Budgets have not kept pace with enrollment in schools which have led to large student-teacher ratios, overcrowded class rooms and schools, and there are not enough textbooks, equipment, and technology. In the health sector the ratio of doctors or trained nurses to patients is extremely out of line to need and investment is less than requirements; this is especially apparent in rural settings. In health, the number of clinics, their services as well as basic equipment and drugs and supplies are uneven across geographic areas.

Data*[mouseover: Hanushek (2003) and Case and Denton (1999)] show that just increasing resources – equipment, financial, or personnel – does not guarantee that the quality of education or health care will improve. Though these are very important tools that contribute to improved education and better educated population it is important to integrate into the education and health equation the quality of service delivery by teachers and health care providers.

In the end, resources alone have a limited impact on the quality of education and health in developing countries. Incentives combined with improvements in resources could lead to large and significant impacts.

Service delivery is seen as a role of key inputs along with service provider ability and service provider effort. The service delivery outcomes are established by the relationship among the service providers, i.e., teachers, educators, health providers, policy-makers, and the citizens they serve.

Health and education outcomes – better educated students and health care for various populations – come about because of a relationship and behaviors of individuals and households.

**Selection of Service Delivery Indicators**

The Service Delivery Indicators Initiative has 20 indicators – 10 each in health and education. The indicators are broken down into three categories:

1. Provider competence and knowledge
2. Proxies for effort (broadly defined)
3. Availability of key infrastructure and inputs

The indicators are quantitative and ordinal in nature (to allow cross-country and country-specific comparisons); robust – the methodology be verified and replicated; actionable; and cost-effective.

**Service Delivery Indicators' link with other research surveys**

The focus of the Service Delivery Indicators Initiative is on quality. It has been designed to link with other research studies in health and education to capture the inputs in policy and institutional environment as well as health or education outcomes.
The following are the surveys by sector linked to SDI:

- **Education**: the Southern and Eastern African Consortium for Monitoring Education Quality (SACMEQ) and Program for the Analysis of Education Systems (PASEC). These are standardized surveys that primarily focus on education outcomes. SDI also links to The World Bank’s System Assessment and Benchmarking for Education Results (SABER) Initiative that focuses mainly on policy and institutional environment.
- **Health**: the Service Availability and Readiness Assessments (SARA) and the Service Provision Assessments (SPA) surveys conducted by USAID’s Measure DHS project are comprehensive and detailed health facility surveys that assess all services offered at health facilities.

**Service Delivery Indicators Timeline**

Most surveys that measure service delivery take as up to a year or more to gather the information and report findings. SDI by design is a nimble survey instrument that can be repeated at greater frequency and at lower cost. By focusing on performance and quality, SDI surveys are complementary to the surveys that focus on availability and service readiness including SACMEQ, PASEC, SARA and SPA.

**Qualitative Data**

The SDI instrument is a quantitative facility-based survey. Data are also collected on many institutional factors that help in interpreting the findings of the survey. Please refer to the instruments for more details [link to instruments]. That information combined with the core indicators contributes to a more detailed analysis of the situation.

**Facility-based Survey**

Currently there are standardizes sources of household surveys, such as the Demographic and Health Survey (DHS) and the Living Standards Measurement Surveys (LSMS), but there are no standardized facility surveys that are repeated with predictable frequency. SDI is designed to fill that gap in the data landscape.

The information is collected on the supply side and the intent is to inform the demand-side with accountability and results by consumers – i.e., parents, policy analysts from public and private sector, and policy-makers including parliamentarians and government officials.

**Sample Design**

The sample design for the Service Delivery Indicators is national and disaggregated by rural/urban locations and provider (education and health) type. SDI has oversample in certain geographic locations in order to adequately capture the data. The sample size is 200-300 facilities and schools (or units) per sector, which provides sufficient precision for the estimates.
The pilots in Tanzania and Senegal show that the precision of the estimates of the indicators depends on the stratification process. It also can depend on how the variables are measured – whether dichotomous or continuous variable.