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**West Bank & Gaza**

***Service delivery survey:  
Health and basic education services***

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**WEST BANK AND GAZA**  
**SERVICE DELIVERY SURVEY**  
**HEALTH AND BASIC EDUCATION SERVICES**

**Draft final report**

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**for**

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**Collaborating partners in the survey:**

**CIETinternational  
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Health, Development, Information and Policy Institute**

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## EXECUTIVE SUMMARY

### Introduction

The West Bank and Gaza Country Department of the World Bank approached the Palestinian Authority (PA) to offer funding for a Service Delivery Survey to assist them in their development and coordination of key public services. Initial discussions and review of existing data suggested that the first SDS cycle should focus on health and basic education services, including pre-school classes.

The survey aims to provide results about the present delivery of health and basic education services and facilitate their use by the PA to improve the effectiveness and efficiency of these services; to help improve the PA's awareness of each provider's relative strengths and present quality of service delivery; as the first SDS, to establish the methodology in the Palestinian context.

### Methods

The methodology used in the service delivery survey, Sentinel Community Surveillance (SCS), has been developed by CIET over two decades of experience. It combines modern epidemiology and opinion research techniques with qualitative Rapid Assessment Procedures to gather evidence while involving clients in the process of evidence-based planning.

Two steering groups were convened, consisting of representatives from the PA and from NGOs and private providers in the health and education sectors. Two smaller technical groups were convened to work in more detail on the survey instruments.

In total, 2,988 households were interviewed; 107 schools and 42 primary care clinics serving the sites were reviewed; 48 focus

### *Survey sample*

The survey sample was designed to give national data and representation of the situation in West Bank and Gaza separately and in urban sites, rural sites and refugee camps separately. The sample frame used was a list of enumeration areas from the Palestinian population, housing and establishment census 1997. The selected sample consists of 25 sites of 100-120 households per site. In order to have a sufficient sample size within small strata, a non-proportional allocation was used (with relative over-sampling in small strata), so weighting factors to take this into account were calculated and are used in the analysis when calculating national figures.

### *Instruments*

Several instruments were developed for the survey, based upon those used in similar surveys in other countries:

- The household questionnaire
- The key informant interview
- Focus group discussion guides for health and education sectors
- Formats for the institutional reviews of basic education schools and primary health care facilities serving the survey sites
- Format for the institutional review of secondary health care facilities

### *Training and data collection*

Supervisors and interviewers were trained over a six day period in May 1998. Five field teams then conducted the data collection in different regions simultaneously, with additional supervision from PCBS.

group discussions were held in the survey sites (24 groups of women discussing health services and 24 groups of men discussing

basic education issues); a key informant was interviewed in each of the 25 communities. A small team identified and trained by HDIP contacted all the secondary health care facilities in West Bank and Gaza and reviewed all but two which did not agree to cooperate.

#### *Data entry and analysis*

Data were coded and entered into the computer using the Epi Info software package. Analysis was undertaken also using the Epi Info software package. When national figures were calculated the weighting factors were applied, to take into account the non-proportional sampling, using the CSAMPLE programme of Epi Info.

## **Results**

### **Population demographics**

The total number of people living in the 2,988 households in the survey is 17,141. The average household size is 5.8 people, with the expected variation by area. Most of the household heads (91%) are male. Overall, 35% of household heads are registered refugees, 2% are non-registered refugees and 63% are non-refugees.

Most household heads (87%) are literate by self-report. Only 43% of the few female household heads are literate, partly because women household heads are older. Literacy rates are higher among the younger household heads; 95% of household heads below the mean age of 42 years are literate. Over half of household heads are in 'elementary occupations' (such as subsistence agriculture, casual labour); 14% are government officials and 14% are unemployed. On average, household heads worked 7.1 months in the last year. More than a third worked all 12 months, but one in five did not work at all.

Focus group discussions in the survey

### **Health services**

#### *Opinion of health services*

Half (49%) of households think the health services available to them are 'good' or 'very good': 43% of households in West Bank and 57% of households in Gaza think this. Refugees and non-refugees have the same rating of health services. The main perceived problem with health services (37% of households) is lack of required medicines. This may be due to inappropriate expectations of treatment or could reflect a real lack of medicines, perhaps due to diversion of supplies.

The most common suggestion for improving services is provision of more medicines (36%). Other suggestions include more staff (especially doctors), better supervision and better physical facilities.

#### *Choice of help for different problems*

Households reported where they would take a child with fever in the morning or in the evening; and a person with severe abdominal (stomach) pain in the morning or in the evening. A child with a fever can usually be dealt with in primary care. However, a sizeable proportion of households say they would take a child with fever to a government hospital, rather than to a primary care facility; the proportion is higher in the evening (when many primary care clinics are closed) and in Gaza compared with West Bank. At least 12% would go to a government hospital (West Bank, morning) and up to 51% (Gaza, evening). For someone with abdominal pain, higher proportions would go to a government hospital (18% to 56%). For this condition, a hospital visit may often be appropriate. For both conditions, more households in West Bank than in Gaza say they would go to a private doctor.

communities suggested that the decision

about where to go with a health problem is not so much influenced by the type of health problem as by the level of service from the chosen facility, its accessibility and the economic status of the household.

#### *Use of secondary health care facilities*

Nearly a third (29%) of households in the survey have at least one member who has visited or been admitted to a hospital because of a health problem during the 12 months before the survey. The figure is higher in West Bank than in Gaza (32% vs 24%). A total of 822 visits were to hospitals in West Bank and Gaza and information about these hospitals was available from the visits undertaken as part of this work.

Of hospital visits, 72% were to government hospitals, 18% to charity and NGO hospitals, 5% to UNRWA hospitals and 4% to private hospitals. More than half those making a hospital visit (56%) are female.

Two thirds (63%) of the reported hospital visits were as inpatients: 73% in West Bank (73%) and 44% in Gaza. There may be recall bias, with inpatient visits being more likely to be remembered than visits without admission.

Overall, half (50%) of those visiting a hospital were referred by a doctor or clinic. Most of the reasons given for going to hospital without a referral are related to having access to a hospital, especially for emergencies. But a quarter say they went directly to the hospital because they considered they would get a better service than from primary care clinics.

The conditions for which people went to the hospital are varied, and most could be appropriate, depending on the severity. Most common are surgery, delivery and More than two thirds (70%) of hospital users are satisfied or very satisfied with the

injuries.

The type of hospital visited does not vary by refugee status. Of those people visiting hospital during the last year, 53% are covered by government health insurance (GHI). Most people (86%) with GHI visited a government hospital, while only about half (55%) of those without GHI used a government hospital.

#### *Experience of secondary health care facilities*

Most people visiting hospital as outpatients (81%) were seen within an hour.

All medicines required were said to be available for two thirds of visits (66%). Availability of all required medicines is highest in NGO/Charity hospitals at 78%, then government hospitals (64%), and lowest in UNRWA hospitals at 58%.

Medicines are the item most commonly paid for in hospitals. Among those who pay, the highest payments are for the consultation. Only about a third of users pay for the consultation in government hospitals, with a much higher proportion paying in hospitals of other providers. The differences between providers in proportions paying are not so marked for medicines and investigations, although less people pay in government hospitals. Two thirds of users of government hospitals have GHI cover and among these 22% pay something for the consultation, whereas among the third without GHI cover 64% pay for the consultation. The amounts paid for different items among those paying anything are less in government and UNRWA hospitals than in NGO/Charity hospitals and private hospitals.

*Opinions of secondary health care facilities* treatment they received from the hospital and three quarters (75%) are satisfied or

very satisfied with the staff who attended them. The ratings of both treatment and staff are higher in Gaza than in West Bank.

Satisfaction with treatment ranged from 65% for government hospitals to 82% for NGO/charity hospitals. Satisfaction with staff ranged from 70% for government hospitals to 87% for NGO/charity hospitals.

Half (50%) of hospital users think there is no problem with the hospital. The commonest problem cited is poor physical facilities (12%). As many as 75% of those using an NGO/charity hospital think there is no problem with the hospital.

There is no difference between men and women in their likelihood of being satisfied with hospital treatment or hospital staff. The mean age of those satisfied is not significantly different from the mean age of those not satisfied. Hospital users residing in urban sites are less likely to be satisfied with hospital treatment than those residing in either rural sites or refugee camps. Refugees are somewhat more likely to be satisfied with hospital care than non-refugees. People without GHI cover are somewhat more likely to be satisfied with hospital care than those with GHI cover. This is still true when type of hospital is taken into account by stratification.

#### *Primary care clinics serving the communities*

Of the 42 clinics visited 21 were government clinics, 10 UNRWA, 1 private, 4 NGO, and 6 charity.

The highest pressure of patients, in terms of patients per specialist doctor (100) and general doctor (127) and in terms of patients seen per hour of clinic opening (52), is in UNRWA clinics, followed by government clinics.

Government clinics seem to be the least well-equipped. For example, only half of them have an ophthalmoscope, which is an important item in the management of conditions like diabetes and hypertension. All the clinics had a stock of the basic medicines that were checked.

Not surprisingly, the highest charges are in the private clinic. The UNRWA clinics visited do not charge for any consultations, medicines or tests.

#### **Kindergarten services**

Most households with children (85%) are aware of local kindergarten classes. The awareness is rather higher in Gaza (88%) than in West Bank (83%).

Most households rate services as good or very good: 81% give this rating to charity kindergartens, 79% give it to those run by women's committees, and 82% give it to those run by private organisations. Ratings are consistently rated more positive by households in Gaza than in West Bank.

The most common suggestion (25%) is for the provision of more qualified staff. A fifth (19%) of households are not able to give any suggestions for improvement.

Overall, 22% of households in the survey have at least one child in kindergarten: 22% in West Bank and 23% in Gaza. The mean annual cost per child is 643 NIS. The mean annual cost is higher in West Bank (812 NIS) than in Gaza (390 NIS).

#### **Basic education services**

##### *Opinions about basic education services*

About three quarters of households (73%) think basic education services available to them are 'good' or 'very good'. The proportion giving this rating is higher in Gaza (81%) than in West Bank (67%).

Overcrowded classrooms are the most common concern (34%), although concerns about teacher qualifications and skills are expressed by nearly a quarter of the households. Only 8% mention the quality of the curriculum and educational standards as their main concern.

While the commonest suggestion for improving basic education (37%) is simply to provide more classrooms, more than 30% comment on the need to pay better qualified teachers or to raise standards and improve the curriculum.

#### *Type of school attended*

Information was sought from households about education experience for the 4603 children between the ages of 5 and 15 years. Among the 2346 children attending one of the 102 schools visited in the survey, the experience of the child in school can be linked to features of the school. Overall, 82% of these children are attending a government school, 15% an UNRWA school, 1% a charity organisation school, and 2% a private school.

Among children of refugee families, half attend UNRWA schools and just under half attend government schools, while among children of non-refugee families, nearly all attend government schools.

#### *Enrolment, dropout, repetition, attendance*

The overall net school enrolment is 85% among children 5-15 years old. There is no difference between boys and girls. Net school enrolment among children in West Bank (90%) is higher than in Gaza (78%). A child in West Bank is more than twice as likely to be enrolled in school compared with a child in Gaza. Once area of residence is taken into account, there is no difference in school enrolment between children of refugee families and children of non-refugee

families. The overall net school enrolment of children aged 6-15 years is 92%.

The drop-out rate, as a proportion of the total children aged 5-15 years, is 1.1%. The drop-out rate is zero up to age 11 years, rising to a maximum of 5.5% among children aged 15 years. There is no apparent gender difference in drop-out among children up to age 15 years, nor any difference between refugee and non-refugee families.

Among the children in school, 9% have repeated one or more grades. A fifth of children aged 15 years have repeated one or more grades, but repetition rates in children up to 10 years old are very low. There is a low repetition rate among children in lower grades, probably reflecting the policy, at least in government schools, of automatic progression to the next grade in these grades. Repetition rates do not differ much depending on the type of school the child is attending.

For reasons why a child has repeated grades, two thirds of household respondents blame the child for not performing or for being stubborn or not bright. They blame the parents more often than they blame the teachers.

Around three-quarters (74%) of the children in school are said to have attended every school day in the last month. And a further 9% only missed one day in the month. The attendance rate among children going to UNRWA schools is lower than for the other schools. Children who do not attend school regularly are twice as likely to have repeated at least one grade, compared with children who attend regularly.

#### *Home environment and children in school*

Less than a third (29%) of the children are said to undertake any work other than school work. Children in Gaza are more likely than children in West Bank to undertake work in addition to their school work. Children from refugee families are more likely to undertake additional non-school work than children from non-refugee families. Girls are more than twice as likely as boys to do additional work as well as their school work.

There is no relationship between the type of school the child attends and the undertaking of extra work by the child.

Older children are more likely to undertake additional work. The proportion working rises around 13% of 6 year olds to 45% of 15 year olds. Few children, even among the older children, are said to work more than two hours a day on top of their school work. When the age of the child is taken into account, children working in addition to their school work are not apparently more likely to repeat classes. But this does not rule out more subtle effects on their academic performance.

Three quarters (75%) of children are said to be given help with their homework. Children in Gaza are nearly twice as likely to be given help with their homework compared with children in West Bank. Children in refugee families are more likely to be helped with their homework than children from non-refugee families. The proportion given help falls from 96% among 6 year olds to 47% among 15 year olds. Around half the children (49%) get help with their homework from one of their parents. Children not given help with homework by their parents are three times more likely to repeat one or more grades in school.

#### *Costs of education*

All households pay for clothes and stationery for children in school, 11% pay

for transport, 72% pay basic school fees, 61% pay for extra activities in school, and 50% pay for extra tuition. The median costs for these items (NIS) are: 250, 100, 160, 50, 30 and 12.

Clothes, shoes and stationery are paid for in all schools. Basic fees are universal, except in UNRWA schools where only 20% pay basic fees. Payments for extra activities are common in most types of schools, less so in UNRWA schools. Parents pay for extra tuition for half the children attending government and UNRWA schools, but for few children in charity and private schools. The mean/median payments for items are higher in charity and private schools than in government and UNRWA schools.

#### *Adequacy of school performance*

This survey does not examine the performance of schools in any detail, but has some indicators.

Most children (84%) received a full set of text books in the first week of the last school year. The proportion is lower in children in UNRWA and charity schools.

Nearly all children (95%) are said to have homework at least once per week, and more than half (55%) are said to have homework six or seven times per week. There is little difference between types of school in the proportion of children having homework at least once a week. More children in UNRWA and private schools receive daily homework than in government and charity schools.

Most (82%) households have met the child's teacher at some time to discuss the child. Less children's parents have ever met the teacher in government schools and the frequency of meetings is less in government and UNRWA schools than in charity and private schools.

Most households (81%) are 'satisfied or very satisfied' with the child's class teacher. The highest satisfaction with teachers is for children in charity or private schools. Nevertheless, in government schools, the level of parental satisfaction with teachers is high for more than three quarters of the children. Parents of children who have not repeated grades are more likely to be satisfied with the teachers than parents of children who have repeated grades.

Most households (73%) are also 'satisfied' or 'very satisfied' with their child's progress in school. More parents of children in charity and private schools are satisfied with their progress than parents of children in government and UNRWA schools. Parents of children who have not repeated a grade are nearly six times more likely to be satisfied with their progress in school than parents of children who have repeated one or more grades.

#### *Features of the schools in the survey*

Nearly all (93%) of the 102 schools visited are permanent structures. The condition of the buildings is good in 60%, needing repair in 29% and 'very bad' in 10%. The condition of buildings is worse for government and UNRWA schools.

The mean number of students per toilet is 66 and per washbasin 79. About three-quarters (73%) of the schools have a library, but this is less common in government schools (64%).

#### *Satisfaction with schools*

Student counselling is available in less than half (42%) the schools visited. It is more common in government schools (63%). Most of the schools (91%) have a parents teachers council.

The headmasters tend to blame the situation at home for children not attending regularly. Headmasters also mostly blame home factors for children dropping out of school and rarely cite any problems concerned with the school itself. Most suggestions from headmasters about how to improve school attendance are aimed at parents and pupils but the need for schools to collaborate with parents is recognised.

#### **Commentary**

This survey gives a picture of the present service in the fields of health and basic education, from the perspective of the service users and intended service beneficiaries. It includes their suggestions for change; essentially their aspirations for what they would consider a good, effective service. This user perspective on its own is not enough to make judgements about which services can be most effectively and most economically provided by different bodies. However, it does give context to other work which is service based and considers costs of different types of service provision.

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## INTRODUCTION

The West Bank and Gaza Country Department of the World Bank approached the Palestinian Authority (PA) to offer funding for a Service Delivery Survey to assist them in their development and coordination of key public services. Initial discussions and review of existing data suggested that the first SDS cycle should focus on health and basic education services, including pre-school classes.

A relatively high proportion of the service provision in health and education is from non-PA sources. This is partly a legacy of the years of occupation of the Palestinian Territories, when most of the basic services were provided by NGOs, and partly due to a high rate of growth of private providers. The role of NGOs has diminished since the creation of the PA and their funding has greatly diminished. Yet the PA is not in a position to take over all the service provision, and nor may this be the best and most cost-effective option in many cases. The present fragmented pattern of services from a range of providers can lead to problems of oversupply in some areas and lack of coverage in others. It also makes it difficult to set and enforce minimum standards of service provision. Thus coordination of service provision between government, non-government and private providers to ensure the most cost-effective provision and to ensure that minimum standards are met irrespective of the supplier, is very important.

Successful coordination and rational planning requires good information about the institutions providing services across the West Bank and Gaza. Much of this information is already available from previous surveys. But the output of the services also needs to be known: one way of measuring this is by asking potential service

users in communities about their use, experiences and opinions of the different services on offer. The primary aim of the SDS is thus to seek information about actual delivery of services to the intended users. This information, put together with data about the cost of different ways of providing services, provides data that can assist with planning and coordination of future service provision. The success or otherwise of any changes in service provision can be monitored by repeating the SDS to see whether public experiences and opinions of the services have changed.

The relatively new PA offers an opportunity of accountability and good governance, with government service providers responsive to the people they serve and setting standards for providers outside the government. The SDS can be one way of making accountability tangible, as service users are asked not only about their experiences and opinions of services, but also about their ideas and suggestions for the sort of service they would like to have. In effect, the SDS findings provide the substrate for dialogue between service users and service providers.

The service users can be made more aware of the need to prioritise services within a limited budget; this is one way of managing the high expectations of services since the creation of the PA. Service providers can take note of the preferences of the users and, where practicable, provide services in line with these preferences.

### **Aims of the Service Delivery Survey**

1. To provide results about the present delivery of health and basic education services and facilitate their use by the PA to improve the effectiveness and efficiency of these services; the same results will help to inform donor decisions and the design

of Bank projects.

2. To help improve the PA's awareness of each provider's relative strengths and present quality of service delivery, with a view to informing service delivery policy.

3. As the first SDS, intended as the first in an on-going process, another aim of this project is to establish the methodology in the Palestinian context and begin the process of institutionalisation so that it can become a sustainable process.

## METHODS

### Methodological approach

The methodology used in the service delivery survey, Sentinel Community Surveillance (SCS), has been developed by CIET over two decades of experience. It combines modern epidemiology and opinion research techniques with qualitative Rapid Assessment Procedures to gather evidence while involving clients in the process of evidence-based planning.

The SCS methodology<sup>1</sup> was originally conceived to build capacities while producing accurate, detailed and actionable data rapidly and at low cost. Ordinarily, SCS focuses on the use of epidemiological data in local or national planning<sup>2</sup>. This may be at the level of a municipality, a city<sup>3</sup>, a state, a number of provinces<sup>4</sup> or an entire country<sup>5</sup>. The approach permits community-based fact finding through a reiterative process, addressing one set of issues at a time. SCS is a cross-design of qualitative and quantitative techniques that permits a holistic picture of -- and locally designed solutions to -- a particular problem. It is a cost-effective way to collect community data, presenting them in an appropriate form for planning at local, regional and national levels.

SCS methodology has been used in community surveys in many countries and specifically in Service Delivery Surveys in a number of different countries<sup>6-9</sup>.

Some of the key features of the CIET methodology are listed below:

- ❑ Data are collected from cluster sites, selected to be representative of a district, a region or a country.
- ❑ It is intended as a repeated cyclical process, each cycle including planning and instrument design, data collection, data analysis and interpretation, and communication of results.

- ❑ Each cycle focuses on a particular issue or problem, not trying to collect data on a wide range of problems.

- ❑ Quantitative data from household questionnaires are combined with qualitative data from focus groups, key informant interviews and institutional reviews *from the same communities* (that is, the data are coterminous) to allow a better understanding of the quantitative data. This combined analysis is called mesoanalysis<sup>1</sup>.

- ❑ Data analysis is not only in terms of indicators (for example, rate of childhood measles) but also in terms of *risk* (for example the risk patient dissatisfaction with one type of hospital compared with another).

- ❑ Analysis gives results in a form that assists planning at household, community, district and national levels.

- ❑ The same sites can be revisited in subsequent cycles of data collection, allowing easy estimation of changes over time or as a result of intervention.

- ❑ Each cycle of data collection and analysis requires a communication strategy to get the information to those who need it for planning.

- ❑ Transfer of skills of data collection, analysis and communication over a number of cycles is an explicit aim.

In the case of West Bank and Gaza, this methodology was suitable because information about the performance of services from the users' perspective was needed to complement existing service based information; because an understanding of how and why people used the services of different providers was needed (from qualitative as well as quantitative data); and because there is an intention to continue to monitor the experienced quality of services over time.

### **Organisation of the work**

Two steering groups were convened, consisting of representatives from the PA and from NGOs and private providers in the health and education sectors. These groups considered the aims and scope of the survey and contributed issues they considered to be important to include in the survey. The focus of the survey was agreed to be use and experience of secondary care facilities in the health sector and basic education, plus pre-school education in the education sector.

Two smaller technical groups were convened to work in more detail on the survey instruments. The resulting instruments were taken back to the steering groups prior to the start of the training and fieldwork.

The membership of the steering groups and the technical groups is given in Annex 1.

### **The survey sample**

The survey sample was designed to give national data and representation of the situation in West Bank and Gaza separately and in urban sites, rural sites and refugee camps separately. The sample frame used was a list of enumeration areas from the Palestinian population, housing and establishment census 1997. This list consists of 3311 enumeration areas. Annexed Jerusalem was excluded because of the practical difficulties of conducting the household survey there.

The selected sample consists of 25 sites of 100-120 households per site. The details of the site selection process and the weighting of the sample to prevent bias in the national data derived from it are described in Annex 2. Briefly, the process is one of stratified systematic random sampling. In order to have a sufficient sample size within small strata, a non-proportional allocation was

used (with relative over-sampling in small strata), so weighting factors to take this into account were calculated and are used in the analysis when calculating national figures, to avoid possible bias due to the relative over-sampling of some areas.

In addition to the household survey of all households in the selected sites, the survey included institutional reviews of the schools providing basic education serving the sites and the primary health care facilities serving the sites. These facilities were selected on the basis that they served the survey sites.

A survey was also carried out of the all the secondary health care facilities in West Bank and Gaza, including those in East Jerusalem. There was no sampling: all facilities were included.

### **The survey instruments**

Several instruments were developed for the survey, based upon those used in similar surveys in other countries and tailored to the particular Palestinian context. The instruments include:

- The household questionnaire
- The key informant interview
- Tally sheets for summarising the preliminary community findings to feed back to the focus groups
- Focus group discussion guides for health and education sectors
- Formats for the institutional reviews of basic education schools and primary health care facilities serving the survey sites
- Format for the institutional review of secondary health care facilities

In addition, training materials were developed for training of the interviewers and supervisors. And data entry formats for the various instruments were designed, using the Epi Info software package (version 6.04)

The various instruments used in the survey are shown in Annex 3. The focus of the instruments is on the use and perceptions of the services. The areas covered in the household questionnaire include, for basic education, information on each child attending school such as the grade attended, class repetition, attendance rate, work outside school hours, payments for education, textbooks and homework, contact with teachers and satisfaction with progress and the teachers. For health services, the areas covered include opinion of services available, perceived problems with services, details of any hospital visit in the last year, with type of hospital, reason for visit, referral status, insurance status, waiting times and drug availability, payments, and satisfaction with the service.

A pilot test of the draft household questionnaire was conducted on 9 May 1998 in Ramallah Governorate. Five interviewers and one supervisor visited households and administered the questionnaire. Small modifications were made to the household questionnaire as a result of the pilot exercise.

### **Training**

Supervisors and interviewers were trained over a six day period in workshops held in Ramallah and Gaza City from 17-21 May 1998. All received the same basic training on the household survey and the recording of the household replies in the special books provided (the Bhopal books)<sup>1</sup>.

At the end of the training workshop the participants took a test to check their understanding and accuracy of completing the household questionnaires. Those who did not perform adequately on this test were In all the communities visited the people were grateful for the opportunity to talk about the services, the problems they

not used in the survey.

Supervisors were selected on the basis of their performance during the training and the results of the practical test. They received additional training on completing the summary sheets for basic findings to be used in the focus group discussions and were trained in how to conduct and record the focus group discussions, how to conduct the institutional reviews and how to identify and interview community key informants. Particular attention was paid to training in conducting focus group discussions, since this was a new area for most of the supervisors.

### **Data collection**

Five field teams were formed, each of six interviewers and two supervisors. They conducted the data collection in different regions simultaneously. Two overall field supervisors (one in West Bank and one in Gaza) from the PCBS (fieldwork directorate) visited the survey sites and supervised the teams. Nine out of 12 interviewers in Gaza were female and all four supervisors were male. In West Bank, 3 out of 15 interviewers and 1 out of 8 supervisors were female.

Collection of data from households began on 24 May 1998 and was completed within two weeks. In total, 2,988 households were interviewed. In addition, 107 schools and 42 primary care clinics serving the sites were reviewed. Forty eight focus group discussions were held in the survey sites: 24 groups of women discussing health services and 24 groups of men discussing basic education issues. A key informant was interviewed in each of the 25 communities.

experienced with them and how, in their view, the services could be improved. The enumeration area representing Hizma was

the only place where people refused to participate in focus group discussions. One of the schools serving this same place felt unable to cooperate without authorisation from their superiors in Jerusalem.

The reviews of secondary health care facilities were conducted by a small team identified and trained by the Health, Development, Information and Policy Institute. They used individuals who had undertaken similar work previously. They contacted all the secondary health care facilities. All but two agreed to cooperate.

### **Data coding and entry**

The collected data were coded according to manuals of codes and instructions prepared for the survey. Five staff of PCBS (all male) undertook this data coding over a 10 day period.

Data entry took place in PCBS in Ramallah from 10-24 June 1998. Five data entry clerks (all male) undertook the work under supervision. A data entry programme was used, designed using the Epi Info software package<sup>10</sup>. All household questionnaires were entered twice and validated using the Epi Info VALIDATE programme; all errors detected were corrected in the final dataset.

### **Analysis**

Analysis was undertaken using the Epi Info software package. This was used for the basic descriptive analysis of the data. When national figures were calculated the weighting factors were applied, to take into account the non-proportional sampling, using the CSAMPLE programme of Epi Info.

Epi Info was also used for undertaking univariate analysis of outcome variables in relation to important explanatory variables. The effects of variables in combination on key outcome variables was examined by means of logistic regression analysis, using the SPSS statistical package<sup>11</sup>.

## RESULTS

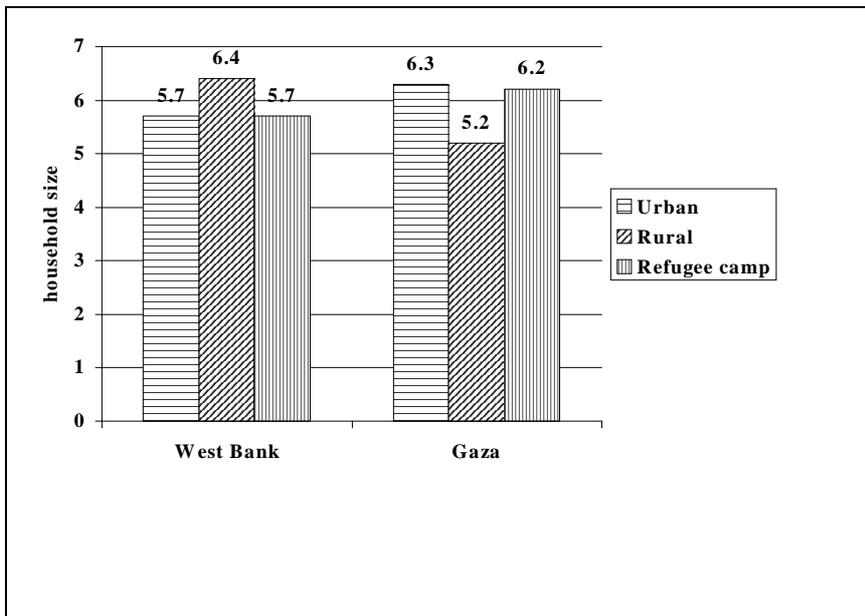
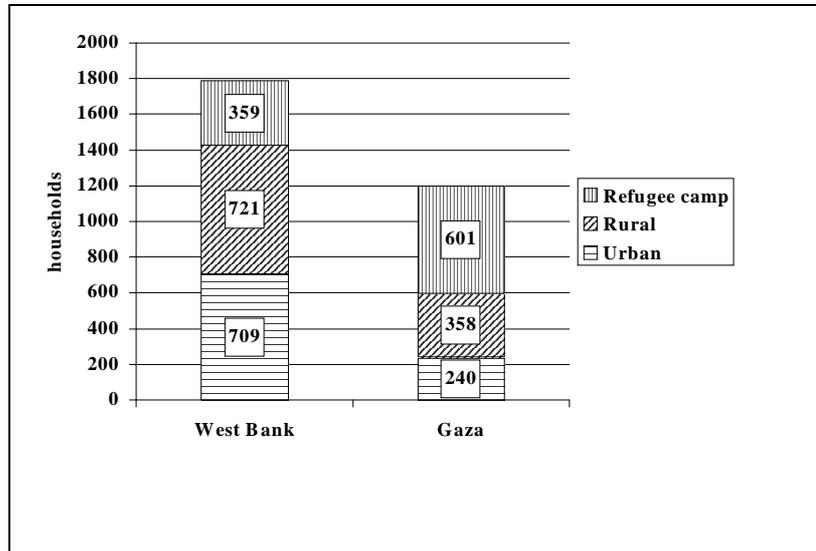
### CHARACTERISTICS OF THE SAMPLE POPULATION

#### The population

A total of 2,988 households were included in the survey, with a population of 17,141 people living in these households. The average household size across the whole sample is 5.8 people.

The distribution of households in the sample in West Bank and Gaza in urban and rural sites and refugee camps is shown in Figure 1.

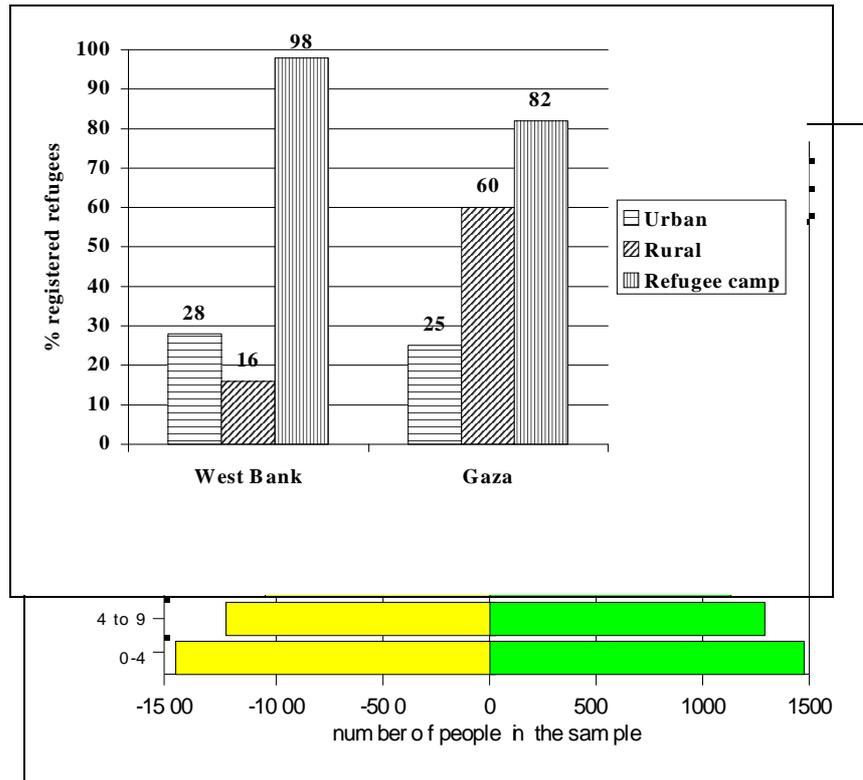
The variation in household size by the same six divisions is shown in Figure 2



The household size is higher in Gaza than in West Bank for urban sites and refugee camps but the in West Bank than Gaza for rural sites. The average household size in the survey sample is close to that found in the Palestine population, housing and establishment census 1997. This tends to validate the sample used for this survey.

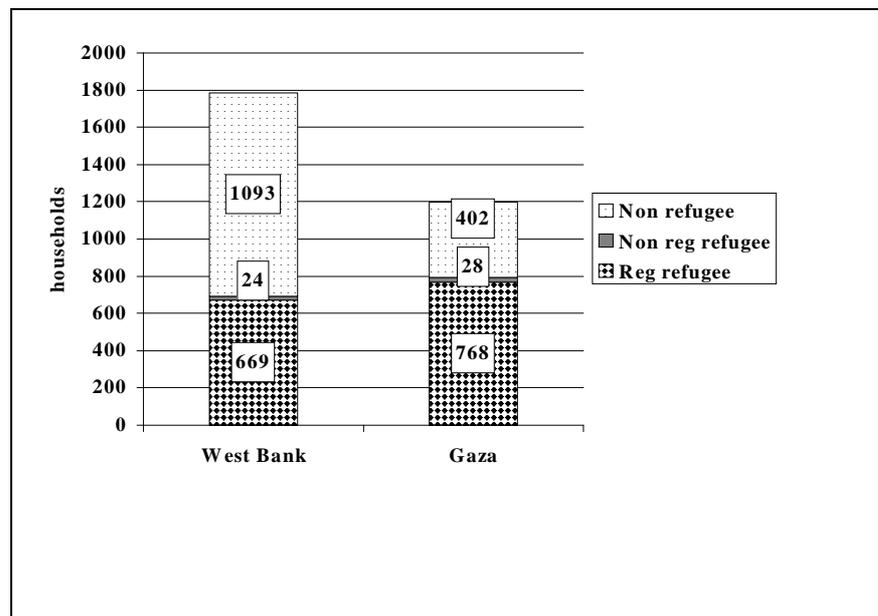
#### Age and sex distribution of the population

The population pyramid for the population in the sample households is shown in Figure 3. Again, this is similar to the population pyramid found in the Palestinian population, housing and establishment census 1997.



### The household heads

Most of the household heads (91%) are male. Overall, 35% of household heads are registered refugees, 2% are non-registered refugees and 63% are non-refugees. The distribution of refugee status among household heads is different between West Bank and Gaza, as shown in Figure 4.



The proportions of households headed by a registered refugee in different types of site in

West Bank and Gaza are shown in Figure 5.

Note that virtually all households (98%) in refugee camps in West Bank are headed by a registered refugee, compared with only 82% in refugee camps in Gaza. But only 16% of rural households in West Bank are headed by a registered refugee, compared with 60% of rural households in Gaza.

Most household heads (87%) are literate by self-report. The proportion literate is much lower among the few female household heads (43%). This is partly because women household heads are older. Literacy rates are higher among the younger household heads; 95% of household heads below the mean age of 42 years are literate.

### Employment of household heads

The main occupations of household heads are shown in Table 1.

**Table 1. Occupation of household head**

Occupation	No. (%) household heads
Elementary occupation	1536 (54)
Government official	410 (14)
Service/shop/market worker	190 (7)
Housewife	127 (4)
Professional	94 (3)
Clerk	25 (1)
Manager	19 (1)
Unemployed	449 (14)

The percentages are shown weighted

The category of 'elementary occupation' includes subsistence agriculture and casual labour etc. The second most common occupation, given as the occupation of one in seven (14%) of household heads, is 'government official'. It is notable that a seventh (14%) of household heads are described as unemployed.

On average, household heads worked 7.1 months in the last year (Table 2).

**Table 2. Time worked by household head in the last 12 months**

Time worked	No. (%) household heads
Did not work at all	647 (20)
0-3 months	288 (9)
4-6 months	432 (15)
7-9 months	307 (10)
10-11 months	188 (7)
Worked all 12 months	1119 (39)

The percentages are shown weighted

More than a third worked all 12 months, but one in five did not work at all in the period.

### Respondents

Two thirds (61%) of respondents to the household questionnaire were women. Usually the respondent was the household head (26%) or the wife of the head (55%).

## RESULTS

### HEALTH SERVICES

#### Opinion of health services in area

Households were asked their opinion of the health services available to them,

Household opinions of health services:

<input type="checkbox"/>	6% think they are very good
<input type="checkbox"/>	43% think they are good
<input type="checkbox"/>	35% think they are neither good nor bad
<input type="checkbox"/>	13% think they are bad
<input type="checkbox"/>	4% think they are very bad

irrespective of the provider.

The responses for West Bank and Gaza separately are shown in Table 3.

**Table 3. Household opinions of available health services**

Rating of service	Number (%) of households	
	West Bank	Gaza
Very good	62 (3)	91 (10)
Good	676 (40)	554 (47)
Neither good nor bad	681 (37)	338 (31)
Bad	245 (14)	173 (11)
Very bad	110 (6)	32 (2)

As shown in Table 3, there tends to be a more favourable assessment of available health services in Gaza than in West Bank. More than half (57%) of households in Gaza rate health services as good or very good, compared with 43% in West Bank. This is apparently not because of the higher proportion of refugees in Gaza (and therefore more access to UNRWA services), since the rating of health services by refugees and non-refugees is not different (49% of refugees rate health services as good or very good, compared with 48% of non-refugees). It may be that the expectations of households in West Bank are higher than those of households in Gaza.

#### Perceived problems of health services

Households were also asked what the main problem with the available health services is, in their opinion. The problems cited by households are shown in Table 4.

**Table 4. Main problems with health services**

Problem	No. (%) households
No problem	213 (7)
Lack of medicines	1082 (37)
Service inefficient	317 (11)
Poor physical facilities	289 (10)
Lack of staff, especially doctors	249 (9)
Lack of routine checks, no 24 hour service	152 (5)
Lack of equipment	149 (5)
Bad attitude of staff	136 (5)
Too expensive	49 (2)
Long waiting times	33 (1)
Poor access	23 (1)
Don't know/can't say	207 (7)

This pattern of cited problems is similar in West Bank and Gaza. The perceived problem of lack of medicines might reflect a real shortage of required medicines but it could also reflect patient expectations of treatment with medicines, which are sometimes inappropriate. In similar surveys in Uganda<sup>8</sup> and Nepal<sup>12</sup>, the most common perceived problem with health services was also lack of medicines. In Uganda, this is at least in part due to corruption, with diversion of drugs supplied to the government health facilities into private drug shops by health care workers<sup>9</sup>. The common public perception of lack of

medicines in health facilities in West Bank and Gaza may merit further study so that it Focus groups in the survey sites also discussed the problems they perceived with health services (for details, see Annex 4). The most common specific problem mentioned in focus groups (96%) was lack of medicines. Most of the groups (67%) also mentioned bad attitude of staff as a problem. Individual respondents may have been more reluctant to mention this (see Table 4).

The focus groups discussed problems with primary care clinics specifically and nearly all groups cited as problems lack of medicines (88%) and lack of staff, especially doctors (96%). In relation to Government clinics, one participant mentioned:

*“In some cases the medicines are available in the clinics but the doctors ask the patients to pay the price for them, despite the patients having GHI.”*

#### ***Problems of service of different providers***

Focus group participants were asked about which type of clinic was considered best and which worst in their area (see Annex 4). The highest number of groups (10/24) considered private clinics the best and the lowest number (3/24) considered government clinics the best. Some groups considered UNRWA and NGO clinics the best and none considered them the worst. Most groups considered government clinics the worst (19/21). This suggests that clinics available near to the community are the ones most likely to be experienced and therefore more likely to be scored either good or bad. It seems that the UNRWA and NGO clinics that are available are mainly considered favourably. And private clinics are more highly rated than government clinics. Reasons for considering a clinic the best or worst are concerned with availability of medicines, staff and equipment and attitude of staff (see Annex 4).

can be addressed adequately.

Doctors often work in more than one type of clinic and some focus group participants suggested this could lead to problems:

*“Some of the doctors in the ministry of health clinics don’t check the patients unless they go first to their special clinics and pay the fees for consultations”*

### **Suggestions for improving health services**

Households were asked to suggest what would improve the health services available to them, in their opinion. This is closely linked to the problems they perceive with the services. The suggestions for improvement are shown in Table 5.

**Table 5. Suggestions for improving health services**

Problem	No. (%) households
Nothing - no problem	163 (6)
Provide more medicines	1069 (36)
Improve efficiency	358 (12)

More staff, especially doctors	247 (8)
Better attitude/supervision/salaries	223 (8)
Improve physical facilities	198 (7)
More services/24 hour service	148 (5)
Provide more equipment	135 (5)
Build more hospitals	105 (4)
Reduced fees/financial support	66 (2)
Punctual, reliable service	29 (1)
Don't know/can't say	247 (8)

The suggestions for improvement are clearly from the perspective of the service user and generally do not cover changes that would be necessary within the services in order to achieve the desired end-points. Improving staff supervision is an exception to this. Otherwise, most of the suggestions are for more of various aspects, particularly medicines.

Focus group discussions confirmed these suggestions for what services are felt to be needed and not available (see Annex 4).

### **Choice of help for different health problems**

A serious concern in West Bank and Gaza is the inappropriate use of secondary care facilities for health problems which should be dealt with in primary care. The reasons for this are not fully understood. An attempt was made to investigate this issue in the survey. Different scenarios about ill health were given to household respondents and they were asked where they would seek help.

#### ***A child with a fever***

This is a problem that can generally be dealt with in a primary care clinic in the first instance. The sources of help that households say they would use if the problem arose at 9am are shown in Table 6.

**Table 6. Sources of help for a child with a fever at 9am**

Source of help	No. (%) households
Private doctor	1155 (41)
Government clinic	718 (27)
UNRWA clinic	503 (9)
Government hospital	402 (16)
Private hospital	75 (2)
Charity/NGO hospital	41 (1)

**Table 7. Sources of help for a child with a fever at 6pm**

Nowhere	72 (3)
---------	--------

Percentages are shown weighted

A high proportion of households say they would go to some form of primary care, most commonly a private doctor (Table 6).

The sources of help that would be used for the same problem at 6pm are shown in Table 7.

Source of help	No. (%) households
Private doctor	1579 (52)
Government clinic	350 (9)
UNRWA clinic	83 (2)
Government hospital	729 (29)
Private hospital	112 (3)
Charity/NGO hospital	34 (1)
Nowhere	75 (3)

Percentages are shown weighted

The main differences at 6pm are that even more would go to a private doctor and the proportion who would go to a government hospital has doubled. A few say they would go to a government clinic although most of these would be closed by 6pm. This confirms that one reason for people using secondary care facilities is lack of access to primary care out-of-hours. Those who can afford a private doctor may use this option but others may be forced to visit a hospital.

The source of help that households say they would use for a child with fever differs between West Bank and Gaza. This is shown in Tables 8 and 9.

**Table 8. Sources of help for a child with a fever at 9am in West Bank and Gaza**

Source of help	No. (%) households	
	West Bank	Gaza
Private doctor	1009 (60)	146 (13)

Government clinic	212 (14)	506 (48)
UNRWA clinic	179 (5)	324 (15)
Government hospital	205 (12)	197 (21)
Private hospital	67 (4)	8 (1)
Charity/NGO hospital	37 (2)	4 (1)
Nowhere	65 (4)	7 (1)

Percentages are shown weighted

**Table 9. Sources of help for a child with a fever at 6pm in West Bank and Gaza**

Source of help	No. (%) households	
	West Bank	Gaza
Private doctor	1208 (69)	371 (27)
Government clinic	75 (4)	275 (17)
UNRWA clinic	35 (2)	48 (3)
Government hospital	271 (15)	458 (51)
Private hospital	88 (5)	24 (1)
Charity/NGO hospital	33 (1)	1 (-)
Nowhere	62 (4)	13 (1)

Percentages are shown weighted

In Gaza less households say they would use private doctors and more would use government and UNRWA clinics and government hospitals. At 6pm, while in West Bank more than two thirds would use a private doctor, in Gaza nearly half would go to a government hospital. These differences may relate to the different availability of different types of service in West Bank and Gaza and also reflect the inability of Gaza residents to pay for private doctors.

#### ***Severe abdominal (stomach) pains***

Depending on the circumstances, it is often appropriate for someone with severe abdominal pain to be seen in a hospital, as it could be due to conditions requiring urgent hospital treatment, including surgery. Households reported where they seek help for someone with severe abdominal pain at 9am and 6pm (Tables 10 and 11).

**Table 10. Sources of help for someone with severe abdominal pain at 9am**

Source of help	No. (%) households
Private doctor	1181 (40)
Government clinic	570 (21)
UNRWA clinic	430 (9)
Government hospital	570 (22)
Private hospital	165 (6)
Charity/NGO hospital	28 (1)
Nowhere	72 (1)

Percentages are shown weighted

**Table 11. Sources of help for someone with severe abdominal pain at 6pm**

Source of help	No. (%) households
Private doctor	1410 (45)
Government clinic	323 (8)
UNRWA clinic	83 (4)
Government hospital	857 (35)
Private hospital	250 (8)
Charity/NGO hospital	22 (1)
Nowhere	19 (1)

Percentages are shown weighted

Not surprisingly, more households would seek help from a hospital for severe abdominal pain at 9am than for a child with a fever (Table 6). At 6pm, a third would go to a government hospital; this may well be appropriate in many cases.

The differences between West Bank and Gaza in seeking help for severe abdominal pain are shown in Tables 12 and 13.

**Table 12. Sources of help for someone with severe abdominal pain at 9am in West Bank and Gaza**

Source of help	No. (%) households	
	West Bank	Gaza
Private doctor	1006 (58)	175 (15)
Government clinic	157 (10)	413 (38)
UNRWA clinic	135 (4)	295 (16)
Government hospital	299 (18)	271 (28)
Private hospital	145 (9)	20 (2)
Charity/NGO hospital	24 (2)	4 (1)
Nowhere	10 (1)	12 (1)

Percentages are shown weighted

**Table 13. Sources of help for someone with severe abdominal pain at 9am in West Bank and Gaza**

Source of help	No. (%) households	
	West Bank	Gaza
Private doctor	1038 (59)	372 (24)
Government clinic	77 (4)	246 (14)
UNRWA clinic	22 (1)	61 (4)
Government hospital	391 (22)	466 (56)
Private hospital	217 (12)	33 (2)
Charity/NGO hospital	20 (1)	2 (1)
Nowhere	10 (1)	9 (1)

Percentages are shown weighted

In Gaza fewer households would use private doctors when seeking help for someone with severe abdominal pain than in West Bank, while more would use government clinics and government hospitals. This is true both at 9am and at 6pm. As for a child with fever, these differences probably reflect the pattern of availability of services and the different socio-economic status of households in West Bank and Gaza.

### **Focus group views**

To shed some more light on why people choose primary or secondary care, these issues were discussed in the community focus groups (see Annex 4). Discussions suggested that the decision about where to go with a health problem is not so much influenced by the type of health problem as by the level of service from the chosen facility, its accessibility and the economic status of the household. The commonest reasons mentioned for going to hospitals with simple health problems are that the care is better and they have better laboratories and equipment. Comments about perceived poor quality of care in clinics made in the focus groups include:

*“A child was taken as a patient to the clinic and he had complications because he was given inappropriate medicine. The family took him to the hospital and he had a surgical operation”*

*“I took my child to the clinic and he was diagnosed as having tonsillitis but he had already had a tonsillectomy.”*

Focus groups suggested that problems likely to be taken to primary care are simple health problems with skin, teeth, upper respiratory infections and the like. About half the groups mentioned control of illnesses like hypertension and diabetes. Many conditions were mentioned as suitable to be taken to hospital, including those such as fever and diarrhoea.

The main things considered in the focus groups as useful to encourage people to go to clinics instead of hospitals are cost (low cost or free services from clinics) and improving access to clinics.

### **Use of secondary health care facilities**

Nearly a third (29%) of households in the survey have at least one member who has visited or been admitted to a hospital because of a health problem during the 12 months before the survey. This figure is similar to that reported from a previous household survey in West Bank and Gaza<sup>13</sup>.

A higher proportion of households in West Bank than in Gaza have had one or more hospital contacts in the last year (32% vs 24%).

Information was collected from households about the last hospital visit by a member of the household during the last year, a total of 862 visits. Some visits were to hospitals in Israel (9) or other countries abroad (17) and in some the hospital visited was not specified. A total of 822 visits were to hospitals in West Bank and Gaza and information about these hospitals was available from the visits undertaken as part of this work. Table 14 shows the type of hospital visited in these 822 visits.

**Table 14. Type of hospital in West bank and Gaza visited in the last 12 months**

Type of hospital	No. (%) visits
Government hospital	591 (72)
UNRWA hospital	44 (5)
NGO hospital	5 (0.3)
Charity hospital	151 (18)
Private hospital	31 (4)

As shown in Table 14, by far the majority of visits are to government hospitals. There are so few visits to NGO hospitals (there is only one such hospital) that these have been combined with charity hospitals in the analysis.

### *Age and sex of service users*

More than half those making a hospital visit in the last year (56%) are female. The proportion of females is a little higher in West Bank (57%) than Gaza (53%) but this difference could easily be due to chance. The proportion of women is higher among those visiting private hospitals (65%); this is not surprising as a number of these are private maternity hospitals.

The mean age of the person visiting a hospital is 30 years, not different between West Bank and Gaza. The mean age for visits to private hospitals is 26 years, the younger age probably again reflecting that some of these are private maternity hospitals.

### *Type of hospital visits*

Two thirds (63%) of the reported hospital visits were as inpatients. More of the visits were as inpatients in West Bank (73%) than in Gaza (44%). This may seem a high proportion as inpatients, given the concern that many people in West Bank and Gaza may be visiting hospitals inappropriately for problems that could actually be dealt with in primary care. However, while a high proportion of people seen in a hospital may have a 'primary care' problem, it could still be that most of the people in the population who visit a hospital go there with a problem requiring admission (planned or emergency).

It could also be that visits nearly a year ago are more likely to be recalled if they were for a more serious problem, requiring admission. The issue of how many people seen in hospital accident and emergency departments are there with 'primary care' problems is considered further in a later section.

The proportion of inpatient and outpatient visits varies between different types of hospitals, as shown in Table 15.

**Table 15. Type of visits in different types of hospital**

Type of hospital	No. (%) visits as inpatients
Government hospital	359 (58)
UNRWA hospital	26 (62)
NGO/Charity hospital	124 (81)
Private hospital	18 (61)

The highest proportion of inpatient visits is to NGO/Charity hospitals.

### *Referral to hospital*

Those who had visited a hospital in the last year were asked whether they went there directly or were referred there by a doctor. Overall, half (50%) of those visiting a hospital were referred by a doctor or clinic. This was much the same in West Bank (49%) and Gaza (51%). There is some variation by type of hospital (Table 16).

**Table 16. Referral for visits in different types of hospital**

Type of hospital	No. (%) visits with referral
Government hospital	295 (48)
UNRWA hospital	22 (41)
NGO/Charity hospital	88 (58)
Private hospital	14 (47)

Rather more of the visits to NGO/Charity hospitals are on the basis of a referral by a doctor or clinic.

Those who went to hospital directly, without a referral, were asked by they had gone directly to the hospital (Table 17).

**Table 17. Reasons for going directly to hospital without referral**

Reason	No. (%) of patients
Emergency	109 (29)
Better service from hospital	90 (24)
Nearest service available	74 (20)
Specialised service needed	37 (10)
Insured/can afford/have relative in service	33 (9)
No choice, clinics closed	29 (8)

As shown in Table 17, most of the reasons are related to having access to a hospital, especially for emergencies. However, a quarter say they went directly to the hospital because they considered they would get a better service than from primary care clinics and one in ten went because they were insured or could afford a hospital visit.

#### ***Reasons for hospital visits***

Self-reported reasons for visiting the hospital (type of health problem) are shown in Table 18. Note that the categories used in Table 18 are derived from descriptions of the condition given by household respondents, sometimes the person who visited the hospital and sometimes a proxy answering on their behalf. Therefore the categories in Table 18 do not correspond to specific medical diagnoses.

Most of the conditions mentioned in Table 18 could be appropriate for hospital treatment, depending on the severity. Most cases of acute respiratory infection and fever should be dealt with in primary care facilities, assuming these are accessible when needed. Hypertension and many chronic illnesses can and should be managed in primary care facilities.

**Table 18. Reasons leading to hospital visits**

Reason	No. (%) of patients
Surgery	168 (20)
Delivery, antenatal care	158 (18)
Injuries	104 (12)
Chest pain, heart attack	78 (9)
Abdominal pain, urinary problems etc	76 (9)
Other chronic illnesses	75 (9)
Acute respiratory infection / cough	44 (5)
Fever	44 (5)
Other acute illness	25 (3)
Faints, debility	23 (3)
High blood pressure	23 (3)
Various pains: ear, tooth, back etc	17 (2)
Poisoning, suicide	14 (2)
Psychological, nervous problem	10 (1)

The pattern of reasons for visiting the hospital is broadly similar across the different providers. Delivery and antenatal care are a more common reason than surgery in all but government hospitals, especially in private hospitals where they account for 42% of visits. This is explained because some of the private facilities are maternity hospitals.

#### ***Refugee status of people visiting hospitals***

Overall, 36% of those visiting a hospital in the last year are registered refugees, 2% non-registered refugees and 63% non-refugees, the same as the refugee status of household heads in the sample population (see above). And, as in the population, the proportion of refugees among those visiting hospitals in Gaza is higher than among those visiting hospitals in West Bank.

Table 19 shows the different types of hospital visited by refugee status.

**Table 19. Type of hospital visited by refugee status**

Type of hospital No. (%)	Registered refugee	Non-reg refugee	Non-refugee
Government	302 (74)	8 (85)	278 (70)
UNRWA	22 (6)	0	22 (5)
NGO/Charity	76 (19)	1 (7)	79 (19)
Private	3 (1)	1 (7)	27 (6)

%ages shown weighted

It can be seen in Table 19 that the proportions visiting different types of hospitals are similar comparing refugees with non-refugees. This suggests that refugee status is not an important factor when choosing between providers, except that refugees seem rather less likely to use a private hospital.

### **Government health insurance and hospital visits**

Of those people visiting hospital during the last year, 53% are covered by government health insurance (GHI). GHI status seems to be importantly related to the type of hospital visited (Table 20).

**Table 20. GHI status and type of hospital visited**

Type of hospital No. (%)	With GHI	Without GHI
Government hospital	390 (86)	190 (55)
UNRWA hospital	9 (2)	34 (9)
NGO/Charity hospital	39 (10)	113 (28)
Private hospital	3 (1)	28 (8)

%ages shown weighted

As shown in Table 20, most people with GHI visited a government hospital, while only about half of those without GHI used a government hospital. It seems that people with GHI cover are more likely to go to a government hospital. This accords with

findings from a previous study<sup>13</sup>.

More hospital users in Gaza have GHI cover than in West Bank (65% vs 48%). The pattern of hospitals visited in those with and without GHI cover in West Bank and Gaza separately is shown in Table 21. The pattern is quite similar in the two areas, allowing for the lack of any UNRWA hospital in Gaza.

**Table 21. GHI status and type of hospital visited in West Bank and Gaza**

Type of hospital No. (%)	West Bank		Gaza	
	GHI	no GHI	GHI	no GHI
Govern	227(86)	119(43)	163(93)	71(81)
UNRWA	9(3)	34(12)	0	0
NGO/Char	27(10)	99(36)	12(7)	14(16)
Private	2(1)	25(9)	1(1)	3(3)

Focus group participants had complaints about the functioning of the GHI system:

*“The patient was taken to the [government] hospital suffering from angina [chest pain] and difficulty breathing. The patient needed to be hospitalised but did not have GHI so the hospital would not accept him before paying the fees. So the family took the patient to a private clinic and then went home because of their bad economic status and the high costs of the hospital.”*

*“I saw a woman delivering in front of the hospital without any help because she did not have GHI.”*

### **Experience of secondary health care facilities**

#### **Waiting time to be seen**

People who attended hospital as outpatients were asked how long they had to wait before seeing the doctor. Most (81%) were seen within an hour. The waiting time for

outpatients in hospitals of different providers is shown in Table 22.

**Table 22. Outpatient waiting time by type of hospital visited**

Type of hospital	No. (%) seen within 1 hour
Government hospital	148 (80)
UNRWA hospital	11 (92)
NGO/Charity hospital	24 (83)
Private hospital	7 (79)

Given the small numbers, there is no difference between providers in waiting times. This is perhaps rather surprising, as it might have been expected that waiting times for outpatients would be longer in government hospitals. Apparently a number of the visits reported here were emergencies rather than routine outpatient appointments.

A different picture may emerge if only routine outpatient visits were considered. It is not possible to identify such visits separately in this survey.

#### **Availability of medicines**

The measure of availability used here is the patient's report of whether all the necessary medicines to deal with their condition were available on the visit. This is subjective and patients may sometimes have inappropriate expectations of what medicines they should receive (for example, they may think antibiotics are required for viral upper respiratory infections or sore throats). Nevertheless, it is a measure of quality from the patient's viewpoint and can be compared between areas and between different providers.

Overall, information about availability of medicines is available for 797 hospital visits. In some cases the information was provided by a household proxy rather than the patient, so some information about visits

was not known. All medicines were available for two thirds of visits (66%).

The availability of medicines in visits to hospitals of different providers is shown in Table 23.

**Table 23. Availability of all required medicines by type of hospital visited**

Type of hospital	No. (%) visits with all medicines available
Government hospital	363 (64)
UNRWA hospital	22 (58)
NGO/Charity hospital	117 (78)
Private hospital	19 (61)

Availability of all required medicines is highest in NGO/Charity hospitals at 78% and lowest in UNRWA hospitals at 58%. It seems surprising that availability of medicines in private hospitals is only 61%, as it might be expected to be higher in this case. The number of visits to private hospitals with information given about availability of medicines is only 30, so the estimate of 61% has wide margins of error. However, it certainly does not seem that reported availability of medicines in private hospitals is higher than in NGO/Charity hospitals. It could be that patient expectations of the medicines they should receive are higher when they visit a private hospital, so this may distort their reports of medicine availability.

If all required medicines were not reported to be available in the hospital, respondents were asked where they obtained the necessary medicines. The usual source is the local pharmacy (89%), with 6% obtaining them from a private clinic.

### **Payment for hospital visits**

Hospital users were asked about payments for consultations, medicines, investigations

**Table 24. Payments for different items associated with hospital visits**

Item	No. (%) who paid	Mean (NIS)	Median (NIS)
Consultation	423 (50)	466	100
Medicines	548 (64)	165	50
Investigations	347 (41)	214	50
Transport	735 (87)	75	20

Apart from transport (not paid to the hospital), medicines are the item most commonly paid for. Among those who pay, the highest payments are for the consultation.

The proportion of users who pay for different items and the amounts paid differ between hospitals of different providers. The proportions of services users paying for different items by type of hospital are shown in Table 25.

**Table 25. Proportion of users paying for different items by type of hospital visited**

Type of hospital	No. (%) who paid		
	Consultant	Medicines	Investig
Government	209 (36)	354 (61)	205 (35)
UNRWA	31 (71)	29 (66)	18 (41)
NGO/Charity	132 (86)	122 (79)	88 (58)
Private	28 (90)	21 (70)	19 (63)

Only about a third of users pay for the consultation in government hospitals, with a much higher proportion paying in hospitals of other providers. The differences between providers in proportions paying are not so marked for medicines and investigations, although less people pay in government hospitals.

Payment for consultation in government

and transport to and from the hospital. The payments for these different items are shown in Table 24.

hospitals is, as expected, related to GHI cover. Two thirds of users have GHI cover (see Table 20) and among these 22% pay something for the consultation, whereas among the third without GHI cover 64% pay for the consultation. Those without GHI cover are more than six times more likely to pay for the consultation (Odds Ratio 6.66, 95% CI 4.35-10.0).

The average amount paid also varies between providers, among those who pay anything. This is shown in Table 26.

**Table 26. Median amount paid for different items by type of hospital visited**

Type of hospital	Median amount paid (NIS)		
	Consultatn	Medicines	Investig
Government	35	50	25
UNRWA	45	50	50
NGO/Charity	311	100	105
Private	500	100	250

The amounts paid for different items among those paying anything are less in government and UNRWA hospitals than in NGO/Charity hospitals and private hospitals. Not surprisingly, the highest costs are in private hospitals. The costs will clearly vary depending on the type of condition and whether the person was an inpatient or an outpatient; however, there were no great differences between the providers in these two aspects in this survey.

### **Opinions of secondary health care facilities**

Those who had visited a hospital in the last year were asked to rate their satisfaction with the treatment and with the staff on five

point scales.

This is a subjective rating and may be influenced by many extraneous factors. However, it is reasonable to compare the level of satisfaction between areas and between users of hospital services of different providers. Table 27 compares satisfaction with hospital treatment and staff between West Bank and Gaza.

**Table 27. Satisfaction with aspects of hospital care West Bank and Gaza**

Aspect of care	No. (%) satisfied / very satisfied	
	West Bank	Gaza
Treatment received	392 (66)	213 (77)
Staff attending	416 (70)	329 (88)

The more positive rating of hospital treatment and staff in Gaza than in West Bank may reflect the overall more positive rating of available health services by households in Gaza (see Table 3).

Table 28 compares ratings of the hospital visit between hospitals of different providers.

**Table 28. Satisfaction ratings by type of hospital visited**

Type of hospital	No. (%) users rating as good /very good	
	Treatment received	Staff attending
Government	388 (65)	410 (70)
UNRWA	34 (78)	37 (80)
NGO/Charity	127 (82)	136 (87)
Private	22 (73)	25 (84)

For all providers, satisfaction levels for attending staff are higher than for the treatment received, suggesting that people believe staff are 'doing their best' and are not responsible for any shortcomings (such as non-availability of medicines). For both

Overall, more than two thirds (70%) of hospital users are satisfied or very satisfied with the treatment they received from the hospital and three quarters (75%) are satisfied or very satisfied with the staff who attended them.

aspects, satisfaction levels are highest for NGO/Charity hospitals and lowest for government hospitals.

Hospital users were asked about what problems, if any, they perceived about the service of the hospital they had attended. The responses are shown in Table 29.

**Table 29. Perceived problems with service of the hospital visited**

Problem	No. (%) of patients
No problem	434 (50)
Poor physical facilities	106 (12)
Not efficient	64 (7)
Bad staff attitude	53 (6)
Lack of medicines, blood	47 (6)
Too expensive	25 (3)
Lack of staff, especially doctors	22 (3)
lack of equipment	20 (2)
Poor access, far away	18 (2)
Long waiting times	15 (2)
Don't know / can't say	58 (7)

Similar problems were mentioned for the different types of hospital, but with varying proportions. Table 30 shows the proportions of users considering there to be 'no problem' with the hospital by type of hospital.

**Table 30. No perceived problem with service by type of hospital visited**

Type of hospital	No. (%) users considering there is 'no problem'
------------------	---

Government hospital	254 (43)
UNRWA hospital	20 (45)
NGO/Charity hospital	117 (75)

Private hospital 17 (57)

The highest proportion of users saying there is 'no problem' with the service is among those who have visited an NGO/Charity hospital. This is in keeping with the high ratings for satisfaction with treatment and staff in these hospitals shown in Table 28.

### Factors influencing satisfaction with hospital services

The results from the five point scale ratings of satisfaction can be expressed in different ways. In Tables 27 and 28 (above), the results are condensed into the proportion rating the service as 'good' or 'very good'. In order to take into account the whole 5 point scale, a satisfaction score can be calculated, with value 5 for 'very satisfied' and value 1 for 'very dissatisfied'. The mean satisfaction score can be compared between groups (Tables 31 and 32).

**Table 31. Mean satisfaction scores for aspects of hospital care West Bank and Gaza**

Aspect of care	Mean satisfaction score	
	West Bank	Gaza
Treatment received	3.623	3.833
Staff attending	3.719	3.993

**Table 32. Mean satisfaction scores by type of hospital visited**

Type of hospital	Mean satisfaction score	
	Treatment received	Staff attending
Government	3.537	3.626
UNRWA	3.818	3.909
NGO/Charity	4.006	4.206
Private	3.867	4.133

Using the satisfaction score (that takes into account the whole scale) gives almost exactly the same answer as using the proportion rating 'good or very good' as the

comparator (compare Tables 27 and 28 with Tables 31 and 32).

In analysing what factors are related to a person's satisfaction with the hospital visited, the dichotomy between rating 'good or very good' and lower ratings is used as the satisfaction outcome measure.

There is no difference between men and women in their likelihood of being satisfied with hospital treatment or hospital staff. The mean age of those satisfied is not significantly different from the mean age of those not satisfied. Hospital users under the age of 25 years (the median age) are as likely to be satisfied as older people.

Hospital users residing in urban sites are less likely to be satisfied with hospital treatment than those residing in either rural sites or refugee camps. When rural sites and refugee camps are combined, users from these places are one and a half times more likely to be satisfied with the treatment they received in hospital (Table 33).

**Table 33. Satisfaction with hospital care for users from different residences**

Residence	Satisfied with hospital care	
	Yes	No
Rural/refugee camps(%)	417 (74)	149 (26)
Urban (%)	188 (64)	104 (36)
Odds Ratio 1.54 (95% CI 1.12-2.13)		

This lower satisfaction among hospital users is still found when the effect of type of hospital is taken into account by stratification.

Refugees are more likely to be satisfied with hospital care than non-refugees (Table 34).

**Table 34. Satisfaction with hospital care for refugees and non-refugees**

Refugee status	Satisfied with hospital care	
	Yes	No

This greater satisfaction among refugees is still found when the effect of type of hospital is taken into account by stratification.

People without GHI cover are somewhat more likely to be satisfied with hospital care than those with GHI cover (Table 35).

**Table 35. Satisfaction with hospital care in relation to GHI cover**

GHI status	Satisfied with hospital care	
	Yes	No
No GHI cover (%)	291 (75)	99 (25)
With GHI cover (%)	301 (67)	151 (33)

Odds Ratio 1.47 (95% CI 1.08-2.04)

This greater satisfaction among those without GHI cover is still found, though less marked, when type of hospital is taken into account by stratification.

### **Primary care clinics serving the survey communities**

Between one and four primary care clinics were visited for each of the 25 sites in the survey. A total of 42 clinics were visited: 21 government clinics, 10 UNRWA, 1 private, 4 NGO, and 6 charity. The NGO and Charity clinics have been combined for the purpose of analysis.

The most important findings in the clinics are described here. Some further findings are given in Annex 4. The relative workloads in the clinics were investigated by asking about the number of staff of different types, the number of hours the clinic opens per day and the average number

Refugee (%)	317 (74)	114 (26)
Non-refugee (%)	286 (68)	138 (32)
Odds Ratio 1.34 (95% CI 0.99-1.83)		

of patients seen per day. The main findings are shown in Table 36.

**Table 36. Workload in different clinics**

Index	Mean numbers by clinic type			
	1	2	3	4
Patients/specialist	55	100	11	15
Patients/GP	69	127	22	43
Patients/staff nurse	77	182	44	32
Patients/practical nurse	71	60	-	20
Patients/room	16	18	6	6
Patients/hour	16	52	3	6

Clinic types: 1=government clinic 2=UNRWA clinic

3=private clinic 4=NGO/charity clinic

The highest pressure of patients, in terms of workload per specialist doctor and general doctor and in terms of patients seen per hour of clinic opening, is in UNRWA clinics, followed by government clinics. These pressures are much lower in private clinics (although only one was reviewed in this survey) and in NGO/charity clinics. These findings confirm findings from previous surveys in West Bank and Gaza<sup>13</sup>.

Certain items were noted as a way of assessing how well equipped the clinics are. Main findings where not all clinics are fully equipped are shown in Table 37. Further details about level of equipment are shown in Annex 4.

**Table 37. Equipment in different clinics**

Item	% present by clinic type			
	1	2	3	4
Separate clinical area	67	90	100	80
Clean clinical area	60	90	100	100
Ophthalmoscope	50	100	100	70
Stretcher	62	100	100	60
IV lines	62	90	100	78

Oxygen 62 100 100 90

Clinic types: 1=government clinic 2=UNRWA clinic

3=private clinic 4=NGO/charity clinic

Government clinics seem to be the least well-equipped. For example, only half of them have an ophthalmoscope, which is an important item in the management of conditions like diabetes and hypertension. It seems that patient perceptions of lack of equipment in government clinics have some objective basis. All the clinics had a stock of the basic medicines that were checked (see Annex 4). This does not mean that all medicines needed are always present, so does not necessarily go against the common complaint from patients of lack of medicines (see above).

The charges made for different items vary between the different types of clinics. The mean charges for different items (as reported by the clinic staff) are shown in Table 38.

**Table 38. Charges made in different clinics**

Item	Mean charge by clinic type (NIS)			
	1	2	3	4
Consultation: specialist	12	0	40	16
Consultation: GP	8	0	20	11
Consultation: nurse	4	0	0	1
Haemoglobin test	2	0	15	7
Urine microscopy	2	0	10	6

Clinic types: 1=government clinic 2=UNRWA clinic

3=private clinic 4=NGO/charity clinic

Not surprisingly, the highest charges are in the private clinic. UNRWA clinics do not charge for any of these items.

## RESULTS

### EDUCATION SERVICES

The survey is concerned with basic education and, to a lesser extent, pre-school services. Information is presented here from the household questionnaire, from focus group discussions, and from the review of schools providing basic education for the survey sites. The experience of individual children is linked to the type and facilities of the schools for those children in the sites attending one of the visited schools.

#### Pre-school (kindergarten) services

##### Knowledge and opinion about services

Most households with children (85%) are aware of local kindergarten classes. The awareness is rather higher in Gaza (88%) than in West Bank (83%).

Households rated the quality of kindergarten services from different providers separately. Most households rate services as good or very good: 81% give this rating to charity kindergartens, 79% give it to those run by women's committees, and 82% give it to those run by private organisations. Ratings from households in West Bank and Gaza separately are shown in Table 39.

**Table 39. Household ratings of kindergarten services from different providers**

Service provider	No. (%) rating service good/very good	
	West Bank	Gaza
Charity	683 (78)	288 (91)
Women's committees	211 (72)	92 (92)
Private	614 (79)	571 (84)

% ages are shown weighted

Table 39 shows that kindergartenn services are consistently rated more positively by households in Gaza than households in West Bank. It is not clear whether this reflects an

objective better level of kindergarten services in Gaza or a lower level of expectations in Gaza. It is in line with the more positive ratings of health services by households in Gaza (see above).

Despite high ratings of services, improvement is always possible and households were asked their suggestions for improving kindergarten services. Their responses are shown in Table 40.

**Table 40. Household suggestions for improving kindergarten services**

Suggestion	No. (%) of households
More qualified staff	622 (25)
Better materials, toys	497 (20)
Better premises	494 (21)
Financial support, less fees	226 (10)
More services	130 (5)
More equipment	8 (0.3)
Can't say/don't know	435 (19)

% ages are shown weighted

The most common suggestion is for the provision of more qualified staff. A fifth (19%) of households were not able to give any suggestions for improvement.

#### Children in kindergarten

Overall, 22% of households in the survey have at least one child in kindergarten: 22% in West Bank and 23% in Gaza.

The costs during the last year for each child were noted. The mean annual cost per child is 643 NIS. The mean annual cost is higher in West Bank (812 NIS) than in Gaza (390 NIS).

### Opinions about basic education services

About three quarters of households (73%) say they think basic education services available to them are ‘good’ or ‘very good’. The proportion giving this very positive rating of services is higher in Gaza (81%) than in West Bank (67%).

Nevertheless, households gave their views on the problems with the basic education services available to them. Their concerns are shown in Table 41.

**Table 41. Perceived problems with basic education services**

Problem	No. (%) of households
Overcrowded classrooms	1016 (34)
Teacher qualifications, skills	688 (23)
Too far away, poor access	279 (9)
Poor curriculum, low standards	241 (8)
Poor physical conditions, lack of equipment	191 (6)
Too expensive, extra tuition payments	53 (2)
No problem	233 (8)
Can't say	287 (10)

Overcrowded classrooms are the most common concern, although concerns about teacher qualifications and skills are expressed by nearly a quarter of the households. Only 8% mention the quality of the curriculum and educational standards as their main concern.

Focus group elaborated on some of the perceived problems.

*“Some of the teachers teach subjects which they are not specialised in: you see a teacher with a degree in mathematics teaching geography.”*

*“Education in our region is very good, but the problem is in the school buildings, especially in the UNRWA schools.”*

*“If you do not push the teachers to take care*

*of your child they will not be interested in him at all.”*

The suggestions from households about how to basic education services could be improved are shown in Table 42. These reflect the perceived problems with the service. Most of the suggestions are for the sort of service people feel they want and they do not address methods for achieving the end result.

**Table 42. Household suggestions for improving basic education services**

Suggestion	No. (%) of households
More classrooms	1093 (37)
More qualified teachers, better salaries	640 (22)
Raise standards, improve curriculum	263 (9)
Improve access to schools	240 (8)
Improve physical conditions, provide more equipment	156 (5)
Financial support, less charges	64 (2)
Nothing: no problem	199 (7)
Can't say / don't know	308 (10)

While the commonest suggestion is simply to provide more classrooms, more than 30% comment on the need to pay better qualified teachers or to raise standards and improve the curriculum. This desire by parents for a better standard of education, rather than simply having children attend classes and get a certificate, is positive and could be useful in efforts to raise standards in basic education.

Again, focus groups gave their views on how to improve matters.

*“The teacher’s salary should be enough to encourage the teacher to work better. What can you do with 1000 shekels in this too expensive life?”*

*“Teachers should give attention to both strong and weak pupils equally in order to keep the weak pupils from dropping out of the school.”*

### **Experience of basic education services**

Information was sought from households about education experience for all children between the ages of 5 and 15 years: a total of 4603 children.

#### **Type of school**

The name of the school being attended by each child was noted. Schools serving the sites were visited and information collected about the type of school and other features of the school (see later). Among the 2346 children attending one of the 102 schools visited in the survey, the experience of the child in school can be linked to features of the school. Overall, 82% of these 2346 children are attending a government school, 15% an UNRWA school, 1% a charity organisation school, and 2% a private school. However, since not all the schools the children attended in West Bank and Gaza were visited, it is not possible to say that these proportions attending different types of schools apply to the whole population of children in West Bank and Gaza.

The type of school attended by children from households where the head of the household is a refugee is different from the type of school from households where the head is a non-refugee (Table 43).

**Table 43. Refugee status of head of household and type of school attended by children**

Type of school (%)	Refugees	Non-refugees
Government	237 (41)	1481 (98)
UNRWA	525 (50)	15 (1)
Charity	9 (2)	8 (1)

Private 29 (6) 10 (1)

Among children of refugee families, half attend UNRWA schools and just under half attend government schools, while among children of non-refugee families, nearly all attend government schools.

### **Enrolment, dropout, repetition and class attendance**

These basic data about education reflect a combination of household, community and school factors.

#### **1. School enrolment**

The overall net school enrolment is 85%. There is no difference between boys and girls. Net school enrolment among children in West Bank (90%) is higher than in Gaza (78%). A child in West Bank is more than twice as likely to be enrolled in school compared with a child in Gaza (Odds Ratio 2.63, 95% CI 1.95-3.55). Once area of residence is taken into account, there is no difference in school enrolment between children of refugee families and children of non-refugee families.

Age specific net enrolment rates are shown in Table 44.

**Table 44. Age specific net school enrolment**

Age	No. (%) of children in school
5 years	2 (0.4)
6 years	119 (32)
7 years	450 (98)
8 years	526 (100)
9 years	440 (100)
10 years	474 (99)
11 years	374 (99)
12 years	441 (98)
13 years	347 (96)
14 years	425 (96)

Children begin going to school from the age of 6 years, with about a third of children of this age in school. There is a slight drop off from age 12 years but nevertheless, 93% of children aged 15 years are attending school. The overall net school enrolment of children aged 6-15 years is 92%.

## 2. Drop out from school

School drop-outs in this study were identified by asking if children aged up to 15 years, not currently in school, had been enrolled into school in the past. The drop-out rate, as a proportion of the total children aged 5-15 years, is 1.1%. The drop-out rate is zero up to age 11 years, rising to a maximum of 5.5% among children aged 15 years. There is no apparent gender difference in drop-out among children up to age 15 years, nor any difference between refugee and non-refugee families.

## 3. Repetition of grades

Among the children in school, 9% have repeated one or more grades. Mostly they have repeated only once but a few have repeated up to three times. The proportion who have repeated one or more grades is higher among older children (Table 45).

**Table 45. Grade repetition by age of children in school**

Age	No. (%) repeated grades
5 years	-
6 years	-
7 years	3 (1)
8 years	12 (2)
9 years	15 (4)
10 years	27 (5)
11 years	38 (11)
12 years	53 (13)
13 years	52 (16)
14 years	62 (14)

A fifth of children aged 15 years have repeated one or more grades, but repetition rates in children up to 10 years old are very low.

Grade repetition by current grade of the child is shown in Table 46.

**Table 46. Grade repetition by current grade of children in school**

Current grade	No. (%) repeated grades
Grade 1	8 (1)
Grade 2	17 (3)
Grade 3	34 (7)
Grade 4	39 (8)
Grade 5	51 (12)
Grade 6	57 (16)
Grade 7	54 (14)
Grade 8	39 (11)
Grade 9	18 (9)
Grade 10	1 (2)

The very low repetition rate among children currently in grade 10 is inevitable, as they cannot have repeated and reached grade 10 by age 15 years, unless they began at less than 6 years old. The low repetition rate among children in lower grades probably reflects the policy, at least in government schools, of automatic progression to the next grade in these grades.

Repetition rates do not differ by gender or by refugee status of the child's family.

Repetition rates do not differ much depending on the type of school the child is attending: 9% among those in government schools, 8% among those in UNRWA schools, 12% among those in charity schools, and none among those in private

schools. Note that there are only 17 children attending charity schools and 39 children

### ***Reasons for repeating grades***

Household respondents gave the reasons why they think their child had to repeat one or more grades. These are shown in Table 47.

**Table 47. Household reasons for children repeating grades**

Reason	No. (%) of households
Poor performance of child	163 (51)
Child stubborn, not bright	40 (13)
Parents not interested	39 (12)
Bad teacher/bad school	30 (9)
Child was sick	28 (9)
School fees not paid	8 (3)
Disruption/change of school	6 (2)
Don't know / can't say	6 (2)

It is notable in Table 46 that two thirds of household respondents blame the child for not performing or for being stubborn or not bright. They blame the parents more often than they blame the teachers. This is surprising, since most of the household respondents are either the wife of the household head or the household head and parents of the children concerned.

## **4. Class attendance**

The index of regular attendance is the number of school days the child did not attend school in a month, as reported by the household respondent. This could be an underestimate of absenteeism rates, as parents may not always know if their children do not attend school.

Around three-quarters (74%) of the children in school are said to have attended every school day in the month. And a further 9% only missed one day on the month.

The proportion of the children with full

attending private schools in this sample.

attendance varies somewhat by type of school (Table 48).

**Table 48. Type of school and children's attendance rates**

Type of school	No. (%) children with full attendance
Government	1275 (73)
UNRWA	369 (67)
Charity	14 (82)
Private	28 (73)

The attendance rate among children going to UNRWA schools is lower than for the other schools, as shown in Table 47.

School attendance is a useful indicator of the child's focus on studies. Children who do not attend school regularly are twice as likely to have repeated at least one grade, compared with children who attend regularly (Table 49).

**Table 49. Regular school attendance and repetition of grades**

Missed school during last month	Repeated at least one grade	
	Yes	No
Yes	128 (12)	919 (88)
No	191 (7)	2629 (93)
Odds Ratio 1.92 (95% CI 1.49-2.44)		

## **Home environment and children in school**

Parents and other family members need to support children in school in order to help them succeed in their studies. Some information about home support is available from this survey.

### **1. Non school work**

Households were asked about how many hours of work their children aged 5-15 years undertake each day, apart from school work.

Overall, less than a third (29%) of the children are said to undertake any work. Children in Gaza are more likely to undertake work in addition to their school work, compared with children in West Bank (Table 50).

**Table 50. Work outside school and area of residence**

Area of residence	Work outside school	
	Yes	No
Gaza (%)	520 (34)	821 (66)
West Bank (%)	630 (26)	1885 (74)
Odds Ratio 1.47 (95% CI 1.04-2.13)		

Children from refugee families are more likely to undertake additional non-school work than children from non-refugee families (Table 51).

**Table 51. Work outside school and refugee status of household head**

Refugee status of household head	Work outside school	
	Yes	No
Refugee (%)	557 (34)	1104 (66)
Non-refugee (%)	590 (27)	1601 (73)
Odds Ratio 1.37 (95% CI 1.19-1.58)		

The relationship between gender of the child and work outside school work is shown in Table 52.

**Table 52. Work outside school and gender**

Gender of the child	Work outside school	
	Yes	No
Girl (%)	735 (39)	1150 (61)
Boy (%)	415 (21)	556 (79)
Odds Ratio 2.38 (95% CI 2.08-2.78)		

Girls are more than twice as likely as boys to do additional work as well as their school work (Table 51).

other than school work.

There is no relationship between the type of school the child attends and the undertaking of extra work by the child.

Older children are more likely to undertake additional work. The proportion working rises around 13% of 6 year olds to 45% of 15 year olds. Few children, even among the older children, are said to work more than two hours a day on top of their school work.

When the age of the child is taken into account, children working in addition to their school work are not apparently more likely to repeat classes. But this does not rule out any effect on their academic performance. More subtle effects could not be detected in a survey of this sort.

## 2. Help with homework

Three quarters (75%) of children are said to be given help with their homework.

This varies by area of residence (Table 53)

**Table 53. Help with homework and area of residence**

Area of residence	Child helped with homework	
	Yes	No
Gaza (%)	1090 (81)	250 (19)
West Bank (%)	1741 (72)	673 (28)
Odds Ratio 1.69 (95% CI 1.43-2.00)		

Children in Gaza are nearly twice as likely to be given help with their homework compared with children in West Bank.

There is also variation by refugee status (Table 54).

**Table 54. Help with homework and family refugee status**

Refugee status	Child helped with
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	homework	
	Yes	No
Refugee (%)	1297 (80)	322 (20)

Children in refugee families are more likely to be helped with their homework than children from non-refugee families. This is also true in West Bank and Gaza separately.

Help with homework depends also on the age of the child. The proportion given help falls from 96% among 6 year olds to 47% among 15 year olds. Boys are slightly more likely to be given help than girls, with the age pattern being about the same in both sexes.

Help with homework from the mother or father may be of higher quality than help from other members of the household. Around half the children (49%) get help with their homework from one of their parents. Again, help from parents is more common in Gaza (57%) than in West Bank (43%), and among refugee families (56%) than among non-refugees (45%). The difference between boys and girls is small and could easily be due to chance.

Help with homework, particularly from parents, is related to better school performance (Table 55).

**Table 55. Help with homework from parents and repetition of grades**

Parents help with homework	Repeating grades	
	Yes	No
No (%)	229 (12)	1718 (88)
Yes (%)	76 (4)	1729 (96)

Odds Ratio 3.03 (95% CI 2.27-4.00)

Children not given help with homework by their parents are three times more likely to repeat one or more grades in school. This effect is found in both younger (up to 10 years) and older children.

Non-refugee (%)	1530 (72)	601 (28)
Odds Ratio 1.58 (95% CI 1.35-1.85)		

### Costs of education

Households were asked how much they paid for each child in school in the past year, for a number of different items. The costs per child for the different items are shown in Table 56.

**Table 56. Costs of education**

Item	No. (%) who paid anything	Mean (median) cost
School clothes, shoes	3831 (100)	443 (250)
Stationery, pens etc	3847 (100)	129 (100)
Transport to school	436 (11)	375 (160)
Basic tuition fees	2804 (72)	101 (50)
Extra school activities	2351 (61)	49 (30)
Extra tuition fees	1927 (50)	35 (12)

The costs are in NIS

The costs associated with education vary by type of school the child is attending, as shown in Tables 57 and 58.

**Table 57. Proportion of children with payment for different items, by type of school**

Item	No. (%) paying for item			
	1	2	3	4
Clothes, shoes	1700 (100)	552 (100)	15 (100)	39 (100)
Stationery etc	1716 (100)	554 (100)	15 (100)	38 (100)
Transport	43 (3)	58 (11)	0	7 (18)
Basic fees	1692 (98)	112 (20)	17 (100)	39 (100)
Extra activities	1259 (73)	268 (49)	11 (65)	32 (82)
Extra tuition	900 (52)	276 (50)	1 (6)	3 (8)

1=government school 2= UNRWA school

3= charity school      4= private school

Clothes, shoes and stationery are paid for in all schools. Basic fees are universal, except in UNRWA schools where only 20% pay basic fees. Payments for extra activities are common for children in most types of schools, although less so for those in UNRWA schools. Parents pay for extra tuition for half the children attending government and UNRWA schools, but for few children in charity and private schools.

**Table 58. Mean and median payments for different items, by type of school**

Item	Mean (median) payment in NIS			
	1	2	3	4
Clothes, shoes	420 (300)	257 (200)	349 (300)	677 (500)
Stationery etc	130 (100)	122 (100)	221 (300)	273 (300)
Transport	341 (120)	164 (150)	0	719 (500)
Basic fees	51 (50)	17 (10)	579 (550)	734 (720)
Extra activities	56 (45)	32 (25)	85 (100)	123 (100)
Extra tuition	47 (20)	17 (10)	50 (50)	167 (200)

1=government school      2= UNRWA school  
3= charity school      4= private school

When payments are made for items, the level of payment is generally higher in charity and private schools than in government and UNRWA schools (Table 58).

There are no consistent differences between boys and girls either in the proportion for which payments are made for different items or in the mean payments for the items.

### **Adequacy of school performance**

This survey has not attempted to examine quality of the educational activities of the schools. However, households were asked whether the children in school had received

a full set of textbooks in the first week of the last school year (as they should have done), how often the children received homework, and when they last met the child's teacher. This third item of course depends on the parents as well as on the schools.

### **Full set of textbooks**

Most children (84%) are said to have received a full set of text books in the first week of the last school year. There is some variation by type of school (Table 59).

**Table 59. Full set of textbooks by type of school**

Type of school	No. (%) children with full set of textbooks on time
Government	1507 (88)
UNRWA	410 (74)
Charity	12 (71)
Private	36 (95)

A lower proportion of children in UNRWA and charity schools received their full set of textbooks within the first week of the school year.

There is no gender difference in this matter.

### **Frequency of giving homework**

The survey was carried out at the end of the school year. A question about homework in the last week was therefore inappropriate as it was not a normal part of term and exams were in progress or completed. The question was asked instead as "how many times per week on average does the child have homework?" Relying on recall, the answer will have more variation than if it could have referred to the last week.

Nearly all children (95%) are said to have homework at least once per week, and more than half (55%) are said to have homework six or seven times per week.

There is little difference between types of school in the proportion of children having homework at least once a week. Table 60

**Table 60. Type of school and frequency of homework**

Type of school	No. (%) children given homework 6 or 7 times a week
Government	759 (45)
UNRWA	380 (69)
Charity	7 (41)
Private	28 (72)

More children in UNRWA and private schools receive daily homework than in government and charity schools.

### *Meetings between parents and child's teacher*

When asked when they last met the child's teacher, some parents said they had never met the teacher. Overall, 82% of households have met the child's teacher at some time to discuss the child. There is variation between types of school in how many children's parents have ever met the teacher and in how long ago they last met the teacher (Table 61).

**Table 61. Type of school and meetings between parents and child's teacher**

Type of school	No (%) of parents who met teacher	Mean time since last meeting (wks)
Government	1305 (77)	5.1
UNRWA	461 (84)	5.2
Charity	14 (82)	4.4
Private	35 (90)	3.6

Less children's parents have ever met the teacher in government schools and the frequency of meetings (among those

shows the proportions of children given homework six or seven times a week in different types of school.

children whose parents have ever met the teacher) is less in government and UNRWA schools than in charity and private schools.

Just over half (52%) of the children's teachers are women. Meetings between parents and teachers are no different for male and female teachers.

### **Satisfaction with schools**

Most households (81%) are 'satisfied or very satisfied' with the child's class teacher. There is some variation by type of school (Table 62).

**Table 62. Parental satisfaction with class teachers by type of school**

Type of school	No. (%) children with parents 'satisfied/very satisfied'
Government	1325 (77)
UNRWA	447 (81)
Charity	16 (94)
Private	35 (90)

The highest satisfaction with teachers is for children in charity or private schools. Nevertheless, in government schools, the level of parental satisfaction with teacher is high for more than three quarters of the children.

Focus groups criticised different types of schools.

*"In the 60s and 70s UNRWA schools were better but now, because of the political situation, the situation is completely the opposite."*

*"The first ten pupils in the GSE always come from the government schools and not the private schools. The private schools give high marks to the pupils to encourage them to come to these schools."*

Parents of children who have not repeated grades are more likely to be satisfied with the teachers than parents of children who have repeated grades (Table 63).

**Table 63. Repetition of grades and satisfaction with teachers**

Repeated grades	Satisfied or very satisfied with teachers	
	Yes	No
No repeats (%)	2874 (81)	674 (19)
One or more (%)	244 (76)	76 (24)
Odds Ratio 1.33 (95% CI 1.00-1.75)		

Most households (73%) are also ‘satisfied’ or ‘very satisfied’ with their child’s progress in school. There is variation by type of school (Table 64).

**Table 64. Parental satisfaction with child’s progress by type of school**

Type of school	No. (%) children with parents ‘satisfied/very satisfied’
Government	1225 (71)
UNRWA	378 (69)
Charity	14 (82)
Private	37 (95)

More parents of children in charity and private schools are satisfied with their progress than parents of children in government and UNRWA schools.

Not surprisingly, there is a strong association between repeating grades and parental satisfaction with the child’s progress (Table 65).

**Table 65. Repetition of grades and satisfaction with child’s progress**

Repeated grades	Satisfied or very satisfied with progress	
	Yes	No
No repeats (%)	2874 (81)	674 (19)
One or more (%)	244 (76)	76 (24)

	Yes	No
No repeats (%)	2710 (77)	828 (23)
One or more (%)	114 (36)	205 (64)
Odds Ratio 5.88 (95% CI 4.55-7.69)		

As shown in Table 64, parents of children who have not repeated a grade are nearly six times more likely to be satisfied with their progress in school than parents of children who have repeated one or more grades. Comparing tables 62 and 64, it is clear that parents often do not blame the teacher for their child’s lack of progress (see also Table 46).

### Features of the schools in the survey

A total of 102 schools serving the sample sites were visited during the survey and certain features were noted. The key findings are described here.

Of the schools visited, 57 are government schools, 40 UNRWA, 2 charity, and 3 private. Sixteen of the schools are co-educational, 45 boys only and 41 girls only. Nearly all (93%) are permanent structures. The condition of the buildings is good in 60%, needing repair in 29% and ‘very bad’ in 10%. The condition of buildings is worse for government and UNRWA schools (Table 66).

**Table 66. Condition of school buildings**

Type of school	Condition of buildings: no. (%)		
	Good	Needs repair	Very bad
Government	30 (53)	23 (40)	4 (7)
UNRWA	27 (68)	7 (18)	6 (15)

Charity	2 (100)	0	0
Private	3 (100)	0	0

All schools have a toilet for pupils and in 94% it is clean. Most (84%) have a separate toilet for girls. Handwashing facilities are available in 92% of the schools. The mean number of students per toilet is 66 and per washbasin 79. These figures are higher in government and UNRWA schools (Table 67). **Table 67. Provision of toilets and handwash washbasins in schools**

Type of school	Mean students/toilet	Mean students/basin
Government	74	108
UNRWA	58	47
Charity	36	42
Private	48	41

washbasin 79. These figures are higher in government and UNRWA schools (Table 67).

Charity	1 (50)
Private	1 (33)

Most of the schools (91%) have a parents teachers council, with varying roles as described by the head teachers (Table 70).

About three-quarters (73%) of the schools have a library, but this is less common in government schools (Table 68).

**Table 68. Presence of a library in schools**

Type of school	No. (%) with a library
Government	36 (64)
UNRWA	32 (82)
Charity	2 (100)
Private	3 (100)

Only two thirds of government schools have a library. This survey did not attempt to assess the quality of the libraries; this may also have been less good in government schools.

Student counselling is available in less than half (42%) the schools visited. It is more common in government schools (Table 69).

**Table 69. Availability of student counselling**

Type of school	No. (%) with student counselling
Government	36 (63)
UNRWA	5 (13)

**Table 70. Roles of parents teachers councils**

Role	No. (%) headmasters citing
Issues of students	99 (114)
Parent-teacher communication	66 (76)
Fund raising	39 (45)
Provide books, equipment	5 (6)

***Other views of headmasters***

Headmasters gave their views about why some children do not attend school regularly (Table 71).

**Table 71. Headmasters' views about why children do not attend regularly**

Reason	No. (%) headmasters citing
Financial, social situation at home	44 (52)
Sickness of child	44 (52)
Parents not interested	29 (35)

**Table 71. Headmasters' views about why children drop out of school**

Reason	No. (%) headmasters citing
Poor performance of child	55 (69)
Social, financial reasons at home	43 (54)
Parents not interested	28 (35)
Early marriage of girls	22 (28)
Working, wanting to work	21 (26)
Problems with teachers	5 (6)
School too far from home	3 (4)

Again, headmasters mostly blame home factors for children dropping out of school and rarely cite any problems concerned with the school itself.

Poor performance of child	25 (30)
Child works at home	15 (18)
School far, travel problems	9 (11)
Mixed reasons	6 (7)
Early marriage	3 (4)

The headmasters tend to blame the situation at home for children not attending regularly.

Headmasters also gave their views about why some children drop out of school (table 72).

Headmasters were asked for their suggestions about how to improve attendance in their school. Their responses are summarised in Table 73.

**Table 73. Headmasters' suggestions for how to improve school attendance**

Suggestion	No. (%) headmasters citing
Improve awareness of parents	67 (73)
Attention to individual children	41 (45)
Better parent teacher contacts	30 (33)

Improve school facilities	28 (30)
Help families financially	17 (19)
Compulsory basic education	5 (5)
More schools, facilities	3 (3)

Most suggestions are aimed at parents and pupils but the need for schools to collaborate with parents is recognised.

## COMMENTARY

This survey is intended as a contribution towards the process of achieving high quality basic services for the population of West Bank and Gaza and, in particular, effective integration of services from different providers. It gives a picture of the present service in the fields of health and basic education, from the perspective of the service users and intended service beneficiaries. It includes their suggestions for change; essentially their aspirations for what they would consider a good, effective service. This user perspective on its own is not enough to make judgements about which services can be most effectively and most economically provided by different bodies. However, it does give context to other work which is service based and considers costs of different types of service provision.

### **Health services**

The focus in this survey is secondary health care and its use, appropriate and inappropriate, by the population in West Bank and Gaza. People make heavy use of secondary health care facilities. The survey has revealed that choices between primary and secondary facilities are often on the basis of access: some people would visit a hospital during the day for a child with fever, but more would do so after the clinics are closed in the evening. Some people choose hospital care over primary care because they perceive they will get better care in a hospital. Similarly, choices between different providers of secondary care are often on the basis of access, sometimes of cost, and less frequently of quality.

The survey allows an analysis of the experience of hospital contacts by type of hospital. In general, the experience is more positive with NGO/charity and private

hospitals than with government and UNRWA hospitals. On the other hand, the costs to the service users are greater with NGO/charity and private hospitals. A major complaint about health services in general and hospitals in particular is the lack of medicines needed to treat the condition. This could be due to inappropriate expectations of medications, but the possibility that it is due, at least in part, to pilfering and diversion of the medicines should be borne in mind. In other countries theft and diversion of medicines has been found to be a major cause of lack of medicines at the point of patient contact.

### **Education services**

As expected, basic education is found to be nearly universal in this survey. Figures for basic literacy, net school enrolment, dropout and class repetition compare favourably with many other countries. Problems with basic education are noted by households, but relatively few mention issues of quality of education rather than of physical concerns.

The situation in government and UNRWA schools is less favourable than in charity and private schools, but costs to households of education in these schools are less than in charity or private schools. Parents are constrained in their choice of school by access and cost. Support for students at home is also variable but important in terms of the child's progress in school.

### **Use of the survey findings**

This survey will have been worthwhile if its findings stimulate discussion about issues of impact, coverage and costs of services from different providers. It does not make any prescriptions about improving service provision, but it does offer pointers about what users want and it could be a baseline

for measuring the impact of any changes in service provision.

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