and Banikoara, without technical assistance, and Mr. Yallou monitors the process and results.

7. Mr. Yallou interviews the Préfet, EME members, and CGMP members about their experiences with and views on GESCOME.

8. Mr. Yallou completes reports on training activities that are new to GESCOME II or to the Lessons Learned activity.

9. The Activity Manager, Mr. Yallou, and a specialist in democracy and governance/decentralization conduct an assessment/situational analysis post GESCOME II.

10. Purchase and distribution of tee shirts for EME and CGMP members.

11. Publication of GESCOME Lessons Learned.

The planned Lessons Learned activity will seek to assess the sustainability of GESCOME and garner lessons for future projects. In addition, continued implementation and bridging to the new USAID project suggest several next steps.

1. To maintain the link between community/neighborhood, municipal, and departmental levels, the CDSE should continue meeting in Round Tables in the various towns and include discussions with CGMPs and other EME members in their meetings.

2. To better bridge between GESCOME II and the new USAID democracy and governance project, Mr. Yallou should be retained through EHP II or another mechanism. This would help ensure that GESCOME structures and communities are prepared for upcoming USAID project activities.

3. EMEs are scheduled to resume participatory health communication meetings after the latrine monitoring is completed during the Lessons Learned period. If possible, Mr. Yallou should follow up on these meetings after the Lessons Learned exercise to maintain momentum.

4. Someone experienced in GESCOME should be given responsibility for ensuring that GESCOME continues even after the end of the project. That person should be able to devote a significant amount of time to the coordination of GESCOME in Borgou and Alibori Departments. S/he might be designated by the Préfet and be part of the Department administration or could be a contractor hired through a donor. S/he could also assist the Préfet in scaling-up GESCOME to the other towns in the two Departments, something the Préfet has already indicated he would like to do.

5. If community latrine monitoring appears to be useful and viable, communities may wish to undertake this monitoring for two to three weeks twice a year, especially during drier seasons. In that way, they could monitor use of their micro-projects and determine whether and how community members wash their hands after defecation in order to focus PCHC efforts.

6. Eventually, communities may wish to track cases of diarrhea in young children to understand the outcome of latrine use, handwashing, and safer food storage and water handling. If EME members find that caregivers take young children with diarrhea to health facilities, EME members could be trained in collecting and tabulating health facility statistics. They would share the results in community meetings. If caregivers frequently resort to traditional healers for children's

diarrhea, perhaps it would be possible to collect statistics on the number of cases from the most popular healers.

7. The GESCOME process seems to work well in Banikoara, Bembéréké, and Sinendé. By incorporating all the neighborhoods in each town simultaneously, the project design, process, and GESCOME structures could be extended, perhaps in two or more waves, to all of Borgou/Alibori and beyond.

8. A survey should be undertaken to evaluate the epidemiological impact of GESCOME. The survey should be accompanied by brief ethnographic research in order to understand the processes that led to epidemiological changes or stasis.

9. At or shortly before the inception of the next project, training of trainers workshops should be held to train those already trained, as well as additional trainers. Those trainers trained in the GESCOME I Sinendé workshop will need more training and support to conduct their first two workshops; Mr. Yallou could best supply this support. More than one training of trainers workshop would have to be held if trainees are not already familiar with GESCOME. Trainers not only would have to learn how to train, but they would also need to learn about GESCOME and how to implement the PRA process, as well as the social mobilization and participatory community health communication. It would be unrealistic to expect civil servants, farmers, or market women to stay away from work for the time that it would take to train them in all these aspects.

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Annex 1

COMMUNITY-BASED ENVIRONMENTAL SANITATION AND HYGIENE (EHP II)

(Continuation of CIMEP in Borgou Department, Benin)

ACTIVITY DESCRIPTION

Objective

The overall objective of this activity is to continue the implementation of the Community Involvement in the Management of Environmental Pollution (CIMEP) pilot activity. The mechanism used to support implementation will be the Indefinite Quantity Contract (Subproject 9365994.10) for Community-based Environmental Sanitation and Hygiene (CESH), under the Environmental Health Project (Phase II).

Background

In October 1997, the Family Health Team (FHT), through the Environmental Health Project (Phase I), started the implementation of an activity called Community Involvement in the Management of Environmental Pollution (CIMEP) in three secondary cities in Benin (Parakou, Bembereke and Banikoara). The objective of the 18-month pilot activity was to train communities to recognize the environmental risk factors that contribute to diarrheal disease transmission and identify means to reduce or prevent disease transmission and, through micro-projects, to build environmental health infrastructures and promote behavior change.

The EHP I project agreement, with an original PACD of March 30, 1999, was granted a no-cost extension by G/PHN and will now end on September 30, 1999. As a result, USAID/Benin was able to extend CIMEP's activities (at no additional cost) to the end of August 1999. This was necessary because CIMEP was unable to liquidate its budget for micro-projects by the original PACD due to problems in procuring cement for planned infrastructures. In addition to completing these micro-projects, before the conclusion of EHP I, CIMEP will begin laying the groundwork for the establishment of a municipal team *(or Equipe Municipale Elargie/EME)* in the town of Sinende, which was recently chosen as a USAID target area in the Borgou region. The CIMEP local coordinator has submitted to the FHT an acceptable action plan through August 31, 1999.

The Mission is in the early stages of designing a new activity related to decentralization that will include a component similar to CIMEP. However, this new activity will not be ready for implementation before mid-2000. The Mission has determined that it should continue to build on CIMEP's successes in its target areas related to community involvement in the management of environmental risk factors to health. Therefore, instead of closing out CIMEP activities until the

start-up of the decentralization activity, and risk losing the momentum that has been building, the Mission would like to continue its activities.

The CESH mechanism in EHP II has been identified as the most appropriate bridging mechanism available between EHP I and the decentralization activity because its explicit purpose is to support community-driven risk factor identification and intervention, especially for diarrheal disease, malaria (and other vector-borne diseases), and acute lower respiratory infections. Over the course of one year, CESH will allow CIMEP to continue working in the existing target areas and expand to the newly identified target area of Sinende.

This activity will contribute to the achievement of USAID/Benin's Family Health Strategic Objective 2, Intermediate Result 4 (IR4), *Increased demand for, and practices supporting use of, family health services, products & prevention measures.*

Statement of Work

This one-year activity will pave the way for implementation of the Mission's upcoming decentralization activity by supporting increased community dialogue and collaboration with local government structures in the identification of local problems and their solutions.

Under the newly awarded Community-based Environmental Sanitation and Hygiene (CESH) IQC, the Contractor shall:

- Build on CIMEP I accomplishments by continuing to strengthen community-based structures such as municipal teams (*Equipes Municipales Elargies*, or EMEs), and the departmental environmental health committee (*Comite Deparmental de Sante Environnementale*, or CDSE) in order to maintain dialogue between communities and local officials

- In collaboration with the Prefet and local elected officials from the target municipalities of Bembereke, Banikoara, Parakou and Sinende, identify criteria and select three new target intervention areas/neighborhoods in each of the target municipalities

- In collaboration with local elected officials in each municipality, select EME and CDSE participants at community, municipal and regional levels and establish a dialogue and mechanisms for communication between the municipal teams and decision makers at the various levels

- Form and train a municipal team (EME) in the new target intervention municipality of Sinende

- Form and train concerned citizen groups in each new target intervention area/neighborhood

- In each target municipality, organize five skills-building workshops covering institutional arrangements, identification of community high-risk behaviors, community monitoring, development of interventions and establishment of a revolving fund mechanism

- Participate in behavior change baseline study in each target intervention area, in collaboration with the University Research Corporation (Benin Integrated Family Health Program/BIFHP)

- Establish baselines for selected key indicators in each target intervention area/neighborhood

- In collaboration with local elected officials from each target municipality, identify priority environmental health risks and behaviors at the community level that contribute to the transmission of diarrheal disease

- Implement three micro-projects per target intervention area/neighborhood that address the environmental problems/risks identified in that area. The micro projects will involve infrastructure development and will be oriented to improving knowledge, attitudes and practices of communities towards preventing disease transmission

- For each micro-project, identify key indicators related to changes in health behaviors and environmental that should result from the intervention

- Set guidelines for community revolving funds, taking into account seasonal conditions that influence communities' ability to make financial contributions to micro-projects

- Organize five (5) Round Table meetings to continue support for the departmental mechanism that encourages dialogue among various levels of governmental officials and community representatives, and allows participants to identify factors that impede collaboration among partners and implementation of planned activities

- Monitor and evaluate community-level behavior change and environmental-health risk factors for selected indicators

- Collaborate closely with URC to facilitate coordinating efforts with other partners such as BASICS, MCDI, etc., in the area of behavior change

- Within two months before the project PACD, organize a training of trainers workshop to transfer skill and knowledge gained through the activity to a wider audience

- Within one month before the project PACD, evaluate the CESH/CIMEP process in Benin.

Results and Indicators

Result 1: EMEs actively participate in CESH/CIMEP.

Indicators:

- Community representatives for the EME in the new target intervention area of Sinendé will be selected within three months of activity start date

- EMEs in all target municipalities will develop and implement a work plan

- EMEs in all target municipalities will plan meetings and meet on a regular basis

Result 2: Round Table meetings will continue, with the support of the *Préfet*, and will involve municipal support for environmental health issues.

Indicators:

- Round Table meetings will be attended by regional officials from various sectors
- Departmental and municipal decision makers will implement action items identified at Round Table meetings

Result 3: In each target intervention area/neighborhood, measurable changes will occur in behavior and environmental conditions directly related to diarrheal disease transmission.

Indicators:

- In each target area, high-risk behaviors contributing to transmission of diarrheal disease will be identified
- Participatory methods will be used to develop and implement strategies for addressing the high-risk behaviors identified
- Neighborhood concerned citizens groups will monitor behaviors on a regular basis
- High-risk behaviors contributing to transmission of diarrheal disease decrease, as measured through qualitative studies

Result 4: In target intervention areas, stakeholders (local elected officials, NGOs and community members) will collaborate to address community problems.

Indicators:

- Mechanisms will be established and used for regular interaction between EMEs and communities
- Mechanisms will be established and used for soliciting community input in local decision making
- Communities will contribute financially to micro-projects, contributing at least 15% of the budget

Revolving funds will be established to support maintenance costs for micro-projects

Resources Required

The total budget planned for this activity under the CESH IQC is US$ 200,000 for one year. It is expected that the home office of EHP II/CESH will provide ongoing backstopping and will

perform a field visit once every six months (i.e., twice during the course of the project). The CIMEP local coordinator will assure the day-to-day management of the activity. An illustrative budget is attached.

Reporting Requirement

The contractor shall submit to USAID/Benin's Family Health Team quarterly progress reports. These reports should include progress made in implementing the work plan as well as the budget. At the end of the activity, a final performance report will be submitted to USAID/Benin.

Attachment II

Illustrative Budget

1. Five training workshops for EME:	$4,000 @ 5 =	$20,000
final evaluation workshop (lessons learned):		$ 5,000
four round tables and other exchange visits among EME:		$18,000
2. Staff: Local Coordinator:		$15,000
Support Staff:		$ 2,000
3. EME functioning cost:		$ 4,000
4. CIMEP office functioning cost:		$15,000
5. Purchase, maintenance and insurance/or rental of a small car:		$10,000
6. Micro-projects:	$5,000 @ 12 =	$60,000
7. Headquarter costs/Admin		$51,000
Total		**$200,000**

Annex 2

DIARRHEAL DISEASE CURRICULUM FOR EME MEMBERS

Workshop on Diarrheal Disease Transmission and Prevention

Training Module

Section A. Introduction to the Workshop (25 minutes)

Step One: Welcome and expectations

Welcome the members of the EME to the half-day training on diarrheal disease. Explain that this training will prepare them to work with the communities on one of the most serious health problems for young children, diarrheal disease.

Ask each participant in turn to say what he or she hopes to learn in this workshop and note responses on a flipchart. (*no need to write whole sentences – just the main idea*)

Step Two: Workshop objectives and schedule

Post the flipchart with the workshop's objectives (flipchart #1, prepared beforehand) next to the participants' expectation list. Read the objectives and compare them to the expectations. If there are any expectations that are not covered by the objectives, say so honestly, and suggest how these might be met later (through documents, another training session, asking an expert, etc.).

Post and present the schedule for the workshop (flipchart #2, prepared beforehand), and answer any questions about the schedule.

Step Three: Workshop overview

Remind the group that the reason for holding this training for the EME is to prepare its members for their role in helping community groups understand the seriousness of diarrheal disease, and to decide on and carry out actions that can prevent children and adults from getting diarrheal disease. Some of these actions will need money and labor, but others would be easy to carry out if community groups knew how. After this training, the EME will be able to help others in the *quartiers* learn about the causes of diarrhea and how to prevent it, especially in little children.

Section B. What Is Diarrheal Disease? (60 minutes)

Step One: Definition of diarrheal disease

Tell the participants that it is important for all to understand what diarrheal disease is in order to help others tackle the problem. Ask the group how they would define diarrheal disease. What words best describe it? Write their answers on a flipchart but don't write repeat ideas.

Answers might include:

- loose watery stools ("selles liquides")
- frequent bowel movements
- stomach cramping
- pain in the gut
- blood in the stool

Tell them that the definition of diarrheal disease generally accepted by the World Health Organization (WHO) and others is having more than three watery bowel movements a day.

Step Two: Different kinds of diarrheal disease

Explain that there are several kinds of diarrheal disease. Ask the participants if they know of different kinds and what causes them. Note their answers on a flipchart. The purpose of this discussion is to find out what people already know, in order to add new information.

Make a brief presentation on different kinds of diarrheal disease. Tell the group that WHO uses the following three categories--acute diarrhea, persistent diarrhea, and dysentery—and explain each one. Post flipchart #3 (prepared in advance) with the information below on it to guide you. (You will probably need to use two or three sheets for this amount of material.)

Different Kinds of Diarrhea

Acute Diarrhea

- frequent loose watery stools (more than 3 per day)
- usually lasts less than 7 days but can last for 2 weeks
- an attack may include fever and vomiting
- causes dehydration, which can lead to malnutrition and death, especially in young children.
- caused by micro-organisms and intestinal parasites

Persistent Diarrhea

- starts as acute diarrhea but lasts a long time – over 2 weeks

- causes dehydration, weight loss; can lead to malnutrition
- Many different micro-organisms can be responsible for persistent diarrhea

Dysentery

- acute diarrhea with blood in the stool
- can cause weight loss, lack of appetite, and damage to the inside of the intestines
- caused by different micro-organisms
- Shigella is an important cause of dysentery

Tell the participants that they will be getting a handout with this information and more at the end of the session.

Step Three: Seriousness of diarrheal disease

Explain to the group that although diarrhea poses a problem for all members of the population, it is particularly serious for small children under age 5.

Ask: *Does anyone know what can happen to small children when they get diarrhea?*

> *[Dehydration is a serious consequence of diarrhea, and so is malnutrition. The frequent bowel movements can rapidly deplete the body of water and food/nutrients. This can lead to death if not quickly treated by oral rehydration and continued feeding (especially breastfeeding.)]*

Ask: *Does anyone knows why children under 5 are especially vulnerable to diarrheal disease?*

> *[Small children are often undernourished, especially while being weaned from breastmilk if they are not getting enough nutritious food. They may also have had infections or other illnesses that leave them weak. An attack of diarrhea can push them to serious malnutrition or even death.]*

Repeat that diarrhea is indeed a serious problem for young children. Where diarrhea is widespread, sometimes people do not think of it as a problem since all children get it and it seems to be a normal part of childhood.

To illustrate how serious it is, present to them the following information on the problem worldwide. Write it up on flipchart:

Every year:

- children under 5 experience 1,000 million episodes of diarrhea
- children experience an average of 3.3 and up to 9 episodes

- 3.3 million children die from diarrhea-related causes

- 80% of deaths due to diarrhea occur in children under 2 years

Remind participants of the survey carried out by GESCOME I in the three project towns. Present the results of those surveys on diarrhea in children and any other available useful statistics on diarrheal disease in northern Benin. The project findings showed that among the households surveyed in Parakou, Bembéréké, and Banikoara, about 35% of children under 5 years had had diarrhea in the previous two weeks. This survey was not carried out during diarrhea season, which makes this finding even more alarming.

To sum up, diarrheal disease is <u>not a normal part of childhood</u> but a serious illness, and participants will learn that there are ways to prevent it (to stop it).

Step Four: Community beliefs and attitudes

Explain that activities under the GESCOME Project will try to reduce the problem of diarrhea, especially in small children. These activities will be carried out by people living in the project *quartiers*, with the help of the EME. Lead a discussion with the participants about how they think community residents view diarrhea in small children.

Use these questions as a guide:

- Do people in the *quartiers* think that diarrhea in small children is a serious problem? Why or why not?

  [Accept what the participants say]

- Do you think men and women believe the same thing about the seriousness of diarrhea? What do you think are the differences, if any, and why?

  [Help participants see that because women—and often older girls—spend the most time with young children, they will have a more realistic understanding of the problem. It is important to include them as full participants in any diarrhea prevention program.]

- What do people think causes diarrhea?

  [Participants may say "teething," and you can agree with this, but you should explain that teething itself does not cause diarrhea. A child of teething age puts things in his mouth that may be contaminated, and is also of weaning age and may be eating unsafe food or not eating enough nutritious food. These factors can lead to diarrhea.]

- Ask participants if they agree with any of these reasons. What makes them correct or not?

  [Help participants see that people interpret disease causes based on observation and experience, and often—but not always—they are very close to the scientific explanation]

- How can we find out what the community's views are?

[By holding community meetings and asking questions]

- How can we find out whether men and women have the same or different views?

[By meeting with and asking questions of groups of women and men separately]

Section C. How Is Diarrheal Disease Spread? (45 minutes)

Step One: Definition of contagion

Explain that in order for people to take action to prevent diarrhea, it is important that they know how it is spread from person to person. Ask if anyone can define "contagion*" (the spread of illness by microbes from a sick person to a healthy one*). Ask the group what illnesses they know about that are contagious. Make a list on a flipchart of their responses.

Here are some examples—but you can use examples participants know best if you want:

- AIDS
- Colds
- Conjunctivitis (eye infection, "Appolon")

Ask: How does the spread of disease or contagion happen?

> *[Disease-causing microbes are spread from a sick person to a healthy one through direct contact (for example, AIDS via sexual contact) or indirect contact (for example, conjunctivitis via sharing a towel), causing the healthy person to get sick too. Microbes can also be carried by vectors (carriers) such as mosquitoes that transmit malaria by biting a sick person and then biting—and infecting—a healthy person.]*

Step Two: How diarrheal disease is spread

Ask the group whether and how they think diarrhea spreads from person to person in a family or a community. Write their responses on a flipchart. Ask the participants to explain their answers; ask the others in the group if they agree or have anything to add.

Possible responses might be: *Diarrhea-causing organisms (microbes) live in feces. When fecal matter isn't properly disposed of (in a toilet or latrine), it can contaminate the environment, getting on hands, food, and in drinking water, and it can infect another person. If people defecate in the bush, others can step in or near it and carry microbes on their shoes or feet into the house. During the dry season, dried feces can be blown by the harmattan winds onto things people eat, drink, or touch.*

Distribute Handout 1, *Routes of Transmission for Diarrheal Disease*. Explain that this diagram shows all the routes of transmission (or spread) of diarrheal disease. Give the group a few minutes to study the diagram and to think about how this spread might happen in the *quartiers*.

Ask someone to give an example of the first route, feces -> fluid -> new host, (people defecate in the open, diarrhea-causing organisms get into unprotected wells, people drink contaminated water). Then ask for an example for the next route, feces -> fluids -> food -> new host (contaminated water is used to wash foods before eating or to keep food fresh in the market). Ask for examples for each route on the diagram from different participants. Call on people who don't raise their hand to give everyone a chance to participate. Write responses on a flipchart.

Here is a sample list of examples. The participants might give other examples that are valid. The important thing is to make sure that they understand the way diarrhea is transmitted:

- Feces->fluids->new host: people defecate in the open; diarrhea-causing organisms get into unprotected water sources; people drink contaminated water.

- Feces->fluids->food->new host: contaminated water is used to wash foods before eating, to keep food fresh in the market, or to prepare food with.

- Feces->fingers->new host: people don't wash hands after defecating, shake hands with others.

- Feces->fingers->food->new host: child caretakers don't wash hands thoroughly after cleaning baby bottoms or after defecating themselves, then they prepare or eat food with contaminated fingers.

- Feces->food: people defecate in the bush or near the market, feces is blown or is carried by people's feet to where food is kept.

- Feces->flies->food: People defecate in the open; flies land on feces; flies land on food and deposit diarrheal disease microbes.

- Feces->bush (or fields)->new host: People defecate in the bush, other people walk through the bush and come in contact with feces

- Feces->bush (or fields)->food->new host: People defecate in the bush, winds carry feces and diarrhea-causing organisms to where people cook and eat.

At the end of this exercise, ask if anyone has any questions about how diarrheal disease is spread. Ask other participants to help answer the questions if they can.

[Note to the trainer: make sure there is agreement among the participants about the role of feces and the fecal-oral route of transmission of diarrheal disease before continuing. Add examples of contamination during the wet season.}

Explain that the next step of the training is to identify ways the spread of diarrheal disease can be prevented (slowed down or stopped).

Section D. How Can Diarrheal Disease Be Prevented? (1 hour, 30 minutes)

Step One: Definition of prevention

Go back to the participants' list of contagious diseases and how they are spread (flipchart developed in Section C). Ask the group how the spread of these diseases can be prevented (how the microbe routes can be cut off).

Examples (use the ones the group identified in Section C, Step One):

- AIDS – use condoms
- Colds – don't sneeze on people, stay at home, use handkerchiefs
- Conjunctivitis – wash towels or clothing of infected person; make sure infected person doesn't touch other people; keep infected children home from school

Explain that, similarly, diarrheal disease can be prevented by cutting the routes of transmission, as with the contagious disease examples just discussed. Ask someone to give an example of how diarrheal disease can be prevented, using the flipchart of examples of ways it can be spread (developed in Section C, Step Two). Ask for other examples.

Possible answers might be:

- use latrines,
- wash hands,
- cover food,
- drink and cook with clean water (water that comes from a protected source and has been safely stored).

Step Two: Small group work on prevention of diarrheal disease

Tell the group that they will now divide into small groups and work on identifying the many ways diarrheal disease can be prevented.

Divide the participants into three or four small groups depending on the number of participants. (Groups should have about five members each.) Give each group felt-tipped markers and flipchart paper, assign them places to work far enough from each other so that they aren't distracted, and give them the following task (on Flipchart #4, prepared beforehand):

Group Task

1. Using Handout 1, "Transmission Routes for Diarrheal Disease," and the examples of how diarrhea can be spread, make a list of ways diarrhea can be prevented by cutting the transmission routes. Try to be as specific as possible.

2. You have 15 minutes for this task. Be prepared to present your prevention list to the other groups.

Circulate around the groups to see how they are working and to answer any questions. Make sure the groups are working on the topic and will be ready to present their ideas.

Step Three: Group reports

Call the group back together after 15 minutes. Ask each group to present its work for no more than 5 minutes. Encourage the others to ask questions at the end of each presentation. Tape each group's work on the wall so everyone can see.

The prevention measures listed below should be included. If some are missing from the small groups' lists, ask questions to help participants think of the measures themselves. If some proposed prevention measures are not appropriate or accurate, ask the others what they think of the measure in question. The trainer may have to be the final arbiter on whether it is right or not.

Prevention measures which should be mentioned:

- use of latrines by all family members at all times
- dispose of babies' and small children's feces safely (by burial or down latrine)
- protect household drinking water from unclean hands, utensils, and dirt
- protect food from dirt and flies
- protect food from handling with unwashed hands
- wash hands thoroughly with soap after every visit to the latrine, after cleaning babies' bottoms or handling babies' feces, before cooking or handling food, and before eating
- use clean hand drying cloth or air dry hands
- drink water only from a tap or pump that is protected
- cook only with clean water (from a protected source and safely stored)
- improve protection of water source
- feed babies with a cup and spoon—not a bottle—if they are not breastfed

Summarize the prevention of diarrheal disease by stating that these actions are the most important to remember:

- Sanitary disposal of feces by all family members all the time
- Drinking and cooking with clean water

- Keeping hands clean

- Keeping food safe from fecal matter

Step Four: Possible micro-projects

Next, remind the participants that in the GESCOME II project, communities will be able to carry out micro-projects designed to prevent diarrheal disease. Ask what prevention measures the communities started during the first phase of GESCOME I.

Looking at the flipchart with participants' prevention ideas, ask what they think are reasonable community micro-projects based on what they now understand about how diarrhea can be prevented. Note down their ideas on a flipchart. Remember: only community projects should be suggested. Ask questions to help the group distinguish between what community groups can do and what individuals and families should do.

Possible micro-projects:

- latrine construction (single or multi-concession)

- well protection

- marketplace sanitation (clean-up, food storage, drainage, etc.)

- solid waste disposal

- community discussion and education, especially by and with women's groups

- water source protection

- soap production and marketing

Distribute Handout 2, "Some Facts about Diarrheal Disease Transmission and Prevention," to the participants and explain that this list can help them remember all the things they have been learning about diarrheal disease.

Section E. What Is the Role of the EME? (30 minutes)

Step One: The role of the EME and the role of the community

Explain to the participants that as a last step in this workshop, it is important for them to be clear about the role of the EME in upcoming project activities and what they actually will do in this role.

Note to the trainer:

If there are new members of the EME who haven't had any training in GESCOME methodology, it might be appropriate to ask an old member to sum up the role of the EME and how it will operate with community groups.

Put up two blank flipchart sheets. On one, write the heading EME. On the second, write the heading Community.

Ask the group for some words that describe the role of the EME and write them under the heading *[possible answers: facilitator, helper, resource, problem-solving process manager, community researcher]*

Next, ask the group for words that describe the role of the community. *[Look for suggestions such as decision-maker, problem solver, actor.]*

Step Two: Focusing the community on prevention of diarrheal disease

Lead a discussion with the group about how the EME will interact with the community on a partnership basis. Being a partner means that the EME must learn what community residents already know and do about diarrheal disease and share information with them, but not make decisions about what actions might be best for the community or how they should manage any future micro-projects.

Reinforce the idea that the EME is there to guide the community members through a problem identification/analysis/solution process. In order to have as big an impact as possible on the health of children under 5 in the community, micro-projects must be focused on the problem of diarrheal disease and the most effective ways to prevent its spread.

Ask the participants how they think they can guide the community groups toward focusing on the problem of diarrhea in young children.

Possible answers might be:

- hold information exchange sessions on diarrhea with community groups
- share the results of the GESCOME I survey with community members
- make maps of the quartiers with community members and draw in areas that encourage the spread of diarrheal disease, such as unprotected water sources and defecation sites near houses
- arrange meetings where local health workers talk with community groups about how many small children come in to clinics with diarrhea.

Write the group's suggestions on a flipchart and add any from the list above if you want.

Workshop Wrap Up (15 minutes)

Step One

Ask the participants to conclude the workshop by writing down three new things they learned about diarrheal disease.

Ask each person to share with the rest of the group the most important new thing he or she learned.

Step Two

Review the next steps in the GESCOME Project or in the training program with the participants.

Bring the workshop to closure by thanking participants for their hard work and creative ideas, or a similar acknowledgment of their efforts and attention.

Handout 2 – English Version*

Some Facts about Diarrheal Disease Transmission and Prevention

What is diarrheal disease?

Diarrhea is generally defined as three or more watery bowel movements in a day. This can be with or without vomiting and fever.

Different kinds of diarrhea

Acute Diarrhea

- frequent loose watery stools (more than 3 per day)
- usually lasts less than 7 days but can last for 2 weeks
- may include fever and vomiting
- causes dehydration which can lead to malnutrition and death, especially in young children

vcaused by micro-organisms and intestinal parasites

Persistent Diarrhea

- starts as acute diarrhea but lasts a long time – over 2 weeks
- causes dehydration and weight loss; can lead to malnutrition
- Many different micro-organisms can be responsible for persistent diarrhea

Dysentery

- acute diarrhea with blood in the stool
- can cause weight loss, lack of appetite, and damage to the inside of the intestines
- is also caused by different types of micro-organisms
- Shigella is an important cause of dysentery

Causes of diarrheal disease

Diarrheal disease is caused by micro-organisms such as bacteria (cholera and shigellosis), intestinal parasites (giardia), and viruses.

Extent of diarrheal disease in the world and in Benin, especially among children less than 5 years old

Every year:

- children under 5 experience 1,000 million episodes of diarrhea
- children experience an average of 3.3 and up to 9 episodes
- 3.3 million children die from diarrhea-related causes
- 80% of deaths due to diarrhea occur in children under 2 years

In households surveyed in Parakou, Bembéréké, and Banikoara under the GESCOME Project, about 35% of children under 5 years had had diarrhea in the previous two weeks. (The survey was not conducted during diarrhea season, which makes the figure even more alarming.)

Effects of diarrheal disease in children under 5

The rapid loss of fluids due to diarrhea can lead to dehydration, a dangerous condition. The body also loses important nutrients, and children can become undernourished during diarrhea. It is a vicious cycle, because a child who is already undernourished is more susceptible to infections and diarrhea and can easily get sick. Undernutrition and dehydration can4and often do4lead to death.

How should diarrheal disease be treated?

- All kinds of diarrhea should be treated with oral rehydration with sugar/salt solution or with UNICEF packets to replace the lost fluids.
- Children with diarrhea should continue feeding and especially breastfeeding to prevent undernourishment.

- Medicines such as antibiotics or antiparasitics should **NOT** be routinely given for diarrhea. Antibiotics are appropriate for dysentery only if prescribed by a health worker.

How is diarrheal disease spread from person to person?

Diarrhea-causing organisms (microbes) live in feces. When fecal matter is not properly disposed of (in a toilet or latrine), it can contaminate the environment, getting on hands, food, and in drinking water, and infect another person. If people defecate in the bush, others can step in or near it and carry microbes on their shoes or feet into households. During the dry season, dried feces can be blown by the harmattan winds onto things people eat, drink, or touch. Babies' feces can contain as many or more diarrhea-causing organisms as adults' and should be considered as contaminated as adult feces.

Why is diarrheal disease so widespread?

- lack of sanitary facilities (latrines and toilets) causing people to defecate in the open
- unhygienic handling and disposal of babies' feces
- lack of soap and water for handwashing
- early weaning of babies (before 4 or 6 months)
- unprotected food, especially weaning foods

How can diarrheal disease be prevented?

At the household level

- construct and use latrines
- dispose of feces of babies and small children (by burial or down latrine)
- protect household drinking water storage from unclean hands, utensils, and dirt
- re-cook foods to kill microbes
- protect food from dirt, flies, and improper handling
- wash hands with soap after every visit to the latrine, after cleaning babies' bottoms or handling babies' feces, before cooking and before eating
- use clean hand-drying cloth or air dry hands
- only drink water that comes from a tap or pump that is protected
- boil or chlorinate drinking water from a well

- immunize children against measles (measles leads to malnutrition)

At the community level

- improve water supply sources to prevent contamination
- promote soap manufacturing, sales, and distribution (good income for women) (Soap manufacturing has been found to be a good local enterprise in some places in the world.)
- carry out hygiene education programs in schools, markets, health centers
- build family and school latrines

* Handout #1 is not a Word file and is in an incompatible format, so cannot be attached. The handout is similar to Figure 4 in the report.

Annex 3

CREPA CURRICULUM ON COMMUNITY MOBILIZATION

CREPA

Introduction

Vivre dans un environnement sain et s'alimenter en eau potable, constituent le but du projet GESCOME dans nos différentes localités du Borgou et de l'Alibori. Les communautés elles-memes identifient leurs besoins qui se traduisent concrétement dans les faits. Vouloir ignorer ces réalisations faites ou qu'une partie de la communauté s'en approprie cela ne fera que porter entorse á l'idéal du projet.

C'est dans ce cas que CREPA va intervenir en qualité de prestataire de service pour ramener toute la communauté des quartiers GESCOME dans des différentes localités autour des objectifs communautaires que ce projet s'est assigné. Cela ne sera possible qu'á travers une série de formations modulaires dont la 1ére en Aout, sera consacrée aux: preambles et á l'organisation pratique d'une Assemblée Générale Communautaire (AG/C).

Methodologie

Nous nous tablerons sur des principes andragogiques et la méthode participative sera tout au long de cette formation utilisée. Le facilitateur jouera un role de guide. On aura donc á faire:

Des exposés suivis de débat et le brainstorming ne seront pas occulté.

La session de formation est d'une journéee par site. Elle débutera chaque fois á 9 heures pour prendre fin á 15 heures avec bien sur une pause d'une heure.

Le suivi des activités sera également d'une journée par site et tiendra compte du calendrier des EME qui exécutent les activités sur le terrain avec la communauté.

La formation de ce mois d'Aout est basée sur un module lui-meme divisé en deux sequences. Une simulation et une evaluation viendront boucler la formation.

Le module de la formation est le suivant:

Module: Préables et organization pratique d'une Assemblée Générale Communautaire (AG/C)

Durée: 5 heures.

Objectifs du module:

Renforcer les compétences des EME dans la preparation des AG/C.

Renforcer la compétence des EME dans la tenue des AG/C.

Résultats attendus:

- Une trés large diffusion de la convocation des AG/C
- Un accroissement progressif du nombre des participants aux réunions communautaires
- Les members des EME utilisent les techniques d'animation pour retenir tous les participants jusqu'á la fin des reunions
- Tous le participants aux runions ont eu du plaisir et ont promis d'assister aux prochaines Assemblées.

Les deux sequences de ce module sont détaillées dans le tableau ci-dessus:

Thémes	**Durée**	**Objectifs**	**Résultats**	**Démarche pédagogique**	**Matérials didactiques**
Séquence 1 A/ Comment préparer une AG/C - Réunion préparatoire entre les members des EME. Date Lieu Le temps Ordre dur jour Comment informer la communauté? Canaux possibles de communications	1H30 30’	Permettre aux members des EME de savoir comment bien préparer une AG/C	1-Les members des EME ont tous la meme comprehension du contenu des AG/C 2-Les members des EME font une large diffusion de la convocation des AG/C	Bref expos (en langue locale si nécessaire)	Papirs de vonférence Marker Cahiers, bics, …
B/Dats	1H	Permettre aux members des EME de s’interagir pour d’egager entre eux les meilleures maniéres de preparation d’une AG/C	Les members des EME en collaboration avec la communauté (leader d’opinion, l’Imam; les groupements organizes…) arretent de maniére démocratique les dates, les lieux, temps des AG/C et le canal de communication efficace pour atteindre toutes les couches de la communauté	Brainstorming	

Thémes	Durée	Objectifs	Résultats	Démarche pédagogique	Matérials didactiques
Séquence 2 A/ Comment animer une AG/C? - Les aptitudes personnelles d'un bon animateur Méthodes d'animation Méthode autocrate Méthode semi-autocrate Méthode debonnaire Méthode démocratique - Le déroulement d'une AG/C - Synthése et réinvestissemement	1H30 30'	Permettre aux members des EME de bien maitriser les techniques d'animation des AG/C	Les members des EME acqui"erent les bonnes techniques d'animation et arrivent á maintenir la communauté jusqu'a la fin des AG/C.	Bref exposé (en langue locale si nécessaire)	Papirs de vonférence Marker Cahiers, bics, …
B/Débats	1H	Permettre aux members des EME de s'interagir pour d'egager eux-memes les meilleures techniques d'animation	Une meilleure technique d'animation est arretée de facon démocratique	Brainstorming	
Simulation	1H	S'assurer que les EME sont outillés pour l'organisation des AG/C.	Les members des EME réussissent les AG/C	Discussion de groupe entre les members des EME	

Thémes	Durée	Objectifs	Résultats	Démarche pédagogique	Matérials didactiques
Auto-évaluation	1H	S'assurer du nombre de presonnes informées S'assurer qu'on pourra atteindre un taux de participation donné S'assurer que les participants sont satisfaits de la formation S'assurer que la decision prise sera démocratique	Les members des EME connaissent le nombre de personnes touches par l'information Les members des EME connaissent le taux de participation ´la reunion Les members des EME apprécient la session de formation La d"ecision est prise par la majorité	Par depot d'un bulletin par participant D'une etiquette auto-adhéhive Par vote	Bulletin de dépot Bulletin auto-adhesive Carte á images Bulletin de vote Etiquette auto-adhesive

Agenda de la formation

Horaires	Activités
9H – 9H30	Présentation des participants et des formateurs
9H30 – 9H45	Présentation du programme de la formation
9H45 – 10H15	Comment préparer une AG/C?
10H15 – 11H15	Débats
11H15 – 12H15	Pause
12H15 – 12H45	Comment animer une AG/C?
12H45 – 13H45	Débats
13H45 – 15H	Simulation
15H – 16H	Auto-évaluation

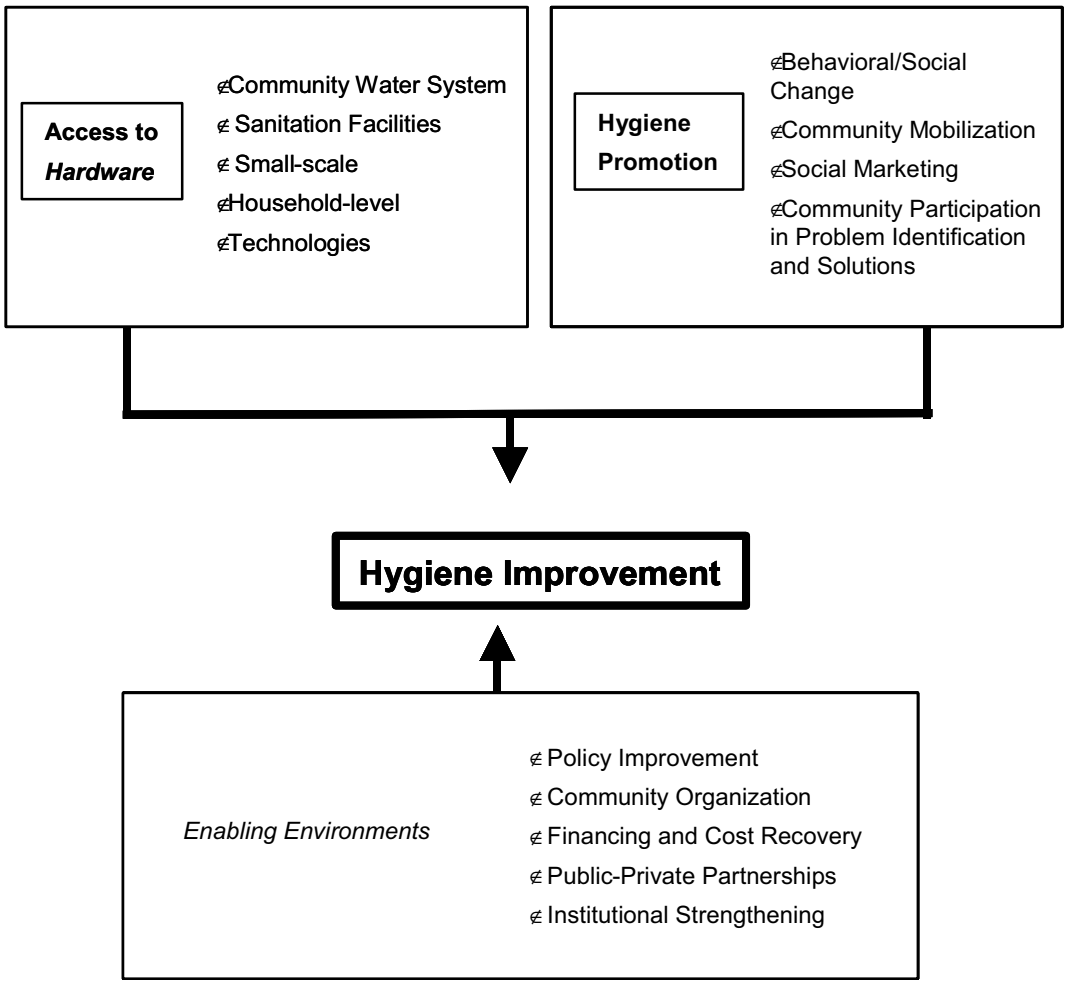
Matérial didactique

- Une rame de feuille A$
- Un cahier de prise de note par participant bic
- Papier de conference (un rouleau)
- Une boite de marker
- 3 piaquettes d'étiquettes auto-adhesives (bleu – rouge)
- 1 pot de colle
- 1 scotch
- Tableau de conférence
- 3 paquets de chemise dossier
- 4 cartes á images

Annex 4

THE PLACE OF GESCOME IN THE REVISED CESH FRAMEWORK

Near the end of GESCOME II, EHP II developed a new CESH framework based exclusively on prevention of diarrheal disease in children under five years old. The activities, process, and development assumptions of GESCOME II contributed to the design of this framework. The new CESH framework follows.



The assumption of the CESH model is that improved hygiene will lead to lower risk of transmitting diarrheal disease to young children. Consequently, there would be lower morbidity and mortality from diarrheal disease, as well as lower mortality due to diseases for which diarrheal episodes place a young child at greater risk of death.

How does GESCOME II fit into the CESH model?

Access to hardware	⊄# Community Water Systems
	⊄# Sanitation Facilities
	⊄# Small-scale, Household-level Technologies

Community water systems. GESCOME delivered hardware to the community through micro-projects that were jointly financed by the community (15%) and GESCOME (85%). GESCOME II aided in providing potable water through installation of 31 water point resources in two towns. In addition, one Banikoaran neighborhood renovated two wells (see section 3.4 of the report for pictures of renovated and unrenovated wells). These water point resources served as part of the community water system. All but one consisted of extension or connection to the national water system through the government company, SBEE.

Sanitation facilities. GESCOME II provided access to sanitation facilities through construction of 21 community latrines. The latrines were equipped with water and soap and are kept clean by a custodian.

Small scale, household level technologies. GESCOME II was not intended to address small-scale, household-level technologies.

Hygiene promotion. GESCOME II did not use the term "hygiene promotion" because "hygiene promotion" relies on outside concepts of what constitutes "hygiene." GESCOME II tried to initiate an EME-led, community negotiation process between public health and local knowledge, employing more neutral terminology. However, public health models for prevention of diarrheal disease were presented, discussed, and considered by the community during the problem finding phase of the PRA and in the PCHC meetings.

Hygiene Promotion	⊄#	Behavioral/Social Change
	⊄#	Community Mobilization
	⊄#	Social Marketing
	⊄#	Community Participation in Problem Identification and Solutions

Behavioral/Social Change. GESCOME II aimed for social change. The project did not seek to change individuals' behavior *per se*. Instead, GESCOME II provided a forum for the community and EME to learn about local knowledge of diarrheal disease transmission, prevention, and treatment, as well as public health knowledge of diarrheal disease transmission and prevention, and to discuss and negotiate between these views. In the facilitated negotiation process between public health and traditional health systems, the project aimed to stimulate group decisions and collective action or social support for changes in what community members did.

Community Mobilization. Both GESCOME I and II were based on community mobilization. Every stage of GESCOME II depended on mobilizing community members to conduct participatory rapid appraisal (PRA), collect and contribute funds to finance micro-projects, elect micro-project management committees, etc. EME members received training in community mobilization topics during the course of two workshops devoted primarily to community mobilization. They immediately put this training into action.

Social Marketing. There are many definitions of social marketing. Social marketing, according to Richard Manoff (1985), is based on understanding the consumer and presenting information or products in ways that s/he finds useful. GESCOME II tried to present health information in ways that community members would find useful. The negotiation process between public health and local knowledge was one of these ways. In addition, GESCOME II used social marketing pre-testing techniques in developing the stimulus pictures used in PCHC meetings. Useful pictures were retained and those that were not useful were discarded or re-photographed, depending upon the feedback from the "consumers" of the knowledge during focus group discussions. This process might be used in other CESH highly participatory country activities.

In GESCOME or CESH scale up efforts, other social marketing techniques may be very helpful (e.g., in introducing the GESCOME process to new towns or advertising GESCOME to other regions or countries in order to stimulate interest).

Community participation in problem identification and solutions. The GESCOME PRA and decision making processes rely upon community participation in problem identification and solutions. The lists of environmental health problems found in the GESCOME II final report were developed by community members attending

community meetings and using PRA techniques. Both GESCOME I and II incorporated a number of PRA tools (e.g., community transect walk, hope trees, decision making trees) to help communities identify and prioritize their problems and reach their own solutions.

Enabling Environments	⊄# Policy Improvement
	⊄# Community organization
	⊄# Financing and Cost Recovery
	⊄# Public-private Partnerships

Policy improvement. Policy dialogue for sustainability was key to GESCOME II activities. The purpose of the policy dialogue was 1. to create an enabling environment to encourage the GESCOME process to continue to support decentralization; and 2. to sustain GESCOME civil society structures and environmental health activities.

The legs upon which creation of an enabling environment stood were:

- **Policy improvement through policy dialogue.** GESCOME structures were institutionalized through a decree by the *Préfet*

- **Community organization.** GESCOME I established a structure to link neighborhoods to the municipal government and towns to departmental government. Within the community, EMEs learned to segment their neighborhoods in terms of natural groups, addressing with each group the diarrheal disease issues that were most relevant to them. The EME also learned about coalition building within the community, which has been so valuable in community organizing for health in North America.

- **Community cost recovery for use of micro-projects.** Once a micro-project was constructed, users' fees, and special community-wide assessments in the case of a large repair problem, were collected to maintain this community infrastructure.

- **Public-private partnerships** are built into the structure of GESCOME units. For example, EMEs include members of government at the municipal level, as well as members of NGOs. Public-private partnerships were also inherent in installation of water point resources, which relied on a parastatal company to install the water point resources for the [private] community. In addition, CREPA, an NGO, was contracted to provide social mobilization training.

The CESH framework does not presuppose that any CESH activity will contain all constituent parts of the framework. GESCOME II, however, contained all but two components: small-scale, household level technologies and cost recovery.

The cost recovery mechanism for micro-projects did not attempt to recover USAID's portion, disbursed through EHP II, of the cost of constructing the micro-projects. This portion was 85% of the construction cost. The remaining 15% was contributed by the community. Since the problem at the top of almost all communities' lists was the nuisance caused by grey water rather than childhood diarrhea, and one neighborhood was unable to raise even the 15% required to participate in GESCOME II micro-projects, it is questionable whether a financing scheme designed to have the community pay the entire cost of the micro-projects would have succeeded at the time. One possible way to address this issue is to provide 85% of the funds for the first round of micro-projects and introduce PCHC at the same time, so that communities might be more amenable to shouldering the entire cost of the next rounds of micro-projects, perhaps through revolving credit schemes.

Annex 5

EME MEMBERSHIP

LIST OF EME MEMBERS

	EME Banikoara	EME Sinendé	EME Bembéréké
1	Bio Yerima	Moussa Traoré Alassane	Koto Yérima
2	Abdoulaye Seidou	Salifou Mouniratou	Gbadamassi Rafiath
3	Ibrahim Kassim	Zakari Mèmounatou	Zato Malick
4	Orou Soulé Ousséni	Issaka Moussa Ousmane	Ali Salifou
5	Bio Agbega Salamatou	Imorou Ibrahim	Bio Adamou Matchou
6	Bani Yaya Fatouma	Sourokou Félix	Mama Dadi
7	Nansounon Irène	Aboudou Orou Moumouni	Bio K. Dama
8	Aliou Azara	Chabi Koni Gandé	Lafia Guerra
9	Mouhamed Issifou	Yacoubou Moussibaou	Alou Soulé
10	Manga Bakè Nina	Amadou B.G. Ouorou	Sacca Célestin
11	Bouyagui Adiza	Bourandi Nafissatou	
12	Lokoto Chabi	Houdou Biba	
13	Dafia Yérima Mathurin	Ali Dado Safoura	
14	Saliou Saïdou		
15	Chakran Benjamin		
16	Arouna Zénabou		
17	Yacoubou Orou Kounsé		

Annex 6

CDSE MEMBERSHIP

Department

Soulé Abdoulaye, Directeur Départemental de la Santé Publique.

Assogba Aristide, Directeur Départemental du Plan et de la Statistique

Bouko Bio Nicolas, Service Affaires Sociales, Préfecture du Borgou/Alibori

Gbaguidi G. Toussaint, Agence Benin Presse, Prefecture du Borgou/Alibori

Moussa Mouhamadou, Attaché de Presse *Préfet* du Borgou/Alibori.

Abdoulaye A. Razizou, Chef Service Affaires Domainiales, Préfecture du Borgou/Alibori.

Parakou

Sékaro Aboulay, Mayor Commune 4, Parakou

Ali Yérima Denis, Chef de la Circonscription Urbaine de Parakou.

Abdoulaye Abdourahmane, Coordinateur EME Parakou.

Bembéréké

Alou Soulé, EME Coordinator, Bembéréké

Sourokou Gandé, Mayor, Bembéréké

Abdoulaye A Bakari, Sous-*Préfet*, Bembéréké

Banikoara

Bio Sourogou Orou Zime, Sous-*Préfet*, Banikoara

Bio Yérima, Coordinateur EME, Banikoara

Sinendé

Abdou Orou Moumouni, Mayor, Sinendé

Traoré Alassane, Coordinateur EME, Sinendé

Gounou B. Clément, Sous-*Préfet* Sinendé

EHP Facilitator/Observer

Salifou Yallou, Coordinator GESCOME Project.

Annex 7

TIMING OF GESCOME II ACTIVITIES

Timing of GESCOME II Activities

ACTIVITY	TIMING
1. 1st Round Table	October 1999
2. 2nd Round Table	December 1999
3. 3rd Round Table	January 2000
4. Training in diarrheal disease	April 2000
5. Training in problem identification (with #4)	April 2000 (during GESCOME I for Sinendé)
6. Problem identification	April-June/July 2000 (during GESCOME I for Sinendé)
7. Training in problem analysis	April (Sinendé), June (Banikoara), July (Bembéréké) 2000
8. Problem analysis	June/July-September, April-June 2000 (Sinendé)
9. 4th Round Table	August 2000
10. Solution finding + community mobilization training	September 2000, June 2000 (Sinendé for solution finding, September for community mobilization for Sinendé)
11. Solution finding, including micro-project development	September-November 2000 (Banikoara), September-December 2000 (Bembéréké) June-December 2000 (Sinendé)
12. Collection of community contribution & election of CGMPs	Same as above
Micro-project proposals submitted	November/December 2000
13. 5th Round Table	December 2000
14. Micro-project implementation	December 2000-April 2001, Bembéréké finished during Lessons Learned period
16. Training in community/social mobilization, gender awareness, PCHC + materials development	March 2001
17. PCHC meetings with natural groups	April, May 2001
18. Development of proposals for 2nd round micro-projects	April 2001
19. 6th Round Table	May 2001
20. 2nd Round micro-project implementation	May 2001-finished during Lessons Learned period