

Capturing access to public services: health and education

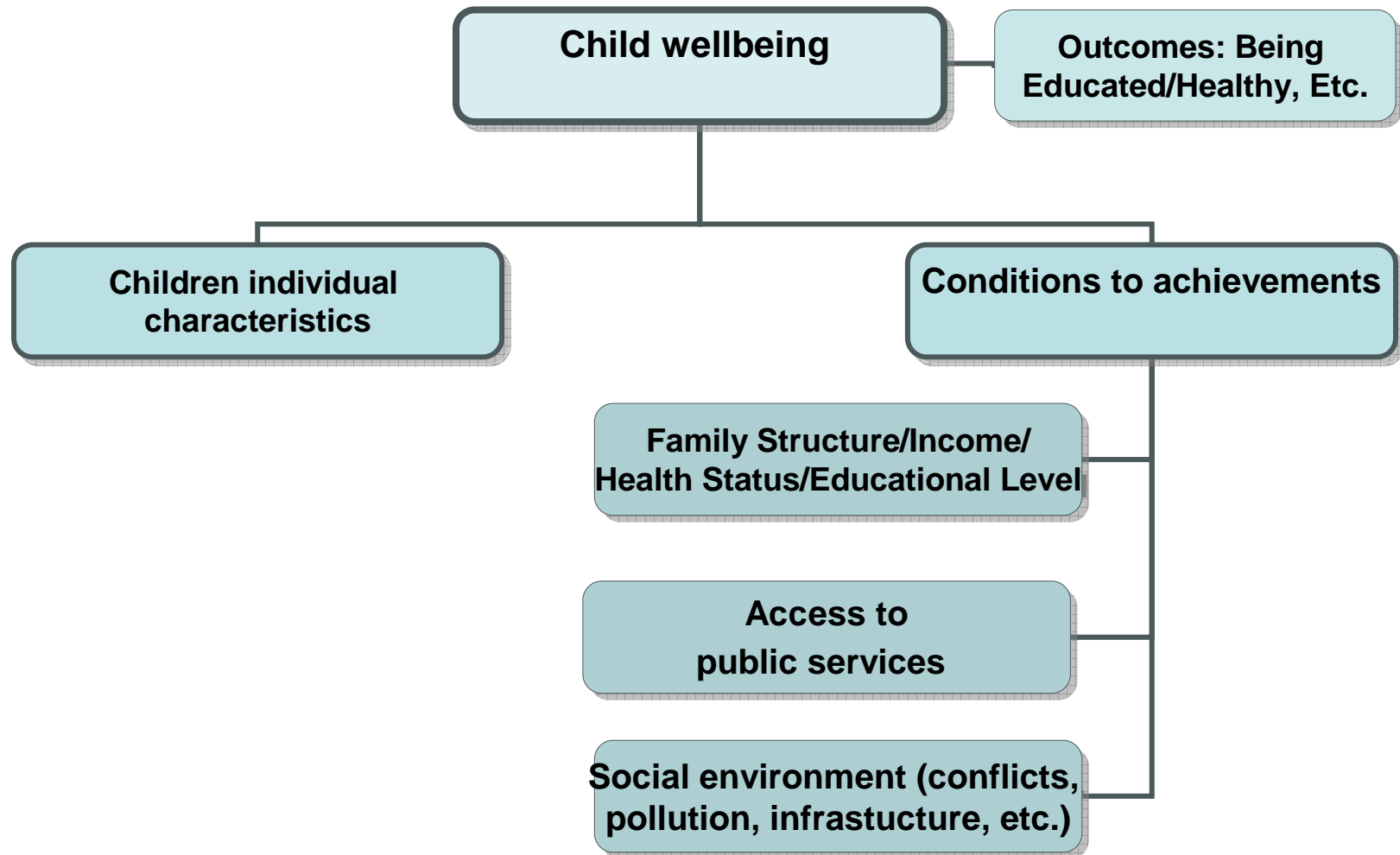
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Technical Consultation on “Making Children Visible in Routine Surveys”
UNICEF Innocenti Research Centre
Florence, 26-27 July 2007

Outline of the presentation

- Present the conceptual framework for measuring and analysing children's access to services
- Analyse data constraints/availability and discuss survey design issues/limits using some examples
- Discuss challenges and provide some recommendations for survey module design

Theoretical framework: child wellbeing



Theoretical framework: access to services

Multidimensional concept with six main components:

- Availability
- Appropriateness
- Quality
- Affordability
- Cultural Acceptability
- Social Accessibility

Steps and operational issues in measuring and analyzing access to services

Need to identify a specific set of indicators to measure all the dimensions of access (use and availability). Selection of the indicators needs to include consideration of equity to avoid creating a situation in which some targets can be achieved without bringing benefits to the most vulnerable groups.

Need to collect data for such indicators – different instruments needed

Need to analyze some of the indicators by background characteristics of the respondents (in case of individual questionnaires) to identify disparities and role of other risk factors (ex. educational level of the parents)

Assessment of data availability

Selected sources: MICS/DHS, EdData, SPA, LSMS

Criteria for selection:

- large use in several countries and international relevance
- multi-topic or linked to multi-topic surveys

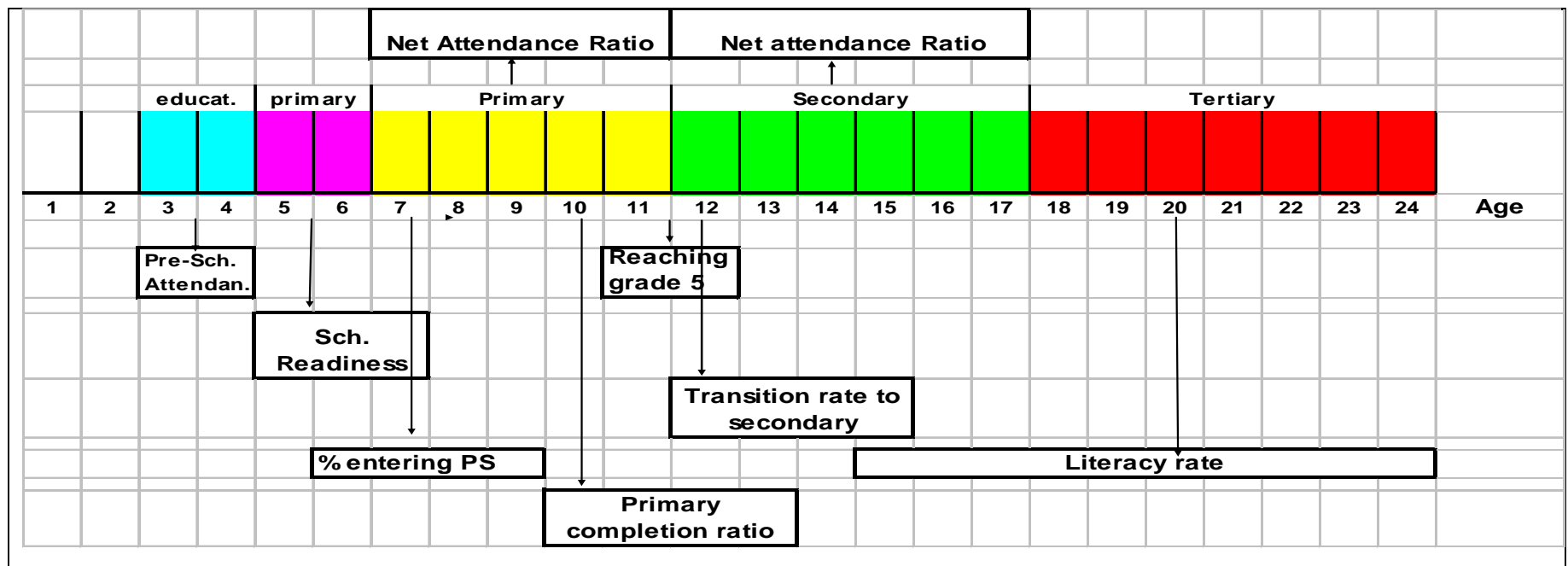
Criteria for assessment:

- pertinence of indicators with regards to the concept of access
- usefulness of the data to develop and monitor policies aimed at guaranteeing universal and equal access to services for children

Access to education in MICS and DHS

Provide information on the education status of the overall population (all household members aged 5-24, women 15-49, MICS: children 3-4)

Access to education is assessed through asking questions about school attendance (ever, current and past year) and highest grade attended/completed



Access to education in MICS and DHS

- No questions on reasons for not attending school (affordability, accessibility, acceptability)
- No information on the availability/appropriateness/quality of education services

DHS India 2005-06

MAIN REASON FOR NOT ATTENDING SCHOOL

- 01 = SCHOOL TOO FAR AWAY
- 02 = TRANSPORT NOT AVAILABLE
- 03 = FURTHER EDUCATION NOT CONSIDERED NECESSARY
- 04 = REQUIRED FOR HOUSEHOLD WORK
- 05 = REQUIRED FOR WORK ON FARM/FAMILY BUSINESS
- 06 = REQUIRED FOR OUTSIDE WORK FOR PAYMENT IN CASH/KIND
- 07 = COSTS TOO MUCH
- 08 = NO PROPER SCHOOL FACILITIES FOR GIRLS
- 09 = NOT SAFE TO SEND GIRLS
- 10 = NO FEMALE TEACHER
- 11 = REQUIRED FOR CARE OF SIBLINGS
- 12 = NOT INTERESTED IN STUDIES
- 13 = REPEATED FAILURES
- 14 = GOT MARRIED
- 15 = DID NOT GET ADMISSION
- 96 = OTHER
- 98 = DON'T KNOW

**New categories included compared to DHS 1998-99
But ONLY one reason asked**

MICS Sudan 2005

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ACCESS TO SERVICES		ATS
ATS 1. DO MEMBERS OF THIS COMMUNITY HAVE ACCESS TO A PRIMARY SCHOOL?	Yes..... 1	2 ⇒ Skip to ATS 3
	No..... 2	
ATS 2. HOW FAR IS THE NEAREST PRIMARY SCHOOL?	Walking Distance in hours _____	
ATS 3. FOR EACH OF THE FOLLOWING GROUPS, WHAT ARE THE MAIN REASONS WHY THE CHILDREN IN THE COMMUNITY MAY NOT BE ATTENDING <u>PRIMARY SCHOOL</u> ? (THREE MAIN REASONS) ATTENDANCE CODE: 1 = INSECURITY 2 = CANNOT AFFORD TO PAY TUITION / COST OF MATERIAL 3 = NO SCHOOL OPENED / ACCESSIBLE OR SCHOOL FULLY ENROLLED 4 = NO TRAINED TEACHERS 5 = NO OR POOR EDUCATION MATERIALS 6 = LACK OF FOOD, NO SCHOOL FEEDING 7 = CHILDREN NEED TO WORK FOR FAMILY 8 = GIRLS MARRY EARLY 9 = PARENTS DON' CARE / CHILDREN REFUSE TO GO 10 = NEWLY / IRREGULARLY ARRIVED 11 = OTHER, SPECIFY	Residents' Boys..... _ , _ , _	
	Residents' Girls..... _ , _ , _	
	<u>IDPs'</u> Boys..... _ , _ , _	
	<u>IDPs'</u> girls _ , _ , _	
	Returnees' Boys..... _ , _ , _	
	Returnees' Girls _ , _ , _	

Access to health in MICS and DHS

- Provide information on the health status of the overall population of women aged 15-49 and children under-five
- Access to health is mainly assess thought asking questions about the utilization of services (public/private) related to some specific issues (health services coverage):

Proportion of one year olds immunized

Proportion of births attended by skilled health personnel

Children 6-59 months of age who received vitamin A supplementation

BUT

In the case of some health issues, no questions on the utilization of services, i.e. child disability

No questions on health issues for children aged 5-18

- No questions on reasons for not using the services (affordability, accessibility, acceptability)
- No information on the availability/appropriateness/quality of health services

MICS and DHS: strength and limits

Strengths:

- Continuity
- Large coverage of health outcomes both for children and mothers
- Multidimensionality

Limits:

- Focus on outcomes rather on the determinants
- Data useful to monitor access but not for the development of policies aimed at improving the access.

EdDATA

- Launched in 1997 and gradually modified in 2004 (EdData II)
- Funded by USAID and carried out by a consortium led by RTI international
- Linked to the DHS (subset of DHS survey households, ex. Nigeria EdData 2004 covered 4,563 households out of the 7,225 used in DHS Nigeria 2003)
- Designed to collect information on education that addresses issues surrounding both the demand for schooling and school availability
- Children aged 4-16 but link to DHS information on parents/guardians characteristics

EdDATA

- More than 700 questions asked to parents/guardians. This include: reasons for never attending school, dropping out of school and absenteeism, household expenditure on schooling, informal training, availability, perceived quality and type of educational services, perceived value of school (benefits and disadvantages), household decision-making about schooling, etc.
- Capture all dimensions of access (demand and supply) but no objective assessment of quality
- But question of sustainability, useful as an *ad hoc* survey for developing/evaluation policies but difficult to use for monitoring (ex. Primary school reform in Uganda) → no periodicity in survey implementation

Service Provision Assessment (SPA)

- Conducted in health facilities and communities
- Objective: to provide information about the characteristics of health services including their cost, quality, infrastructure, utilization, and availability.
- Flexibility
 - national or subnational
 - can be stand-alone assessment of services or can supplement household-based health information from the DHS
- Compares services of various providers and aims to track service improvements over time.
- Plans underway to conduct qualitative research related to SPA

Surveys of services providers (SPA)

Five key services: child health, maternal health, family planning, sexually transmitted infections, and HIV prevention, care, and support.

Indicators include: Facility infrastructure, Equipment and supplies, Support systems, Management systems, Providers' adherence to standards

Nationally representative sample of over 400 facilities and covers all types of health services sites from hospitals to health posts.

ONLY covers supply side components, i.e. availability and quality of services – no information on affordability, barriers to use and factors influencing demand for health

Living Standards Measurement Study Surveys (LSMS)

Developed to understand the determinants of observed social and economic outcomes and to assist policy makers in their efforts to elaborate policies to positively affect these outcomes

Three main modules: consumption, income, sectoral module (household roster, housing, education, health/fertility, anthropometric, migration)

Multiple questionnaires: Household Questionnaire, Community Questionnaire, Price questionnaire, Facility Questionnaire

Multi-topic questionnaire increasingly customized to fit specific country circumstances

Living Standards Measurement Study Surveys (LSMS)

Household questionnaire

Education: Completed schooling and schooling expenditures for all household members 5 or older

Health: utilization of health services and medical expenditures for any illness in the last four weeks; utilization of and expenditures for preventive services in the last 12 months

Community questionnaire (community leader/headmaster/health workers)

Education: location and characteristics of school serving community

Distance to primary and middle schools; public or private; for boys or girls, or both, how many classes there are, and when it was built. Enrollment rates and reasons why children do not attend school are also collected.

Health: location and characteristics of health facilities serving community

Distance and travel time to the nearest of each of several types of health workers (doctor, nurse, pharmacist, midwife, family planning worker, community health worker, traditional birth attendant and traditional healer) and each type of several types of health facilities (hospital, dispensary, pharmacy, maternity home, health post and family planning clinic).

Special Facility Questionnaires: detailed information on schools and health clinics

Living Standards Measurement Study Surveys (LSMS)

Good information on service availability, quality and appropriateness but limited information on the demand for schooling and factors influencing this demand

Multi-topic but not multidimensional

Limited focus on children (exception: Kyrgyzstan questionnaire for children)

Sustainability

Operational use of the LSMS: the example of Jamaica

First conducted in 1988. Sixteen rounds of the survey were completed from August 1988 to July 2002

Initial proposal elaborated by the Government to assess the effectiveness of its Human Resources Development Programme (HRDP) on health, education and nutrition

HRDP developed to revitalize the social sectors and improve access to social services

Short version of the questionnaires used with focus on Health and Education (questions from the community questionnaires included in the household questionnaire) implemented in 45 minutes (household questionnaire), students knowledge test

Data from LSMS data linked to Labour Survey Data, Administrative and Teacher Data, Health Services Data

More recently: data used by the government for reforming secondary education

Challenges, data implications and recommendations

- **The multidimensional nature of the concept of access makes it difficult to ensure consistent, complete and harmonized reporting**
 - Difficulties in assessing all the dimensions as part of the overall assessment of children wellbeing
 - General (cost and flow) versus specialized survey
 - When possible, Integrate data coming from household surveys with information obtained through other sources, such as administrative data
- **The goal of guaranteeing universal and equal access increases the need for policy-oriented indicators**
 - Need to collect data on processes and causes (how and how) via quantitative tools
 - Integrate data coming from sample surveys with information obtained through more participatory techniques
 - involve policy-makers in data collection process
- **Specific suggestions for improving MICS modules ?**