Call to Action - International Day of Action for Women's Health

Essential, Not Optional: Strengthening Health Systems to Uphold Health Rights and SRHRJ in Times of Polycrisis

Why this Call to Action?

This Call to Action was prepared in light of May 28, which marks The International Day of Action for Women's Health. In the months leading up to this day, organizations, networks, activists and social justice movements from regions across the world came together to co-create this document which reflects our collective demands on our right to health, including our sexual and reproductive health and rights and justice (SRHRJ). Rooted in the theme *Essential, Not Optional: Strengthening Health Systems* to Uphold Health Rights and SRHRJ in Times of Polycrisis*, this Call to Action underscores that even in the midst of multiple overlapping crises (polycrisis) worldwide, SRHRJ is not optional and must continue to be prioritized as it is fundamental to our right to health and to building equitable, people-centered health systems that are accessible to all.

How was this Call to Action developed?

The Call to Action was developed through a multi-stage process, including an open invitation to participate in pre-consultations, learning sessions and global consultations, which brought together over 100 organizations and rights advocates from Africa, Asia and the Pacific, Eurasia, and Latin America and the Caribbean. These diverse voices, perspectives, and contexts were brought together to co-create this document and shape the theme for this year's May 28 International Day of Action for Women's Health. **The full report from the Global Consultations, which contains more in-depth discussions on the kinds of polycrisis being addressed in this call to action, can be accessed here.**

This Call to Action, therefore, reflects our shared priorities and collective vision and we look forward to this being used to guide actions worldwide in advancing our sexual and reproductive health, rights and justice (SRHRJ) as part of our fundamental right to health.

Why do we need to act now?

With just four years remaining until 2030, the world is already far off track from achieving the Sustainable Development Goals (SDGs), particularly SDG 3 (Good Health and Well-being), SDG 5 (Gender Equality), and SDG 10 (Reduced Inequalities). Progress remains insufficient: every day, more than 700 women die from preventable causes related to pregnancy and childbirth.[1] This moment reflects not only a failure of implementation, but a deeper crisis in accountability. Across contexts, governments are failing to meet their human rights obligations, while global systems of power and financing continue to prioritize militarization, austerity, and profit over people's health and wellbeing.

Ongoing polycrisis, marked by climate change, disasters, environmental degradation, pandemics and endemic diseases, economic instability, conflict, rising authoritarianism, fundamentalism, racism, and shrinking civic space—is worsening the already under-resourcing of health infrastructure, including prevention and mitigation efforts and service delivery, while amplifying cascading effects across health systems and communities. Prevention and care systems are increasingly weakened, leaving millions of people without access to essential services.

Research further demonstrates the scale and urgency of these intersecting crises. An estimated 3.6 billion people already live in areas highly vulnerable to climate change, and between 2030 and 2050, climate change is expected to cause approximately 250,000 additional deaths per year from undernutrition, malaria, diarrhoea, and heat stress alone. The direct costs of climate-related damage to health are projected to reach between US$2–4 billion annually by 2030.[2] These impacts place additional strain on already fragile and under-resourced health systems, particularly in low- and middle-income countries, where governments are struggling to respond to overlapping crises while ensuring continuity of essential health and SRHR services. Without urgent action to limit global temperature rise to 1.5°C and strengthen resilient, rights-based public health systems, the health and survival of millions of people will remain at risk.[3]

This is undermining the resilience, quality, and accessibility of health systems and pushing SRHRJ targets further out of reach, particularly for marginalized communities. Countries are increasingly falling behind on Universal Health Coverage (UHC),[4] reducing progress on preventable pregnancy-related mortality and morbidity among women, girls, and gender-diverse people, ensuring universal access to SRHR, advancing gender equality, and eliminating health-related inequalities.

This systemic erosion compromises the right to health and SRHRJ, including the right to access safe abortion, and contributes to the persistence and escalation of

discriminatory and harmful practices such as child marriage, female genital mutilation, gender-based violence, denial of safe abortion and post-abortion care, forced sterilization, and other coercive and discriminatory forms of healthcare access that directly affect the health and well-being of women, girls, and gender-diverse people.

This regression also signals a broader failure by the governments to uphold longstanding global commitments, under international human rights frameworks and international documents including the SDGs,[5] Beijing Declaration and Platform for Action (BPfA),[6] the Platform for Action of the International Conference on Population and Development Programme of Action (ICPD PoA),[7] and the political commitments made by governments worldwide during the 2023 United Nations High-Level Meeting (UNHLM) on UHC.[8]

In a moment of escalating global instability, we stand in collective resistance against far-right coalitions, authoritarian governance, budget cuts, restrictive regulations, and anti-rights movements that continue to undermine bodily autonomy, restrict access to essential health services (contraception, abortion, maternal care) and information, disrupt supply chains, and dismantle decades of hard-won rights.

During this May 28 International Day of Action for Women's Health, we affirm, unequivocally: the right to health and SRHRJ is essential, not optional.

What actions are now needed to advance our right to health and SRHRJ in times of polycris?

This moment demands more than mere recognition of the crises and vague commitments. This May 28, we call on governments, global institutions, donors, and all actors of power to move beyond words and act with urgency because true change happens when lived realities, community-led evidence, and collective action shape how systems are designed, financed, and held accountable.

We demand decisive, collective action from all to confront these intersecting crises, address structural inequalities and reclaim the right to health, and SRHR as a fundamental human right.

Recommendations to governments:

1. *On accessible and quality health care information, delivery and services*

(i) Build equitable, accessible and non-discriminatory health systems: Ensure that all health and SRHR services are accessible to everyone, free from discrimination, coercion, violence, and stigma, particularly in contexts where intersecting crises deepen exclusion and inequality. Ensure that the right to health is upheld without distinction of any kind, including on the basis of sex, sexual orientation, gender identity and expression, sex characteristics (SOGIESC), age, disability, health status, ethnicity, race, religion, language, nationality, profession, migration status, socioeconomic status, or geographic location.

(ii) Remove structural and systemic barriers to accessing health services: Eliminate provider bias, stigma, and coercive practices that restrict access to care and limit informed consent, including denial of services, moral judgment, and discriminatory treatment, especially in fragile and overstretched health systems. Remove unnecessary administrative and documentation requirements that create barriers to care, particularly for young people, unmarried individuals, migrants, and those without formal identification. Ensure that no one is subjected to forced conversion therapy, mandatory waiting periods, or coercive procedures, including requirements to view ultrasounds or listen to fetal heartbeats as a condition for accessing abortion or other SRHR services.

(iv) Integrate survivor-centric gender-based violence responses within health systems: Guarantee survivor-centered, trauma-informed, and accessible health, legal, and psychosocial services for all survivors of gender-based violence, recognizing this as a core expression of people-centered health systems. Ensure that health systems are designed to respond to the lived realities of victim-survivors, particularly as crises such as conflict, displacement, economic instability, and digital harm increase exposure to violence and barriers to care. Institutionalize accountability, protection, and reparations mechanisms within public health systems, and ensure coordinated, multi-sectoral service delivery that upholds dignity, autonomy, confidentiality, and informed consent.

2. *On making strategic investments to strengthen health systems*

(i) Strengthen equitable and people-centered public health systems: Invest in strong, publicly financed health systems that address gender inequalities, social determinants of health, disabilities and local vulnerabilities, particularly in contexts where intersecting crises are weakening system capacity and deepening unmet health needs. Expand, adequately resource, and ensure effective coordination of community-based and primary health care systems. Ensure continuity and integration of care across all levels of the health system, recognizing that individuals do not experience health in silos and that fragmented systems create risks across the continuum of care. This includes comprehensive SRHRJ services, menstrual health, psychosocial support services, and the prevention, diagnosis, and management of reproductive health conditions such as endometriosis, which remains under-recognised and under-treated within health systems. Strengthen access to accurate information and services as a core element of continuity of care, and ensure that health systems are designed to prevent fragmentation, exclusion, and gaps that undermine health outcomes.

(ii) Institutionalize comprehensive sexuality education (CSE) as part of health and education systems strengthening: Invest in increasing access to scientifically accurate, rights-based, age-appropriate, and inclusive comprehensive sexuality education (CSE) in both formal and non-formal settings, as a core component of education systems, gender empowerment, and public health. Ensure CSE is grounded in consent, bodily autonomy, gender equality, and freedom from violence, and is protected from political, ideological, or religious interference. Recognize CSE as both a critical preventive health intervention and a transformative education and rights-based tool that shapes knowledge, attitudes, and behaviors across the life course. It reduces unmet SRHRJ needs, prevents gender-based violence, and strengthens the effectiveness, equity, and responsiveness of health systems. Ensure that CSE meaningfully addresses the realities of adolescents and young people, including their evolving sexuality, relationships, mental wellbeing, and health needs, equipping them with accurate information and agency to make informed decisions.

(iv) End militarization and prioritize public investment in health, education, and care systems: Cease all armed conflict, occupation, and attacks on civilians and civilian infrastructure, including health and education facilities and reallocate public resources away from militarization, occupation, and security expansion toward publicly funded health systems, education, social protection, and care economies. Recognize that excessive military expenditure and armed conflict systematically undermine the realization of the right to health, deepen inequality, and exacerbate gender-based violence and structural injustice. Adhere to international humanitarian

law and mechanisms and invest in the safeguarding of health facilities as neutral, life-saving spaces.

(v) Integrate SRHRJ into climate, conflict, and humanitarian responses: Invest into integrating SRHRJ as life-saving and non-negotiable in all crisis contexts to ensure that humanitarian, climate, and conflict response frameworks include comprehensive SRHRJ services from the outset, including contraception, safe abortion, maternal health care, gender-based violence (GBV) response, and psychosocial support, even in disrupted or fragile settings. Invest in health systems to be anticipatory, adaptive, and responsive to intersecting crises, including pandemics, conflict, displacement, environmental and climate-related disasters and ecological crises. Invest in systems that provide urgent, gender-responsive action through preparedness, early response, and recovery mechanisms that maintain uninterrupted access to essential health services, including SRHR, before, during, and after crises in line with international standards as provided under the Minimum Initial Service Package (MISP) and the Sphere Handbook.

(vi) Strengthen supply chains: Invest in improved access and availability of essential and quality medicines, vaccines, diagnostics, and other health supplies necessary for the realization of the right to health, ensuring continuity even under conditions of systemic disruption.

3. *On safeguarding rights in times of polycrisis*

(i) End austerity and transform economic systems for health justice: Immediately reverse austerity-driven policies and fulfill obligations to progressively realize the right to health through sustained, adequate, equitable, and gender-responsive public financing. Strengthen domestic resource mobilization, reduce out-of-pocket expenditure, and reject privatization models that deepen inequality. Advance debt justice and economic reforms that expand fiscal space for health, care, and social protection.

(ii) Eliminate gender-based violence through comprehensive legal and policy action: Through legal and policy reforms, recognize gender-based violence as a systemic human rights and public health crisis that is intensified in contexts of overlapping political, economic, and social instability, with direct impacts on bodily autonomy, SRHRJ access, and overall health outcomes. Adopt, fully fund, and enforce comprehensive legal and policy frameworks to prevent, address, and eliminate all forms of discrimination, gender-based violence, including sexual violence, intimate partner violence, obstetric violence, and technology-facilitated gender-based violence.

(iv) Protect health workers and community-based providers: Through strong implementation of laws, ensure the safety, dignity, and labor rights of all health workers, including community health workers, abortion providers, doulas, acompañantes, and frontline health providers. Where needed, legal and policy level gaps or shortcomings must be addressed to protect them from violence, harassment, burnout, and criminalization, and guarantee fair compensation, safe working conditions, and professional recognition.

(v) Protect civic and digital space in times of polycrisis: Put in place laws to guarantee freedoms of expression, association, assembly, and access to information as foundational conditions for functioning health systems and effective SRHRJ delivery in contexts of polycrisis. Eliminate discriminatory laws to end the criminalization, surveillance, harassment, and defunding of feminist, LGBTQIA+, youth-led, and human rights organizations that are essential to health service delivery, community-based care, and accountability. Put in place strong laws and policies on digital governance to ensure access to accurate SRHRJ information, prevent algorithmic censorship, and address technology-facilitated gender-based violence that undermines health access and safety.

4. *On strengthening government accountability through partnerships*

(i) Uphold the obligations of the government to respect, protect, and fulfill the right to health and SRHRJ: Governments must recognize and act on their primary responsibility as duty-bearers under international human rights law, ensuring that all policies, laws, and investments advance the realization of health and SRHR without discrimination.

(ii) Strengthen accountability mechanisms: Establish transparent, participatory, and rights-based accountability systems that enable communities and civil society to monitor, evaluate, and demand action on health commitments. This includes establishing community-led monitoring systems and grievance mechanisms at local health facilities and across different levels of health systems to ensure real-time accountability, responsiveness of services, and corrective action where gaps in care occur.

(iii) Ensure meaningful participation and leadership of marginalized communities in health systems: Governments should strengthen partnership with civil society and affected communities, the most marginalized, recognizing them as knowledge-holders, and ensure their meaningful participation in co-creating, implementing, and monitoring health systems. This should include women, young people, LGBTQIA+ persons, persons with disabilities, Indigenous peoples, migrants,

and other structurally excluded groups in all stages of health system governance, including design, implementation, monitoring, and accountability.

(iv) Strengthen democratic governance, transparency, and accountability in health systems: Intersecting crises are weakening institutions and eroding public trust. So, governments must work with civil society and communities to ensure health systems remain responsive to intersecting crises, including conflict, climate change, economic instability, and public health emergencies. These partnerships can help build accountable institutions that uphold human rights, prevent corruption, and guarantee equitable allocation of public resources towards health and SRHR. It will also ensure that policy and legal reforms are informed by community and movement-led evidence so that lived experiences, service gaps, and accountability data is integrated into health system planning, monitoring, and policy processes.

Recommendations to funders and donors:

1. *Funders and donors on shaping priorities and resource flow to tackle polycrisis*

(i) Invest in neglected and underfunded areas of SRHRJ: Increase sustained investment in neglected and underfunded areas of SRHRJ, including menstrual health, midwifery care, endometriosis research and advocacy, and integrated services for people affected by climate change, humanitarian crises, HIV, TB, mental health conditions, and disability. Ensure that research, services, and innovation respond to intersecting inequalities and the evolving needs of crisis-affected populations. Strengthen integrated and person-centered health systems that guarantee continuity of care across the life course, without fragmentation or exclusion. This includes ensuring that all women, girls, and gender-diverse people are meaningfully informed about their options and have access to the full range of evidence-based HIV prevention methods, safe and non-stigmatizing abortion and post-abortion care, and affordable, accessible, and equitable health innovations.

(ii) Provide rights-based, equitable, flexible, and long-term funding: Donors and funders provide direct, flexible, long-term, and core funding for feminist, youth-led, LGBTQIA+, Indigenous, and community-based organizations working on SRHR and health justice and most affected by intersecting crises but remain structurally under-resourced. Provide sustained funding for feminist and social movements, grassroots, last-mile and community led organizations including advocacy, organizing, coalition-building, care work, crisis response, and collective infrastructure. Recognize movements as essential infrastructure for accountability, service delivery, and rights protection in contexts of intersecting crises.

Recognize and actively protect SRHR defenders, abortion rights activists, acompañantes, and feminist organizations that are operating under conditions of polycrisis, where austerity-driven funding cuts, economic asphyxiation, and defunding restrict their ability to sustain essential SRHR work. End donor complicity in shrinking civic space and ensure funding systems do not expose organizations to heightened risks from criminalization, digital violence, harassment, judicial persecution, and coordinated anti-rights attacks that undermine human rights and health justice.

(iii) Design sustainable funding models: Donors and funders should create quick-response funding mechanisms, supported by a diversified donor and funder base, that are capable of responding rapidly to conflict, climate and natural disasters, and public health emergencies. These mechanisms must ensure continuity of essential services, including SRHRJ, even in crisis contexts. At the same time, funding systems must uphold the principles of local leadership, autonomy, participation, and contextual knowledge. Transform funding models to prioritize equity, decolonial approaches, and the redistribution of resources toward the Global South.

2. *Funders and donors to ease access to funding*

(i) Simplify and reform funding processes: Reduce bureaucratic barriers, administrative burdens, and ensure timely disbursement of funds to make funding accessible. Adapt reporting and compliance requirements to be proportionate and accessible, particularly for grassroots, youth-led, and small organisations. Proactively address barriers created by restrictive legal and regulatory environments that limit access to funding, and develop flexible, context-responsive mechanisms to ensure that activists and organisations operating in such contexts are not excluded from critical resources.

3. *Funders and donors to contribute towards the building of resilient health systems*

(i) Advance global economic justice and debt relief: Funders and donors must use their influence with global financial institutions to expand fiscal space for health, care, and social protection. Structural drivers such as debt burdens and austerity policies deepen intersecting crises and undermine resilience. By supporting debt relief, rejecting harmful conditionalities, and promoting financing models grounded in equity and rights, funders can ensure governments are able to progressively realize the right to health and SRHRJ, even in contexts of economic instability and compounded crises. Initiatives such as the Debt x Health initiative, of which the Global Fund is a key partner, demonstrate how debt relief can be directly linked to

investments in health and serve as critical models that should be scaled, replicated, and made accountable to the communities most affected.

(ii) End all harmful conditionalities and ideological restrictions: Development assistance should be grounded in human rights and equity, not used as a tool of political or ideological control. In times of polycrisis, when barriers to health and justice are already heightened, donors have a responsibility to ensure their funding expands access rather than deepens exclusion, enabling the governments and communities to realize the right to health, SRHRJ. Funders and donors must actively advocate to reverse policies such as the Global Gag Rule that have entrenched barriers and caused lasting harm. Donors and funders can do so by removing all conditions that restrict access to SRHRJ information and services, including abortion-related restrictions such as the Global Gag Rule.

(iii) Do proactive advocacy: Funders and donors must go beyond reversing harmful restrictions by actively investing in advocacy that strengthens comprehensive SRHRJ services and accountability. In polycrisis contexts, where conflict, climate shocks, economic instability, and public health emergencies converge, this proactive approach ensures accessible, rights-based funding towards SRHRJ and resilient health systems under the most challenging conditions.

(iv) Shift accountability toward people, not just funders: Funders must reform funding practices to ensure accountability is directed toward communities and movements rather than solely toward donor priorities, indicators, and reporting systems.

Notes

*** On the term "women":** While we use the term 'woman/women' we do so with a critical reflexivity that recognizes the nuances and right to people's unique sexual and gender identities and expressions. We also recognize that 'women' are not a monolithic group and that they have diverse identities that vary due to their social location and the socio-economic, political, and multicultural contexts in which their lives are embedded. When using 'woman', we include transgender women, gender-diverse people, and women in all their diversities across contexts.

*** Polycrisis:** The term "polycrisis" was originally coined by French complexity theorists Edgar Morin and Anne Brigitte Kern in the late 1990s to describe the "complex intersolidarity" of multiple interconnected global crises. Rather than viewing crises as isolated events, they argued that political, economic, environmental, social, and institutional crises interact with and intensify one another. The concept has since been further developed by scholars including Adam Tooze, who popularized the term in contemporary global discourse to describe how crises such as climate change, pandemics, war, inflation, debt, democratic backsliding, and inequality do not occur independently, but compound and reinforce each other in ways that make their collective impacts more severe than the sum of individual crises. See: Lawrence, M., Homer-Dixon, T., Janzwood, S., Rockström, J., Renn, O., & Donges, J. F. (2024).

Global polycrisis: The causal mechanisms of crisis entanglement. *Global Sustainability*, 7, e6. https://doi.org/10.1017/sus.2024.1

*** Strengthening Health Systems:** This involves the development and implementation of primary health care oriented health policies and realistic strategic plans that focuses on improving the institutional and organizational capacity of a country to provide health services to the whole population. These policies and strategies are prepared within the context of national socio - economic development, and the improvement of health services performance in terms of quality safety, effectiveness, efficiency, coverage and equitable access and use. This contributes to the attainment of the goal of Health for All, where the healthcare system is responsive to the needs of all members of society, regardless of their socioeconomic status, ethnicity, culture, gender or other factors. See: World Health Organization Regional Office for Africa. Health systems strengthening. https://www.afro.who.int/health-topics/health-systems-strengthening

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