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Community Involvement

Lessons Learned

Environmental Health Project

May 1999

During the past five years, the Environmental Health Project (EHP) has developed and refined a community-based methodology known as CIMEP—Community Involvement in the Management of Environmental Pollution. This approach has enabled local governments and communities to build partnerships and trust so that they can identify environmental health problems and then work together to solve them through improved service delivery and infrastructure.

CIMEP is rooted in the idea that environmental health problems must be addressed cross-sectorally. Interruption of disease transmission routes, which can only be understood from a community perspective, means involving leaders from many sectors—public works, health, environment—as well as the private sector, traditional leaders, and nongovernmental organizations (NGOs). CIMEP gives government officials and communities a way to address the underlying environmental and behavioral risk factors that contribute to poor health. CIMEP creates a partnership between

municipal technical staff, decision makers, and communities through an 18-24 month process of skill-building workshops, follow-up in the field, policymaker roundtables, community-implemented low-cost microprojects, training of trainers, evaluations, and national or regional scale-up.

EHP Goal: Enable municipalities to plan and implement environmental health programs with full community involvement.

CIMEP is especially applicable to the conditions of secondary cities, whose populations, in many cases, have quadrupled in the last 30 years, causing environmental mismanagement, resource depletion, and public health crises. The issues in secondary cities require a new vision and new policies and approaches that enable government to work better with local and traditional management structures.

Under EHP, the CIMEP methodology has evolved and has been implemented in Ecuador, Tunisia, Bolivia, and Benin—in whole or in part.

Ecuador. Despite the general success of national programs to reduce or eliminate cholera, the disease persisted in certain Ecuadorian provinces. From October 1994 to October 1995, EHP worked with USAID/Quito and the Ministry of Health to identify behaviors and beliefs that increase the risk of cholera. Regional and community health teams were formed and trained to analyze local beliefs and behaviors in conjunction with community members and to design suitable interventions. A 1996 evaluation using a survey and household observations found evidence of behavior changes, such as a 27% increase in households in which people washed their hands after defecating, and an increase from 6% to 100% of households storing water in safe containers. In the project communities, cholera cases fell dramatically.

Bolivia. EHP began a two-year activity in Bolivia in January 1997 to facilitate behavior change at the household and community levels to reduce high levels of diarrheal disease in several communities where USAID and other donors had made substantial investments in water and sanitation

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infrastructure. Based on the Ecuador model, community and departmental teams were created, and, through a process that included a study tour to Ecuador, a baseline assessment, skill-building workshops, and microprojects, behavior-based solutions were developed to address diarrheal disease.

Tunisia. From January 1995 to September 1996, EHP implemented a CIMEP initiative in two towns in Tunisia in collaboration with USAID's Regional Housing and Urban Development Office (RHUDO). Here, the objective was creation of partnerships to extend municipal services to underserved peri-urban communities. Municipal teams created in the two pilot towns went through a series of skill-building workshops while parallel policymaker roundtables were conducted.

Municipal officials learned to apply participatory methods in working with communities. There was a shift in thinking: municipal managers came to recognize that poor communities do have resources and can be part of the solution, not just the problem.

Local communities began to understand the impact of the environment on their health and made changes such as corralling animals, building latrines, and using trash containers.

Benin. In October 1997, EHP began implementation of CIMEP in three towns in Benin. Municipal teams were trained to work with communities to identify transmission routes and household behaviors which contribute to diarrheal disease. Departmental and national environmental health policy roundtables, bringing together government officials, NGOs, and traditional leaders, enabled local institutions to respond better to community needs. A regional workshop held in May 1998 highlighted the approach to other countries, shared lessons learned among stakeholders, and involved donors who would be key to scaling up the process in the region.

Specific results will be assessed in 1999 using baseline data collected in 1998.

LESSONS LEARNED

Despite the variability of the demographic and cultural contexts and objectives of the CIMEP programs over the past five years, several cross-cutting lessons have emerged. They are based on the experience of local collaborators and community participants as well as EHP's staff and consultants.

Lesson One: CIMEP works best where government decentralization is taking place.

CIMEP helps government officials to redefine their roles and responsibilities and develop a new understanding and rapport with the communities they serve. Government officials are often more willing to consider a new mode of operation when decentralization is taking place, with a clear mandate that agencies change how they operate. CIMEP can be a model for governments attempting to design mechanisms to shift decision making and resources from national ministries to local municipalities. CIMEP helps to build a relationship of trust among government officials, other local partners—such as NGOs and private sector collaborators—and residents.

Lesson Two: Involving government decision makers is critical to the success and sustainability of CIMEP.

The CIMEP process engages government decision makers on multiple levels through: 1) establishing national- and departmental-level roundtables which meet on a regular basis and 2) creating municipal teams, with members from varied local institutions and community groups, who go through a series of skill-building workshops and establish on-going working relationships and common

goals. To date, this process has been used to target environmental health issues, but it could also be applied to other areas such as education, microenterprise development, and population.

Development projects have often tried to bypass local governments by working solely with NGOs. The CIMEP process acknowledges that government entities possess valuable human and capital resources. It is possible to enable governments to function in a more efficient and effective manner and to make better use of the resources at hand. This often requires changing attitudes and modes of operation. Government officials will not change their behavior after a one- or two-week workshop. Such change requires training over 18 to 24 months, an opportunity to apply the skills between training sessions, and concrete experiences such as successful community-based microprojects. In such a process, behavior change can take place gradually and become institutionalized.

Lesson Three: Baseline data must be gathered to enable community identification of risk factors, design of interventions, and measurement of impact.

As CIMEP has evolved, attention has shifted from the development of the methodology per se to achieving and measuring specific health impacts—or from the process to the results. EHP's attempt to evaluate the health results of CIMEP Tunisia brought to the fore the necessity of preparing for project monitoring by collecting appropriate baseline data. The initial background information collected for CIMEP Tunisia had provided input for designing the project, but did not provide an adequate baseline for a quantitative measurement of health results achieved. There were ample qualitative data and lots of anecdotal information, but the data needed for a

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rigorous assessment of health impact were missing. From this experience, EHP has learned the importance of establishing health impact indicators from the outset and gathering baseline data on them for monitoring and evaluation as well as for project design purposes.

In Bolivia, the goal was to reduce childhood diarrheal disease. Baseline surveys were conducted in the pilot communities to gather data on environmental conditions, infrastructure coverage (access to clean water and latrines), relevant knowledge, attitudes, and practices (KAP), and prevalence of diarrhea in children. These surveys were designed using information gathered in focus groups and community training workshops and were conducted by locally trained specialists. Analysis of the baseline data identified some of the key local risk factors for childhood diarrheal disease and played a key role in guiding and informing the community process to design interventions or microprojects. As

a result, community members developed a better understanding of the links between environmental conditions, individual behaviors, and disease transmission. Their subsequent development of community solutions reflected this new understanding. The baseline surveys also provide a tool for communities to monitor and measure the impact of their microprojects. (EHP Applied Study 9: “The Environment and Children’s Health: A Practical Guide for Measuring Health Impacts” provides guidance on this issue.)

Lesson Four: *Community members must learn skills to identify the issues and develop their own solutions.*

A one-size-fits-all approach to development—promoting any specific intervention, such as building latrines on a wide scale—misses a whole range of other issues and has limited impact and results. For example, the baseline

survey in Benin found that about 90% of the population in several neighborhoods in Parakou had access to sanitation services; in other neighborhoods in two other towns, it was at most 10%. The health problems and effective solutions for them will not be the same in all neighborhoods.

Given variability among communities and the reality that the interests of communities and individuals cross many sectors, residents must learn problem-solving and analytical techniques to identify what the issues are and what the common vision is for their shared environment. To encourage true behavioral change, the starting point must be understanding what is important to each community and, from there, introducing specific changes. Tools used for this process are community mapping, environmental health cause and effect “problem trees,” and focus groups.

Lesson Five: *Community microprojects allow residents to put theory into practice and see some tangible results.*

Numerous community-level microprojects to address identified risk factors emerged from the Tunisia experience. For example, household water containers were vulnerable to contamination, caused by animals or children handling the containers or drinking directly from them. People also brought water from untreated sources into their homes. Microprojects funded and carried out by the community and municipality extended piped water to 90 houses that needed it and built corrals to keep animals away from water containers.

In Ecuador, most of the microprojects focused on providing household water containers and changing people’s water handling and storage practices. In Bolivia, microprojects included providing household water containers and building latrines near schools. All microprojects had a hygiene behavior change component.

Interview with the Mayor of Kasserine, Tunisia, as reported in “La Presse,” June 13, 1996 . . .

A New Method of Local Governance

Q: How was your city chosen to take part in the CIMEP project?

A: There’s no mystery here. Kasserine was selected by the Ministry of the Interior for two main reasons: first, because of the many problems it needs to solve and, secondly, because of the dynamic team of local leaders. Well before the CIMEP project, we were already looking to get private citizens more involved.

Q: Exactly why do you consider community participation so important?

A: I am speaking to you here from experience. Spending more means nothing without community participation. The more you get the general public involved in the governance of their community, the more you can move the city forward, depending on the group involved. If you know the people are with you, you can feel confident that, even if you’re not there, your work will go on....

Q: What sort of results have you achieved?

A: Let’s take the example of a neighborhood with clearly defined boundaries. We hold community meetings where we allow the public to sound out their problems (problems involving the environment, latrines, trash cans, wastes, etc.)....The public is made aware of the means at our disposal and we encourage them to see the project as their own rather than as the city’s project.... You realize that it is growing resentment or discontent which kills a city. A private citizen will not always understand the reasons why the city repaired his neighbor’s street, for example, and not his. By getting him involved in the governance process, we give him hope that his turn will soon come....The results we’ve achieved are so encouraging that I feel that this experience should be replicated on a larger scale.

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Advantages of the CIMEP Methodology

The CIMEP project in Ecuador "improved the level of education in the community and developed new leaders in the areas of health and sanitation. These leaders not only learned about health, but they put their knowledge into practice.

"I see the possibility of using this methodology in a variety of health identification and promotion activities, such as in agriculture, forestation, animal vaccination, and the development of community-based clubs."

—Dr. Adela Vimos, State Health Director, Chimborazo, Ecuador

Microprojects enable community members to take concrete action to address an environmental health problem and make a direct impact on it. At the same time, the microprojects provide a vehicle for institutional strengthening and building trust. Communities and NGOs, which often do not have their own financial resources or which lack financial management experience, learn how to handle accounting and disbursement of funds for the microprojects. They also must determine what resources—financial, technical, or in-kind—the community can contribute to the process. In sum, the microproject component is critical for building and reinforcing individual and institutional capability and trust.

OUTSTANDING ISSUES

The CIMEP approach is evolving as it is implemented in different contexts. Along with the lessons learned, the following issues have emerged regarding its future application.

Important unresolved issues still remain about scaling up CIMEP.

EHP experience has shown that it is necessary to identify and involve stakeholders for scale-up from the very beginning. Engaging stakeholders on all levels (national, departmental, and local) is crucial in scale-up for several reasons.

Early involvement creates ownership of the process and the data that it generates. For instance, in Tunisia, national-level decision makers did not want to accept the results of the environmental health assessment, even though it was carried out by Tunisian sociologists, because they had not been initially part of this process. In Benin, on the other hand, Ministry of Health officials were engaged in the process from the beginning and worked with EHP to present the baseline survey data to the communities.

Identifying and including donors and other stakeholders is important as they will be key advocates in leveraging funds and support for scale-up.

But key unanswered questions about scale-up remain. Who should be involved: high-level government decision makers, the private sector, donors? What are some of the constraints to coordinating these partners? In poorer countries, external donors may be crucial funding partners; how can local implementors of CIMEP activities learn to access donor resources?

Other questions cluster around the topic of microprojects. Should they be set up as grants or revolving funds? Will governments sustain funds for microprojects as a contribution to improved public health? How can private sector partners be involved? Must the microproject component of CIMEP be financially self-sustaining?

Ways must be found to

incorporate traditional leaders in decision making. Identifying and involving traditional leaders who have respect and influence in their communities is a challenge that is currently facing the program in Benin. Dialogue among traditional leaders, government officials, and community members has begun, but how traditional community-level decision making can be incorporated with government power and the alignment of goals by all stakeholders is still an open question.

The long-term impact of CIMEP has not been studied or evaluated.

Since CIMEP is a relatively new approach, the longer-term evolution of completed CIMEP projects has not been studied. Evaluating the sustainability and impact of Ecuador and Tunisia projects in the next year or two might provide some new insights, especially in terms of the scale-up issues outlined above.

—May Yacoub, EHP Technical Director for Community Participation and Hygiene Education, and Margo Kelly, EHP Assistant Activity Manager

Reports Available from EHP

"Addressing Environmental Health Issues in the Peri-Urban Context: Lessons Learned from CIMEP Tunisia." (EHP A.R. 24). (Available in French and English.)

"Building Community Partnerships for Change: The CIMEP Approach." (Available in English, French, and Spanish.)

"Cholera Prevention in Ecuador: Community-Based Approaches for Behavior Change." (EHP A.R. 19).

"Community-Based Approaches for Environmental Health in Secondary Cities in West Africa and the Scale-Up Process: Proceedings of a Workshop Held in Cotonou, Benin, May 18-20, 1998" (EHP A.R. 50).

"Monitoring the Effect of Behavior Change Activities on Cholera: A Review in Chimborazo and Cotopaxi, Ecuador." (EHP A.R. 25).



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