SOUTH CENTRE

ADVANCING WOMEN AND GIRLS' HEALTH IN A TIME OF CONVERGING CRISES

South Centre Briefing Session, April 2025

Advancing Women and Girls' Health in a Time of Converging Crises

Report[1]

1. Introduction

The South Centre hosted a high-level briefing session aimed at advancing the health rights of women and girls in the face of multiple global challenges. The meeting coincided with the South Centre's 30th anniversary and the 30th anniversary of the Beijing Declaration and Platform for Action, bringing together ambassadors, health experts, and representatives of international organisations to discuss the protection and advancement of sexual and reproductive health and rights (SRHR) in the Global South.

The global community faces unprecedented challenges in realising the right to health for all. Persistent health inequities are being exacerbated by the converging impacts of recent international events, including pandemics, escalating conflicts, economic instability, and the accelerating climate crisis. While progress towards the Sustainable Development Goals (SDGs) acknowledges the importance of gender equality and SRHR, this progress is threatened by persistent inequalities, the lingering effects of the COVID-19 pandemic, escalating climate change impacts, ongoing conflicts, and socioeconomic disparities. These compounding challenges threaten to reverse hard-won gains and jeopardise the achievement of the SDGs, particularly those related to reducing maternal mortality (SDG 3.1), improving neonatal and child survival (SDG 3.2), and achieving universal access to sexual and reproductive health (SDG 5.6).

These converging crises disproportionately affect vulnerable populations, particularly women and girls. Climate change exacerbates these challenges through displacement, food insecurity, and increased vulnerability to gender-based violence. Existing conflicts and humanitarian crises further disrupt access to SRHR services, often leading to

[1] This report was prepared by the South Centre's Secretariat and its content reflects the Secretariat's own summary of the presentations and dialogue among the panellists and delegations participating at the meeting.

increased sexual violence and limited access to essential care. The shifting geopolitical landscapes and changing priorities among donor nations impact resource flows for global health, including SRHR, creating uncertainty and hindering developing countries' ability to strengthen health systems. Additionally, challenges to multilateralism and attempts to undermine established norms affect funding, cooperation, and access to SRHR services.

The 2030 Agenda for Sustainable Development and the Pact for the Future provide important frameworks to align these efforts; however, practical implementation requires strengthened international cooperation and addressing the root causes of SRHR inequities. This briefing enabled participants and panellists to highlight the persistent challenges, share best practices and propose concrete actions to defend gains while addressing ongoing disparities.

2. Welcome Notes by South Centre

Carlos Correa, Executive Director of the South Centre, opened the session, emphasising SRHR as integral to the human right to health. Despite United Nations resolutions and guidance from the SDGS and the Pact of the Future, persistent social and economic disparities continue to hinder progress. He noted that the world remains significantly off track to meet the SDG target 3.1 (reducing the global maternal mortality ratio to less than 70 per 100 000 live births by 2030), which would require a much faster average annual rate of reduction (approximately 15%) than the current decline of around 1.5%.[2] Furthermore, reductions in humanitarian aid and development assistance are actively threatening fragile progress, forcing countries to roll back vital services.

He highlighted the South Centre's significant record in human rights and health work. He announced a recently signed agreement with the Health and Development Partnership for Africa and the Caribbean (HeDPAC) to strengthen the South Centre's work on SRHR. Prof. Correa mentioned that the meeting aimed to identify key challenges to achieving SRHR goals, discuss the importance of integrating SRHR into primary healthcare (PHC), increase the discussion of SRHR in the human rights context, and share best practices from various countries.

Prof. Correa noted the alarming situation regarding maternal and child mortality highlighted at the recent World Health Organization (WHO) Executive Board and called for greater engagement from Global South countries in future discussions. He

[2] World Health Organization (WHO), *Trends in maternal mortality estimates 2000 to 2023: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division* (2025). Available from https://iris.who.int/bitstream/handle/10665/381012/9789240108462-eng.pdf?sequence=1.

referenced two recent South Centre publications: one on a human rights-based approach to preventable maternal mortality (February 2025)[3] and a policy brief on advancing women's, children's, and adolescent health (April 2025),[4] analysing the WHO global strategy.

3. Panel Discussion: Current Challenges for Realising the Right to Health and of Sexual and Reproductive Health and Rights (SRHR)

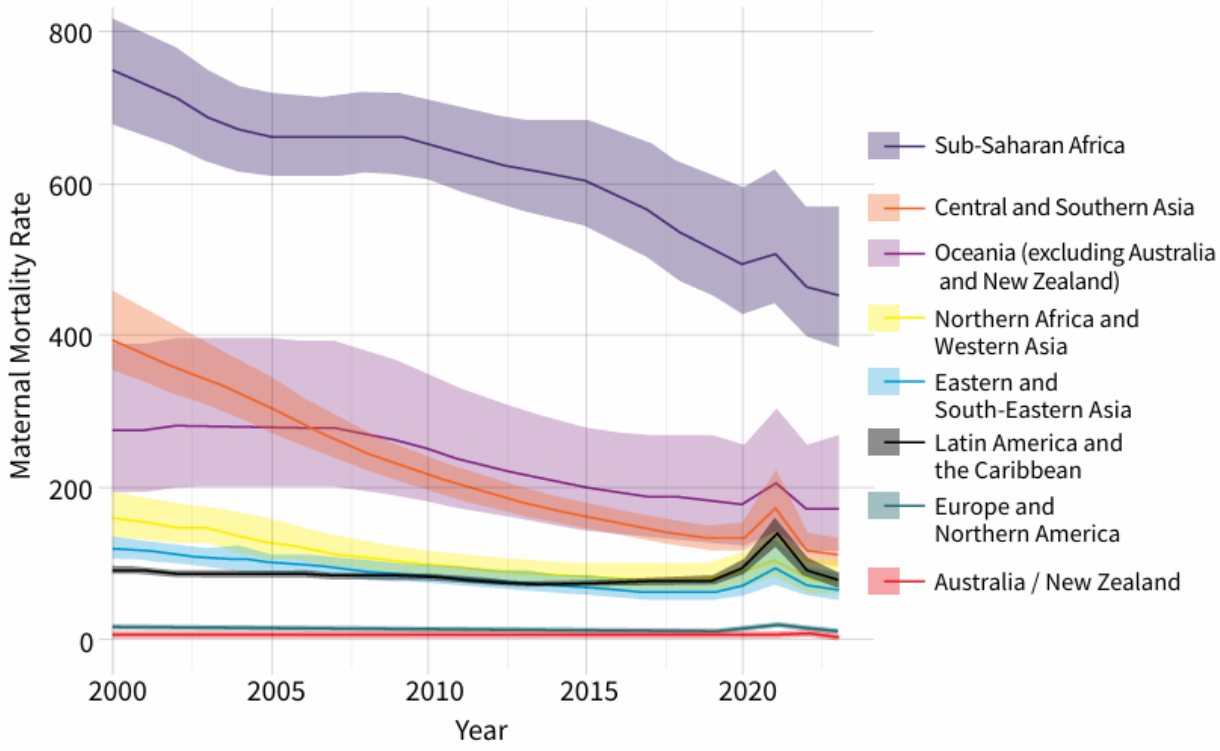
Dr. Haileyesus Getahun, Executive Director of the HeDPAC, emphasised the right to health and reproductive health as affirmative human rights enshrined in international conventions like the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (Article 12).

He presented data showing progress based on a rights-based approach, such as a global 40% reduction in maternal mortality between 2000 and 2023. However, Dr. Getahun highlighted that significant problems remain: the global maternal mortality ratio (MMR) in 2023 was estimated at 197 deaths per 100,000 live births, translating to roughly 700 women dying daily from preventable pregnancy complications (see Figure 1). He also explained that the vast majority of these deaths stems from preventable complications like severe bleeding, infections, high blood pressure, delivery complications, and unsafe abortion.

[3] South Centre, "Input on the update to the technical guidance on the application of a human rights-based approach to the elimination of preventable maternal mortality and morbidity" (Submission pursuant to Human Rights Council Resolution 54/16, February 2025). Available from https://www.southcentre.int/wp-content/uploads/2025/02/SC-input-on-the-update-to-the-technical-guidance-pursuant-to-HRC-54-16.pdf.

[4] Bianca Carvalho and Viviana Munoz Tellez, "Advancing Women's, Children's and Adolescents' Health and Inequalities in Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health: Highlights from the 156th Meeting of the World Health Organization's Executive Board", Policy Brief No. 139 (Geneva, South Centre, 2025). Available from https://www.southcentre.int/wp-content/uploads/2025/04/PB139_Advancing-Womens-Childrens-and-Adolescents-Health-and-Inequalities-in-Sexual-Reproductive-Maternal-Newborn-Child-and-Adolescent-Health_EN.pdf.

Figure 1.- Maternal Mortality Trends by SDG Region (2000-2023)



Source: World Health Organization, Trends in Maternal Mortality Health (2000 – 2023), 2025

Mr. Getahun highlighted that adolescent pregnancy remains a critical issue, with an estimated 21 million pregnancies occurring each year among adolescent girls (aged 10-19) in Low and Middle-Income Countries (LMICs), and 58,000 adolescent pregnancies occurring daily. Sub-Saharan Africa (SSA) reports adolescent birth rates (ABR) more than double the global average.

Dr. Getahun emphasised that SSA and conflict-affected or fragile states bear a disproportionate burden. SSA accounts for approximately 70% of all maternal deaths, and nearly two-thirds (64%) of maternal deaths in 2023 occurred in countries classified as being in conflict or experiencing institutional or social fragility.[5] Conflict areas face maternal mortality rates almost five times higher than non-conflict states (504 vs 99 per 100,000), and the lifetime risk of maternal death is significantly higher in fragile settings (1 in 51 compared to 1 in 593 in more stable countries). Women and girls in humanitarian emergencies face some of the highest risks globally.[6]

[5] WHO, *Trends in maternal mortality estimates 2000 to 2023.*
[6] *Ibid.*

For Dr. Getahun, climate change poses a growing challenge. Foreign aid reductions are disruptive, although he suggested they might be a "blessing in disguise," given that several African countries, including Nigeria, South Africa, Ethiopia, the Democratic Republic of the Congo, and Ghana, responded by increasing their domestic health investments. He cited recent literature showing that past aid sanctions had derailed maternal mortality progress by 60 per cent over five years[7] and also raised concerns about the Geneva Consensus Declaration (GCD) as an initiative that undermines SRHR. The GCD, initiated in 2020 and rejoined by the United States in 2025, explicitly states "no international right to abortion" and affirms national sovereignty on abortion laws, contrasting with SRHR commitments in frameworks like the Global Strategy for Women's, Children's and Adolescents' Health (GSWCAH).

Finally, he called for protecting critical gains made in sexual and reproductive rights, and advanced two concrete recommendations to strengthen accountability through Universal Periodic Reviews (UPRs) and integrate community health workers (CHWs) into the civil service.

H.E. Amb. Leslie Ramsammy (Ambassador of Guyana), an advocate for the right to health, framed women's health as "gender justice" and rejected inequities between Nairobi and Geneva, or Kigali and Boston. Recalling his time as President of the World Health Assembly in 2008, he reiterated his call for a global initiative to ensure that no country has a life expectancy below 75 by 2025, arguing that this requires addressing women's health inequities, including violence and access to SRHR services.

Amb. Ramsammy highlighted Guyana's progress, noting that the country has increased women's life expectancy from 68.5 to 74.5 years (2008-2024), reduced maternal mortality from 120 to 80 per 100,000, and decreased neonatal mortality from 25 to 12 per 1,000 live births. Furthermore, Amb. Ramsammy considered that women's autonomy and decision-making power regarding their own Sexual and Reproductive Health (SRH) are severely limited in many parts of the world. Data from 57 countries indicates that only 55% of married or in-union women aged 15-49 make their own decisions regarding sexual intercourse, contraceptive use, and their own healthcare.[8]

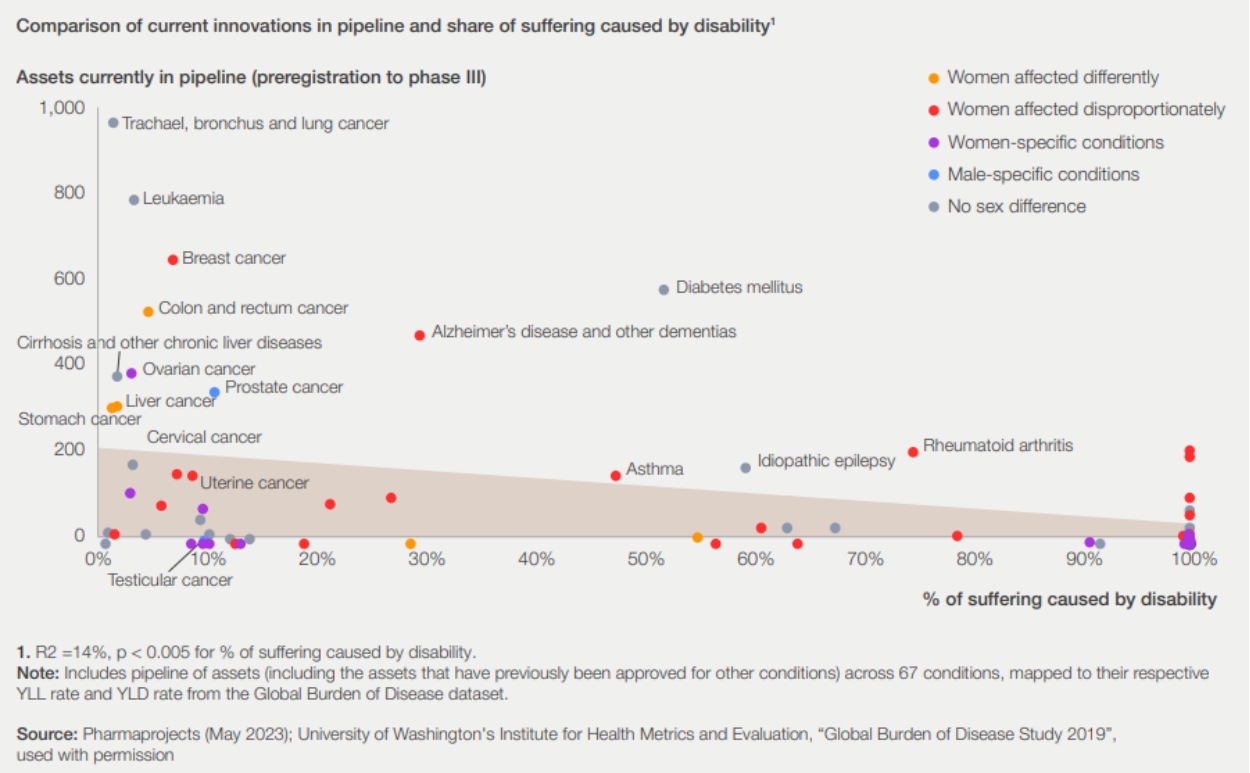
Regional disparities in accessing SRH services are also vast. Less than 40% of women

[7] Ruth M Gibson and others, "The impact of aid sanctions on maternal and child mortality, 1990–2019: a panel analysis", *The Lancet Global Health* (2025).
[8] United Nations Population Fund (UNFPA), *State of World Population 2021: My Body is My Own: Claiming the Right to Autonomy and Self-Determination* (2021). Available from https://www.unfpa.org/sowp-2021.

have access to these services in Middle and Western Africa (below 10% in Mali, Niger, Senegal), compared to nearly 80% in some countries in Europe, South-eastern Asia, and Latin America and the Caribbean. He also explained that such disparities limit the autonomy of women and girls, which is a fundamental barrier to health.

Amb. Ramsammy emphasised the research gap, noting that most health research focuses on men and the Global North, with 90% of research funds allocated to studying 10% of the population (Figure 2). Historically, women were largely excluded from clinical research. Despite mandates for inclusion (e.g., NIH 1993), underrepresentation persists: women constitute only 22% of participants in Phase 1 clinical trials. Funding disparities mirror this: in the US, diseases primarily affecting men receive twice as much research funding as those primarily affecting women. In 75% of cases where a disease disproportionately impacts one gender, funding patterns favour men. Only 1% of non-oncology healthcare research and innovation (R&I) funding was invested in female-specific conditions in 2020. Conditions with high burden on women, like premenstrual syndrome (PMS), menopause, and endometriosis, received less than 1% of the cumulative research funding allocated (2019-23) to key gap drivers. For instance, endometriosis startups received $44 million, compared to $1.24 billion for erectile dysfunction startups (2019-2023). Even for leading killers like cardiovascular disease, only 4.5% of coronary artery disease research funding targets women.

Figure 2.- Comparison of Current Innovations in Health Research



1. R2 =14%, p < 0.005 for % of suffering caused by disability.
Note: Includes pipeline of assets (including the assets that have previously been approved for other conditions) across 67 conditions, mapped to their respective YLL rate and YLD rate from the Global Burden of Disease dataset.

Source: Pharmaprojects (May 2023); University of Washington's Institute for Health Metrics and Evaluation, "Global Burden of Disease Study 2019", used with permission

For Amb. Ramsammy, the research gaps hinder the understanding of women's specific health needs, contributing to diagnostic delays, less effective interventions, and women spending 25% more of their lives in poor health compared to men. Amb. Ramsammy also highlighted a basic data gap due to the prevalence of paper-based health records in the Global South and advocated for South-South cooperation on electronic health records, aligning with recommendations to strengthen health information systems.

H.E. Amb. Marcela Arias Moncada (Ambassador of Honduras) shared Honduras's advances in improving healthcare access and realising sexual and reproductive rights, particularly in three pillars: 1) A legal framework recognising constitutional health rights guided by universality, equity, and non-discrimination, incorporating international law (International Covenant on Economic, Social and Cultural Rights (ICESCR), CEDAW) via conventionality control, consistent with a human rights-based approach; 2) Record-high social and public health investment resisting commodification, prioritising infrastructure, maternal/child health, and primary care; 3) Advancing gender equality governance through mandated gender units in all state institutions integrating gender perspectives into policies and budgets.

Amb. Arias Moncada highlighted that a cornerstone of Honduras's strategy is the advancement of gender equality governance, notably through Honduras's Law for Equality of Opportunities for Women (Law 151) enacted in 2000.[9] The law aims to eliminate discrimination against women and ensure equal rights and opportunities across various sectors, including family, health, education, work, and political participation. It mandates the State to promote gender equality and protect women's rights. This foundational law is supported by other regulations, such as the Labour Code, which provides rights for pregnant women, and rules on reproductive health and gender-based violence protection.

Law 151 also mandated the creation of Gender Units in all state institutions. These units work to integrate a gender-sensitive perspective across public administration, with tangible impacts in areas such as comprehensive care for survivors of sexual violence (Ministry of Health) and health services for vulnerable women, including older women and Afro-Honduran communities (Ministry of Social Development). These units also monitor maternal mortality surveillance, collaborating with community women's care centres with the mandate of implementing sexual violence protocols, organizing health fairs for vulnerable women, monitoring maternal mortality surveillance, and facilitating access to services via women's care centres called “Ciudad Mujer" (see Box 1).

[9] Equality of Opportunities for Women Law, Law 151 (Honduras) 2000.

Box 1

Ciudad Mujer ("Women City") Program

Ciudad Mujer is a social protection program in Honduras, elevated to a National State Policy, that offers free comprehensive services to women, adolescents, girls, and boys. Its objective is to improve their living conditions and well-being through the coordination of approximately 15 state institutions that provide over 70 services under one roof.

Key Components (Attention Modules):

Attention Module	Brief Description (based on module name)
Economic Attention Module	Focused on the economic development and financial autonomy of women.
Sexual and Reproductive Health Module	Provides services and guidance on sexual and reproductive health.
Attention and Protection of Women's Rights Module	Offers assistance and protection in cases of rights violations.
Adolescent Care Module	Addresses the specific needs of young women.
Community Education Module	Offers educational and awareness programs for the community.
Child Care Module	Provides services and care for the users' children.

Ciudad Mujer operates through fixed centres and a mobile unit, based on principles of gratuity, equality, and confidentiality, seeking the empowerment and comprehensive development of Honduran women.

Ambassador Arias noted these efforts contributed to a historic 27.4% decrease in maternal mortality in 2024, with 2025 declared the Year of Universal Health Coverage.[10] Amb. Arias also emphasised further progress in Honduras, including the adoption of a comprehensive sexuality education law and the recent lifting of the ban on emergency contraception. Finally, she concluded by emphasising the need for solutions sensitive to local realities and global crises, calling for international cooperation to address systemic obstacles and advance gender equality. Honduras reaffirmed its commitment to these goals, with the speaker also acknowledging the supportive role of male colleagues dedicated to gender equality.

[10] "Presidenta Castro declara 2025 como el Año del Acceso y Cobertura Universal de Salud en Honduras" (TNH.gob.hn). Available from https://tnh.gob.hn/gobierno/presidenta-castro-declara-2025-como-el-ano-del-acceso-y-cobertura-universal-de-salud-en-honduras/ (accessed 8 May 2025).

H.E. Amb. Mxolisi Nkosi (Ambassador of South Africa) called for "defending and advancing" women's health rights due to serious pushback seen in forums such as the Human Rights Council, International Labour Organization, United Nations High Commissioner for Refugees, and the World Health Organization. Despite health being a fundamental right according to the Universal Declaration on Human Rights (UDHR)[11] and the WHO Constitution,[12] women spend 25 percent more time in poor health services compared to men,[13] face misdiagnosis, and suffer high maternal mortality (800 deaths/day reported, mostly developing countries; global estimate 700 deaths/day in 2023),[14] and preventable diseases like cervical cancer. Women are more vulnerable in crises, such as armed conflict, disasters, and sexual and gender-based violence (SGBV), including rape as a weapon of war.[15] Conflict actively dismantles health systems, breaks supply chains, increases sexual violence, and dramatically elevates maternal health risks.[16]

South Africa prioritizes these rights through its constitution (right to health, non-discrimination, access to reproductive healthcare), the 1996 Choice on Termination of Pregnancy Act (reduced related mortality by 91%), the 2007 Sexual Offenses Act, and the 2024 Generation Act addressing SGBV. The National Adolescent and Youth Health Policy (2017) provides youth-friendly services, and the National Strategic Plan targets HIV/TB/STIs. President Ramaphosa leads the **Global Leaders Network (GLN) for Women's, Children's, and Adolescents' Health (WCAH)**, convened by the Partnership for Maternal, Newborn & Child Health (PMNCH) (see Box 2).

[11] See: Universal Declaration of Human Rights (adopted 10 December 1948), UNGA Res 217 A(III)), art. 25.
[12] See: Constitution of the World Health Organization (adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 States, (1948) Off Rec Wld Hlth Org, 2, 100). Preamble.
[13] World Economic Forum, "Women's health conditions are often missed, misdiagnosed or a mystery. How can we change this?". Available fromhttps://www.weforum.org/videos/women-s-health/ (accessed 9 May 2025).
[14] See: WHO, *Trends in maternal mortality estimates 2000 to 2023*.
[15] UN Women, "Facts and figures: Women, peace, and security", 23 October 2024. Available from https://www.unwomen.org/en/articles/facts-and-figures/facts-and-figures-women-peace-and-security#90012 (accessed 9 May 2025).
[16] *Ibid*.

Box 2

Global Leaders Network (GLN) for Women's, Children's and Adolescents' Health

- **Nature:** A significant, first-of-its-kind Southern-led global health diplomacy effort.
- **Launch:** 2023, with nine initial Heads of State members, chaired by South African President Cyril Ramaphosa.
- **Aim:** To mobilize political will at the highest level, advocate for increased investment, strengthen policies, and enhance service delivery for WCAH.
- **Core Priorities:** Financial prioritization for WCAH. Expanding equitable access to quality health services and SRHR commodities; and promoting progressive laws to protect health and bodily autonomy.
- **Target:** To accelerate progress against maternal, neonatal, and adolescent mortality indicators in 10-11 key countries, aiming for a one-third reduction by 2030.
- **Significance:** Represents a high-level political impetus to complement technical strategies like the WHO's GSWCAH and foster South-South leadership.

South Africa prioritised women's health in its Group of Twenty (G20) presidency. Ambassador Nkosi urged viewing aid cuts as a "wake-up call" for the Global South to take responsibility and reclaim health sovereignty, aligning with trends towards South-South cooperation platforms like HeDPAC.

Catrin Schulte-Hillen, Reproductive Health Specialist, United Nations Population Fund (UNFPA), focused on SRH for the most vulnerable, particularly in humanitarian settings. She highlighted stark disparities in access to health services for women, for example, Somalia's 1-in-17 maternal death[17] risk vs. Finland's 1-in-4,000. The lifetime risk of maternal death for a 15-year-old girl is estimated at 1 in 51 in fragile settings,[18] compared to 1 in 593 in more stable countries. Mrs. Schulte-Hillen noted 80% of countries miss the maternal mortality SDG targets, with the world significantly off-

[17] United Nations Children's Fund (UNICEF), "Aid cuts threaten fragile progress in ending maternal deaths, UN agencies warn" (Press Release, 7 April 2025). Available from https://www.unicef.org/press-releases/aid-cuts-threaten-fragile-progress-ending-maternal-deaths-un-agencies-warn (accessed 9 May 2025).

[18] WHO, *Trends in maternal mortality estimates 2000 to 2023* (UN Report, 2025) as cited in UNICEF, "Aid cuts threaten fragile progress in ending maternal deaths, UN agencies warn".

track.[19] She continued by highlighting that disparities are increasing despite overall progress; Asia improves while Sub-Saharan Africa faces accumulated challenges (high mortality, low contraception, adolescent HIV/pregnancy), accounting for ~70% of global maternal deaths and having high unmet need for modern contraception (e.g., 49M women in East/Southern Africa, over half young).[20]

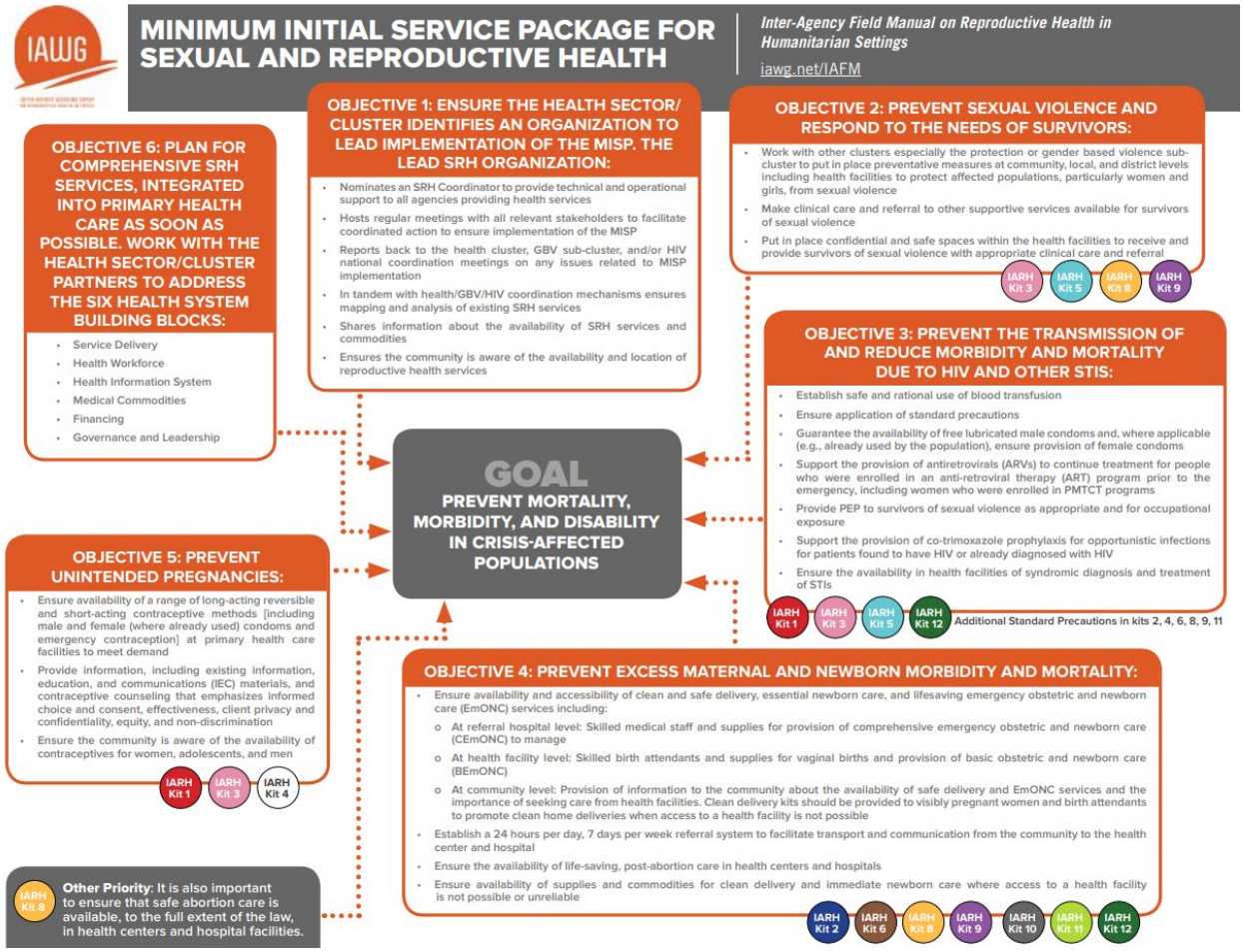
She introduced the Minimum Initial Service Package (MISP) for SRH in humanitarian settings, which was developed in 1996.[21] Mrs. Shulte-Hillen explained that MISP is a coordinated set of priority, life-saving activities that must be implemented at the onset of every humanitarian emergency, without requiring initial needs assessments. She continued by explaining that it is an international standard of care integrated into Sphere standards (see Figure 3). Its core objectives include ensuring coordination of the SRH response; preventing and responding to sexual violence; preventing HIV/STI transmission; preventing excess maternal/newborn deaths/illness (including ensuring access to Emergency Obstetric Care); preventing unintended pregnancies (including making contraceptives available); and planning for the transition to comprehensive SRH services integrated into primary care.

[19] UNICEF DATA, Maternal mortality rates and statistics. Available from https://data.unicef.org/topic/maternal-health/maternal-mortality/ (accessed 9 May 2025). See also United Nations Department of Economic and Social Affairs (UN DESA) Statistics Division, Goal 3 — SDG Indicators (UNStats SDG Report 2024). Available from https://unstats.un.org/sdgs/report/2024/Goal-03/ (accessed 9 May 2025).

[20] WHO, "Maternal mortality" (WHO Fact Sheet, 7 April 2025). Available from https://www.who.int/news-room/fact-sheets/detail/maternal-mortality (accessed 9 May 2025).

[21] UNFPA, "Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crises: Distance Learning Module – Reference Material". Available from https://www.unfpa.org/sites/default/files/resource-pdf/MISP-Reference-English.pdf (accessed 9 May 2025).

Figure 3: Minimum Initial Service Package for Sexual and Reproductive Health



Source: United Nations Population Fund (UNFPA)

Mrs. Schulte-Hillen shared findings from recent UNFPA MISP readiness assessments in 77 countries, highlighting that 48 per cent felt insufficiently prepared, even in non-crisis times, to provide essential MISP services and absorb a crisis shock. Readiness was lowest for family planning and clinical management of rape. She also mentioned that SRH is systematically sidelined in humanitarian responses, partly due to challenging social norms and stressed the need for SRH visibility within Primary Health Care integration and system strengthening, focused on emergency preparedness and resilience. Mrs Shulte-Hillen emphasised UNFPA's commitment to midwives, whose competencies align well with MISP needs and warned against losing agreed international standards (like MISP), which are key tools in humanitarian contexts, especially amid challenges to the humanitarian architecture and terminology.

Discussion

Participants emphasised the disproportionate impact of converging crises (conflicts, climate, inequalities) on women and girls in vulnerable contexts. They highlighted that crises exacerbate inequities and that conflict settings concentrate nearly two-thirds of maternal deaths. Participants committed to ensuring continued access to Sexual and Reproductive Health (SRH) services, accompanied by a call for state and international investment in resilient health systems.

Participants called for consolidating efforts in the Global South and strengthening South-South cooperation amid the unpredictability of aid. They suggested analysing past aid impact versus internal progress and rethinking strategies. Participants expressed support for a human rights approach to health, linking it to the right to life, and emphasised the role of education and information in health literacy and access, including Comprehensive Sexuality Education.

Participants also congratulated the South Centre on its 30th anniversary, acknowledging its vital role as a think tank. They highlighted the critical need for good research and relevant data to inform efficient resource prioritisation amid constraints, calling for the South Centre's help in this area. This, participants noted, aligns with the need to address systemic data gaps and gender bias in research. Participants appreciated leadership efforts in Africa and stressed that service availability and readiness must be coupled with affordability to achieve Universal Health Coverage (UHC) and prevent catastrophic costs for women. Participants also expressed a commitment to Sexual and Reproductive Health and Rights (SRHR) and South-South cooperation.

4. Future Steps

The South Centre committed to continuing work in SRHR, leveraging its partnership with HeDPAC, through publications and convening dialogues among Global South countries. A meeting report will be prepared for dissemination, potentially to the Group of 77 (G77) + China and members of the Non Aligned Movement (NAM). Increased country engagement and advocacy in forums like HRC and WHO were encouraged. The South Centre was urged to develop strategies for the Global South to defend SRHR gains and reclaim health sovereignty. Strengthening South-South cooperation was identified as a key future direction, focusing on research, data systems (electronic health records), sharing best practices (e.g., Angola-Malawi cooperation mentioned), and building new networks, aligning with the goals of platforms like HeDPAC.

5. Recommendations

Consolidated recommendations emerging from the discussions include:

- **Reinforce Political Commitment & Human Rights Framework:** Affirm SRHR as fundamental human rights; actively defend SRHR gains against political/social pushback; utilize accountability mechanisms like UPR more effectively for SRHR, demanding specific commitments and follow-up; implement intersectoral policies promoting human rights and addressing social determinants.
- **Boost Domestic Financing & South-South Cooperation:** Increase domestic health investment, taking ownership post-aid cuts; foster South-South cooperation for sharing practices, technology (e.g., management of electronic health records), data, research, and resources; protect and increase predictable official development assistance (ODA) dedicated to women's and girls' health, particularly SRH and maternal health, urging donors to avoid harmful policy restrictions; explore innovative financing mechanisms.
- **Address Data & Research Gaps:** Invest significantly in closing the gender health research gap (inclusive of women, relevant to Global South); improve health data collection (e.g., universal electronic health records) for evidence-based planning; use data (e.g., MISP readiness assessments) to target interventions; promote gender equity within the health research workforce, including in leadership positions and on grant review panels; broaden research evaluation criteria beyond mortality reduction to include quality of life, morbidity, and patient-reported outcomes relevant to women.
- **Build Resilient & Equitable Health Systems:** Strengthen PHC; integrate comprehensive SRH into PHC/UHC while ensuring visibility; invest in the health workforce (CHWs as civil servants, midwives); enhance the resilience of supply chains for essential medicines, diagnostics, and health commodities; build emergency preparedness and system resilience; build national regulatory capacity for health products and technologies.
- **Focus on Key SRHR Interventions & Equity:** Prioritize maternal/newborn mortality reduction; address adolescent SRH needs (education, contraception, pregnancy/HIV prevention); ensure access to full SRH services including MISP in crises; guarantee access to safe abortion services to the full extent of the law, and ensure universal access to quality post-abortion care; improve the quality and coverage of maternal and newborn care, including skilled birth attendance, antenatal and postnatal care, and access to Emergency Obstetric and Newborn Care (EmONC); tackle underlying inequities (nutrition, SGBV, education, child

marriage); promote universal HPV vaccination; ensure service affordability alongside availability/readiness; implement equity-focused strategies that explicitly address the needs of populations facing intersecting forms of discrimination; strengthen multi-sectoral efforts to prevent and respond comprehensively to SGBV, ensuring survivor-centred care; meaningfully engage men and boys as allies.

- **Uphold International Standards:** Maintain and defend agreed international standards for SRH care (e.g., MISP) as essential tools, especially in humanitarian contexts and against challenging social norms.

6. Conclusion

The session concluded by committing the South Centre to continue work in this area and encouraging countries to be vocal in support of a rights-based approach. The meeting underscored the urgency of defending and advancing SRHR as fundamental human rights, particularly in a time of converging global crises and resource constraints. Participants emphasised that progress requires appropriate legal frameworks, increased investments, genuine South-South cooperation, and the reclaiming of health sovereignty by Global South countries themselves.

The need for resilience, improved data, targeted research, and adherence to international standards, especially in humanitarian settings, were central themes throughout the discussions. Advancing the health and well-being of women and girls is not merely a health issue; it is a matter of fundamental human rights, social justice, and economic development, intrinsically linked to achieving gender equality and building prosperous, stable, and resilient societies. What is now required is a renewed global commitment, intensified and coordinated action, and unwavering political leadership. Finally, there is a need to collectively voice the support of developing countries for SRHR at key upcoming international forums. These include the 78th World Health Assembly, scheduled for May 19-28, 2025, which presents an immediate opportunity to engage with global health leaders. Furthermore, the 59th session of the Human Rights Council, held from June 16 to July 11, 2025, and its subsequent sessions later in the year**,** offer vital platforms to champion these fundamental rights. Seizing these moments for collective advocacy will be instrumental in advancing the SRHR agenda and ensuring accountability for commitments made.

South Centre
International Environment House 2
Chemin de Balexert 7-9
1219 Geneva
Switzerland
Tel.: +41 22 791 8050
south@southcentre.int
www.southcentre.int

SouthCentre
South Centre, Geneva
SouthCentre GVA
southcentre.gva
South_Centre
SouthCentre