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What is the Service Delivery Indicator initiative?

The SDI initiative is a partnership of the World Bank, the African Economic Research Consortium and the African Development Bank. The World Bank is the implementing partner of this initiative for the first 5 years of this ten year program. The World Bank implements the SDI surveys jointly with host country governments. In addition to data collection, the two other components of the SDI initiative are: (i) capacity building of stakeholder in analysis and (ii) creative communication to disseminate the data and findings.

Why SDI?

Addressing the unfinished quality agenda.

Access to schools and clinics has increased in many African countries, but many children who leave school are unable to read and do basic arithmetic, and the quality of care in clinics remains uneven. Increased spending and expansion in access to education and health services have not been matched with commensurate improvements in human development outcomes, suggesting an unfinished quality agenda.

Quality is critically dependent on what service providers know and what they do.

Inspired by the World Bank’s 2004 World Development Report *Making Services Work for Poor People*, we know that a key characteristic that distinguishes education and health services is that these services are determined by provider behavior. In these services the effort provided is highly discretionary, i.e. determining how much effort to provide on which patient or student is a judgment. This complicates how relationships of accountability for education and health services are structured.

Accountability for public resources.

Developing country governments allocate roughly a third of their recurrent budgets to education and health. Demands for accountability and for the efficient use of public resources—from citizens and tax payers in developed or developing countries alike—are gaining in prominence, partly because of the global economic situation.
What you don’t measure you can’t hold service providers accountable for.

Without consistent and accurate information on the quality of services, it is difficult for citizens or politicians to assess how service providers are performing, to work towards corrective action, and ultimately bring about improvements in service delivery.

The SDI surveys and data are different from other available studies in a few key ways:

- The SDI surveys use robust and cutting edge data collection methods.
- The survey instrument is nimble allowing for relatively rapid fieldwork and data analysis, making it more usable for decision-making and policy discussions.
- It is focused on the links between expenditure and human development outcomes.
- The indicators are standardized allowing comparison national and subnational boundaries and over time.
- The surveys are repeated with a predictable frequency of every second year.

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Sources of data

Doesn’t this information already exist?

There are currently several surveys and data collection activities that capture aspects or portions of health and education service delivery.

The SDI data are different from those in several ways: SDI is designed to provide the link between investment and the performance outcomes; it includes both health and education; it is more frequent – every two years rather than five or 10 year-cycles; and the SDI survey instrument has been standardized so the data can be compared internally as well as across countries.

Finally, it does not rely on facility-based management information system data – this is data that are self-reported by health workers and educators at the community-level. The reporting can vary from clinic to clinic or school to school leading to data inconsistencies.

SDI is committed to having consistent and accurate information on the providers’ knowledge and performance to assess the quality and accountability of the delivery services.

How is SDI different from DHS and other surveys funded by donors?

SDI is more than just a survey, it has three distinct components: the service delivery indicators data, capacity building of local organizations, and communication.

With its partner the African Economic Research Consortium SDI builds the capacity of local organizations in research and policy analysis, and in communication SDI makes sure the data
and information are disseminated and made available to all interested parties so it can help in making future decisions in health and education service delivery.

Also, SDI is different from other surveys in its frequency – it is conducted every two years; it focuses on both the health and education sectors; and the methodology is standardization to be used and compared across countries.

**What are examples of service delivery indicators?**

There are 20 questions – 10 for health sector and 10 for education – that comprise the service delivery indicators. These indicators are designed to measure both the efforts and abilities of health providers and educators as well as the health and education facilities’ resources, such as books and materials in schools and medicine and equipment in health clinics.

There are established acceptable standards that schools and clinics must meet for service delivery and the SDI survey monitors where a country’s facilities and professional staff are regularly meeting those standards.

For example, in education the indicators record how much time a teacher is spent teaching in the classroom or what the student to teacher ratio is. In health, indicators capture a health provider’s adherence to clinical guidelines or what the caseload is per clinician.

**Implementation and funding**

**Who is funding this project? Why isn’t the World Bank funding this?**

Funding is being provided by the World Bank. The World Bank saw this need and made the commitment to design and initially fund the SDI in six countries.

The World Bank was joined by the African Economic Research Consortium and the African Development Bank to implement SDI. Contributions also have been made by several private foundations with in-kind technical leadership from universities and international organizations.

The World Bank has made a major financial commitment to SDI and plans to continue to support it with technical assistance and grants. The World Bank saw there was a gap in frequent frontline service delivery indicators and so developed the SDI to address this need. With its partners it has conducted the SDI survey in six African countries and there are plans to expand to other countries.

The World Bank welcomes additional support from other donors and organizations – public and private – to allow SDI to expand beyond these initial countries.

The service delivery indicators benefit decision-makers in government and private sector as well as donors and their programs to track progress in performance and investment returns over a
specific period of time. It also allows citizens to hold their governments accountable for public spending.

**Who is implementing the project?**

The World Bank has joined with the African Development Bank and the African Economic Research Consortium to develop and implement the Service Delivery Indicators. The World Bank is the initial partner with the AERC handling the country-level implementation that includes gathering the data and providing technical leadership to local entities on conducting policy-relevant economic inquiries.

SDI has a Technical Panel comprised of experts from leading education and research institutions that focus on the quality and integrity of the SDI survey and analysis.

SDI also has a Steering Committee made up of representatives from various international think tanks and international organizations that provide advice and guidance.

**Where has SDI been conducted?**

The Service Delivery Indicators survey has been conducted in six countries: Uganda, Tanzania, Kenya, Senegal, Togo and Nigeria.

The Kenya Service Delivery Indicators will be launched on July 12, 2013 in Nairobi attended by the government of Kenya’s Ministers of Health and Education and representatives from civil society, The World Bank, and other donor organizations.

Later in 2013 the SDI will be released in Nigeria, Tanzania, Senegal and Uganda.

**Perspectives on/from SDI**

**Could the Service Delivery Indicators be interpreted as a judgment on a country’s commitment to education and health?**

SDI is an evidence-based tool that helps policy makers and implementers – health providers and educators - measure the performance of their health and education delivery services. It is not a final grade or a judgment on people or services but a status report.

It reflects where the services are in a given period time and whether there is progress or - hopefully not - regression.

One of the values of the SDI is its frequency. By being conducted every two years it allows for adjustments and changes in the service delivery system and time to capture those changes.
Many African countries spend roughly a third of their budgets on education and health. While access to care at public health clinics and education in schools has increased in many African countries, the quality of these services remains uneven.

The quality of education and health care services is heavily reliant on the knowledge and quality of care of teachers and educators.

Consistent and accurate information on the providers’ knowledge and performance is needed to assess the quality and accountability of these services.

**How do you respond to education and health officials that see this as critical of the work performed by many dedicated professionals in their sectors?**

Educators and health professionals deserve tremendous credit for their work in often less than ideal situations. SDI is in fact providing evidence for many of the issues raised by unions, civil society and private individuals that the demands of more students and patients and less funding available is making it more difficult to do their jobs.

SDI shows where there is progress and where there is regression and possible ways to fix these. It is not a final grade – SDI is a long-term look at where changes can be made to improve quality and performance in service delivery.

**Is it fair to only use quantitative research to measure the indicators?**

The methodology for the service delivery indicators is quantitative; however, we take into consideration other issues when analyzing the data. For example, any political or social conditions or even natural disasters that may cause absenteeism or delays in delivery are documented and are incorporated into the overall analysis.

**Design/Methodology**

**What are the analytical underpinnings of SDI?**

The Service Delivery Indicators takes as its starting point the literature on how to boost education and health outcomes in developing countries. While resources alone appear to have a limited impact on the quality of education and health in developing countries, it is possible that inputs are complementary to changes in incentives and so coupling improvements in both may have large and significant impacts. The fact that budgets have not kept pace with enrollment, leading to large student-teacher ratios, overstretched physical infrastructure, and insufficient number of textbooks, etc., is problematic. However, simply increasing the level of resources might not address the quality deficit in education and health without also taking providers’ incentives into account. A production function for service delivery is a key theoretical underpinning of the service delivery indicators. Service delivery is thought of as a function of key inputs, service provider ability and service provider effort. Service delivery outcomes are
determined by the relationships of accountability between policymakers, service providers, and citizens. In turn, health and education outcomes are the result of the interaction between various actors in the multi-step service delivery system, and depend on the characteristics and behavior of individuals and households.

**How were the indicators chosen?**

SDI proposes three types of indicators: (i) provider competence and knowledge; (ii) proxies for effort, broadly defined; and (iii) availability of key infrastructure and inputs. In addition, we wanted to select indicators that are (i) quantitative (to avoid problems of perception biases that limit both cross-country and longitudinal comparisons), (ii) ordinal in nature (to allow within and cross-country comparisons); (iii) robust (in the sense that the methodology used to construct the indicators can be verified and replicated); (iv) actionable; and (v) cost effective.

**How does SDI link with other surveys?**

- **Education.** The Southern and Eastern African Consortium for Monitoring Educational Quality (SACMEQ) focuses primarily on education outcomes. The System Assessment and Benchmarking for Education Results (SABER) initiative of the World Bank focuses mainly on policy and institutional environment. The focus of the SDI on quality, offers potential complementarities with these instruments by linking inputs, policy and institutional environment factors on the one hand, and education outcomes on the other.

- **Health.** Service Availability Mappings (WHO) and Service Readiness Assessment Surveys (USAID/Macro International) are health facility surveys, which are very comprehensive. We view these comprehensive data efforts complementary to the SDI, which will focus on a sub-set of key health facility indicators, but be a more nimble tool that can be repeated at lower cost and with greater frequency.

- **Health.** Demographic and Health Surveys (DHS) (USAID/Macro International) are household surveys aimed at assessing: health service access and utilization and health outcomes (such as infant mortality rate and under-5 mortality rate). In this sense the SDI and DHS surveys are highly complementary and SDI goes beyond measuring utilization, but assesses the functioning of services that people have access to.

**What is the level of representatively of SDI surveys?**

The sampling strategy aims to generate nationally representative data disaggregated by rural/urban locations and provider type. To maximize the utility to the in-country dialogue, the stratification and/or selective oversampling of certain geographic locations will be adapted to country-level needs.

**Why are no qualitative data collected by SDI surveys?**

SDI focuses on quantitative facility-based data. That said, information is collected on many institutional factors that help one understand and interpret the results of the indicators—i.e. SDI surveys do not only collect the data for the 5-6 indicators per sector, but collect other contextual
information to correctly interpret the indicators and for more detailed analysis beyond the indicators.

**Why does SDI have an exclusive supply-side focus?**

SDI surveys focuses on facility-based data, which is a gap in the data landscape. While there are standardized sources of household surveys (e.g. DHS, LSMS) that give insight into health and education outcomes and their socio-economic determinants, this information is not always helpful to talk about what the service delivery systems should be held accountable for. This is the gap that SDI aims to fill.

**Is there a risk of laying the blame on providers for service delivery weaknesses?**

The actions of service providers are viewed as a reflection of underlying systems’ weaknesses or strengths — rather than an indictment of individual service providers. From the consumer’s point of view, however, providers’ ability and effort are what they see, hence this focus in SDI.

**What is SDI doing to build capacity to better use the data?**

The SDI partners are committed to make anonymized raw SDI data available. But it cannot be automatically assumed that everyone will be able to access and use the data. One of the SDI partners, the African Economic Research Consortium (AERC) will implement in each SDI country two types of training workshops: one for basic analysis targeting young researchers, and a second shorter more compact module for advanced analysts/researchers. Mini-grants will be awarded to promising analyses to develop them into SDI Policy Briefs.

**Do the SDI surveys not undermine the investment made in health and education management information systems?**

The experience with MIS has been mixed. Take the example of health MIS. There is a long history of investment in the HMIS, but the WHO’s structured assessments of the HMIS has continued to point to serious weaknesses in the system that undermines the conclusions that one is able to draw. For example, the completeness of HMIS submissions is a challenge, and those performing in the range of 70% are performing reasonably well. But it is rarely that the same 70% of facilities are reporting (in which case corrections can be made in the analysis. This is not the case. Also, it is often assumed that this is a capacity problem, and investments in training and information systems have been made — yet the problem persists. It can be argued that not all types of data should be collected in management information systems in the first place, and that the type of quality data that are being collected in SDI are best suited to be collected by (independent) third parties.

**What are the 15-20 SDI countries, how were they decided and what are the minimum requirements to participate as an SDI country?**

All the SDI countries have not been selected. The main requirement is country demand, the commitment to making the findings available within about 3 months of data collection, data
transparency, i.e., to make the data available for primary analysis (with the necessary ethical protections such as anonymization). Finally, the survey should be implemented in both the education and health sectors.

Are private sector providers included in SDI surveys?

SDI covers both public and private sectors. In the education sector both non-profit private sector providers (mainly FBOs) as well as low cost for-profit providers have been included. In the health survey only non-profit private providers (mainly FBOs) have been included. Some aspects of the survey instrument need to be adjusted for private providers, as the conclusions and policy implications may be quite different. For example, drug stock-outs at a private practitioner’s office may be quite different. In some countries drug dispensing is not allowed, or limited to certain drugs. But the clinical competence modules will still be relevant. The inclusion of private for-profit providers also depends on their magnitude as service providers.

Why not include other services and health and education?

The quality of services such as water and sanitation must typically be measured through a household survey. This differs from the facility-based approach of the SDI surveys. Surveys on water and sanitation are probably better administered independently of the SDI surveys.

How sure are we that the appropriate sample size is 200-300 units per sector?

The pilots in Tanzania and Senegal showed that the precision of the estimates of the indicators depends a lot on the efficiency of the stratification process. It also depend on how some of the variables are measured (whether a dichotomous or a continuous variable). The precision of the estimates should be continuously monitored to determine whether the sample size in future surveys should be increased or decreased. However, the most critical variable for the sample size is the level of precision that we require in our estimates. Changes in the confidence intervals of a few percentage points have large implications for sample size. Experience has shown that 200-300 facilities per sector is enough to meet these needs.

Why is there not a management or leadership indicator?

Management can be seen as a primary input because organization of the inputs is crucial for efficient service production. If a good indicator of this aspect can be identified, it can be included among the indicators. So far, we have not identified this indicator. Leadership is clearly an important factor explaining quality of services, but again, a simple and telling indicator is hard to identify. We suggest however that various proxy indicators are collected as part of the underlying data.


(ii) As noted by Duflo, Dupas, and Kremer (2009).
For an overview, see Hanushek (2003). Case and Deaton (1999) show, using a natural experiment in South Africa, that increases in school resources (as measured by the student-teacher ratio) raises academic achievement among black students. Duflo (2001) finds that a school construction policy in Indonesia was effective in increasing the quantity of education. Banerjee et al (2000) find, using a randomized evaluation in India, that provision of additional teachers in nonformal education centers increases school participation of girls. However, a series of randomized evaluations in Kenya indicate that the only effect of textbooks on outcomes was among the better students (Glewwe and Kremer, 2006; Glewwe, Kremer and Moulin, 2002). More recent evidence from natural experiments and randomized evaluations also indicate some potential positive effect of school resources on outcomes, but not uniformly positive (Duflo 2001; Glewwe and Kremer 2006).

The suggested indicators for education and health are partly based on an initial list of 50 PETS and QSDS indicators devised part of the project “Harmonization of Public Expenditure Tracking Surveys (PETS) and Quantitative Service delivery Surveys (QSDS) at the World Bank” (Gauthier, 2008). That initial list, which covers a wide range of variables characterizing public expenditure and service delivery, was streamlined using this project’s criteria and conceptual framework.

SDI surveys aim to address a key methodological challenge experienced by facility surveys, namely they usually consist of interviews of the medical officer or head nurse. This method has been found to have sub-optimal validity in a recent review of health facility surveys (International Facility Assessment Network, presentation at American Association of Public Health Conference, 2011). The SDI surveys are based on primary collection of observational data that is verified by the enumerator. For example, in assessing access to electricity SDI assesses whether the electricity is functioning— and for example, in schools whether the light quality that the electricity generates is adequate (using a light meter).