Costing of Reproductive Health Services

By Marc D. Mitchell, Joan Littlefield and Suzanne Gütter

Context: The principles endorsed by delegates to the 1994 International Conference on Population and Development expanded the areas typically included in reproductive health. Yet implementation of more comprehensive reproductive health programs has been slow, and the impediments to program expansion need to be identified.

Methods: The elements of a reproductive health care program were identified, and in 1995, the disaggregated costs of providing some of these services were gathered from a program of the Zimbabwe National Family Planning Council (ZNFPC) and from MEXFAM, a nongovernmental organization in Mexico affiliated with the International Planned Parenthood Federation. These data were used to estimate and compare the costs (in U.S. dollars) of various components of reproductive health care per visit (or per diagnosis and treatment) in the two countries.

Results: The costs of providing contraceptive methods, particularly surgical ones, as well as gynecologic and general health services, varied between ZNFPC and MEXFAM. Whereas tubal ligation cost $70 and oral contraceptives $3 at ZNFPC, a tubal ligation cost $269 and oral contraceptives $4 at MEXFAM. During a gynecologic visit, the cost of treatment for a sexually transmitted disease was $19 at ZNFPC and $29 at MEXFAM. The cost of providing an adolescent with a routine examination and iron supplement was $5 at ZNFPC and $4 at MEXFAM. At ZNFPC, providing a Pap smear, screening for a reproductive tract infection and checking an IUD during a single visit cost $4, compared with $6 when the procedures were performed separately.

Conclusions: Costing reproductive health programs requires breaking service components into individual cost elements. This process can help managers understand both the financial and programmatic implications of alternative implementation strategies.


The 1994 International Conference on Population and Development (ICPD) endorsed a universal right to reproductive health care. Nonetheless, family planning and primary health care programs have been slow to incorporate the comprehensive range of services called for in the conference Programme of Action. We believe there are three principal reasons why: There is confusion about what a woman’s reproductive health program should include; many service delivery organizations believe holistic reproductive health care is too expensive to implement; and few organizations know where to start.

In this article, we review each of these barriers and suggest how cost data can be used for program development and implementation. First, we present the key components of a holistic reproductive health program. We then provide data on the costs associated with some of these reproductive health services, based upon research conducted in 1995 by MEXFAM, a nongovernmental organization in Mexico that is affiliated with the International Planned Parenthood Federation, and the Zimbabwe National Family Planning Council (ZNFPC). Finally, we explore the implications of the cost data.

What Is Reproductive Health?

In recent years, attention has shifted from maternal and child health (which typically focused on children) and family planning (often made available through population programs) to reproductive health, “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and its function and processes.”¹ Reproductive health has three components: the ability to procreate, regulate fertility and enjoy sex; the successful outcome of pregnancy through infant and child survival and growth; and the safety of the reproductive process.²

Programs that adopt a holistic approach to reproductive health care will help women maintain good health, be productive and have the benefits of a safe and satisfying sexual life.³ They will also bring in client populations that typically have been underserved. Although we cannot list every component of a comprehensive program in this article, we consider these to be key:

• family planning services that offer complete and accurate information about all contraceptive methods and that make contraceptive methods, supplies and counseling accessible;
• antenatal care, which research suggests lowers rates of maternal mortality;⁴
• safe delivery services, so that all women deliver under some type of supervised care and so that referral systems are established to provide emergency treatment of life-threatening complications of delivery;
• postnatal care that contributes to a woman’s ability to have a speedy and complete recovery from the stress of pregnancy and childbirth, to enjoy sexual relations without pain and to have safe pregnancies and deliveries in the future;
• management of the complications of abortion where safe abortions are not widely available;⁵
• infertility services that enable women to achieve their reproductive goals; and effective screening for or control of reproductive tract infections (RTIs), because RTIs are the most common preventable cause of involuntary infertility and ectopic pregnancy, as well as of chronic pelvic pain and recurrent infection;⁶
• management and treatment of systemic sexually transmitted diseases (STDs), such as HIV and hepatitis B;
• symptomatic treatment of urinary tract infections;
• detection and treatment of breast and reproductive tract cancers, such as cervical cancer;
• attention to and treatment of dysmenorrhea, which in some cases is the first sign of other problems, such as pelvic inflammatory disease, endometriosis, fibroids, endometrial cancer and ectopic pregnancy;⁷
• nutritional supplementation to meet the

Marc D. Mitchell is development associate at the Harvard Institute for International Development, Cambridge, MA, USA. Joan Littlefield is with Management Sciences for Health as training advisor with the EQUITY project in South Africa. Suzanne Gütter is a health volunteer with the Peace Corps in Nicaragua. Funding to support the research for this article was provided by the U.S. Agency for International Development (USAID) through the Family Planning Management Development project, under cooperative agreement number CCP-A-00-95-00000-02. The views expressed in it are those of the authors and do not necessarily reflect those of USAID.
special needs of adolescents, pregnant or lactating women, and women older than 50; 
- services for menopause and other health problems that women encounter as they grow older; and 
- services for adolescents, including family planning and STD prevention and treatment.

**Approaches to Cost Analyses**

Since the ICPD, the costs associated with reproductive health care have been of great interest to policymakers and program planners and managers, among others. In part, this is due to the concern voiced at the conference that the costs associated with the delivery of a full package of reproductive health services would be more than most countries could afford. However, the interest also has grown out of an acknowledgment that the lack of empirical cost information about health services in general (and reproductive health services in particular) has made it difficult to project the true costs of expanding reproductive health services.

Typically, one of three approaches has been used by investigators to determine the costs of reproductive health services. The first, and perhaps simplest, is one that relies on price data available in either the private or the public sector, or both. Several early studies used this model to determine method-specific costs of contraceptives. While price data are easy to collect, they do not necessarily represent the actual cost of services, since price is determined as much by willingness to pay (demand) as by the underlying cost (supply).

The second approach is an economic one, wherein data on the total costs of a reproductive health program are collected and then allocated to an array of services or outputs. This methodology is effective for calculating the average costs of an existing program, and is therefore useful for estimating the likely cost of expanding services already provided. However, because such an approach includes all costs related to service delivery, it is less useful for projecting the costs of adding new program components when these can be integrated with the existing infrastructure for little additional cost. This methodology’s overestimation of the costs of program expansion may be one reason for the wide concern among program managers about the high costs of implementing the ICPD Programme of Action.

The third approach that has been widely used to determine the costs of reproductive health services is an accounting model, similar to that which is used in this article. Data on the costs of separate items from individual service delivery points are aggregated to build the total cost of each type of service provided. The advantage of this methodology is that the availability of disaggregated data offers managers the opportunity to cost a variety of approaches to introducing or expanding a reproductive health program. However, the collection of data from individual sites for this type of study is time-consuming and requires extensive fieldwork by investigators trained in financial analysis. Nevertheless, more of these studies are being done as the utility of this type of costing information has come to be better understood.

MEXFAM and ZNFP were selected for our study because they were already delivering an array of reproductive health services and had financial accounting systems that facilitated a cost study, using existing information. In addition, since one is a public program and the other is a private one, it is possible to use the results to compare programs in the public and private sectors.

**Methodology**

Cost data were collected from MEXFAM and ZNFP, based on their current practices and array of services. To make cost information most useful to managers planning to incorporate new program components into existing services, we determined the costs of individual interventions rather than those of complete programs. With costs presented in this modular way, managers can better consider the incremental costs of adding any single component to a reproductive health program.

Results are presented per client visit (or if noted, per course of treatment) in U.S. dollars. This allows comparisons to be made between programs and will help managers project the future costs of programs that are greatly affected by the volume of clients seen. Since serving additional clients may not reduce the cost per client in reproductive health programs, this method gives reasonably accurate data for projecting total program component costs, if the number of clients can be estimated.

To develop standards for alternative approaches to service provision, we analyzed existing reproductive health programs and reviewed the literature. This helped us to carefully define the specific elements that are required to initiate a reproductive health intervention and to categorize them as individual cost elements.

For example, the steps involved in serving a client with symptoms of an RTI include registering her at the clinic, taking a history, performing a physical examination, looking at vaginal discharge under a microscope, administering antibiotics (if needed), counseling and providing appropriate follow-up care, and treating the client’s partner or partners. These are all cost elements, since each entails a cost to the program—either a labor cost, a supply cost or both.

We gave careful consideration to cost elements of care appropriate to the setting. For example, cultures for the diagnosis of RTIs are currently difficult to carry out and unreliable in many settings, and therefore were not included. Costs were identified for the latest recommended treatments, even if they cost more than those currently in use. Among therapies recommended, the most economical and practical were used for costing (for example, single-dose treatment for RTIs).

After the cost elements of reproductive health care were identified, we collected cost data from MEXFAM and ZNFP. The data available from the two programs were not in the same format: For Zimbabwe, costs were identified separately for each cost element, while for Mexico, the data were available in a format in which some elements (registration, history, examination and specimen taking) were already added together. Nevertheless, by using all available data from each institution, we were able to estimate roughly comparable cost figures for the two organizations. This will enable other organizations to project what expenses they can expect to incur by providing these services.

Many of the data that we use in this article could be taken directly from the organizations’ own financial systems, although they were organized in a costing model specific to the organization’s management needs. Each organization had good data on the total costs of inputs in the delivery of services, including staff, materials, transportation and pharmaceuticals.

Labor is by far the largest cost in a service delivery organization; therefore, we paid considerable attention to estimating personnel costs. They were higher at MEXFAM than at ZNFP because of the much higher labor costs in Mexico than in Zimbabwe. In addition, the programs had different patterns of personnel use: Doctors perform many services at MEXFAM,
while nurse-midwives are more likely to do so at ZNFPC.

To estimate ZNFPC’s personnel costs, we developed standard times for each staff category per activity (in minutes) and multiplied by the total compensation package for each type of worker (dollars per minute). The methodology used for estimating MEXFAM’s personnel costs was similar. However, its doctors are not paid a salary; instead, they receive an honorarium based upon the number and type of clients they see and on the fees paid by the clients.

Nonclient time, including time spent on support activities—e.g., infection control, keeping the clinic clean and maintaining records—also must be considered as part of the total cost per client visit. In order to understand how much the entire service mix costs the program, we allocated these indirect costs according to the volume of clients for each activity.

MEXFAM has developed a methodology for allocating indirect costs to each type of intervention. Their technique allocates a higher percentage of these costs to services that require more support (referred to as a “utility factor”). The system is not complex, and essentially has surgical procedures bearing a higher percentage of the allocated costs than routine family planning or reproductive health visits, which require less support staff time and less complicated administration.

We obtained supply costs for ZNFPC by analyzing with providers each cost element step-by-step to identify the supplies used for each intervention. The costs of the supplies were obtained from the purchasing department. These costs could easily vary between organizations or with new practice standards. MEXFAM went through much the same process and identified the materials cost per client for each kind of service visit.

We obtained the unit costs of pharmaceuticals from the International Drug Price Indicator Guide and gathered data on the amounts of pharmaceuticals used from each institution.

We did not include estimates of the costs associated with capital equipment or buildings, for several reasons. First, most programs, especially government ones, do not have good data on the costs of buildings and other capital equipment, since these are typically donated or purchased in bulk for multiple uses. Second, capital cost calculations are sensitive to the assumptions made in determining how to allocate them. In the case of a building, for example, use of historical construction costs versus replacement costs can have a dramatic influence on the cost of outputs. Similarly, the time periods used for depreciation of capital equipment and buildings are more important than the initial costs in determining final unit costs.

The third, and perhaps most important, reason for not including capital costs is that managers tend to be concerned with the marginal cost of adding services—that is, the cost of adding new services to an existing infrastructure. We believe that many institutions delivering reproductive health services operate significantly below their physical capacity to see clients, and that much of the equipment required for expanding reproductive health services may already be available for use in family planning and other health services. Thus, the marginal capital costs of adding most types of reproductive health services should be small.

Finally, we took the data from each organization and aggregated them into estimates of the costs of implementing each component of a reproductive health program. When there was only one approach to implementing the component, this was straightforward.

For example, Table 1 shows the separate costs of the various components of the diagnosis and treatment of a reproductive tract infection in the two countries. In Zimbabwe, basic activities for the client’s initial visit (registering the patient, taking her history, examining her, obtaining a specimen and counseling her) cost a total of $3, on average; administering the appropriate drugs costs an additional $3, following up on her treatment costs $3 and treating her partner costs $9. Combined, these figures produce a total cost of nearly $19 to treat an individual woman’s infection in Zimbabwe. A similar estimate for Mexico was substantially greater ($29), because of higher costs for the initial visit, for follow-up and for partner treatment.

Analyzing cost is only part of the strategic planning process. But when resources are limited, cost is a factor to be considered. We do not advocate the least expensive interventions, but present information to help managers answer questions such as “What can we afford to provide?” and “How can we provide the best care with the human, physical and financial resources we have?”

In this article, we compare costs (in U.S. dollars) that would be encountered by ZNFPC and MEXFAM (whenever information was available from both).

Table 2. Estimated per visit costs of contraceptive methods, gynecologic services and general health services

<table>
<thead>
<tr>
<th>Service</th>
<th>ZNFPC</th>
<th>MEXFAM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contraceptive method</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tubal ligation</td>
<td>$70.19</td>
<td>$268.58</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>29.21</td>
<td>298.00</td>
</tr>
<tr>
<td>Hormonal implant insertion</td>
<td>43.15</td>
<td>45.25</td>
</tr>
<tr>
<td>Hormonal implant removal</td>
<td>22.34</td>
<td>20.47</td>
</tr>
<tr>
<td>IUD insertion</td>
<td>2.94–8.70</td>
<td>5.83</td>
</tr>
<tr>
<td>Oral contraceptives</td>
<td>2.54</td>
<td>4.34</td>
</tr>
<tr>
<td>Injectables</td>
<td>2.77</td>
<td>5.15</td>
</tr>
<tr>
<td><strong>Gynecologic service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reproductive tract infection</td>
<td>18.62</td>
<td>29.00</td>
</tr>
<tr>
<td>Cervical cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inspection and cryotherapy</td>
<td>11.82</td>
<td>50.25</td>
</tr>
<tr>
<td>Inspection andLEEP§</td>
<td>19.58</td>
<td>72.63</td>
</tr>
<tr>
<td>Pap smear, cone biopsy and</td>
<td>91.70</td>
<td>433.94</td>
</tr>
<tr>
<td>hysterectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menstrual problem</td>
<td>3.67</td>
<td>5.22</td>
</tr>
<tr>
<td><strong>General health service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment of anemia‡</td>
<td>1.20</td>
<td>1.20</td>
</tr>
<tr>
<td>Adolescent care§</td>
<td>4.88</td>
<td>3.99</td>
</tr>
<tr>
<td>Postmenopausal woman§</td>
<td>5.82</td>
<td>7.37</td>
</tr>
</tbody>
</table>

Note: †- unavailable; MEXFAM data were not available as separate cost elements.

A comparison of the costs of various contraceptive methods shows that the costs of providing them, particularly surgical methods, range widely (Table 2): A vasectomy costs $29 at ZNFPC and $298 at MEXFAM, and injectables cost 60% as much at ZNFPC as they do at MEXFAM. MEXFAM’s obstetric care data were not available as separate cost elements, and the ZNFPC program does not provide obstetric care. At MEXFAM, the cost of antenatal care was $7, the cost of ultrasound (which is included because some organizations may be considering whether to add this diagnostic tool to one or more of their sites or for specific services) was $38 and the cost of postpartum care was $5. A basic infertility workup cost $3 at ZNFPC.
Table 3. Costs of an IUD check, a Pap smear and a screening for a reproductive tract infection (RTI), per separate and combined visits, ZNFPC

<table>
<thead>
<tr>
<th>Service</th>
<th>IUD check</th>
<th>Pap smear</th>
<th>RTI screen</th>
<th>Separate visits</th>
<th>Combined visit</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$1.10</td>
<td>$2.27</td>
<td>$2.50</td>
<td>$5.87</td>
<td>$3.67</td>
<td>$2.20</td>
</tr>
<tr>
<td>Registration*</td>
<td>0.05</td>
<td>0.05</td>
<td>0.05</td>
<td>0.15</td>
<td>0.05</td>
<td>0.10</td>
</tr>
<tr>
<td>History/counseling</td>
<td>0.15</td>
<td>0.15</td>
<td>0.65</td>
<td>0.95</td>
<td>0.65</td>
<td>0.30</td>
</tr>
<tr>
<td>Pelvic exam</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labor</td>
<td>0.50</td>
<td>0.75</td>
<td>1.00</td>
<td>2.25</td>
<td>1.25</td>
<td>1.00</td>
</tr>
<tr>
<td>Screening supplies*</td>
<td>0.40</td>
<td>0.40</td>
<td>1.00</td>
<td>2.40</td>
<td>1.20</td>
<td>0.80</td>
</tr>
<tr>
<td>Pap screening supplies*</td>
<td>na</td>
<td>0.92</td>
<td>na</td>
<td>0.92</td>
<td>0.92</td>
<td>0.00</td>
</tr>
<tr>
<td>Microscopy</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>0.40</td>
<td>0.40</td>
<td>0.00</td>
</tr>
</tbody>
</table>

*The cost calculation was based upon labor costs only for a return client who already had a registration and history card. †Cost includes $0.72 for a cervical brush for an endocervical smear; a cotton swab would cost $0.08. Note: na=not applicable.

and $5 at MEXFAM. No cost data were available for delivery or abortion services, since they are not provided by either institution.

We could determine costs per gynecologic visit for many services, although cost data for a breast exam and for the diagnosis and treatment of breast cancer were not available from either organization. Data on the cost of providing three alternative approaches for the diagnosis and treatment of cervical cancer were collected. The less-invasive methods (inspection and cryotherapy, inspection and loop electrosurgical excision procedure) may be all that is feasible in many settings, and they can be made available at a lower cost. For example, the cost of visual inspection and cryotherapy was $12 at ZNFPC and $50 at MEXFAM; in contrast, the cost of a Pap smear, cone biopsy and hysterectomy was $92 at ZNFPC and $434 at MEXFAM.

We were unable to obtain costs for treating anatomical abnormalities (mostly surgical conditions requiring repair) because the costs vary greatly. More research is needed to observe specific activities in this category and to provide cost information.

We also collected data on the costs of providing some general health services, including services for adolescents and postmenopausal women (Table 2). Although considered important, cost data for nutritional supplements were not available from either MEXFAM or ZNFPC. Calcium supplements were included in the cost of a routine visit for a postmenopausal woman, which cost $6 at ZNFPC and $7 at MEXFAM.

Typically, adolescents require interventions that are similar to those provided to other women of reproductive age, although the services may need to be performed differently. For example, we assumed that extra time would be needed to counsel and examine adolescents. Included in a routine visit by an adolescent were iron supplements, under the assumption that adolescents in much of the developing world are not optimally nourished for their own health or their potential (or actual) childbearing. The cost of a visit by an adolescent was $5 at ZNFPC and $4 at MEXFAM.

To compare the personnel and supply costs of providing services during three separate visits versus during a single visit, we collected data on the costs of having an IUD check, a Pap smear and an RTI screening at ZNFPC (Table 3). Although additional time was required for the history, counseling and examination when services were combined, it was not as much time as was needed when each service was provided separately.

The labor portion of the savings (46% in this example) was more important when the providers were fully occupied than when they were not, although the client’s convenience was important as well. The basic cost of supplies (gloves and solutions to clean the speculum) was incurred only once during a combined visit—68% of the supplies costs if counted separately. (Possible medication costs for this client were not included.)

Discussion

The study reported in this article was designed to help reproductive health program managers estimate the costs of adding new interventions to existing family planning or maternal and child health programs, and to make rational decisions about what types of services to add. The decision-making process involves reviewing the potential costs and benefits of adding new services. When we analyzed our results, three cost considerations stood out.

The High Cost of Staff

Staff, who are compensated by salary, are paid the same amount whether they are busy or not, and therefore represent a fixed program cost. Where the volume of patients is low and the staff are not fully occupied, the cost of adding new activities will increase the total program costs minimally. In addition, the efficient use of staff can have an impact on the cost of seeing each client.

Costs for comparable interventions were consistently lower at the ZNFPC than at MEXFAM, in large part because specially trained nurse-midwives, rather than doctors, provide most family planning and reproductive health care at the ZNFPC. Thus, using less expensive staff can dramatically affect the total cost of service delivery.

Opportunities for Cost Savings

In the provision of reproductive health services, adding additional clients does not necessarily reduce the cost per client. This is primarily because most of the costs of reproductive health services come from labor, and it is neither practical nor desirable to try to reduce these beyond what can be achieved through improving provider efficiency.

In general, costs will increase more or less linearly with the expansion of the numbers of clients being served and the array of services provided. This is an important concept, since we anticipate that most programs will grow substantially in the next 10 years, due to three factors: population growth; increases in the contraceptive prevalence rate; and expansion of services to new kinds of clients, such as adolescents and women beyond their reproductive years. Even in those countries that have already achieved a high contraceptive prevalence rate and lower population growth rates, the number of clients seeking reproductive health care will increase within the next few years, when the children and young adolescents of today enter their childbearing years.

However, some cost savings may be achieved by purchasing larger volumes of commodities or pharmaceuticals. Additionally, the cost of each service decreases substantially when visits are combined, because frequently the same cost elements are involved. This is especially true in women’s reproductive health, where the interaction with the client is often similar for different health problems: taking a history, providing counseling and performing a physical examination. Therefore, in most programs, increasing the number of clients will have a greater impact on cost than will adding new services to current client visits.

Most health and family planning programs operate well below their capacity to see clients. This is most often true for the physical facilities (buildings), for equipment (such as examining tables, scales, blood pressure cuffs, sterilizing equipment and specula) and for staff.
When resources are underutilized, the apparent costs per client are much higher, since the total costs are allocated over a smaller number of services. For many programs, therefore, the cost of adding reproductive health services will be low.

Adding Packages of Services

When designing and implementing a reproductive health program, planners must not lose sight of the health outcomes they hope to achieve. Strategies found to be effective in one setting should not be adopted for another, unless the appropriate resources for diagnosis and follow-up care are available. For example, Pap smears are an excellent screening method for early cervical cancer. However, they require reliable laboratory facilities and appropriate treatment to make them useful. When these resources are not available, managers and planners must think in terms of alternative approaches (in this case, visual screening) to lower the morbidity and mortality associated with cervical cancer.

Conclusion

The ICPD Programme of Action made clear the types of services that should be included in a comprehensive reproductive health program. However, it did not clarify what the operational requirements would be, which has considerably slowed the implementation of a reproductive health approach in many countries.

We calculated the costs associated with reproductive health services provided by two organizations on a national basis, by breaking each service into individual cost elements. The simple methodology we used can help managers consider some of the financial implications of alternative approaches to reproductive health care, by allowing them to evaluate the implications of different arrangements of those elements, depending on the infrastructure available. Breaking the components of reproductive health into individual operational elements may help lessen the confusion about what a reproductive health program includes when it is implemented at the service delivery level. We hope that providing this information will accelerate the implementation of more holistic reproductive health programs in the near future.

References

9. Kumar N, National Health Accounts of Egypt, Data Book, New York: Irvington Publishers, 1994; and Ladipo OA, Wasserheit JN, The significance and scope of reproductive health into individual operational elements, by allowing them to evaluate the implications of different arrangements of those elements, depending on the infrastructure available. Breaking the components of reproductive health into individual operational elements may help lessen the confusion about what a reproductive health program includes when it is implemented at the service delivery level. We hope that providing this information will accelerate the implementation of more holistic reproductive health programs in the near future.

Résumé

Contexte: Les planificateurs de programmes ont besoin d’informations sur les coûts de l’offre d’un large éventail de services d’hygiène de la procréation pour prendre des décisions politiques pertinentes au niveau national et local.


Résultats: Les coûts de l’offre de méthodes contraceptives (avec intervention chirurgicale surtout) et de prestations de nature gynécologique et génériques ont été assez variables entre le ZNFPF et MEXFAM. La ligature des trompes et les contraceptifs oraux coûtaient, respectivement, 70 et 3 dollars au ZNFPF, par rapport à 269 et 4 dollars, respectivement, chez MEXFAM. Lors d’une visite gynécologique, le coût du traitement d’une maladie (continued on page S29)
ladie transmissible sexuellement était de 19 dollars au ZNFFC et de 29 dollars chez MEXFAM. Le coût d’une visite de routine et d’un traitement d’apport de fer, pour une adolescente, s’élevait à 5 dollars au ZNFFC et à 4 dollars chez MEXFAM.

Au ZNFFC, le coût d’un frottis vaginal, du dépistage d’infection de l’appareil reproducteur et du contrôle d’un stérilet à l’occasion d’une simple visite était de 4 dollars, par rapport à 6 dollars si les procédures étaient effectuées séparément.

**Conclusions:** Les coûts d’interventions comparables étaient systématiquement moindres au ZNFFC que chez MEXFAM, en raison, surtout, de frais de personnel moindres. Les coûts marginaux de l’ajout de nouveaux services peuvent en fait s’avérer faibles si les installations et le personnel existants sont sous-utilisés.