Overview
What is the Service Delivery Indicator initiative?

SDI is an initiative coordinated by the Chief Economist Office in the Human Development Practice Group at the World Bank. It was launched in 2010 as a partnership between the World Bank Group and the African Economic Research Consortium (AERC). They were later joined by the William and Flora Hewlett Foundation and The African Development Bank. The World Bank implements SDI surveys jointly with host country governments, providing a robust, cutting-edge and standardized data tool to measure the service delivery experience of average citizens in primary schools and primary health centers. The SDI initiative: a) aims to improve the monitoring of service delivery to increase public accountability and good governance; b) assess the quality and performance of education and health services for decision-makers, and c) provide a set of metrics to act as benchmarks for the performance of schools and health facilities (over time and across countries).

Why should we use SDI?

The Service Delivery Indicators aim to identify gaps in service delivery and to track progress within and across countries over time. The broad availability of the data and publicity around key indicators helps mobilizes policymakers, citizens, donors and other stakeholders into action. For a country government, the SDI offers the chance to measure multiple aspects of human capital and to compare across the health and education sectors. The survey provides detail that cannot be seen from routine reporting and which can guide future policy decisions.

The SDIs also offer a few key advantages:

- The survey instruments are nimble, allowing for relatively rapid fieldwork and data analysis.
- SDIs use robust, cutting-edge data collection methods.
- Indicators are standardized, allowing for comparisons between countries and over time.
- SDIs builds capacity of local organizations in research and policy analysis.
- SDIs help countries identify some of the key drivers of low human capital outcomes.
- SDIs provide the only internationally-comparable data on provider absenteeism and knowledge in education and health sectors in developing countries.

Sources of data
Doesn’t this information already exist?

Although there are currently several surveys and data collection activities that capture aspects or portions of education and health 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 education and health; it is more frequent; and the SDI survey instrument has been standardized so the data can be compared internally as well as across countries.

Finally, SDI does not rely on data that are self-reported by educators and health workers at the community level, which can be inconsistent. Instead, an SDI team conducts the survey.

How is SDI different from 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 of the results.

The SDI Initiative builds the capacity of local organizations in research and policy analysis. The SDI Initiative makes sure the data and information are made available to all interested parties so it can help in making future decisions in education and health service delivery.

Also, SDI is different from other surveys because it is more frequent – it is designed to be conducted
every two years; it focuses on both the education and health sectors; and the methodology is standardized to be used and compared across countries.

**What are examples of Service Delivery Indicators?**

The indicators are designed to measure both the efforts and abilities of health providers and educators as well as the education and health facilities’ resources.

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

For example, in education the indicators record how much time a teacher spends 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. In terms of resources, the survey records whether the appropriate books and materials are available in schools and medicine and equipment in health clinics.

**Where has SDI been conducted?**

Since the inception of the initiative in 2010, twenty-six surveys have been completed in twelve countries in Africa, capturing the health and primary education service delivery experience of over 500 million people. The surveys have been extended in Africa (with SDIs in the pipeline or envisioned in Benin, DRC, Cameroon, Madagascar, Ethiopia, Cote D’Ivoire, Gambia, Guinea Bissau, Malawi, and Mali) and beyond: data collection for the first SDI surveys in Latin America (Guatemala), East Asia/Pacific (Indonesia), Europe and Central Asia (Armenia, Moldova and Ukraine), Middle East and North Africa (Iraq), and South Asia (Bhutan) are underway or being considered. The results are available under the **Countries** tab, above.

**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 policymakers and implementers, health providers and educators measure the performance of their education and health delivery services. It is not a judgment on people or services. Instead, it is a status report: it reflects where the services are in a given time period and whether there is progress or–hopefully not–regression.

Many low and middle-income countries spend a big proportion of their budgets on education and health. While access to care at public education and health facilities in schools has increased, the quality of these services remains uneven.

Consistent and accurate information on the providers’ knowledge and performance is needed to assess the quality and accountability of these services. Moreover, as countries begin to reimagine their health and education systems post-COVID, SDI offers clear lessons on what changes are needed.

**Might education and health officials 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 providing evidence for many of the issues raised by unions, civil society and private individuals who have said that the demands created by more students and patients coupled with reduced funding are making it more difficult for them to do their jobs.

SDI shows where there is progress and where there is regression and possible ways to fix these.

**How can numbers alone give a fair picture of the situation?**
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**

**How were the indicators developed?**

The Service Delivery Indicators initiative takes as its starting point existing research on how to improve education and health outcomes in developing countries. While resources alone appear to have a limited impact on the quality of education, it is possible that inputs are complementary to changes in incentives. The fact that budgets have not kept pace with enrollment, has led to large student-teacher ratios, overstretched physical infrastructure, and insufficient number of textbooks, etc. However, simply increasing the level of resources might not address the quality deficit in education and health if providers’ incentives are not taken into account. 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 uses three types of indicators: provider competence and knowledge; measures of effort; and availability of key infrastructure and inputs (or resources). In addition, the indicators are quantitative (to avoid problems of perception biases that limit both cross-country and longitudinal comparisons); ordinal (to allow within and cross-country comparisons); robust (the methodology used to construct the indicators can be verified and replicated); actionable; and 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 two other major health facility surveys. These comprehensive data efforts are 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. USAID/Macro International’s *Demographic and Health Surveys* (DHS) are household surveys aimed at assessing health service access and utilization, and health outcomes (such as infant mortality rate and under-five mortality rate). The SDI and DHS surveys are highly complementary, while SDI goes beyond measuring utilization, but assesses the functioning of services that people have access to.

**How reliable are SDI surveys?**

The survey has been designed to capture data that can be analyzed in several ways, including by location (rural or urban) and provider type (health and education.) The survey can be adapted to the needs of each country, for example, with more data collected in certain locations if that is useful to inform policy.

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

Although it is true that SDI focuses on quantitative facility-based data, information is also collected on
institutional factors that help to understand and interpret the results. Beyond the indicators in each sector, the other information gathered helps to interpret the indicators and to perform a more detailed analysis.

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

SDI surveys focus on facility-based data, which is data that isn’t gathered systematically anywhere else. While there are household surveys that give insight into education and health outcomes and their socio-economic determinants, this information does not show what these 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 weaknesses in the underlying system rather than a judgment on individual service providers. From the consumer’s point of view, however, providers’ ability and effort are what they see, hence this is the focus of SDI.

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

The SDI partners are committed to making raw SDI data available. However, not everyone will be able to access and use the data.

During the analysis stage of the SDI project-cycle, the SDI core team works along with the technical working group in the country to build their capacity in data for decision-making through the following steps:

- Through a two-week workshop, preliminary analyses of the core indicators are undertaken.
- Capacity of the technical working group is built around data analysis and interpretation.
- At the end of this stage, key results tables and summary results slides are drafted for preliminary review by the task team and the client.

**Do the SDI surveys undermine the investment made in education and health management information systems?**

SDI and existing management information systems can work hand in hand. Not all types of data are suitable for collection in management information systems. The type of data that are being collected in SDI are best suited to collection by (independent) third parties.

**How are the participating countries chosen? What are the roles of the Task Teams and the SDI core team once demand is identified?**

The main requirement is country demand: countries ask to participate. Once interest is generated by country counterparts, Task Teams help generate the initial momentum for a survey within the country. This often means connecting stakeholders, introducing the survey to government counterparts, and helping foster dialogue and interest in the results. The SDI core team provides technical guidance, supporting the Task Teams and ensuring that a high-quality survey can take place.

Specifically, Task Teams are responsible for:

- Identifying opportunities and initiating dialogue around SDI with the client; the SDI core team will support technical discussions.
- Identifying a local SDI technical working group of ministry and regional officials, development partners, and research/academic institutions.
- Contracting and managing a survey firm.
- Taking the lead in analysis and report writing.
- Creating a dissemination strategy.
And the SDI Core Team provides:
• Standardized materials and suggestions for survey adaptation.
• Technical guidance on survey design, and sampling procedure.
• Protocol and assistance on quality control.

**Are private sector providers included in SDI surveys?**

Yes. SDI covers both public and private sectors. In the education sector both non-profit private sector providers (mainly faith-based organizations or FBOs) as well as low cost for-profit providers have been included. In the health survey only non-profit private providers (also mainly FBOs) have been included.

**Why not include services other than education and health?**

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 best administered independently of the SDI surveys.