

Cost Study of Maternal Health Services

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Data Collection Instruments



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Cost Study of Maternal and Reproductive Health Services Facility Form #1

Facility-level Standard Treatment Protocol Form

PURPOSE AND RATIONALE: Standard treatment protocols are necessary in order to determine which supplies and medicines are typically used as part of each type of service, the amount routinely used to provide the service, and the unit cost of each. Providers are also interviewed on the amount of time spent on each service in case of insufficient observations.

DATA SOURCES: National standard treatment protocols if available as well as interviews with providers in each facility.

SUGGESTED SAMPLE SIZE: Four providers; one provider per facility, drug and procurement price lists, Ministry of Health management information system data.

SPECIFIC INSTRUCTIONS FOR INTERVIEWERS:

ANTENATAL CARE

Is antenatal care provided in this facility?									
How many antenatal clients do you see in a given day / week / month [circle]?									
How many antenatal days do you have in a week?									
Code	Description of treatment line	Type	Notes		How many of those antenatal clients are here on a first visit?	How many of those antenatal clients are here on a repeat visit?			
How many of these clients receive the following drugs and supplies for this treatment?									
L	Blood slide								
L	Blood group test								
L	Haemoglobin test								
L	Urine protein test								
L	VDRL (RPR)		syphilis test						
V	Tetanus vaccine	Injection							
M	Ferrous sulfate	Tablets							
M	Folic acid	Tablets							
M	Vitamin supplements	Tablets							
M	Vitamin A								
M	Nitrofurantioin	Tablets	urinary infection-- 1st line						
M	Amoxicilin	Tablets	urinary infection-- 2nd line						
M	Cotrimazole (Septrin)	Tablets	urinary infection-- 2nd line						
M	Metronidale (Flagyl)								
M	Methylodopa [HYPERTENSION]	Tablets							
M	Diazepam [HYPERTENSION]								
M	Cloroquine [MALARIA]								
M	Mebendazole [HOOKWORM]								
M	Nystatine [CANDIDASIS]	Vaginal							
M	Benzathine benzylpenicillin [SYPHILIS]								
M	Erythromycin [SYPHILIS]								
S	Gloves								
S	Cotton wool								
S	Stationery – prenatal card (client based)	Stationery							
S	Stationery – prenatal card (clinic based)	Stationery							
	Other								
How much time do the following medical personal spend with the client in this treatment?									
P	Specialist [specify] _____	Minutes	[specify % of clients seen by a specialist] _____		___m	___m			
P	Doctor	Minutes			___m	___m			
P	Medical Assistant	Minutes			___m	___m			
P	Nurse/Midwife	Minutes			___m	___m			
P	Nursing Aide	Minutes			___m	___m			

VAGINAL DELIVERY						
Is vaginal delivery done in this facility?						
How many vaginal deliveries are done in this facility on a given day / week / month [circle]?						
Code	Description of treatment line	Type	Notes			
How many of these clients receive the following drugs and supplies?						
ADMISSION						
L	Blood group test					
L	Haemoglobin test					
L	Urine protein test					
	Other					
LABOR						
M	Ampicillin	Injection				
M	Oxytocin	Injection				
M	Pethidine					
M	Dextrose					
	Other					
DELIVERY						
M	Ergometrine maleate	Injection				
M	Aspirin	Tablets				
M	Chlorhexidine (hibitine)	Solution				
M	Paracetamol	Tablets				
S	Alcohol with hibitine	Disinfectant				
S	Gloves					
S	Giving set					
S	Cannulae					
H	Hospitalization	Days	[specify average length of stay]			
	Other					
EPISIOTOMY						
% OF WOMEN THAT RECEIVE AN EPISIOTOMY						
M	Lidocaine, 2%	Injection				
S	Cotton wool					
S	Gauze					
S	Sutures					
	Other					
INDUCED LABOR						
% OF WOMEN THAT LABOR INDUCED						
M	Dextrose 10% in water + set					
M	Oxytoxin 5 IU/ml					
	Other					
NEWBORN CARE (in %)						
M	Eye ointment 1%	Ointment				
S	Cord ligatures					
S	Nasal catheters					
	BCG					
	Polio 0					
	Vitamin K					
	Other					
POSTPARTUM CARE						
M	Oxytocin	Injection				
M	Pethidine	Injection				

M	Ergometrine	Injection				
	Other					
How much time do the following medical personal spend with the client in this treatment?						
ADMISSION						
P	Specialist <i>[specify]</i> _____	minutes <i>[specify % of clients seen by a specialist]</i> _____				___m
P	Doctor	Minutes				___m
P	Medical Assistant	Minutes				___m
P	Nurse/Midwife	Minutes				___m
P	Nurse Aide	Minutes				___m
LABOR						
P	Specialist <i>[specify]</i> _____	visits X minutes per visit <i>[specify % of clients seen by a specialist]</i> _____				
P	Doctor	visits X minutes per visit				___v ___m
P	Medical Assistant	visits X minutes per visit				___v ___m
P	Nurse/Midwife	visits X minutes per visit				___v ___m
P	Nurse Aide	visits X minutes per visit				___v ___m
DELIVERY						
P	Specialist <i>[specify]</i> _____	minutes <i>[specify % of clients seen by a specialist]</i> _____				___m
P	Doctor	Minutes				___m
P	Medical Assistant	Minutes				___m
P	Nurse/Midwife	Minutes				___m
P	Nurse Aide	Minutes				___m
NEWBORN CARE						
P	Specialist <i>[specify]</i> _____	minutes <i>[specify % of clients seen by a specialist]</i> _____				___m
P	Doctor	Minutes				___m
P	Medical Assistant	Minutes				___m
P	Nurse/Midwife	Minutes				___m
P	Nurse Aide	Minutes				___m
POSTPARTUM						
P	Specialist <i>[specify]</i> _____	days X visits X minutes per visit <i>[specify % of clients seen by a specialist]</i> _____				
P	Doctor	days X visits X minutes per visit				___d ___v ___m
P	Medical Assistant	days X visits X minutes per visit				___d ___v ___m
P	Nurse/Midwife	days X visits X minutes per visit				___d ___v ___m
P	Nurse Aide	days X visits X minutes per visit				___d ___v ___m

Cesarean Section

Cesarean Section				
Are caesarean sections done in this facility?				
How many caesarean sections are done in this facility on a given day / week / month [circle]?				
Code	Description	Type	Notes	
How many of these clients receive the following drugs and supplies?				
ADMISSION				
L	Blood group test			
L	Urine protein test			
L	Haemoglobin test			
	Other			
LABOR				
M	Ampicillin	Injection		
M	Oxytocin	Injection		
M	Pethidine			
M	Dextrose			
M	Buscopan			
S	Oxygen			
	Other			
DELIVERY				
L	Blood group test			
L	Haemoglobin test			
L	Urinary protein test			
M	Blood	Unit		
M	Ampicillin	Injection		
M	Gentamicin	Injection		
M	Penicillin			
M	Oxytocin 5 IU/ml	Injection		
M	Ergometrine	Injection		
M	Paracetamol	Tablets		
M	Dextrose 5% in water + solution	Solution		
M	Saline	Solution		
M	Sodium lactate (Ringer's)	Solution		
M	Chlorhexidine (hibitine)			
M	Alcohol with hibitine	Disinfectant		
M	Alcohol with iodine	Disinfectant		
S	Bag, urine collection, 2000ml	urine collection		
S	Giving set			
S	Cannulae			
S	Foley catheter			
S	Gauze			
S	Gloves			
S	Butterfly needle			
S	Surgical blade			
S	Sutures			
H	Hospitalization		[specify average length of stay] _____	
	Other			
ANAESTHESIA				
% of caesarean section with general anaesthesia				
M	Atropine	Injection		
M	Sodium citrate	Injection		
M	Suxamethonium	Injection		
M	Thiopental	Injection		
M	Ketamin	Injection		

M	Ether	Gas		
M	Halothane gas	Gas		
S	Oxygen	Gas		
	Other			
% of caesarean sections with spinal				
M	Dextrose, 7.5%			
M	Lidocaine, 5%	Injection		
M	Distilled water			
	Other			
POSTPARTUM CARE				
M	Oxytocin			
M	Pethidine			
M	Gentamycin			
	Other			
How much time do the following medical personal spend with the client in this treatment?				
ADMISSION				
P	Specialist [<i>specify</i>] _____ [<i>specify % of clients seen</i>] _____	Minutes		
P	Anaesthetist	Minutes		___m
P	Doctor	Minutes		___m
P	Medical Assistant	Minutes		___m
P	Nurse/Midwife	Minutes		___m
P	Nurse Aide	Minutes		___m
LABOR				
P	Specialist [<i>specify</i>] _____ [<i>specify % of clients seen</i>] _____	visits X minutes per visit [<i>specify % of clients seen by a specialist</i>] _____		
P	Doctor	visits X minutes per visit		___v ___m
P	Medical Assistant	visits X minutes per visit		___v ___m
P	Nurse/Midwife	visits X minutes per visit		___v ___m
P	Nurse Aide	visits X minutes per visit		___v ___m
OPERATION				
P	Specialist [<i>specify</i>] _____ [<i>specify % of clients seen</i>] _____	Minutes		
P	Anaesthetist	Minutes		___m
P	Doctor	Minutes		___m
P	Medical Assistant	Minutes		___m
P	Nurse/Midwife	Minutes		___m
P	Nurse Aide	Minutes		___m
POSTPARTUM				
P	Specialist [<i>specify</i>] _____ [<i>specify % of clients seen by a specialist</i>] _____	days X visits X minutes per visit		
P	Doctor	days X visits X minutes per visit		___d ___v ___m
P	Medical Assistant	days X visits X minutes per visit		___d ___v ___m
P	Nurse/Midwife	days X visits X minutes per visit		___d ___v ___m
P	Nurse Aide	days X visits X minutes per visit		___d ___v ___m

POST-ABORTION COMPLICATIONS

Are post-abortion complications treated here?

How many women are treated for abortion complications on a given day / week / month [circle] in this facility?

Code	Description of treatment line	Type	Notes	How many women who present post-abortion complications have a threat of miscarriage?	How many women who present post-abortion complications have abortions in course?	How many women who present post-abortion complications have serious complications such as sepsis, etc.?
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How many of these clients receive the following drugs and supplies for treatment of this condition?

L	Blood group test					
L	Haemoglobin test					
M	Blood	Unit				
M	Aspirin	Tablets				
M	Gentamycin, 20 mg/ml	Injection				
M	Ampicillin	Injection				
M	Ampicillin	Capsule				
M	Penicillin G	Injection				
M	Ergometrine maleate	Injection				
M	Oxytocin 5 IU/ml	Injection				
M	Amoxicilin					
M	Metronidazole (Flagyl)	Tablets				
M	Phenobarbitol	Tablets				
M	Metronidazole, 1g IV					
M	Indomethacin					
M	Diclofenac					
M	Diazepam					
M	Pethidine					
M	Paracetamol					
M	Chlorhexidine (hibitine)					
M	Saline					
M	Dextrose 5% in water + set	Solution				
M	Sodium lactate (Ringers) + set	Solution				
S	Giving set					
S	Cannulae					
S	Oxygen					
S	Gloves					
S	Gauze	Pair				
S	Cotton wool					
S	Plaster	Tape				
S	Clorine solution	Disinfectant				
S	Suture, catgut ob sterile w/needle		Repair			
H	Hospitalization	Days	[specify average length of stay]			
	Other					

How much time do the following medical personal spend with the client in this treatment?

P	Specialist [specify] _____ [specify % of clients seen by a specialist] _____	(days X visits X min./visit)	__d __v __m	__d __v __m	__d __v __m
P	Doctor	(days X visits X min./visit)	__d __v __m	__d __v __m	__d __v __m
P	Medical Assistant	(days X visits X min./visit)	__d __v __m	__d __v __m	__d __v __m
P	Nurse/Midwife	(days X visits X min./visit)	__d __v __m	__d __v __m	__d __v __m
P	Nurse Aide	(days X visits X min./visit)	__d __v __m	__d __v __m	__d __v __m

POSTPARTUM HAEMORRHAGE							
Is postpartum haemorrhage treated here?							
How many women are treated for postpartum haemorrhaging on a given day / week / month [circle] in this facility?							
Code	Description	Type	Notes		How many women with PPH have uterine atony?	How many women with PPH have tears and lacerations?	How many women with PI have retained placenta?
How many of these clients receive the following drugs and supplies for treatment of this condition?							
L	Blood test type						
L	Haemoglobin test						
M	Blood	unit					
M	Ampicillin	injection					
M	Ampicillin	capsules					
M	Gentamycin 40 mg/ml	injection					
M	Metronidazole	injection					
M	Ergometrine maleate	injection					
M	Oxytocin	injection					
M	Paracetamol	tablets					
M	Penicillin	injection					
M	Pethidine	injection					
M	Lidocaine	injection					
M	Chlorhexidine (hibitine)	solution					
M	Saline	solution					
M	Dextrose 5% in water + solution	solution					
M	Sodium lactate (Ringer's)	solution					
S	Oxygen	gas					
S	Blood giving set						
S	Infusion giving set						
S	Catheter, foley						
S	Butterfly needle						
S	Gauze pad, sterile, 12ply 76x76						
S	Gloves						
S	Suture, catgut ob sterile w/needle						
H	Hospitalization	days	[specify average length of stay]				
	Other						
How much time do the following medical personal spend with the client in this treatment?							
P	Specialist [specify] _____	days X visits X minutes per visit	[specify % of clients seen by a specialist] _____		__ d __ v __ m	__ d __ v __ m	__ d __ v __ m
P	Doctor	days X visits X minutes per visit			__ d __ v __ m	__ d __ v __ m	__ d __ v __ m
P	Medical Assistant	days X visits X minutes per visit			__ d __ v __ m	__ d __ v __ m	__ d __ v __ m
P	Nurse/Midwife	days X visits X minutes per visit			__ d __ v __ m	__ d __ v __ m	__ d __ v __ m
P	Nurse Aide	days X visits X minutes per visit			__ d __ v __ m	__ d __ v __ m	__ d __ v __ m

ECLAMPسيا				
Is eclampsia treated in this facility?				
How many women are treated for eclampsia on a given day / week / month [circle] in this facility?				
How many of these clients receive the following drugs and supplies for treatment of this condition?				
L	Blood group test			
L	Haemoglobin test			
L	Urine protein test			
M	Calcium gluconate 10%	Injection		
M	Creatinin			
M	Diazepam 5 mg/ml	Injection		
M	Hydralazine	Injection		
M	Hydralazine	tablets		
M	Magnesium sulfate 10%	injection		
M	Nifedipin	capsules		
M	Propranolol (Inderal)	tablets		
M	Oxytocin	injection		
M	Lasix	injection	diuretic	
M	Dextrose 5% in water + set	solution		
M	Sodium lactate (Ringer's)	solution		
M	Saline	solution		
M	Manitol	solution		
S	Giving set			
S	Cannulae			
S	Foley catheter			
S	Butterfly needle			
S	Oxygen	gas		
H	Hospitalization	days	[specify average length of stay] _____	
	Other			
How much time do the following medical personal spend with the client in this treatment?				
P	Specialist [specify]	Days X visits X minutes per visit		
P	Doctor	Days X visits X minutes per visit	__d __v __m	
P	Medical Assistant	Days X visits X minutes per visit	__d __v __m	
P	Nurse/Midwife	Days X visits X minutes per visit	__d __v __m	
P	Nurse Aide	days X visits X minutes per visit	__d __v __m	

DRUG LIST

Code	Description of treatment line	Note	Number	Times per day	Days per case/episode	Treatment units per case/episode	Unit cost
ANTENATAL CARE							
M	Amoxicillin, tablets 250 mg						
M	Aspirin, tablets 300 mg	Pains					
M	Benzathine benzylpenicillin, inj. 2.4M IU	woman and partner (1 injection each)					
L	Blood group test	blood group and Rh factor					
S	Blood lancet, disposable	take blood sample					
L	Blood slide						
M	Chloroquine, tablets 150mg	malaria treatment					
M	Cotrimoxazole, tablets 400mg+80mg						
S	Cotton wool						
M	Diazepam 5mg/ml, injection 2ml						
M	Erythromycin, capsule 250mg	woman and partner allergic to penicillin					
M	Ferrous sulphate, 60mg tab	iron supplementation					
M	Folic acid, tablet, 5 mg						
S	Gloves, examination, latex, sterile, pair	examination					
L	Hemoglobin test	blood test					
S	JIK, Antiseptic Sol 750ml						
M	Magnesium trisilicate, tab 250mg + 120mg						
M	Mebendazole, tablets 100mg	hookworm treatment					
M	Methyldopa, tablet 250mg						
M	Metronidazole, tablets 200mg						
M	Multivitamin tablet						
M	Nalidixic acid, tablets 500 mg	UTI					
M	Nitrofurantoin, tablets 100mg						
M	Nystatin, pessary 100 000 I.U.	urinary tract infection					
M	Paracetamol, tablets 500mg	Pains					
M	Phenobarbital, tablets 30mg						
L	RPR syphilis test kit, incl syringe+swab	syphilis test					
S	Stationery – prenatal card (client based)	stationery					
S	Stationery – prenatal card (clinic based)	stationery					
S	Syringe, 5ml, dispos+needle+swab	for tetanus vaccination					
M	Tetanus vaccine, injection	tetanus vaccination					
L	Urinary protein test strips	urine test					
M	Vitamin A, tablets 200,000 IU						
M	Water for injection, 5ml	woman and partner (1 injection each)					
POST-ABORTION COMPLICATIONS							
M	Amoxicillin, tablets 250 mg						
M	Ampicillin, injection 500mg	antibiotics IV					
M	Ampicillin, tablets 250mg	antibiotics follow-up					
M	Aspirin, tablets 300 mg						
S	Blood giving set with needle, disposable	for blood transfusion					
L	Blood group test	for blood transfusion					
S	Blood lancet, disposable	take blood sample					

B	Blood, one unit	severe blood loss					
S	Cannula, 22G, disposable						
M	Chloramphenicol, capsules 250mg						
M	Chlorhexidine concentrate, 5% solution, 1l	preparation					
M	Cotrimoxazole, tablets 400mg+80mg						
S	Cotton wool						
M	Crystalline penicillin 1MIU						
M	Dextrose 5% IV 500ml	fluid balance					
M	Diazepam 5mg/ml, injection 2ml	sedation for repair of uterine perforations					
M	Diclofenac, tablets 25 mg						
M	Ergometrine maleate, 0.5mg/ml						
S	Gauze pad, sterile, 12ply 76x76	repair of uterine perforations					
M	Gentamicin 40 mg/ml, injection 2ml	antibiotics IV					
S	Gloves, surgeons, disposable, pair	repair of uterine perforations					
L	Hemoglobin test	blood test					
H	Hospital bed	hospital stay					
M	Indomethacin, tablets 25mg						
M	Infusion giving set with needle, disposable						
S	JIK, Antiseptic Sol 750ml						
M	Lidocaine 1%, injection 50ml	repair of vaginal tears					
M	Metronidazole 5mg/ml, injection 100ml	antibiotics IV					
M	Metronidazole, suppositories 250mg						
M	Metronidazole, tablets 200mg						
M	Oral rehydration salts	Fluid replacement					
S	Oxygen, 100 liters						
M	Oxytocin 10 IU/ml, injection 1ml	to start uterus contractions					
M	Paracetamol, tablets 500mg	pain management					
M	Pethidine 50mg/ml, injection 1ml	analgesic					
M	Phenobarbital, tablets 30mg						
S	Plaster adhesive 75mm X 5m						
M	Salbutamol						
M	Sodium chloride 0.9% + set, 500ml						
M	Sodium lactate (Ringer) + set, 500ml	IV					
S	Suture, catgut chromic 2	repair of uterine perforations					

VAGINAL DELIVERY

S	Alcohol with hibitine						
M	Ampicillin, injection 500mg	antibiotics IV					
M	Aspirin, tablets 300 mg						
M	BCG vaccine, vial	vaccination					
S	Blood giving set with needle, disposable						
L	Blood group test	blood group and Rh factor					
S	Blood lancet, disposable	take blood sample					
S	Cannula, 22G, disposable						
M	Chlorhexidine concentrate, 5% solution, 1l	preparation					
S	Cotton wool						
M	Dextrose 5% IV 500ml	fluid balance					
M	Ergometrine maleate, 0.5mg/ml	oxytocic					
S	Gauze pad, sterile, 12ply 76x76	episiotomy					
S	Gloves, examination, latex, sterile, pair	delivery					
L	Hemoglobin test	blood test					
H	Hospital bed	hospital stay					
M	Infusion giving set with needle, disposable						

S	JIK, Antiseptic Sol 750ml						
M	Lidocaine 1%, injection 50ml	episiotomy					
M	Methylethergometrine 0.2mg/ml, injection 1ml	oxytocic					
S	Nasal catheters						
M	Oxytocin 10 IU/ml, injection 1ml	control bleeding					
M	Oxytocin 10 IU/ml, injection 1ml, induce	to induce labor					
M	Paracetamol, tablets 500mg	pain management					
M	Pethidine 50mg/ml, injection 1ml	analgesic					
M	Polio vaccine, oral (OPV zero)	vaccination					
S	Savlon 5 L						
M	Silver nitrate eye drops, 1%	conjunctivitis baby					
S	Soap, slucing						
S	Stationery – delivery record (clinic based)	delivery					
S	Suture, catgut chromic 1 round needle	episimiotomy					
S	Syringe, 10ml, dispos+needle+swab	lidocaine injection					
S	Syringe, 5ml, dispos+needle+swab	oxytocin injection					
M	Tetracycline, eye ointment 1%	conjunctivitis baby					
S	Umbilical tape	Cord tie					
L	Urinary protein test strips	urine test					
M	Vitamin K						

ECLAMPSIA

L	Blood group test	blood group and Rh factor					
S	Butterfly needle						
M	Calcium lactate, tablets 300mg						
S	Cannula, 22G, disposable						
S	Catheter, foley	measure urine output					
M	Dextrose 5% IV 500ml	for diazepam/hydralazine IV					
M	Diazepam 5mg/ml, injection 2ml	sedation					
M	Furosemide 10mg/ml, injection 2ml	diuretic					
L	Hemoglobin test	hemoglobin test					
H	Hospital bed	hospital stay					
M	Hydralazine, powder for injection 20mg	control of hypertension, IV					
M	Hydralazine, tablets	control of hypertension, IV					
S	Infusion giving set with needle, disposable	infusion					
M	Magnesium sulfate, 10%						
M	Mannitol 20% 500ml IV						
M	Nifedipine, capsules 10mg						
S	Oxygen, 100 liters						
M	Oxytocin 10 IU/ml, injection 1ml	to induce labor					
M	Propranolol, tablets 40mg						
M	Sodium chloride 0.9% + set, 500ml						
M	Sodium lactate (Ringer) + set, 500ml	IV drip					
M	Urinary protein test strips	Creatinin					
L	Urinary protein test strips	urine test					

CAESEAREAN SECTION

S	Alcohol with hibitine						
M	Ampicillin, injection 500mg	antibiotics IV					
M	Atropine 1mg/ml, injection 1ml	general anaesthesia					
S	Bag, urine collection, 2000ml	urine collection					
M	Bisacodyl, 5mg tab						
S	Blood giving set with needle, disposable						
L	Blood group test	for blood transfuion					

B	Blood, one unit	severe blood loss					
S	Butterfly needle						
S	Cannula, 22G, disposable						
S	Catheter, foley	measure urine output					
M	Chlorhexidine concentrate, 5% solution, 1l	antiseptic					
M	Crystalline penicillin 1MIU						
M	Dextrose 5% IV 500ml	fluid balance					
M	Diazepam 5mg/ml, injection 2ml	General Anaesthesia					
M	Ergometrine maleate, 0.5mg/ml						
M	Ether anaesthetic, 500ml	anaesthesia					
S	Gauze pad, sterile, 12ply 76x76	caesarean section					
M	Gentamicin 40 mg/ml, injection 2ml	antibiotics IV					
S	Gloves, surgeons, disposable, pair	caesarean section					
M	Halothane gas, 250ml	general anaesthesia					
L	Hemoglobin test	blood test					
H	Hospital bed/hotel costs	hospital stay					
S	Infusion giving set with needle, disposable						
S	Iodine solution, 500ml						
S	JIK, Antiseptic Sol 750ml						
M	Ketamine, injection 50mg/ml	general anaesthesia					
M	Lidocaine 1%, injection 50ml	peridural anaesthesia					
M	Lidocaine 5%, injection 2ml	peridural anaesthesia					
M	Metronidazole 5mg/ml, injection 100ml						
S	Oxygen, 100 liters	general anaesthesia, (100L for 20 cases)					
M	Oxytocin 10 IU/ml, injection 1ml	stop bleeding					
M	Paracetamol, tablets 500mg	pain management					
M	Pethidine 100mg/2ml, injection	analgesic					
M	Sodium chloride 0.9% + set, 500ml						
M	Sodium citrate						
M	Sodium lactate (Ringer) + set, 500ml	fluid balance					
S	Surgical blades						
S	Suture, catgut chromic 0	caesarean section					
S	Suture, catgut chromic 1	caesarean section					
S	Suture, catgut chromic 1 round needle	caesarean section					
S	Suture, catgut chromic 2	caesarean section					
S	Suture, silk 1	caesarean section					
M	Suxamthionium 50mg/ml, injection 2ml	relaxant					
S	Syringe, 10ml, dispos+needle+swab	for lidocaine					
S	Syringe, 5ml, dispos+needle+swab	for gentamicin					
S	Syringe, 5ml, dispos+needle+swab	for ampicillin					
S	Syringe, 5ml, dispos+needle+swab	for thiopental					
M	Thiopental, injection 1g	general anaesthesia					
M	Trichulium						
L	Urinary protein test strips	urine test					
M	Water for injection, 5ml						
POSTPARTUM HAEMORRHAGE							
M	Ampicillin, injection 500mg	antibiotics IV					
M	Ampicillin, tablets 250mg	follow-up treatment					
S	Blood giving set with needle, disposable	for blood transfusion					
L	Blood group test	blood group and Rh					
B	Blood, one unit	blood transfusion					

S	Butterfly needle						
S	Cannula, 22G, disposable						
S	Catheter, foley	measure urine output					
M	Chlorhexidine concentrate, 5% solution, 1l	sedation					
M	Crystalline penicillin 1MIU						
M	Dextrose 5% IV 500ml						
M	Ergometrine maleate, 0.5mg/ml						
S	Gauze pad, sterile, 12ply 76x76	tears					
M	Gentamicin 40 mg/ml, injection 2ml	antibiotics IV					
S	Gloves, surgeons, disposable, pair	retained placenta					
L	Hemoglobin test	hemoglobin test					
H	Hospital bed	hospital stay					
S	Infusion giving set with needle, disposable	all haemorrhage					
M	Lidocaine 1%, injection 50ml	local anaesthesia					
M	Metronidazole 5mg/ml, injection 100ml	antibiotics IV					
M	Metronidazole, suppositories 250mg	antibiotics IV					
M	Metronidazole, tablets 200mg	antibiotics IV					
S	Oxygen, 100 liters	oxygen 1 hour at 6-8l/minute					
M	Oxytocin 10 IU/ml, injection 1ml	oxytocic					
M	Paracetamol, tablets 500mg	pain management					
M	Pethidine 100mg/2ml, injection	analgesic					
M	Sodium chloride 0.9% + set, 500ml						
M	Sodium lactate (Ringer) + set, solution 500ml	all haemorrhage					
S	Suture, catgut chromic 1 round needle	repair of tears, episiotomy					
S	Syringe, 5ml, dispos+needle+swab						
S	Water for injection, 5ml						

Cost Study of Maternal and Reproductive Health Services Facility Form #2

Records Review Form

PURPOSE AND RATIONALE: The purpose of this form is to collect data on the utilization in each facility by type of service and to determine personnel expenditures, including salary and benefits, for each employee who works in the facility. Forms are also included to obtain information on which to calculate the facility's indirect costs. Information on user fees charged in each facility will also be recorded in this set of forms.

DATA SOURCES: Interview with in-charge as well as review of district and facility records.

SUGGESTED SAMPLE SIZE: Four in-charges (one in each facility).

SPECIFIC INSTRUCTIONS FOR INTERVIEWERS:

Facility Form #2a. Facility Utilization (Most Recent Year Available)

Name of Facility: _____
 Type of Facility: MOH NGO or Mission Private
 Level of Facility: Hospital Health Center

Date: [][][]
 Interviewer Number: [][]
 Facility Number: [][]

Fill in number of cases per month both for maternal health care and for all other services delivered in facility.
 (Use intervention list as a guide, but add all additional services offered.)

No. of Hospital Beds: _____ No. of Maternity Beds: _____
 No. of Patients per Doctor: _____
 Average Length of Stay: _____

ACTIVITY	NO. OF CASES PER MONTH IN _____ (ENTER YEAR)												TOTAL NO. OF CASES PER YEAR	Aver Lngh of Stay (in- pat)
	J	F	M	A	M	J	J	A	S	O	N	D		
Maternal Health Activity														
Antenatal Care														
Vaginal Deliveries														
Cesarean Deliveries														
Eclampsia														
Postpartum Hemorrhage														
Post-Abortion Complication														
Other Maternal Health Care														
General Health														
Pediatric Care														
Child Immunization														
Medical Services														
Surgical Services														
General Out-patient Services														
Other (specify)														

Facility Form #2b. User Fees

Name of Facility: _____
 Type of Facility: MOH NGO or Mission Private
 Level of Facility: Hospital Health Center

Date:
 Interviewer Number:
 Facility Number:

Fill in all user fees charged at the facility. Copy lists of fees if available and add another sheet to record fees if required.

SERVICE	USER FEE CHARGED (IN LOCAL CURRENCY)		
	First Visit	Follow-up Visit	Private
Registration			
Antenatal Care			
Vaginal Delivery: Normal Twin or Triplets Episiotomy			
Cesarean Delivery			
Vacuum Extraction			
IV			
Consultation			
Admission			
In-patient Day			
Laboratory Services (standard tests)			
Laboratory Services (special investigations) (specify)			
X-Rays			
Ultrasound			
Other (specify)			

Comments:

Facility Form #2c. Salary and Benefits Form

Name of Facility: _____
 Type of Facility: MOH NGO or Mission Private
 Level of Facility: Hospital Health Center

Date:
 Interviewer Number:
 Facility Number:

List all personnel that directly and indirectly provide maternal health services.

PERSONNEL CATEGORY	NUMBER IN FACILITY	SALARY SCALE
Directly provide Maternal Health Services		
Medical Assistants		
Medical Officers (Specialists)		
Clinical Officers		
State Registered Nurse/Midwives		
Midwives		
Enrolled Nurse/Midwives		
Patient Attendants		
Maids		
Other (specify)		
Indirectly Provide Maternal Services		
Anesthetists		
Anesthetist Assistants		
Lab Technicians		
Hospital Administrators		
Accountant		
Clerks		
Copy Typists		
Health Surveillance Assistants		
Health Educators		
Health Inspectors		
Health Visitors		
Pharmacists		
Others (specify - be sure to include all managerial and support personnel)		

Facility Form #2c. Salary and Benefits Form (cont d)

List a monetary value for the benefit whenever possible. For example, for housing, try to estimate comparable rent. or willingness to pay for housing unit..

Empl #	Empl Name	Empl Title	Days Work per Week	Part- or Full time	Housing	Financial Incentives (From User Fee Pool)	Transport	Medical Benefit	Educ Benefit	Pension Scheme	Paid Leave	Leave Grant	Other (Specify)	
													Type	Value

How many days of sick leave does each staff person have per year? _____

How many holidays per year (e.g. New Year's Day) does each staff person have? _____

Facility Form #2d. Indirect and Capital Costs

Name of Facility: _____
 Type of Facility: MOH NGO or Mission Private
 Level of Facility: Hospital Health Center

Date: [][]
 Interviewer Number: [][
 Facility Number: [][

Maintenance and Utility Costs

CATEGORY	ANNUAL COST		
	Salaries	Supplies	Equipment
Rent (if applicable)			
Building Maintenance Cost			
Utilities Cost			
Electricity			
Gas			
Fuel wood			
Water			
Telephone			
Emergency Vehicle Maintenance			
Motor Fuels and Oils			
General Maintenance (e.g. electrical equipment, grounds, etc.)			
Cleaning			
Laundry Service			
Food			
Other (specify)			

Were any capital investments (e.g. renovations) made in this health facility within the last five years?

What was the investment? _____

When did the investment take place? _____

How much did it cost? _____

Who financed the investment? _____

Facility Form #2e. Interview Regarding Supervision

[Ask the District supervisor about supervision in their district. Then, interview the supervisor using the table below. Also be sure to include the supervisor's salary and benefits information on Form 2c. Do not interview the supervisors in the facility since they will be asked about time spent on supervision in Form 5.]

Name of Supervisor: _____
 Title of Supervisor: _____

Supervisor No. [__]
 Date: [__][__][__]
 Interviewer Number: [__][__]

ACTIVITY	NO. OF DAYS SPENT ON ACTIVITY IN LAST THREE MONTHS			
	Facility 1	Facility 2	Facility 3	Facility 4
Number of days worked in the office				
Number of days visited facility				
Number of days attended outreach clinics				
Number of days attended other sites (specify sites)				
Number of days other supervisory visits made				
Number of days attended meetings				
Number of days received training				
Number of days gave training				
Number of days spent on leave				
Number of sick days				
Number of day offs				
Other (specify)				
Total number of days accounted for in the month				

Cost Study of Maternal and Reproductive Health Services Facility Form #3

Facility Personnel Observation Form

PURPOSE AND RATIONALE: Direct observation of key health personnel will be undertaken so that their time can be allocated to different types of activities and services in a manner that directly reflects current practices.

DATA SOURCES: Direct observation of key health personnel

SUGGESTED SAMPLE SIZE: Four eight-hour shifts at health centers

Four eight-hour shifts and two four-hour shifts (5 p.m.–9p.m.) at hospitals

SPECIFIC INSTRUCTIONS FOR INTERVIEWERS: Observers should sit in a central location so that they have easy access to observation of all personnel. They should only record that a worker is doing an activity if it is observed. If the worker cannot be located, 'Provider no present' should be checked.

Facility Personnel Observation Form Form #3a

Facility Number: _____

Observer No.: []

Provider Names, Designation, and Time of Arrival: _____

Date: [][][]

Hour of Observation: [][]

01. Time the observer arrived at the health facility: []

Personnel No.																						
	Activity	Time	03	06	09	12	15	18	21	24	27	30	33	36	39	42	45	48	51	54	57	00
A. General/Administrative																						
02. Prep/Close Service																						
03. General Recordkeeping																						
04. Preparing for Next Client																						
05. Greeting Clients																						
06. Work-related Discussion																						
07. Official Meeting																						
08. Unoccupied Time																						
09. Chatting /Talking																						
10. Eating/ Snacking																						
11. Tea or Lunch Break																						
12. Time with Family/Friend																						
13. Personal Leave																						
14. Bathroom/ Rest																						
15. Provider Not Present																						
B. Antenatal Care																						
16. Prepare for next client																						
17. Health Education																						
18. Recording Client History																						

Personnel No.																						
	Activity	Time	03	06	09	12	15	18	21	24	27	30	33	36	39	42	45	48	51	54	57	00
19. Measuring Weight/Height																						
20. Taking Blood Pressure																						
21. Physical Examination																						
22. Lab Work																						

Form #3b Services Provided During Observation Period

[Fill out at the end of the day using facility records]

Facility Name: _____
Interviewer #: _____

Date: [][][]

Number	Service	Number (Include if ongoing)	Comments on Outcomes (if applicable)
301	Antenatal Care		
302	Vaginal Deliveries (includes care of newborn)		
303	Cesarean Deliveries (includes care of newborn)		
304	Eclampsia		
305	Postpartum Hemorrhage		
306	Abortion Complications		
307	Child Care		
308	Other Adult Services		

**Cost Study of Maternal and
Reproductive Health Services
Facility Form #4**

Maternal Health Intervention Observation Form

PURPOSE: To obtain information on the protocols followed in facilities

RATIONALE: To evaluate quality of care of facility service delivery

DATA SOURCES: Observation

SUGGESTED SAMPLE SIZE: 1 observation of each intervention per facility

SPECIFIC INSTRUCTIONS FOR INTERVIEWERS: At beginning of antenatal care service, give card to 10 clients with time on it. This form will be used to time length of antenatal care service at exit interview.

Facility Form #4 Maternal Health Intervention Observation Form

Facility No: [][]

Date: [][] [][]

Interviewer/Observer No. []

Providers: Doctor _____, Clinical Officer _____, Registered Nurse-Midwife _____, Enrolled Nurse-Midwife, Patient Attendant _____

Antenatal Care Service

No.	Activity	<i>Check the box if the activity takes place:</i>	
401	Health Education given	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
402	Recording Client History	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
403	Weighing Client	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
404	Taking Blood Pressure	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
405	Lab Work: Urinalysis	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
	VDRL	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
	Hemoglobin	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
406	Giving Tetanus Toxoid Injection	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
407	Giving Physical Examination	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
408	Ferrous Sulfate (iron tablets) given	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
409	Folic Acid Tablets Given	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
410	Counseling	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
411	Other (specify)	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No

412. How much time was spent on recordkeeping (in minutes)? _____

413. Were gloves used for pelvic assessment?

Comments:

Facility Form #4 Maternal Health Intervention Observation Form

Facility No.: [][]
Interviewer/Observer No. []

Date: [][] [][] [][]

Vaginal Delivery

Providers: Specialist _____, Doctor _____, Clinical Officer _____, Registered Nurse-Midwife _____, Enrolled Nurse-Midwife, Patient Attendant _____

No.	Activity	<i>Check the box if the activity takes place:</i>		Room Activity Takes Place
Labor				
414	History Taken	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
415	Timing of Contractions	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
416	Physical Exam	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
417	Lab Work	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
418	Use of Labor Graph	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
419	Provision of IV	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
420	Labor Support	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
Delivery				
421	Infection Prevention Procedures (specify)	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
422	Control of Bleeding	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
423	Episiotomy and Repair	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
424	Vitamin A given	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
Care of Newborn				
425.	Infection Prevention Procedures: for Cord	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
	for Eyes	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
426.	Resuscitation	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	

427.	Weighing of Baby	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
428.	APGAR score recorded	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
429.	Infant wrapped in warm towel	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
430.	Baby resuscitator used	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
431.	Vitamin K given	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
432.	Breastfeeding initiated	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
Immediate Post-delivery			
433.	Blood Pressure Taken	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
434.	Uterine Contraction Checked	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
435.	Bladder Control	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
436.	Check for bleeding/tears	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
437.	Other (specify)	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No

Comments:

Facility Form #4 Maternal Health Intervention Observation Form

Facility No.: [][]
Interviewer/Observer No. []

Date: [][][]

Cesarean Delivery

Providers: Specialist _____, Doctor _____, Clinical Officer _____, Registered Nurse-Midwife _____, Enrolled Nurse-Midwife, Patient Attendant _____

Number	Activity	<i>Check the box if the activity takes place:</i>		Room Activity Took Place
438	Anesthesia Administered	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
439	Abdomen Scrubbed with Antiseptic	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
440	Patient draped	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
441	Provision of IV	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
442	Availability of Oxygen	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
443	Antibiotics Administered	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
444	Analgesics Administered	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
445	Pitocin or Oxytocin Given	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
446	Availability of Blood	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
447	Appropriate Equipment used: Knives Forceps Retractor	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
448	Care for Newborn Adequate	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
449	Other (specify)	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	

450. Time Incision Made: []

451. Time Baby Was Delivered: []

452. Was a sterile field maintained? 1 Yes 2 No

Comments:

Facility Form #4 Maternal Health Intervention Observation Form

Facility No.: [][]
Interviewer/Observer No. []

Date: [][][]

Postpartum/Antenatal Hemorrhage

Providers: Specialist _____, Doctor _____, Clinical Officer _____, Registered Nurse-Midwife _____, Enrolled Nurse-Midwife, Patient Attendant _____

Number	Activity	<i>Check the box if the activity takes place:</i>	
453	History Taken	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
454	Physical Exam	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
455	Provision of IV	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
456	Lab Work	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
457	Resuscitation given	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
458	Blood Transfusion available	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
459	Control of Bleeding	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
460	Oxygen available	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
461	Other (specify)	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No

462. Was the equipment sterilized? 1 Yes 2 No

463. Was a sterile field maintained? 1 Yes 2 No

Comments:

Facility Form #4 Maternal Health Intervention Observation Form

Facility No.: [][]
Interviewer/Observer No. []

Date: [][][]

Eclampsia

Providers: Specialist _____, Doctor _____, Clinical Officer _____, Registered Nurse-Midwife _____, Enrolled Nurse-Midwife, Patient Attendant _____

Number	Activity	<i>Check the box if the activity takes place</i>	
464	History Taken	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
465	Physical Exam	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
466	Provision of IV	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
467	Lab Work	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
468	Resuscitation given Airway cleaned	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
469	Diazepam Given	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
470	Hydrolazine given	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
471	Blood Transfusion available	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
472	Catheter Inserted	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
473	Oxygen available	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
474	Suction machine available	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
475	Other (specify)	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No

476. Was the equipment sterilized? 1 Yes 2 No

477. Was a sterile field maintained? 1 Yes 2 No

Comments:

Facility Form #4 Maternal Health Intervention Observation Form

Facility No.: [][]
Interviewer/Observer No. []

Date: [][][]

Abortion Complication

Type of Procedure: _____

Providers: Specialist _____, Doctor _____, Clinical Officer _____, Registered Nurse-Midwife _____, Enrolled Nurse-Midwife, Patient Attendant _____

Number	Activity	<i>Check the box if the activity takes place:</i>		Room Activity Took Place
478	History Taken	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
479	Lab Work	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
480	Physical Examination	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
481	Analgesics Administered	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
482	Anesthesia Administered	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
483	Antibiotic Administered	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
484	Provision of IV	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
485	Procedure	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
486	Family Planning Counseling/Provision	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	
487	Other (specify)	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No	

488. Was the equipment sterilized? 1 Yes 2 No

489. Was a sterile field maintained? 1 Yes 2 No

Comments:

Cost Study of Maternal and Reproductive Health Services Facility Form #5

Facility-level Provider Form

PURPOSE: Providers in each facility will be interviewed in order to provide a cross check with the direct observation of providers by having them recall the time they spend on specific maternal health interventions, as well as the time they spend performing administrative tasks, in training, attending meetings, and providing home visits or outreach services. In addition, it asks for estimates of official leave taken over the last month.

RATIONALE: Salaries and benefits often represent the largest cost component in providing health care services. It is estimated that in primary health care programs, costs associated with labor typically represent from one-third to three-quarters of the total program costs. Because these costs are such a large proportion of the total costs, it is important to estimate and allocate them as accurately as possible. The most accurate method is to use a combination of approaches, such a time-and-motion study with direct observation of how providers spend their time, in addition to relying on provider recall estimates to fill in the gaps.

DATA SOURCES: Interview with facility-based health providers in four facilities: public hospital, NGO hospital, public health center, and NGO health center using the following provider questionnaire.

SUGGESTED SAMPLE SIZE: All health providers involved in delivering maternal and reproductive health services should be interviewed, including doctors, medical assistants, nurses, nurse-midwives, midwives, and nurse aides.

SPECIFIC INSTRUCTIONS FOR INTERVIEWERS

Facility Form 5

Facility-level Provider Form

Facility Name: _____

Date: _____

Type of facility: _____

Interviewer Number: _____

Level of Facility: _____

Name of provider: _____

Type of Provider: _____

TIME ALLOCATION PER SERVICE

NUMBER	QUESTION
--------	----------

501	Do you currently provide the following services?
-----	--

- A. Antenatal care
- B. Vaginal delivery & newborn care
- C. Cesarean section
- D. Management of eclampsia
- E. Management of postpartum hemorrhage
- F. Management of post-abortion complications

502	Percentage of total time spent providing maternal health services in the last month?
-----	--

503	In an average 40-hour week, how many hours do you spend providing the following services?
-----	---

Number of Hours

- | | | |
|----|---|--|
| A. | Antenatal care | |
| B. | Vaginal delivery | |
| C. | Cesarean section | |
| D. | Management of eclampsia | |
| E. | Management of postpartum hemorrhage | |
| F. | Management of post-abortion complications | |

GENERAL TIME ALLOCATION

504	How many days did you work in this facility last month?
-----	---

505	How many hours did you spend in outreach last month?
-----	--

506	How many hours did you attend meetings last month?
-----	--

- 507 Days spent on supervision last month
- 508 How many days of training did you receive last year?
- 509 How many days of training did you provide last year?
- 510 How many hours did you work outside of normal hours last month?
- 511 How many of those overtime/on-call hours did you spend providing maternal health services last month?
- 512 How many total days did you work last month?
- 513 How many days were you on sick leave last year?
- 514 How many days did you take as vacation leave last year?
- 515 [If female provider] How many days were you on maternity leave last year?

PROVIDER PERCEPTION OF QUALITY

- 516 In general, how would you rate the quality of care provided in this facility?
- 517 How do you think the service here could be improved?

Cost Study of Maternal and Reproductive Health Services Facility Form #6

Facility-level Quality Checklist

PURPOSE: The information collected with this form will be used to obtain a quick measure of the quality of maternal and reproductive health care in each types of facility and among community providers. It looks at six areas of quality: facility space, general cleanliness, availability of key supplies, availability of key medicines, existence and use of systems, and availability and age of key equipment.

Rationale: All cost studies should attempt to control for differences in quality of care. Program costs may differ significantly because of differences in quality. Quality of care is also mentioned by many consumers as a barrier to their seeking health care services in certain facilities. Understanding how consumers perceive quality of care and how it can be improved may also help facilities to improve utilization and improve consumer satisfaction.

DATA SOURCES: Direct observation of facilities using the following checklist.

SUGGESTED SAMPLE SIZE: A checklist should be completed for each facility where services are to be costed.

SPECIFIC INSTRUCTIONS FOR INTERVIEWERS:

Facility Form # 6

Facility-level Quality Checklist

Name of Facility: _____

Type of Facility: _____

Level of Facility: _____

Date: _____

Interviewer Number: _____

Facility Number: _____

FACILITY SPACE			
601	Is there a designated waiting area in the facility?	YES	NO
602	Are there waiting benches?	YES	NO
603	Are there any health education/IEC posters on the walls?	YES	NO
604	Is there a separate delivery room?	YES	NO
605	Are there separate laboratory facilities?	YES	NO
606	Are there curtains or partitions between patient beds or consultation rooms?	YES	NO
607	Is the facility overcrowded?	YES	NO
608	Are there enough beds?	YES	NO
609	Do patient share beds?	YES	NO

GENERAL CLEANLINESS "Clean" is used to indicate that the floors have been recently swept, rooms are free of trash/debris, and things are generally put away or stored as appropriate, etc.			
610	Is the delivery room clean?	YES	NO
611	Are there sheets and blankets on the beds?	YES	NO
612	Are instruments/equipment autoclaved before each use?	YES	NO
613	If no, are instruments/equipment sterilized before each use?	YES	NO
614	Is an incinerator available to dispose of waste?	YES	NO
615	Is a placenta pit used?	YES	NO
AVAILABILITY OF KEY SUPPLIES			
616	Are the following key supplies available today?		
	A. emergency lighting	YES	NO
	B. gloves	YES	NO
	C. mackintosh	YES	NO

	D. sterile gauze pads	YES	NO
	E. suture material	YES	NO
	F. umbilical tape	YES	NO
	G. bulb syringe (for suction)	YES	NO
	H. needles and syringes	YES	NO
	I. IV	YES	NO
	J. blanket (to wrap baby in)	YES	NO
	K. basic family planning supplies or contraceptives	YES	NO
617	Do you have a source of water within the facility compound?	YES	NO
618	Is that water potable/drinkable?	YES	NO
AVAILABILITY OF KEY MEDICINES			
	A. Tetanus toxoid	YES	NO
	B. pitocin/oxytocin	YES	NO
	C. dextrose	YES	NO
	D. ergometrine	YES	NO
	E. lidocaine	YES	NO
	F. diazepam	YES	NO
	G. hydralazine	YES	NO
	H. general antibiotics	YES	NO
	I. paracetamol	YES	NO
	J. atropine	YES	NO
	k. calcium gluconate	YES	NO
	L. epinephrine	YES	NO
EXISTENCE AND USE OF SYSTEMS (E.G., RECORDS, BILLING)			
619	Are user fees visibly and consistently posted?		
620	Are receipts given to clients upon payment?		
621	Where and how are records kept, stored, organized? [Describe briefly below]		

EQUIPMENT		Available and in Working Order		Age (years)	# of Units available
ANTENATAL CARE					
622	Tape measure	Yes	No		
623	Adult weighing scale	Yes	No		
624	Height measuring device	Yes	No		
625	Gestational wheel	Yes	No		
626	Fetoscope	Yes	No		
627	Blood pressure cuff	Yes	No		
628	Uristicks	Yes	No		
DELIVERY ROOM					
629	Baby weighing scale	Yes	No		
630	Dissecting forceps (toothed 200 mm)	Yes	No		
631	Kidney dish (stainless steel)	Yes	No		
632	Sponge bowls (stainless steel)	Yes	No		
633	Surgeons hand brush with white nylon bristles	Yes	No		
634	Towels	Yes	No		
635	Towel clamps	Yes	No		
636	Cord-cutting or blunt-ended scissors	Yes	No		
637	Resuscitation Kits	Yes	No		
638	mucous extractor	Yes	No		
639	Delivery bed	Yes	No		
640	Manual hand-operated vacuum extractor	Yes	No		
641	Cord clamp (placenta forceps)	Yes	No		
642	Tissue forceps	Yes	No		
643	Monitor	Yes	No		
644	Fetoscope	Yes	No		
PERINEAL REPAIR					
645	Sponge forceps (200 mm)	Yes	No		

646	Artery forceps (large 160 mm)	Yes	No		
647	Artery forceps (small 140 mm)	Yes	No		
648	Needle holder (180 mm)	Yes	No		
649	Stitch scissors	Yes	No		
650	Dissecting forceps (toothed 200 mm)	Yes	No		
651	Vaginal speculum (Sims)	Yes	No		
652	Vaginal speculum (Cusco)	Yes	No		
MVA EQUIPMENT PACKAGE					
653	Vaginal speculum	Yes	No		
654	Sponge ring forceps or uterine forceps	Yes	No		
655	Single tooth tenaculum forceps	Yes	No		
656	Long dressing forceps	Yes	No		
657	Vacuum syringes (single or double valve)	Yes	No		
658	Flexible cannulae (4-12 mm)	Yes	No		
659	Portable light source (lamp)	Yes	No		
OPERATION ROOM EQUIPMENT					
660	Instrument tray with cover (stainless steel)	Yes	No		
661	Sponge forceps (200 mm)	Yes	No		
662	Straight artery forceps (16 cm)	Yes	No		
663	Uterine hemostasis forceps (215 mm) (hemostats)	Yes	No		
664	"Hysterectomy forceps (straight, 22 mm)"	Yes	No		
665	Mosquito forceps (12.5 cm)	Yes	No		
666	Tissue forceps (20 cm)				
667	Uterine tenaculum forceps (280 mm)	Yes	No		
668	Needle holder (straight, 180 mm)	Yes	No		
669	Surgical knife handle #4	Yes	No		

670	Surgical knife handle #5	Yes	No		
671	" Abdominal retractor, size 4"	Yes	No		
672	Abdominal retractors (double-ended)	Yes	No		
673	" Curved operating scissors (blunt pointed, 17 cm)"	Yes	No		
674	" Straight operating scissors (blunt pointed, 17 cm)"	Yes	No		
675	"Scissors (straight, 145 mm)"	Yes	No		
676	Suction tube	Yes	No		
677	Sucker	Yes	No		
678	Dressing forceps (155 mm)	Yes	No		
679	Dressing forceps (25 cm)	Yes	No		
680	Anesthetic face mask	Yes	No		
681	Oropharyngeal airways (82 mm)	Yes	No		
682	Laryngoscopes	Yes	No		
683	"Endotracheal tubes (with cuffs, 7.5 mm)"	Yes	No		
684	Intubating forceps or ovum forceps	Yes	No		
685	Anesthesia apparatus (draw-over system)	Yes	No		
686	Oxygen tank with flowmeter	Yes	No		
687	Fetoscope	Yes	No		
688	Monitor	Yes	No		
689	Instrument sterilizer	Yes	No		
LAB EQUIPMENT					
690	Ultrasound machine	Yes	No		
691	Other (specify)				

Cost Study of Maternal and Reproductive Health Services Facility Form #7

In-patient and Out-patient Exit Questionnaire

PURPOSE: Facility-based patient exit interviews will be conducted in four facilities (public hospital, NGO hospital, public health center, and NGO health center) using the following questionnaire developed and pre-tested in coordination with PHR. These exit interviews will be conducted to determine referral information, decision to seek care at the facility and purpose of visit, travel time, the total cost of the visit to the patient (including formal as well as informal fees, supplies, drugs, and transport costs), patient perceptions of the quality of care, and patient willingness to pay for maternal health services.

Rationale: This information will address demand-side cost issues by estimating the real cost to the client in procuring specific maternal health services. Although user fees may be minimal in a given setting, examination of informal charges, costs associated with travel, and additional costs of drugs or supplies that are not provided as part of service delivery provides a more accurate picture of the total costs of the services to the client. Understanding the barriers that keep families from seeking maternal care services, such as hidden additional costs, is a key element in the design of policies aimed at increasing service utilization. With this information, policymakers and program managers can design and develop maternal and reproductive health care services that better meet the needs of consumers, respond to consumer concerns about the quality of care, and are more sustainability through the use of improved cost sharing mechanisms.

DATA SOURCES: Interviews with in-patients and out-patients in four facilities: public hospital, NGO hospital, public health center, and NGO health center.

SUGGESTED SAMPLE SIZE: In the hospital, forty out-patients should be interviewed and in the health center, twenty out-patients should be interviewed.

SPECIFIC INSTRUCTIONS FOR INTERVIEWERS:

- Interviews should be conducted in a private setting, in the absence of the provider.
- Interviewers should provide each mother entering the facility with a card with the time she arrived. This will be recorded at the top of the form before the interview starts, along with the time the interview began.

Facility Form #7

In-patient and Out-patient Exit Questionnaire

Name of Facility:
Type of Facility:
Level of Facility:
Patient Number:
Date:
Interviewer Number:

NUMBER QUESTION

- 701 Time patient arrived in facility (ask patient for time card)
702 Time interview began
703 How old were you at your last birthday (in years)?

704 [If pregnant] Is this your first pregnancy?
705 Did you seek antenatal care during your last pregnancy?
706 Where did you seek antenatal care?
706 For your last pregnancy, where did you deliver?
707 What brought you to this facility?

REFERRAL

- 708 Have you sought care elsewhere before coming here?
709 Where did you seek care before coming here?

711 How many times have you visited a health facility for the service you
are seeking today?
712 Did you visit the same facility each time?
713 Why did you decide to seek care at this particular facility?
714 Did you have information on how much your visit was likely to cost you
before you arrived at the facility?
715 From where did you get information on how much your visit was likely to
cost you?
716 Did this information influence your decision about where to seek care?

TRAVEL TIME AND COSTS

- 718 How did you travel to this facility?
- 719 Using this mode of transport, how long (in minutes) did it take you to travel one-way to this facility?
- 720 How much did you pay for transportation to get here (one way)?
- 721 Did someone accompany you?
- 722 If yes, how many people accompanied you?
- 723 What is their relationship to you?
- 723 How long did you have to wait before you obtained care or were admitted?

USER FEES

- 724 How much did you pay in fees in total for the service you sought?
- 725 Did you have to pay any of the following fees? If yes, how much did you pay?
- A. Registration
 - B. Fee for an antenatal card
 - C. Laboratory fees
 - D. Other investigations
 - E. Other
- 726 Were you admitted?
- 727 How many days did you spend in this facility?
- 728 Did you have to pay any of the inpatient fees?
- A. Delivery fee
 - B. Surgery fee
 - C. Admission stay (per night)
 - D. Other (specify)
- 729 Were you exempted from paying any user fees?

- 730 Why were you exempted from paying?
 A. Antenatal care is exempted
 B. Relative or spouse of staff member
 C. unable to pay
 D. DK

731 Are you currently covered by a medical scheme?

732 What percentage of maternal health care services is covered by this scheme?

OTHER COSTS

733 Did you obtain all the medicines that you needed or were you told to buy them outside of the facility?

- Obtained all
- Obtained some
- Obtained none and told to buy elsewhere
- Not applicable

734 Did you pay for the medicines in addition to the user fees you paid or was the cost of the drugs included?

735 Apart from expenses for travel and health care, did you spend money to buy food or drinks in connection with your visit? If so, approximately how much did you spend?

736 Were you asked to buy any of the following drugs or supplies for your care this visit? If yes, how much did you pay for the item?

	If yes, enter number and cost	
	Number	Amount per item
A. record book		
B. needle and syringe		
C. drugs (specify)		
D. cotton wool		
E. mackintosh		
F. gloves		
G. bed linen		
H. other (specify)		

737 Total spent on drugs and supplies

QUALITY AND WILLINGNESS TO PAY			
I would like to ask you about the quality of services you received during your visit today. Please rate each of the characteristics of your visit as good, satisfactory or poor. (Note: categories can be changed if other terminology better)			
738	Privacy/Confidentiality	Very good Good Satisfactory Poor	
739	Attitude of Doctors	Very good Good Satisfactory Poor	
740	Attitude of Nurses	Very good Good Satisfactory Poor	
741	Attitude of Other Health Staff	Very good Good Satisfactory Poor	
742	Overall Impression	Very good Good Satisfactory Poor	
743	Based on this impression, suppose the price of the service you sought today increased by 50%* in this facility, would you still use this facility?	1 Yes	2 No
744	Suppose the price of the service you sought today increased by 100%* in this facility, would you still use this facility?	1 Yes	2 No
745	How do you think the service you received at this health facility could be improved?	Less waiting time More drugs available Better health worker attitude More or better advice More staff Better staff Cleaner facility Better waiting facilities (e.g. benches) No improvements needed DK Other (specify)	
746	Would you be willing to pay more in order to have the improvements you mentioned above?	1 Yes	2 No

Cost Study of Maternal and Reproductive Health Services Community Form #8

Community Provider (Midwife/TBA) Questionnaire

PURPOSE: The purpose of this questionnaire is to determine the costs of providing and using community maternal health services using provider recall. Due to time constraints and lower utilization rates among community providers, observation will not be used for community providers. The questionnaire seeks to determine approximate utilization and referral rates, user fees charged for specific services, additional costs paid by clients, and costs to the provider for providing the services.

RATIONALE: Because many births take place outside of health facilities (65%), it is important to examine the costs of providing and using community-based maternal health services.

DATA SOURCES: Interviews with private midwives and TBAs from the district where the study took place.

SUGGESTED SAMPLE SIZE: The interviewer should plan to interview twenty private midwives and twenty TBAs over the five-week period of data collection.

SPECIFIC INSTRUCTIONS FOR INTERVIEWERS:

**Cost Study of Maternal and
Reproductive Health Services in Uganda
Community Form 8**

Community Provider (Midwife/TBA) Questionnaire

Type of community provider:
Community Provider Number:
Name of Provider:
Date of Interview:

UTILIZATION

- 801 How many total patients do you usually see in one month?
- 802 Do you currently provide the following services? If yes, how many patients per month?
- A. Antenatal care
 - B. Vaginal delivery
 - C. Other maternal health services (specify)
 - D. Other health services (e.g., malaria) (specify)
- 803 How much time do you usually spend providing each type of service (in hours)?
- Time spent with client(hours) Related time (hours)
- A. Antenatal care
 - B. Vaginal Delivery
 - C. Other maternal health services (specify)

USER FEES FOR PATIENTS

- 804 Do you charge fees for your services?
- 805 How much do you usually charge for each of the services below
- | | Amount in Local currency | Amount in Kind |
|--|--------------------------|----------------|
| A. Antenatal care | | |
| B. Vaginal delivery | | |
| C. Other maternal health services (specify) | | |
| D. Other health services (e.g., malaria) (specify) | | |

COST OF SERVICES

806. Who supplies the following medicines and supplies?

Medicine or Supply	Source (e.g., provider, client, donor (specify))	Cost in local currency	Useful life
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- A. gloves
- B. needle and syringe
- C. drugs (specify):
- D. cotton wool
- E. mackintosh
- F. bed linens
- G. food
- H. kidney dish
- I. fetascope
- J. bleach
- K. razor blade
- L. scissors
- M. delivery bed
- N. other (specify):

807 Do you pay any of the following costs? If yes, how much do you pay per month? check box below for yes of No

- A. staff or assistants
- B. rent
- C. License
- D. Others

(For midwives only, use Form 1A on Antenatal Care and Vaginal Delivery to ask about their standard treatment protocols.

Cost Study of Maternal and Reproductive Health Services Facility Form #9

Records Review Form

PURPOSE: This form will be used to obtain a quick measure of the quality of maternal and reproductive health care among community providers. It collects information on six areas of quality: facility space, general cleanliness, availability of key supplies, availability of key medicines, existence and use of systems, and availability of key equipment.

DATA SOURCES: Direct observation of private midwife and TBA facilities using the following checklist.

SUGGESTED SAMPLE SIZE: A checklist should be completed for each community provider (midwife/TBA) interviewed.

SPECIFIC INSTRUCTIONS FOR INTERVIEWERS:

Community Form # 9

Community Provider Quality Checklist

Type of community provider:

Community provider Number:

Date:

Interviewer Number:

FACILITY SPACE

901 How many rooms do you use to see patients?

902 How many beds are available?

GENERAL CLEANLINESS

903 Is the facility clean?

904 Are there sheets and blankets on the beds?

905 Are instruments/equipment autoclaved before each use?

906 Are instruments/equipment sterilized before each use?

AVAILABILITY OF KEY EQUIPMENT AND SUPPLIES

907 Are these key supplies available today?

A. gloves

B. mackintosh

C. sterile gauze pads

D. suture material

E. umbilical tape

F. bulb syringe (for suction)

G. needles and syringes

H. IV

I. blanket (to wrap baby in)

J. basic family planning supplies or contraceptives

908. Is there a source of water within a 15 minute walk of your facility?

909 Is that water potable/drinkable?

AVAILABILITY OF KEY MEDICINES

910 Are these key medicines available?

- A. tetanus toxoid
- B. pitocin/oxytocin
- C. dextrose
- D. ergometrine
- E. lidocaine
- F. diazepam
- G. magnesium sulfate
- H. general antibiotics (e.g., ampicillin)
- I. acetaminophen

EXISTENCE AND USE OF SYSTEMS

910 Are user fees visibly and consistently posted?

911 Are receipts given to clients upon payment?

912 Do you have an appointment system to help with patient flow?

913 Where and how are records kept, stored, organized?

Is the following list of standard equipment available and in working order today? If available, enter age and number of units.

EQUIPMENT	AVAILABLE AND IN WORKING ORDER?	AGE (YEARS)	SOURCE	
ANTENATAL CARE				
915. Tape measure				
916. Adult weighing scale				
917. Height measuring device				
918. Gestational wheel				
919. Fetoscope				
920. Blood pressure cuff				
921. Uristicks				

DELIVERY ROOM				
922. Baby weighing scale				
923. Dissecting forceps				
924. Kidney dish				
925. Sponge bowls				
926. Surgeon's hand brush with white nylon bristles				
927. Towels				
928. Towel clamps				
929. Cord-cutting or blunt-ended scissors				
930. Delee suction				
931. Baby ambu bag				
932. Delivery bed				
933. Manual hand-operated vacuum extractor				
934. Cord clamps				
935. Monitor				
Perineal Repair				
936. Sponge forceps (200 mm)				
937. Artery forceps (large 160 mm)				
938. Artery forceps (small 140 mm)				
939. Needle holder (180 mm)				
940. Stitch scissors				
941. Dissecting forceps (toothed 200 mm)				
942. Vaginal speculum (Sims)				
943. Vaginal speculum (Cusco)				