

Invisibility problem: why current economic evaluations understate the value of sexual and reproductive health and rights, and three strategic shifts to address it

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INTRODUCTION

The value of sexual and reproductive health and rights (SRHR) has been imprecisely calculated. Despite extensive evidence demonstrating wide-ranging social, economic, environmental, peace and security benefits of SRHR interventions,^{1 2} most economic evaluations include only health-sector benefits such as disability-adjusted life-years averted or the quality-adjusted life-years gained.³ For example, based on modelling of WASH data collected between 2000 and 2019, an estimated 500 million women and girls who menstruate lack access to basic menstrual materials; safe, private and clean sanitation facilities; and/or quality menstrual health services.⁴ Poor menstrual health can deter girls from attending school and may limit women's workforce participation, leading to long-term economic disadvantages for individuals and society.⁵ While some economic evaluations of menstrual health include productivity losses, many short-term and long-term outcomes across health, education, labour and social protection systems are not considered.⁶ Overly narrow evaluations miss impact and cost-savings in sectors other than health and across the life course. This may result in the under-prioritisation of high-impact SRHR interventions and suboptimal investment decisions.^{7–9}

In 2023, only 23% of donors allocated more than 5% of their overseas development assistance to SRHR, and total SRHR funding fell by 27% to US\$10.77 billion despite overall increases in development aid.¹⁰ This shortfall expanded in 2025, when the USA, the largest donor, accounting for 54% of the

SUMMARY BOX

- ⇒ Most economic evaluations of sexual and reproductive health and rights (SRHR) interventions capture only health-sector benefits, rarely accounting for cross-sectoral returns in education, labour, justice and social protection.
- ⇒ A 27% reduction in global SRHR financing in 2023, compounded by donor withdrawal since 2025, driven mainly by geopolitical pressures, is undermining progress across health, education, economic development and equity goals.
- ⇒ Better evidence is unlikely to reverse decisions made on economic grounds, but evaluations that make cross-sectoral returns visible give ministries beyond health a demonstrable stake in SRHR investment and standing to defend it.
- ⇒ We propose three strategic shifts to make the broader returns on SRHR investments more visible: adopting multisectoral and societal rather than a uniquely health-sector perspective; embedding life-course and intergenerational analysis and applying disaggregated approaches to address equity concerns, including those enabled by emerging analytical methods.

US\$23 billion total donor government health assistance in 2024, withdrew support from key United Nations institutions, further constraining access to SRHR, including contraception, maternal healthcare and HIV services.^{11 12}

In this commentary, we argue that funding for SRHR interventions is under-prioritised, in part, because existing economic evaluations capture only a fraction of their true benefit, with multisectoral gains, intergenerational effects (ie, benefits accrued to aid recipients' children and/or grandchildren) and rights-based outcomes frequently left

out and, consequently, less visible to donors and policymakers. To make the benefits of SRHR interventions more visible and to accelerate progress across health, education, economic development and equity goals, we propose three strategic shifts.

CURRENT EVALUATIONS DO NOT COUNT CROSS-SECTORAL BENEFITS OF SRHR INVESTMENTS

Accumulating evidence highlights that investment in SRHR supports and amplifies education, labour, justice and social protection interventions.^{1 2 13} For example, investment by a Ministry of Education in puberty education in schools, complemented by Ministry of Health investment in adolescent health services that provide contraception, prevent iron deficiency anaemia due to heavy menstrual bleeding or vaccinate against cervical cancer, can collectively lead to both improved educational and health outcomes. So, while funding for SRHR quietly underwrites educational returns, this contribution is unlikely to appear on the education account.

As another example, Ministries of Labour may invest in women's workforce participation by subsidising child-care and parental leave policies. At the same time, SRH services yield labour-market returns through increased productivity by enabling reproductive autonomy and maternal health services. For instance, a synthesis of diverse data sources from Kenya, Nigeria and other African settings associates access to contraception with roughly a 10–12% increase in paid work the following year and a 15% increase in women's control over earnings.² In these scenarios, SRHR interventions are likely to create significant but mostly hidden subsidies.¹⁴ Policymakers across sectors may therefore miscalculate returns on their own investments because the benefits that SRHR deliver to their sectors do not appear in their evaluations.

Health economic evaluations of SRHR interventions are intended to assess whether such interventions meet cost-effectiveness thresholds within the health sector. They are currently not structured to generate estimates of the total return on investment across multiple sectors and cannot support cross-sectoral budget allocation decisions. This limitation applies both to SRHR interventions that generate benefits beyond the health sector and to investments in non-health sectors that, when combined with SRHR interventions, produce greater collective, multisectoral gains.¹⁵ Promisingly, this shortcoming has begun to receive formal acknowledgement and is being addressed incrementally in comparable areas of public health.^{7–9}

WHAT THE EVIDENCE INDICATES

Table 1 provides examples of the types of costs and outcomes that are included in current economic evaluations of SRHR.¹⁶ Broader societal outcomes, such as educational attainment, lifetime earnings, social participation, autonomy and intergenerational benefits, are almost entirely absent from existing evaluations.

Where studies attempted to include costs and benefits beyond the health sector, unavailability of data (on both costs and outcomes) was the primary constraint. Economic evaluations of SRHR interventions will not be able to meaningfully expand the range of outcomes and sectors included without advances in data infrastructure. Further, use of short time horizons prevents existing evaluations from capturing dynamic, multisectoral and long-term effects that may constitute significant value of an SRHR intervention across the life course. This includes, for example, analyses of gender-based violence that stop short of measuring intergenerational impacts. Similarly, an evaluation of access to self-care interventions for SRHR might count clinic visits avoided, health-worker time saved, cervical cancer screening rates with human papillomavirus self-sampling or unintended pregnancies averted with self-injectable contraception. Taking a life-course approach would expand the lens of analysis to include chronic cancer care costs averted, workforce productivity benefits due to reproductive autonomy as well as the knock-on health impacts attributable to increased agency and healthy behaviours among those engaging in self-care.¹⁷ Constraints in current analyses mean that, even for demonstrably cost-effective SRHR interventions,² wider multisectoral benefits and intergenerational impacts remain largely invisible to policymakers.

THREE STRATEGIC SHIFTS TO MAKE CROSS-SECTORAL RETURNS VISIBLE

Addressing this invisibility problem requires more than methodological refinement⁷; it calls for the strategic repositioning of SRHR within budget allocations across multiple sectors so that its broader value is more accurately reflected. Drawing on an analysis of existing evidence and inputs from stakeholders (see 'Acknowledgements'), we propose three strategic shifts to underpin the transformational change required.

First, replacing the narrow health-sector lens with both multisectoral and societal perspectives can facilitate the inclusion of costs and benefits across, for example, education, labour and justice sectors. While a societal perspective measures the total costs and returns to everyone, a multisectoral perspective identifies which sectors bear those costs and capture those returns. Broadening the scope of economic analyses will not only bring the estimated return on investment (ROI) for SRHR interventions closer to their true value, but this information may make spillover impacts—costs, benefits or both—and subsidies to other sectors more visible. To illustrate this point, a modelling study in Pakistan found that 53% of projected savings from averting unintended pregnancies accrued outside the health sector, primarily as avoided public spending on schooling.¹⁸ These cost savings to the education sector arise when women realise their intention to avert pregnancy, not from attainment gains, but a health-sector-only perspective would have missed either. Taking a multisectoral and societal perspective,

Table 1 Examples of evaluation components used in current economic evaluations of SRHR and potential gaps^{*16}

Evaluation component	What is typically measured (n=82)	Potential gaps and why they matter
Perspective	49=healthcare provider perspective 3=patient costs added (a “quasi-societal” view) 16=societal perspective 9=payer perspective. 5=did not report perspective	Costs and benefits falling on other sectors—education, labour, justice, social protection. Their exclusion could be a reason why SRHR’s cross-sectoral returns stay invisible in budget decisions.
Costs	79=included direct medical or programme inputs, eg, commodities and vaccines, service contacts, provider and intervention costs. 3=did not report any cost	Implementation costs, indirect costs (productivity losses, caregiving), indirect medical costs (transport, time) and the social costs of stigma and discrimination. Omitting these may understate the burden SRHR interventions relieve.
Outcomes	74=health outcomes: 9=explicitly report pregnancies averted, avoided or prevented 16=infections averted 12=complications avoided 27=QALYs 10=DALYs	Educational attainment, lifetime earnings, social participation, autonomy and agency and spillover benefits or intergenerational effects (benefits accrued to aid recipients’ children and/or grandchildren)—the ‘thrive’ and ‘transform’ gains that justify cross-sectoral investment.
Time horizon and life-course	51=used short time horizons 25=used lifetime (of the recipient). 6=did not report time horizon	Life-course and intergenerational (extending to recipients’ children and/or grandchildren) viewpoint. SRHR benefits may compound across decades and generations—dynamics that short-horizon, static models cannot capture.
Equity and rights	82=used aggregate (average) cost-effectiveness. 0=reported distributional or extended cost-effectiveness analysis	The ways in which costs and benefits are distributed across populations (eg, by gender, age, disability, racial or ethnic group), and rights-based outcomes such as agency.
Analytical method	69=model-based evaluations (7=combined within trial/cohort analysis with long-term modelling) 12=within-trial, cohort or empirical costing 1=did not report method	Model’s internal validity and transferability across settings.

*This table summarises patterns observed across studies evaluated in a rapid scoping review of 82 articles identified from MEDLINE (design details and findings can be found in ¹⁶).

DALY, disability-adjusted life-year; MEDLINE, Medical Literature Analysis and Retrieval System Online; QALY, quality-adjusted life-year; SRHR, sexual and reproductive health and rights.

however, could risk double counting errors; cross-sectoral accounting thus requires an explicit inventory.⁷ Because narrow health-sector evaluations apply a decision rule based on a cost-effectiveness threshold reflecting the health-budget opportunity cost (ie, health displaced elsewhere in the system), applying multisectoral and societal perspectives to SRHR evaluations would require correspondingly redefined decision rules or thresholds, applied consistently across competing claims.¹⁵

Second, embedding life-course and intergenerational analysis can help capture long-term and dynamic effects that static models overlook. For instance, WHO’s guideline on the SRHR of women living with HIV recognises a rights-based approach to their health and well-being across their lives.¹⁹ Evaluations of SRHR interventions that adopt a life-course perspective could better capture, for example, the economic impacts of unaddressed symptoms of menopausal transition in women living with HIV, as well as intergenerational effects beyond vertical

transmission of HIV, such as SRHR knowledge, educational attainment or economic participation in their children.²⁰ Integrating economic evaluation with a rights-based framework helps assess not only whether an intervention delivers value, but whether it does so equitably and in accordance with human rights principles and legal obligations.²¹

Third, using disaggregated data and analysis can better capture population health inequities to inform public health programming and related policymaking. For example, disaggregating 2015–2016 survey data on adolescents aged 15–19 by sex in two states in India highlighted that while roughly 1 in 5 adolescents reported symptoms of a genital infection, 2–3 times as many boys sought treatment than girls.²² Disaggregating SRHR data by sex, age and other characteristics identifies specific population health needs and helps target services accordingly, thereby likely further enhancing their ROI¹³—especially if the full range of cross-sectoral benefits are captured.

Moreover, distributional cost-effectiveness analysis can help quantify trade-off(s) between improving total population health and reducing health inequities,²³ while extended cost-effectiveness analysis additionally captures non-health implications for equity such as financial risk protection.²⁴ However, these disaggregated methods have largely been used within a narrow health sector perspective and would similarly necessitate a revised decision rule applied across SRHR and all comparator interventions.

Making these shifts could produce a more comprehensive assessment of the multisectoral costs and benefits of SRHR interventions. A consolidated account of returns on investment would, in turn, make the broader value of SRHR more visible to policymakers across sectors and give them a stake in SRHR investment.

CHALLENGES AND THE PATH FORWARD

Structural barriers, including siloed institutional and financing arrangements and weak cross-sectoral coordination, impede integrated approaches to comprehensively assessing the economic value of SRHR.²⁵ These are formidable challenges, particularly since a geopolitical environment that resists investing in SRHR is unlikely to prioritise, for instance, sex-disaggregated data and other SRHR data infrastructure.²⁶

Multisectoral and societal, intergenerational and equity-oriented analyses depend on linking SRHR data (eg, health service utilisation records) with data collected and maintained in other sectors (eg, educational enrolment and/or attainment records, employment earnings), ideally at the individual or community levels. Importantly, records disclosing, for example, abortion care or HIV status, pose a real risk of harm where these areas are criminalised or socially sanctioned, disproportionately affecting the same individuals missing from many existing evaluations. Conducting rights-based economic evaluations therefore requires rights-based data infrastructure,²⁷ including legal safeguards against data-sharing; stakeholder input regarding data linkages; and a preference for aggregate approaches at the cost of precision if individual-level linkage compromises safety. Triangulation of population-level datasets offers one route to building a rights-based data infrastructure,²⁸ but the lack of digital information systems—and limited health data capacity more generally—remain important barriers. Multiple funding sources, including national governments, philanthropic organisations and some bilateral donors, would be required.

In the current geopolitical climate, demonstrating that defunding SRHR degrades educational returns, reduces workforce productivity and increases social protection costs across multiple sectors while harming health, particularly for underserved and marginalised communities, creates a qualitatively different policy conversation than evidence of poor health outcomes alone. By making benefits and opportunity costs visible to policymakers in other sectors and demonstrating a net ROI, economic

evaluations of SRHR that take an explicitly multisectoral approach could effectively broaden the tent of relevant stakeholders and enhance cross-sectoral policy alignment.²⁸ Further, if sectors benefitting from SRHR interventions were to compensate the health sector for implementation costs, an overall cost-saving could be achieved.⁹ Enhanced collaboration with policymakers beyond the health sector and greater focus on governance mechanisms for multisectoral action are therefore also needed.²⁹

CONCLUSION

SRHR programmes generate returns across health, education, labour, justice and social protection spheres, but current economic evaluations fail to capture these returns. We advocate for three strategic shifts in the way economic evaluations of SRHR interventions are conducted so as to more accurately capture their wide-ranging value and make it more visible to policymakers. With global health funding in crisis and geopolitical pressures intensifying, the cost of continuing to understate the value of SRHR is too high, not only for the health and related sectors, but for people whose health and well-being depend on it.

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