URBAN EXAMPLES

FOR URBAN BASIC SERVICES DEVELOPMENT IN CITIES

OCTOBER 1984 UNICEF UE-8

MANAGEMENT OF URBAN BASIC SERVICES - THE REALITIES OF CO-ORDINATION (II)

THIS EDITION IS THE SECOND OF A TWO-PART SERIES WHICH PRESENTS EXAMPLES OF HOW SOME GOVERNMENTS ARE RE-ORGANIZING THEIR INTITUTIONAL STRUCTURES AND THEIR MANAGEMENT PROCEDURES FOR SERVICE DELIVERY IN URBAN POOR AREAS.*

THE INNOVATIVE ASPECTS INVOLVE NEW GEOGRAPHICAL PATTERNS FOR SERVICE DELIVERY, ACTIVE PARTICIPATION OF LOWER LEVELS OF GOVERNMENT AND NEW INSTITUTIONAL RELATIONSHIPS IN THE CONVERGENCE AND INTEGRATION OF FUNCTIONS, PROGRAMMES AND RESPONSIBILITIES. WITH THE NEW STRUCTURES, THE PER CAPITA COSTS ARE SUBSTANTIALLY LOWER THAN THOSE OF TRADITIONAL DELIVERY SYSTEMS.

AT THE COMMUNITY LEVEL, LEADERS BECOME MEMBERS OF QUASI-GOVERNMENTAL ORGANIZATIONS WHICH ARE RESPONSIBLE FOR SOME ASPECTS OF THE PROGRAMMES BOTH IN THE COMMUNITY AND AT HIGHER LEVELS. COMMUNITY RESIDENTS SERVE AS VOLUNTEERS OR HONORARIUM-PAID WORKERS.

* Some of the intitutional structures described here date back to 1981. It is fair to assume that these structures are not stationary and that the present situation differs from the one described here.

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1)	NAME OF PROJECT:	ENVIRONMENTAL HEALTH AND COMMUNITY DEVELOPMENT PROJECT IN THE SLUMS AND SHANTIES OF COLOMBO, SRI LANKA
2)	TARGET POPULATION:	Urban poor groups in the slums and shanties of Colombo, a population of approximately 300,000.
3)	TIME FRAME:	1979--1983.
4)	EXECUTING AND CO-OPERATING AGENCIES:	Overseeing the project are: Ministry of Plan Implementation - Steering Committee and Ministry of Local Government, Housing and Construction. Executing the project are: Colombo Municipal Council, Public Health Department, Common Amenities Board, Women's Bureau and National Youth Services Council.
5)	COSTS:	--
6)	SOURCES OF FUNDS:	Common Amenities Board, Colombo Municipal Council and UNICEF.
7)	OBJECTIVES:	General (i) Improve environmental conditions, community health and community relations, and promote development on the basis of self-help. Specific (ii) To create awareness and confidence in the communities that problems can be dealt with through collective understanding and action; (iii) To organize the communities into cohesive, strong social groups capable of obtaining, enjoying and maintaining needed services; (iv) To increase knowledge, acceptance and practice of health norms; (v) To provide income opportunities and skill training; and (vi) To promote greater and fuller participation of women in development activities.

8) BRIEF DESCRIPTION: ENVIRONMENTAL HEALTH AND COMMUNITY DEVELOPMENT PROJECT IN THE SLUMS AND SHANTIES OF COLOMBO, SRI LANKA

Background

Between 1950 and 1970, the urban population of Sri Lanka doubled. During the period 1970 to 1980 it increased by approximately 12 per cent annually. Approximately 50 per cent of the city population is believed to be living in slums and shanty "gardens". Almost none of these areas have sewers; few households have water; and health education has been non-existent.

The Government of Sri Lanka is giving priority to urban development efforts, including not only physical transformation of urban conditions, but also social development actions.

Programme

Following an initially limited UNICEF assistance to the Common Amenities Board (CAB), a statutory body under the Ministry of Local Government, Housing and Construction, UNICEF and CAB developed a proposal for a five-year integrated project to help develop the quality of life in the low-income "gardens". Emphasis was placed on: construction or improvement of latrines and water standpipes, motivation and mobilization of the beneficiary community for the maintenance of facilities, training of women in income-earning activities, and vocational counselling and guidance. Activities to ensure these services have included: recruitment, training and deployment of 90 health wardens from the communities to promote nutrition and health education; establishment of 300 community development councils and a of three-tier council system for co-ordination, identification and orientation of over 1,000 leaders, and training of 600 for environmental activities.

Institutional setting for management[1]

Effectively, there is a three-tier community development council system: (a) at the community level in the slum gardens, (b) at the district level, with representatives from the garden community development councils in each district and (c) at the city level, with representatives of government organizations involved in implementation at the district level.

National. The project is under the responsibility of a Steering Committee of the Ministry of Plan Implementation, which reviews it quarterly. The Ministry of Local Government, Housing and Construction is the parent organization for the two local organizations which implement the programme, the Common Amenities Board and the Colombo Municipal Council (CMC) Public Health Department. Two other organizations, the Women's Bureau and the National Youth Services Council, both national level groups, are also implementing agencies. Thus, actual project implementation is a joint national/local effort.

Municipal. Under the leadership of the Mayor of Colombo, a Municipal Co-ordinating Committee meets every six months to review municipal policy and actions effecting implementation progress and management. It is composed of the Mayor, the Municipal Commissioner and respresentatives from the Ministries of Education and Social Services, the Women's Bureau, the Slum and Shanty Unit of the Urban Development Authority, the Common Amenities Board and UNICEF.

1/ See diagram "Institutional Setting for Management" on page 5.

Heads of all relevant municipal departments attend the meetings as observers. The Committee concerns itself mainly with municipal policy affecting implementation.

In order to supervise the co-ordination of the inter-sectoral aspects of the programme, a City Community Development Council, chaired by the Chief Medical Officer of Health, Colombo Municipality, has been established.

Communities. At the community level, the health wardens of the Municipal Council Public Health Department had been successful as of mid-1981 in encouraging the communities to establish almost 300 Community-level Development Councils, whose members are elected by the residents.

In addition, sixteen months after the inauguration of the project, six District Development (co-ordinating) Councils had been established under the chairmanship of the medical officers of health responsible for the six health districts in the Colombo municipal area. These councils consist of public health personnel, the district municipal engineer and the elected resident leaders representing the local Community Development Councils.

Programme management

The Community-level Development Councils usually meet bi-monthly. At the meetings, any resident may participate in discussions on problems of common interest, in the review of the involvement of the residents in community welfare work and in plans for future community development activities. The community development councils are responsible for the implementation and management of self-help projects and for making programme proposals. The residents are therefore encouraged to participate in the identification of needs, decisions on priorities and the planning of the sequence of implementation.

The District Community Development Councils are responsible for bringing about closer inter-departmental co-ordination between municipal offices and representatives of the community-level development councils.

The City Community Development Council ensures co-ordination between the participating agencies and monitors and controls the project as a whole. No community residents participate at this level.

A very effective management tool has been developed to monitor the delivery of each programme activity. At the beginning of every year, the executing agencies decide on an Annual Work Plan which details the overall targets for the total project period, the cumulative actual performance as of the end of the previous year and the targets for the current year with a monthly breakdown of these targets against each activity undertaken by each agency. A monthly progress report keeps the management system au courant of programme completion and forms the basis for a monthly project review by the City Community Development Council.

In addition, the community health wardens are expected to submit a monthly report to their supervisors detailing the work carried out for each activity under their responsibility. These form the basis for monthly discussions and follow-up actions at the district community development council meetings.

Results

Based on a scheme whereby local resident health wardens mobilized the communities to organize Community Development Councils, a system has been established to implement and manage local development activities. This system was further strengthened by the action of District Development Councils whose function as co-ordinating bodies is to assist the Community Development Councils in clearing bottle-necks and official delays in the delivery of basic services to the communities. Proposals have been made to include community representatives on the City Development Council as well.

Through this system, the residents have been able to participate in planning six-month programmes for the delivery of municipal health services. The direct results of community participation in the council meetings included an 80 per cent immunization coverage in 23 council areas, a mass legalization programme of unregistered marriages in the slums, and efforts to obtain national identity cards for many who did not have them.

Aside from participation in the planning and implementation of the activities of the officially sponsored project, the Community Development Councils have also initiated important community projects on their own.

The initial success of the health warden scheme has prompted other local authorities to follow the example set by Colombo. Modelled on the establishment of the community-level development councils, 23 school health councils have been formed for less privileged schools.

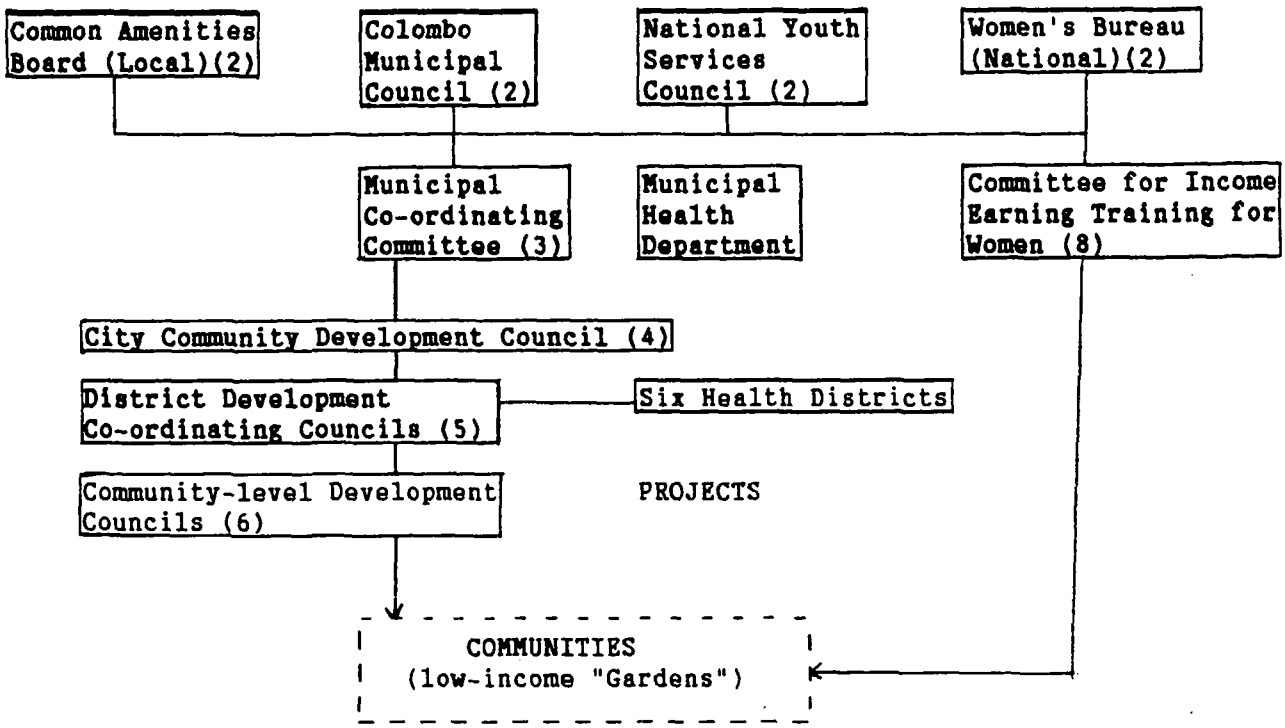
Based on excerpts from "Environmental Health and Community Development Project in the Slums and Shanties of Colombo (A Sri Lanka Experience)", by Leo Fonseka, October 1981, a case study prepared as an input to "Urban Basic Services: Reaching Children and Women of the Urban Poor (E/ICEF/L.1440 of 5 March 1982). This and other case studies were also summarized in "Addendum: A summary of nine case studies" (E/ICEF/L.1440/Add.1).

(i) For a copy of the Colombo Case Study, write to UNICEF HQ Library, New York.
(ii) For further detailed information write to UNICEF Representative, Colombo, Sri Lanka.
(iii) For any additional help or information, write to William J. Cousins, Senior Adviser - Urban Affairs, UNICEF, New York.

Diagram 1

Institutional setting for management

SRI LANKA: ENVIRONMENTAL HEALTH AND COMMUNITY DEVELOPMENT PROJECT IN THE SLUMS ANS SHANTIES OF COLOMBO



(1) Parent organization for local implementing organizations (Common Amenities Board and Colombo Municipal Council.

(2) Project implementing organizations.

(3) Policy and management review. Composed of Mayor, Municipal Commissioner and representatives from Ministries of Education and Social Services, the Women's Bureau, the Slum and Shanty Unit of the Urban Development Authority, the Common Amenities Board and UNICEF.

(4) Chaired by Chief Medical Officer of Colombo. Members of Council include, as well, representatives from National Youth Services Council, Water Works, Community Amenities Board, Women's Bureau and Urban Development Authority of Colombo. Supervises the co-ordination of the inter-sectoral aspects of the project.

(5) Chaired by medical officer of each health district and composed, as well, of public health personnel, the district municipal engineer and the elected resident leaders representing the community-level development councils. The district council assists the local level development councils in clearing bottlenecks and delays in the delivery of basic services to the communities.

(6) Established by communities at the encouragement of health wardens.

(7) Residents of communities recruited, trained and employed as community health wardens to promote nutrition and health education.

(8) Composed of representatives from the Municipality, Common Amenities Board, Ministry of Social Services and various women's Non-Governmental Organizations.

1)	NAME OF PROJECT:	URBAN KAMPUNG SERVICES PROGRAMME INDONESIA (FOUR SELECTED CITIES)
2)	TARGET POPULATION:	Low-income population in kampungs (neighbourhoods) of four selected cities.
3)	TIME FRAME:	1979--1984
4)	EXECUTING AND CO-OPERATING AGENCIES:	At the national level: Department of Home Affairs - Directorate of Administration of Urban Development, Department of Public Works - Directorate of Urban and Regional Planning in co-operation with Departments of Health, Education and Social Affairs and the National Planning Board. At the municipal level: governments of the cities of Cirebon, Yogyakarta, Surabaya and Ujung Pandang
5)	COSTS:	--
6)	SOURCES OF FUNDS:	National government, four selected municipalities and UNICEF
7)	OBJECTIVES:	i) To produce convergence and integration in the delivery of urban basic social services ii) To strengthen the ability of the community and local government to plan, organize and manage their own system of social development activities using a community participation approach. iii) To link national sectoral programmes with community-based development. iv) To develop, support, test and refine the methodologies, institutional arrangements, policies and procedures needed for implementation of similar activities nation-wide.

8) BRIEF DESCRIPTION: URBAN KAMPUNG SERVICES PROGRAMME INDONESIA (FOUR SELECTED CITIES)

Background

In recent years increasing attention has been given to the development needs of the urban poor in Indonesia. Low-income kampungs (neighbourhoods), where most of the urban poor live, are not only accepted but considered a basic resource. They are now being maintained and improved rather than demolished and replaced with new constructions.

Since 1972, when the Government adopted new urban policy directives which took the problems of the urban poor into account, UNICEF has provided support through technical assistance for research and analysis, programming and project formulation, monitoring, evaluation and training.

Current programme

A five year programme for co-operation on urban basic services between the Government and UNICEF at the national level has been established for 1979--1984. In addition, UNICEF co-operation at the local level is provided through sub-agreements with each of four municipalities: Cirebon, Yogyakarta, Surabaya and Ujung Pandang.

At the national level UNICEF supports a multi-sectoral, multi-level programme funded through national budgets. The basic services programme components are: primary health care, maternal/child health (midwives), school health, an expanded programme for immunization, water supply and sanitation, family nutrition improvement programme, non-formal education, community self-help activities and skill training. Research activities are also undertaken to find ways to improve the delivery of basic services. Finally, technical assistance and training activities are also supported.

UNICEF direct assistance at the local level involves cash grants (block grants) to the four municipalities for community-based projects identified by the communities as part of an agreed upon planning process. This has provided needed programme flexibility at the ground level. A full-time consultant is also contracted by UNICEF to work with the National Directorate of Administration of Urban Development and the four city governments. Finally, UNICEF provides honoraria for a programme co-ordinator and funds for administrative expenses in each city.

Institutional setting for management[1]

The programme has been designed to operate to the maximum extent possible through existing government and community organizations. However, some new institutional arrangements have been introduced. These include steering and intersectoral technical committees at the national level and the designation of city government officials as co-ordinators and executive secretaries for local programme implementation.

1/ See diagram on "Institutional Setting for Management" on page 10.

National Most social services continue to be delivered through sectoral departments. The national Department of Home Affairs and the programme co-ordinator in each city are responsible for co-ordination and for the convergent delivery of services in the selected cities. To achieve this, the Department of Home Affairs has an intersectoral technical committee, composed of a secretariat and a technical team which reviews and amends annual programme proposals and management directives. The technical team guides and supervises the planning, programming, implementation and evaluation of the national programme, as sectorally conceived.

Municipal In each city, a programme co-ordinator and an executive secretary co-ordinate the programming, implementation and monitoring of the national sectoral programmes that are carried out at the local level in conjunction with the municipal sectors concerned. They also supervise the complete planning, implementation, management and evaluation of community projects funded by block grants from UNICEF.

Community At this level, programming and implementation are carried out through the existing community structures and organizations. These are used as channels for community participation in programme activities. They play a particularly important role in selecting and implementing the projects funded by block grants.

Programme management

Much of the existing governmental system is sectoral and vertical, involving "top-down" planning, programming, implementation and subsequent management. A fundamental goal of the kampung urban basic services programme is to encourage, on a small scale, a complementary, urban-specific horizontal system on two levels: municipality and community.

Central government programming activities to develop "bottom level" capabilities have involved technical assistance to the cities for surveys and analyses and for the development of procedures and methodologies for project formulation, monitoring and evaluation. The Directorate of Administration of Urban Development of the National Department of Home Affairs provides operational support to local governments by ensuring that annual project proposals for programmes are correctly formalized into national budgets, by monitoring implementation, by providing horizontal and vertical co-ordination among sectoral departments and local governments and by providing management assistance to the cities.

Results

A set of programme components for the selected kampungs was developed at the beginning of the five-year planning period as a broad guideline for programming. This procedure appears to have been effective. Almost all programmes which were earmarked are operating in these kampungs and all sectoral services have reached the communities of the selected kampungs. Community volunteers have participated in the implementation of sectoral programmes with local women's groups being particularly active in basic services delivery. The community participation is based on pre-existing traditions of co-operation. The participation -- from planning and provision of supplies to implementation -- has played a key role in the effectiveness of the programme.

The Indonesia example represents a situation in which the central government took concerted action to develop a national level management system for urban basic services through research, analysis, policy determination, training and sectoral co-ordination. The purpose was to ensure that national sectoral programmes were integrated at the community level with municipal level programmes involving community participation. This process of municipal and community programme development is be reflected upwards in budget proposals for national sectors.

Based on excerpts from "Urban Case Study, Indonesia: Cirebon, Yogyakarta, Surabaya, Ujung Pandung", October 1981 prepared as an input to "Urban Basic Services: Reaching Children and Women of the Urban Poor (E/ICEF/L.1440 of 5 March 1982). This and other case studies were also summarized in "Addendum: A summary of nine case studies" (E/ICEF/L.1440/Add.1).

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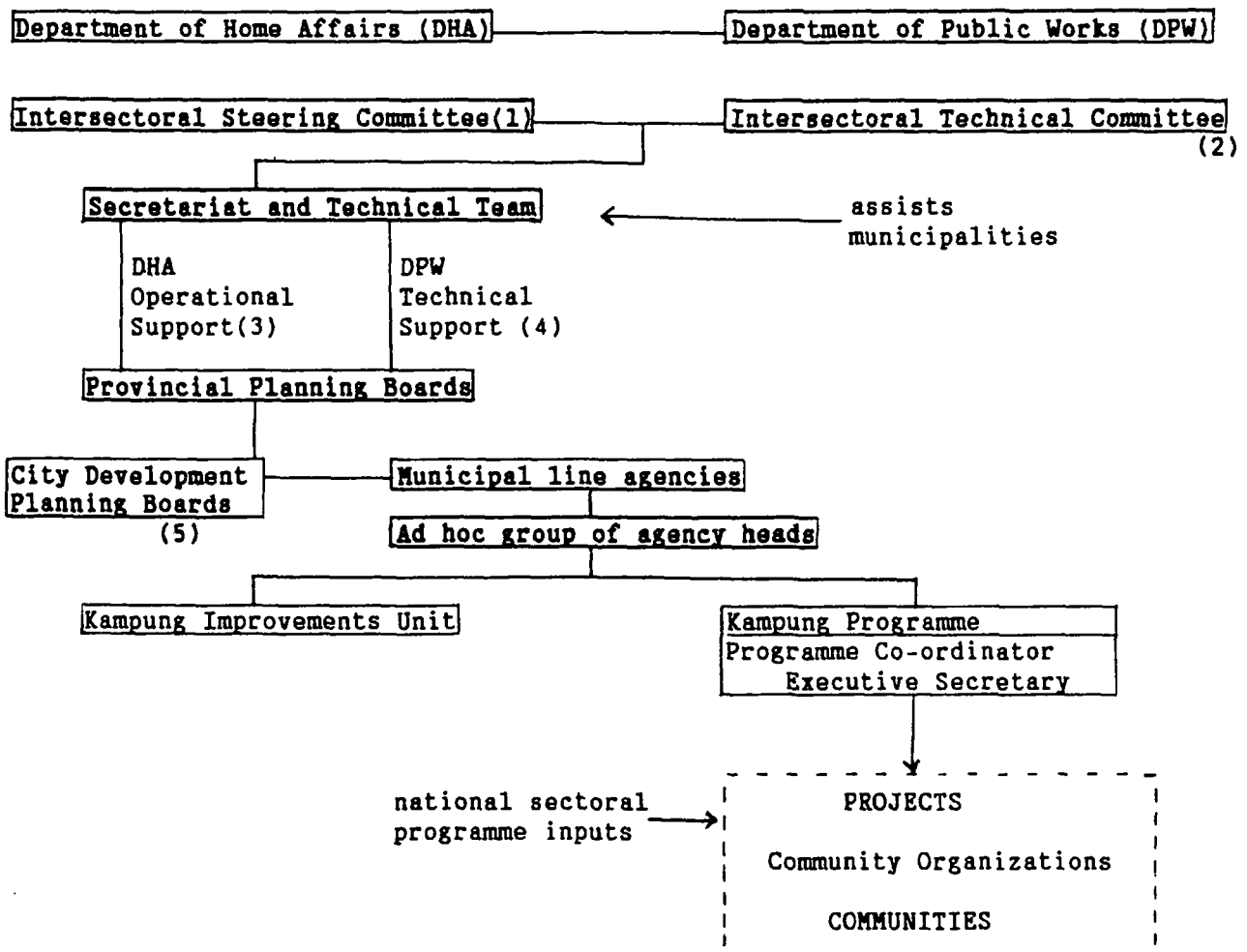
(ii) For further detailed information write to UNICEF Representative, Jakarta, Indonesia.

(iii) For any additional help or information, write to William J. Cousins, Senior Adviser - Urban Affairs, UNICEF, New York.

Diagram 2

Institutional setting for management

INDONESIA: URBAN KAMPUNG SERVICES PROGRAMME
(Jakarta, Cirebon, Surabaya, Ujung Pandang)



(1) Makes major policy, approves budgets and programmes.
(2) Directorate for Administration of Urban Development of Department of Home Affairs acts as Secretariat. Latter reviews and amends annual programme proposals and technical and management guidelines and directives. DHA co-ordinates implementation in cities through this Committee.
(3) Ensures programme proposals for annual projects are formalized into national budgets, monitors implementation and provides horizontal and vertical co-ordination among sectoral departments and local governments, provides management assistance.
(4) Provides technical assistance for social surveys, plan programming, monitoring and evaluation systems, plus technical training.
(5) Composed of the Directors of Health, Non-formal Education, Social Affairs and Community Development Offices.

1)	NAME OF PROJECT:	BASIC SERVICES FOR SQUATTER AREAS GUAYAQUIL, ECUADOR
2)	TARGET POPULATION:	Two low-income squatter areas (suburbios) of 91,800 total population.
3)	TIME FRAME:	1980--1983
4)	EXECUTING AND CO-OPERATING AGENCIES:	Ministry of Health, Ministry of Social Welfare and Popular Promotion and UNICEF.
5)	COSTS:	--
6)	SOURCES OF FUNDS:	Ministry of Health, Ministry of Social Welfare and Popular Promotion and UNICEF.
7)	OBJECTIVES:	Primary health care:
	(i)	To provide improved health services to the marginal urban areas, through primary health care programme; and
	(ii)	To raise the levels of health and community welfare through activities in environmental sanitation, nutrition, immunization, mother-child health care, health education, family planning and first aid.
		Other sectoral services objectives: Improve conditions in squatter areas through: pre-school education, child-care homes, child/juvenile sports and recreation, and the development of a system for social communication and information.

8) BRIEF DESCRIPTION: BASIC SERVICES FOR SQUATTER AREAS GUAYAQUIL, ECUADOR

Background

Forty per cent of the population of Guayaquil, the largest city of Ecuador (1,200,000 inhabitants) is concentrated in the suburbios, or low-income squatter areas, which occupy existing or converted swamps and where public services are either deficient or non-existent. The population under 15 years of age represents 46.7 per cent of the total population of the project area. The UNICEF-supported activities, which are designed to demonstrate non-conventional means of providing basic social services, are in two suburbios where 90 per cent of the population is affected by gastro-intestinal diseases, infant and child mortality are high, nutrition is exceedingly poor and opportunities for primary education are very limited.

Pre-project history

An earlier UNICEF-supported project for the Guayaquil suburbios was carried out through a planning and programming unit, PREDAM (Rehabilitation Plan for Urban Marginal Areas), which combined the efforts of various national institutions. Although important as a planning effort, it was not successful at the community level.

At the end of 1978 new steps were taken to involve UNICEF in an inter-institutional process which would serve to establish integrated social and economic development activities in the suburbios. A number of institutions were encouraged to collaborate in these activities through a strategy involving community participation.

Important community activities initiated or reinforced included: a child-care centre staffed by mothers (who received special training), a clothing workshop, a workshop on improvement and construction of housing, the creation of production activities, and the training of health promoters from the communities. This initial activity created conditions for organizing inter-sectoral co-ordination, defining cost-effective solutions to problems and establishing a good basis for managing the project and its activities together with the community.

Institutional setting for management[1]

The Guayaquil basic services project is not situated in an administrative unit of the government, nor is it in a unit resulting from a single agreement between institutions. Nonetheless, it is held together by a coherent concept and by inter-institutional co-ordination, especially at the field level.

The Ministry of Health and the Ministry of Social Welfare and Popular Promotion are the two government agencies responsible for programme implementation. Work proceeds under the concept of "convergent actions". Actual inter- institutional co-ordination is achieved at the community level through the Inter-Institute Committee for Community Participation (COIC) composed of those representatives of the institutions who are directly involved in implementation and of representatives of participating community organizations.

1/ See diagram on "Institutional setting for management" on page 15.

This "convergent actions" structure that includes community members, permits a problem solving approach to day-to-day management that has rendered project objectives more attainable.

Programme management

The project is being implemented through the two government ministries. The Ministry of Health has selected a Field Co-ordinator and Field Supervisor for its primary health care programme and the Ministry of Social Welfare and Popular Promotion has placed its own promoters in each of its programmes (pre-school, day-care, social communications and recreation). The community resident staff for each of the foregoing programmes are chosen by the communities.

The following programme activities are undertaken as part of the normal activities of the Ministries, but use a new strategy involving community participation:

(a) PROCAPE, the pre-school programme, is managed through operational centres located in selected areas. A centre is always established through the intermediary of a local neighbourhood organization which is responsible for identifying the service area, selecting the promoters, mobilizing the users and co-ordinating community support. A committee of parents oversees the activities.

(b) PHAI, the child-care programme, has a home committee for each community home (residence of selected mother). The families of the enrolled children participate in these committees.

(c) The child/youth recreation programme is developed through organized groups of community youths, under the guidance of a community promoter and a professional.

(d) The primary health care programme is run by health promoters who are always residents of the community. They are selected by the community and each promoter covers an average of 2,000 persons and should visit each family four times per year. Registration cards are maintained for basic information, initial health care, follow-up and analysis for future programming.

An Administrative Group is responsible for overall programme management. It is composed of the Provincial Health Director, the Technical Director of the Provincial Health Service, the Director of the Maternity Centre and the Field Co-ordinator. A technical team composed of two nurses, a health educator and a statistician is responsible for training, supervising and evaluating the performance of the promoters.

(e) The programme-support communications (PSC) component provides the community with educational information and news about the development programmes. The activities of basic social information, recreation, mobile library and information on appropriate technology are managed by local community organizations through volunteers and programme users. Programme development and evaluation are the responsibility of a co-ordinator and four social promoters, residents of the local community.

Results

Results have included: substantial community participation in the project since community representatives and community-selected programme staff have been directly instrumental in programme development and management; greater confidence of the community in the work of the external institutions; and creation of a good information base for programme implementation. In addition, the primary health care programme, the first in urban areas in Ecuador, is serving as a model for other cities in the country. The project's principal impact has been on women who benefit indirectly (specialized care of their children) and directly (training and paid employment).

The difficulties encountered included the determining the geographical limits of each community, clarification of the issues of community leadership and the opening up of the community to external institutions. In specific ways, however, the basic services planning and management strategy has opened the way for external support, with community collaboration, in the provision of services. The Ministry of Social Welfare has now allocated funds for the first stage of a national programme of 1,000 day-care homes for infants. Groundwork is being done for the pre-school programme which would follow the same strategy. In sum, as a result of this pilot experimental exercise in Guayaquil, rational policy and programmes for urban basic services with community participation is evolving on the basis of grassroots experience.

Based on excerpts from "Basic Services for Marginal Areas, Guayaquil", a case study prepared as an input to "Urban Basic Services: Reaching Children and Women of the Urban Poor (E/ICEF/L.1440 of 5 March 1982). This and other case studies were also summarized in "Addendum: A summary of nine case studies" (E/ICEF/L.1440/Add.1).

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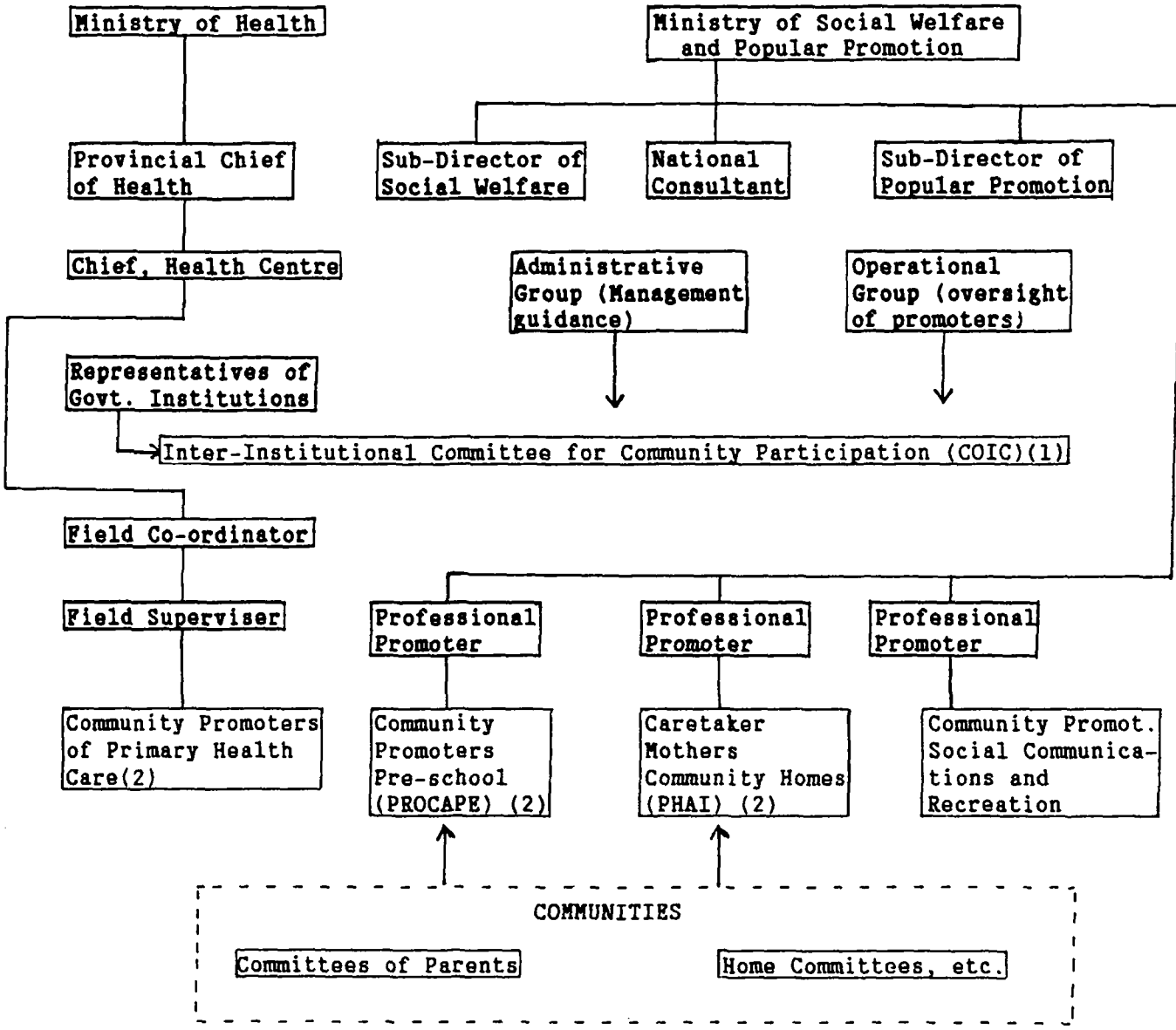
(iii) For any additional help or information, write to William J. Cousins, Senior Adviser - Urban Affairs, UNICEF, New York.

Diagram 3

Institutional setting for management

ECUADOR: BASIC SERVICES PROGRAMME OF MARGINAL AREAS, GUAYAQUIL



(1) Actual inter-institutional co-ordination is achieved through the Inter-Institutional Committee for Community Participation (COIC) which is composed of representatives of institutions directly involved in resource implementation and those of community organizations that participate.

(2) Community staff (community residents who are trained and employed for their functions).