

HEALTH SYSTEM COST OF UNSAFE ABORTION

INTERVIEWER'S MANUAL

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Questionnaires A and B are data-collection forms that are designed to gather the needed information to be able to make estimations of the cost to health systems of treating post-abortion complications. The information from these questionnaires is to be used with a modified version of the Mother-Baby Package (MBP) costing tool developed by the World Health Organization.

The basic assumption behind this methodology is that experts in the health field who have good knowledge of and experience about treating serious abortion complications can give reasonable estimates of the quantities of several inputs that go into providing full treatments of the various complications of abortion. Although each expert's answers may be inaccurate to a certain extent, when the answers of all experts are averaged, the accuracy of the estimates is increased.

This methodology is not expected to give completely accurate cost estimates. It may be theoretically possible to achieve high accuracy, but the cost of such a study would be very high. This methodology sacrifices some accuracy for ease, simplicity and low cost. In that sense, it may be the most cost-effective methodology available. The output, while not useful for management purposes, is well-suited to policy questions where cost estimates need not be highly accurate.

One advantage of this methodology is that it takes into account the four main categories of direct costs to the health system: direct physical inputs of drugs, supplies and materials, direct inputs of personnel time, overhead costs and capital costs. The latter two components are intrinsically difficult to measure and have frequently been omitted in other studies. This completeness of approach is one of the main reasons that the MBP methodology was selected here.

Because this methodology uses the MBP approach, it has some limitations. First of all, it is built around a model of a health system that has three levels of health facilities. Throughout the questionnaires, these are referred to as "health posts", "health centers" and "hospitals." Probably no health system conforms exactly to these three levels. There may be more levels, or less. Some facilities may be in between the normal levels. On the other hand, the three-level model approximates many actual health systems. To use this methodology, however, the investigator will have to make some compromises (e.g., considering a certain facility as a "health post" even though that particular facility may be half health center and half hospital).

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The other MBP limitation is that only five types of post-abortion complication are modeled, albeit they are the most significant complications and probably cover well over 95% of all post-abortion care (PAC). These are: incomplete abortion, sepsis, shock, cervical/vaginal lacerations and uterine lacerations/perforations. Neither minor complications nor other serious, but rare complications are covered.

One last word of introduction must be stressed concerning this methodology. The information to be collected in Questionnaires A and B can be characterized as informed opinion. Only in a few instances do the questionnaires ask for responses to be taken from information recorded somewhere in the system's statistical information database (HIS/MIS). The idea is that the key informants will make reasonable estimates when they answer. Much of the information requested would be very difficult to obtain from records; some would require extensive calculations; some may not be collected at all; some that is collected may be out of date or inherently inaccurate. Trying to collect data in that way would be very tedious and in many instances practically impossible. It cannot be over-emphasized that, in using this methodology, one is collecting informed opinions, not recorded facts.

Using this manual: The questionnaires are designed to be used at all levels of the health system. Therefore, this manual is divided into sections meant for interviews at the central level, at the hospital level, at the health center level and at the health post level. The user should skip those sections that do not apply to the facility level at which the interviews are planned.

Note: boxes for "Respondent's ID" (respondent identification) are included for every question in the questionnaires. The reason for this is so the response to each question can be identified with the informant who gave the answer. A single questionnaire may be answered by different informants, each expert and knowledgeable in certain parts of the questionnaire. If, after data collection, a clarification of the answer to a particular question is needed, the respondent's ID allows the interviewer to re-contact the correct informant for follow up.

QUESTIONNAIRE A

Respondent Selection

The Central Level. Sections 1.1 and 3.1 are to be filled out by interviewing appropriate key informants at the central level, typically in the ministry of health or equivalent. At the central level, it may usually be the case that different experts answer different parts of the questionnaire. The interviewer should always ask respondents who seem unsure how to respond to a particular question whether there is another person in the organization who is better qualified to answer the question.

Although each study setting will vary, the kinds of key informants who should be interviewed may include the following: the head of the gynecology/obstetrics department, the head of the maternal/child health department, the head of the reproductive health department, the head of the statistical department, the head of personnel, the head of administration, and/or the head of accounting.

Before interviews are conducted, support for the study must be sought and assured so that the experts to be interviewed will cooperate willingly. If the institution has not “bought into” the study, then the quality and validity of the data obtained will be questionable at best.

Hospitals. Sections 1.2, 2.1 and 3.2 are to be filled out by interviewing appropriate key informants at hospitals.

Although each study setting will vary, the kinds of key informants who should be interviewed may include the following: the head gynecologist/obstetrician, the head of personnel, the head of administration, and/or the head of accounting.

Before interviews are conducted, support for the study must be sought and assured so that the experts to be interviewed will cooperate willingly. If the hospital staff has not “bought into” the study, then the quality and validity of the data obtained will be questionable at best.

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Health Centers. Sections 1.3, 2.2 and 3.3 are to be filled out by interviewing appropriate key informants at health centers.

Although each study setting will vary, the kinds of key informants who should be interviewed may include the following: the head gynecologist/obstetrician, the head nurse, and/or the head of administration.

Health Posts. Sections 1.4, 2.3 and 3.4 are to be filled out by interviewing the chief medical officer at health posts.

PART 1: ABORTION COMPLICATIONS

The objective of Part 1 of Questionnaire A is to collect information on (1) the number of PAC patients served by the health system and (2) the distribution of post-abortion complications by type of complication.

It is vital for accurate cost estimates to get reliable information on the number of PAC patients served annually. In fact, it is anticipated that this information will come from a source other than this questionnaire, perhaps from a prior study focused on the incidence of abortion and abortion complications. If there is no other source available, Part 1 has questions which elicit the information from the health facilities which are canvassed. However, in that case a sampling scheme must first be developed which assures that the data gathered can be used to obtain a national estimate of the number of PAC patients. In other words, the health facilities (health posts, health centers and hospitals) sampled should be such that multipliers can be justifiably used to inflate the sample numbers to a reasonable national number. It is beyond the scope of this manual to explain how to do this, but suffice it to say that experts in statistical sampling procedures should be involved.

The second type of data collected in Part 1 is about the pattern or composition of post-abortion complications. Again, it would be preferable if this information came from a study focused on that subject. In the absence of such data, questions in Part 1 attempt to collect the required data. Here too, however, pre-survey planning—in terms of sampling design—must be done so as to assure an accurate estimation of the distribution of complications that receive care in the health system.

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Questions A002, A102, A202, A302

Ask this question only if the health system has reasonably complete, accurate and up-to-date statistics on the number of women attended to for post-abortion complications at all the facilities in the system. If the quality of the data is at all doubtful, opinions should be gathered from different key informants about the accuracy of the statistics. Just because a number has been recorded does not necessarily make it reliable. Do all facilities report usage punctually? Are statistical data-entry procedures scrutinized routinely? If there is doubt, also ask Question A004 (or A102, etc.).

Questions A003, A103, A203, A303

If the data are more than two years old, assume that the information from the statistical system is unreliable and ask Question A004 (or A103, etc.).

Questions A004, A104, A204, A304

The respondent should give his/her best estimate (his/her informed opinion), adding together the patients from all the facilities in the country. The estimate should be of women with serious complaints, not women with minor symptoms. Obviously, the respondent will only be able to make an approximate estimate. Assure the respondent that the study will not rely solely on his/her guesstimate, but that similar information will be collected at all levels of facilities.

Questions **A005** and **A007** (or A105 and A107, etc.) ask for the same information in two different ways. If, in the respondent's (socio-cultural) setting, you (the interviewer) are sure that one question is framed better than the other, then just ask the one question. If, however, you are not sure which form of question will yield a more accurate response, then ask both questions.

Questions A005, A105, A205, A305

In this question, get the respondent to think about 100 post-abortion complications treated in the health system last year. It may be difficult for the respondent to think of complications instead of women patients. Explain that a woman may have two or even three of the complications, so that he/she should make the mental effort to think of each complication as a "unit". Out of 100 such units, how many were incomplete abortions, how many cases of sepsis, etc. **Note:** do not make too much effort to make the five numbers add up to 100. The pro-rating can be done later, when the responses are being checked and recorded.

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Questions A006, A106, A206, A306

The methodology used here focuses on the five most important post-abortion complications, but there are a small number of other serious complications that occur to women (e.g., peritonitis, renal failure, etc.). This question is meant to get an estimate of the proportion of all serious complications are these other complications—usually the proportion lies between 1% and 3%.

Questions A007, A107, A207, A307

This question complements Question A005 (or A105, etc.). If the respondent cannot think in terms of complications, this question allows him/her to think in terms of women patients. Now however, the respondent must mentally add up all the complications that the theoretical group of 100 women may have. For example, if 70 women have just one complication, 20 women have two complications and 10 women have three complications, then the respondent should be visualizing 130 complications ($70 + 40 + 20$). Make sure that the respondent is thinking this way before he/she answers the question.

Questions A008, A108, A208, A308

If both A005 and A007 (or A105 and A107, etc.) were asked, it is important to ask A008 (or A108, etc.) as well. Post-interview, it will help during the data-quality checking phase too determine whether to accept the response to A005 or to A007 (or A105 and A107, etc.) as the more accurate one.

PART 2: COST OF PERSONNEL

The objective of Part 2 of Questionnaire A is to collect data on the amount of time input by medical personnel in treating PAC clients. It also asks questions about hospitalization.

The questions on personnel inputs are divided into five sections, one for each of the five major complications (incomplete abortion, sepsis, shock, cervical/vaginal lacerations or perforations, and uterine lacerations). The respondent should concentrate on one complication at a time while estimating the time each type of medical worker spends in treatment. Avoid the tendency some respondents may have to lump all treatments together. The respondent should think of average cases of each complication that would require average amounts of time spent by each type of worker.

Data related to the monetary compensation of medical (and other) workers are collected in Part 3 of Questionnaire A.

Questions P101-P110, P201-P210 and P301-P310

For each complication, the respondent is asked for two data: (1) the proportion of women with that particular complication that are seen by a particular worker; and (2) the number of minutes that a particular worker spends in a typical treatment for that complication. The first question is framed in terms of ten cases with the specific complication because pilot testing showed that respondents preferred thinking about ten cases than thinking in terms of percentages.

For example, suppose that of all women who present at a hospital with symptoms of incomplete abortion, around 80% are seen by nurses at some point during their treatment. The respondent should answer “typically, 8 out of 10 cases are seen by a nurse.” The second question, about number of minutes spent in treating cases of incomplete abortion, asks the respondent to think about those eight cases and to estimate the average amount of time a nurse (or nurses) would spend with the patients. Note that the respondent should consider the total time spent by all nurses in treating one patient with that complication. Also note that the answer should pertain to treating the particular complication, not the time treating the average patient since patients may have multiple complications, each requiring time input of health workers.

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As another example, suppose that anesthetists are never involved in the treatment of post-abortion sepsis at a certain health center. Then the respondent should answer “zero sepsis cases out of 10 are seen by an anesthetist.” In this case, the second question about average time spent by anesthetists should not be asked since it obviously does not apply.

Questions P111, P211 and P311

One further piece of information concerning personnel inputs is collected via a question about the amount of time spent not attending patients. This is time spent in work activities not directly related to medical treatment. Examples of such activities include the following: supervisory duties, administrative duties, filling of forms, attending work-related meetings, time spent in training, travel time, etc. The reason for collecting this information is that a part of the time spent by medical workers in non-medical activities should be charged to PAC because such activities are indirectly related to PAC service provision. Without them no services could be delivered.

Questions P112-P116, P212-P216 and P312-P316

Five questions (one for each type of complication) ask respondents to give their best estimates of the proportions of PAC clients who require hospitalization because of the severity of the post-abortion complications afflicting them. Again, the questions are framed in terms of ten women suffering from a particular complication. Hospitalization is defined as being interned in the facility for a period of time that includes at least one over-night stay.

If the facility being surveyed does not have the provision for hospitalizing clients then these questions should be skipped.

PART 3: CAPITAL AND OVERHEAD EXPENSES

Part 3 of Questionnaire A collects data on capital and overhead costs. Capital costs are investments in construction, equipment and vehicles that function and provide benefits to the health system over several years (their lifetimes) before needing to be replaced. These investments are costs that need to be made in order to provide all the health services available in the system, including PAC services. Hence, part of these costs should be allocated to PAC. The same logic applies to overhead costs. Overhead costs are recurrent costs for general services provided by non-medical staff within the health system. An example of an overhead cost is the sum of salaries and other costs expended in operating the various administrative departments within the health system. An appropriate part of overhead costs should also be assigned to PAC services.

Whereas Parts 1 and 2 of Questionnaire A are probably best answered by medical officers with long experience in the treatment of post-abortion complications (i.e., senior doctors and/or nurses), Part 3 covers costs, many of which may better be answered by senior administrative personnel. It is likely, especially at the central level and in hospitals, that more than one respondent may be needed. If the respondent feels that he/she is not the best qualified person to give an estimate for a particular question, that person should be asked to name another officer in the facility who should be asked for this information.

Much of the information sought in Part 3 is difficult to estimate. Some of it may be available from records, but they should not be used unless they are readily at hand and the respondents are very confident that the data on record are accurate. If there are any doubts, the best estimates of the informants should be sought. Best estimates, though not precise, are perfectly acceptable in the area of capital and overhead costs because the errors in estimation will be quite small in the final analysis since overhead and capital costs make up, typically, only 20-30% of total costs and PAC costs themselves are only a small fraction of total costs for all health services.

Questions K001-K003

Notwithstanding what was said about best estimates above, official data on the number of hospitals, health centers and health posts may (should) be readily available from administrative records. If they are not, however, best estimates of these numbers are acceptable. As mentioned in the introduction, some facilities may not fit easily into one of the three facility categories. Such facilities should, nonetheless, be placed in one level or

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another and a mental note made of where these *sui generis* facilities have been placed. Defunct facilities or planned facilities should not be counted, only operational ones.

Questions K004-K005, K101-K102, K201-K202, K301-K302

A “contact” is defined as a visit by a patient (male or female) to a facility where service or a referral is provided. One treatment to a patient may require multiple contacts. This information may also be easily retrievable from the HIS/MIS. If not, best estimates are acceptable.

Questions K006-K007

Best estimates should be sought for the distribution of female first contacts and actual cases by facility level since it is doubtful that the HIS/MIS will have such statistics readily available. Do not spend time recalculating percentages during the interview that do not sum to 100—that adjustment can be done later, during data checking and data entry phases.

Questions K008, K103, K203-K204, K303-K304

A referral occurs when a woman presents at a health facility, is attended to but receives no care (aside from triage) and is immediately sent to another facility because the first facility does not have the capacity to treat her condition. In some cases, health posts automatically refer all women with post-abortion complications to health centers or hospitals. In such cases, responses to questions K008a and K008b (or K303 and K304) should sum to 100%.

Example: Suppose K008 (a) is estimated to be 70%. This would mean that 70% of all women with post-abortion complications who first come to health posts for treatment are immediately referred to health centers for treatment.

Questions K009-K014, K104-K105, K205-K206, K305-K306

The next set of questions asks the respondent to estimate capital costs of structures as well as average lifetimes. It is difficult to obtain precise figures for these items, so the key informants should give their best estimates for each cost and lifetime. All costs should be given in the local currency.

For hospitals, the cost estimate should include all installed equipment as well as the construction cost. In other words, the estimated average cost should be the “turn key” cost—what a facility would cost if it was brand new, fully equipped and ready to begin operation from day one. Estimating the average cost of hospitals will necessarily be an

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approximation because hospitals in the system will likely vary considerably in size and function. The average of several estimates from key informants will produce an overall estimate of greater precision.

For health centers and health posts, the cost estimate should include only the cost of construction, not of equipment (whose costs are requested in questions K207 and K307, respectively). Health centers and health posts may be of more standard design and hence their capital costs may be easier to assess.

The lifetime of a structure is the number of years that the structure can function usefully in the role it was designed for. The estimate should be based more on actual experience in the health system rather than what the respondent may consider to be ideal. For instance, in practice health posts may be used for 30 years in a certain country, while administrators feel that they should be replaced after 20 years. The response should be 30 years, unless there is evidence that health posts older than 20 years do not function properly or are dangerous to occupy.

Questions K207, K307

These questions are asked only at health centers and health posts. The list of equipment may be fairly complete at the lower levels of the health system, so they form a checklist of equipment. The respondent should nonetheless be encouraged to think of other relevant equipment not listed here.

Note: Leave lines that are not applicable to the surveyed facility blank. The costs entered should be total costs. For example, if the facility has three refrigerators costing \$1,500, \$1,000 and \$700, then the total cost to be entered is \$3,200.

Questions K015, K106, K208, K308

The respondent is asked to estimate average annual salaries for medical workers in the health system. The respondent should estimate salaries for the average worker in each job category according to his/her experience. When estimating salaries, the respondent should include benefits such as pension contributions, insurance contributions, etc., but should not include annual leave. Use the local currency as the monetary unit.

At the central level, respondents should try to estimate salary variations that may exist among the three facility levels (e.g., younger, lower paid staff may be found mostly at health posts; on the other hand, staff at health posts may receive a hardship benefit). At hospitals,

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health centers and health posts, salary estimates should be based on the set of workers currently employed at the facilities. For example, if there are three nurses and/or midwives currently employed at a surveyed health center, then the estimate for the average salary for nurses at that facility should be the estimated average salary of those three nurses/midwives. Again, estimates from knowledgeable informants are sufficient. Avoid using official reports, statistics, etc. unless they are known to be accurate, are readily at hand and are current (and the respondent insists on using them).

In some countries, certain services may be outsourced. For example, a hospital may have no anesthetists on staff, instead contracting with a private group of anesthetists to provide services whenever needed. In such cases, the respondent should reduce the total bill for this outsourced service by the proportion of the service estimated to go to PAC.

Another area where outsourcing may exist is lab testing. In this case, the interviewer should record the prices paid to the private labs for each type of test done in PAC cases.

Questions K016, K107, K209, K309

The normal number of working hours per year varies from one country to another. Calculate this figure together with the respondent by multiplying the normal number of hours worked per week by the statutory number of work weeks per year. In calculating the number of work weeks per year, the respondent should not subtract weeks of paid leave but should subtract paid holidays from the total.

Example. If the work norm is 40 hours per week, 48 weeks per year and 10 paid holidays (= 2 work weeks), then the number of hours worked per year for full-time employees is: $40 \times (48 - 2) = 1840$ hours.

Questions K050-K051, K150-K151, K250-K251, K350-K351

These questions ask the respondent to estimate the number and average salaries of all non-medical personnel working at health facilities. The list of workers in the questionnaire is a general one and in any particular setting may have to be altered to accurately reflect the types of workers actually employed. Add/change/remove names of workers as needed for the health system being surveyed.

“Full-time equivalent” means the number of full-time employees. If, for example, at a particular health center, one guard is employed full-time and two other guards are each

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employed half-time, the response to question K050a (or K150a, etc.) should be “2”, meaning two “full-time equivalent” guards.

The average salary question asks to estimate average salaries per worker, not the total salary bill for all workers.

Questions K056-K058, K152, K252, K352

These questions ask the respondent to estimate a number of other overhead costs. These are annual costs. Best estimates are adequate—there is no need to get exact figures from administrative reports. The list may miss some important overhead costs in the health system being surveyed. The respondent may be probed to see what other overhead items should be included.

QUESTIONNAIRE B

Respondent Selection

The Central Level. Questionnaire B is to be filled out by interviewing appropriate key informants at the central level, typically in the ministry of health or equivalent. At the central level, it may usually be the case that different experts answer different parts of the questionnaire. The interviewer should always ask respondents who seem unsure how to respond to a particular question whether there is another person in the organization who is better qualified to answer the question.

Although each study setting will vary, the kinds of key informants who should be interviewed may include the following: the head of the gynecology/obstetrics department, the head of the maternal/child health department, and/or the head of the reproductive health department.

Before interviews are conducted, support for the study must be sought and assured so that the experts to be interviewed will cooperate willingly. If the institution has not “bought into” the study, then the quality and validity of the data obtained will be questionable at best.

Hospitals. Questionnaire B is to be filled out by interviewing appropriate key informants at hospitals.

Although each study setting will vary, the key informant who should be interviewed will usually be the head gynecologist/obstetrician or equivalent.

Before interviews are conducted, support for the study must be sought and assured so that the experts to be interviewed will cooperate willingly. If the hospital staff has not “bought into” the study, then the quality and validity of the data obtained will be questionable at best.

Health Centers. Questionnaire B is to be filled out by interviewing appropriate key informants at health centers. Although each study setting will vary, the kinds of key

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informants who should be interviewed may include the following: the head gynecologist/obstetrician, and/or the head nurse.

Health Posts. Questionnaire B is to be filled out by interviewing the chief medical officer at health posts.

Structure of Questionnaire B

The questionnaire is divided into five parts, one for each major post-abortion complication. Each part, in turn, is divided into a number of sub-sections. Each sub-section consists of a number of lines, each line naming a possible input in the treatment of each specific complication. In this questionnaire inputs are drugs, supplies, materials or lab tests.

In the main, the inputs listed in this form are taken from WHO sources and supplemented with information from a panel of experts. We have tried to make the lists as comprehensive as possible. Therefore, there are many more inputs listed than would normally be used in treating a particular complication. Indeed, there are many sub-sections where, typically, only one of several choices of drug would be selected. On the other hand, there may be inputs missing that are commonly used in the surveyed facility. In the latter case, the blank rows should be used to add these inputs.

It is important for respondents to think in terms of treatments when answering the questions. One patient may be treated for more than one complication, so the percentages they are being asked to estimate are the percentages of all cases treated for each specific complication. Another important consideration is that Questionnaire B refers to drugs, supplies, etc. that the facility provides as part of its service. Drugs and supplies that are provided privately by the patient or her family should not be included.

Column (B) contains the name of the inputs, i.e., the drugs, supplies, materials or lab tests. If there are other inputs that are normally used in treating a complication in the facility, please add these inputs in the blank rows provided. If an input is added, please be sure to fill in columns (B) through (I) for that input. Please note that this form collects data on consumable inputs, that is, inputs that are consumed, or used up, in the course of the treatment. Therefore, equipment that may be used to treat many patients should **NOT** be added here (information on them is obtained elsewhere).

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Column (C) describes the way the drug is presented (and is not applicable for non-drug inputs), for example, “200mg” for tablets with 200 milligrams of medicine.

Column (D) contains the units for each input.

Column (E) gives the number of units of the input dispensed at one encounter with the patient.

Column (F) indicates the number of times per day that the input is administered to the patient.

Column (G) shows the number of days during which the input is administered to the patient.

These columns make most sense in the case of drugs where, for example, a particular antibiotic may be presented as a 200mg tablet (column C), the normal dose may be two tablets (column E), which may be given three times per day (column F), for seven days (column G). The questionnaire seeks the same data for non-drug inputs, even if in many cases only one unit may be given in the whole course of the treatment.

Column (H) is the product of columns C-G. Using the same example, the total amount of antibiotic given would be $200\text{mg} \times 2 \times 3 \times 7 = 8,400\text{mg} = 8.4\text{g}$.

For many inputs in Questionnaire B, the suggested values are already given for columns B-H with the hope that this will ease the burden of data collection. If, however, the treatment regimen of a certain input in the facility differs from the suggested values given here, please cross out the suggested numbers the respondent wishes to change and insert the respondent’s own numbers. After you have made the changes, please make sure that the total (Column H) agrees with the data in columns C-H from which it is derived.

For inputs where some or all of columns C-H are blank, the respondent should enter the appropriate data, according to the usual practice for treating the complication at the facility. Please make sure that the data entered are consistent, in particular that the total (column H) is the product of the data entered in columns C-G. It is important to check all aspects of a drug (its presentation, the units, the dose, the frequency and the duration) to make sure that all these data accord with the normal practice at the facility.

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Column (I) is the most important column in the questionnaire. It is here that the respondent gives his/her best estimate of the proportion of women with a particular complication are given a particular input in the treatment of that complication.

Pilot tests of this questionnaire determined that a suitable way of asking respondents for these proportions is by asking respondents to think in terms of ten typical cases of the complication and then estimate how many of the ten would normally be given the particular input. Thus the possible range of responses to each input is from “0” (i.e., no woman suffering from the complication under consideration would be administered that input) to “10” (i.e., all women with that complication would be administered the input).

It is essential that each cell in column I be filled in by the respondent(s). Since there are so many possible inputs, this may become a tedious task. Be careful that the respondent does not become fatigued or the responses will not be the best possible estimates. It may be necessary to break up the interview into two or more sessions to avoid this problem.

Some sub-sections present options (i.e., several drugs only one of which would normally be administered in any given case). As an example, Part 2, sub-section 1 lists a series of antibiotics for sepsis. Suppose that antibiotics are invariably administered in the surveyed facility to women presenting with symptoms of sepsis, but some women are given ampicillin and some are given ciproflaxin depending on other indications. The respondent should estimate some number for column I for ampicillin (say, “7”) and another number (say, “3”) for ciproflaxin. The respondent is estimating that 30% of sepsis cases receive ciproflaxin and 70% receive ampicillin. All other antibiotics should be given a value of “0”, indicating that these types of antibiotic are never given for sepsis cases at that facility.

It is important to realize that there may be several inputs listed under a particular complication that may never be used in treating that complication (since standards vary from place to place). In such cases, column I will have “0” entered, indicating that input X is never administered in the treatment of complication Y. No cell in column I should be left blank.