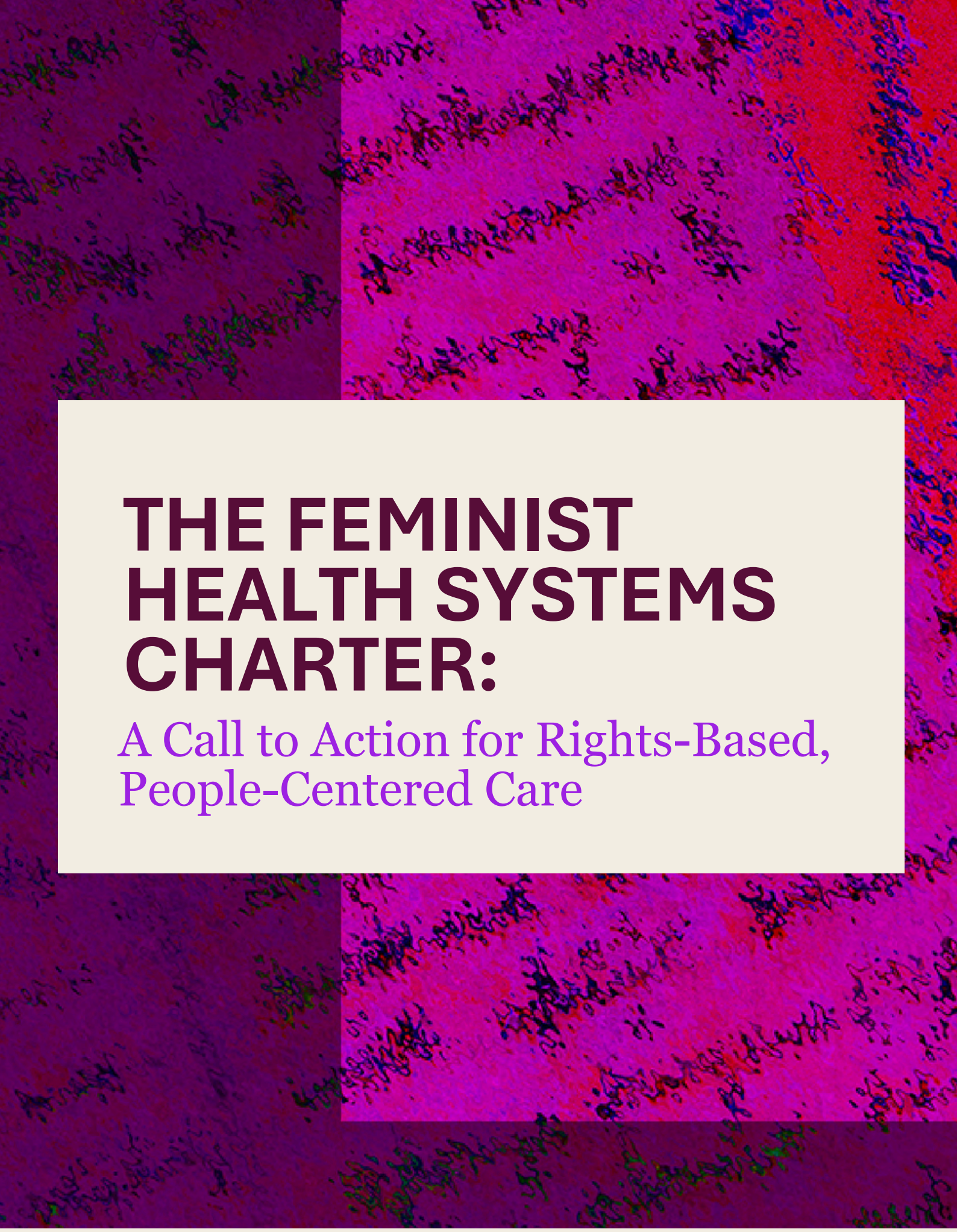

THE FEMINIST HEALTH SYSTEMS CHARTER:

A Call to Action for Rights-Based, People-Centered Care

COLUMBIA | MAILMAN SCHOOL OF PUBLIC HEALTH
HEILBRUNN DEPARTMENT OF POPULATION & FAMILY HEALTH

hsg Health Systems Global

International Confederation of Midwives

PUSH For Rights, For Women, For Midwives

Women Deliver

Purpose and Intended User of this Charter

The Feminist Health Systems Charter is an advocacy tool for advancing feminist health systems grounded in human rights, gender justice, and public accountability. It translates States' existing human rights obligations into clear principles for how health systems should be designed, governed, financed, delivered, and held accountable.

The Charter sits alongside the Melbourne Declaration for Gender Equality. Where the Declaration calls for a rebalancing of the gender equality ecosystem around State responsibility, public accountability, collective voice, and solidarity, this Charter applies that vision to health systems. It sets out what it means for States to respect, protect, and fulfill the right to health — including sexual and reproductive health and rights (SRHR) — in ways that are feminist, rights- based, people-centered, and accountable to the communities they serve.[1]

The Charter is intended for governments, multilateral institutions, researchers, civil society, health workers, feminist movements, and advocates. It can be used to guide reform, shape policy and research, strengthen advocacy, and hold States accountable for building health systems that are equitable, inclusive, accessible, and transformative.

The Charter provides a shared foundation of principles and State obligations. It is not intended to be exhaustive or one-size-fits-all. Users are encouraged to adapt and build on it through research, implementation pathways, accountability frameworks, indicators, monitoring, and reporting mechanisms that respond to local contexts and community priorities.

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1 The Charter uses the Guttmacher-Lancet Commission definition of Sexual and Reproductive Health and Rights, which offers a rights-based and comprehensive understanding of sexual and reproductive health across the life course. This definition serves as an interpretive framework, allowing the Charter to address SRHR issues that are not specifically named in the principles.

Why do we need feminist health systems?

Health systems around the world are failing to meet the needs of the populations they serve. Funding gaps, aid cuts, privatization, and weak infrastructure are all part of the problem. But the deeper issue is that many health systems are not designed around people's lives, rights, or realities. They often ignore how gender, race, class, disability, age, migration status, sexuality, and other forms of inequality shape whether people can access quality, respectful, and affordable care.

The failures of health systems around the world are not inevitable. They reflect choices about power, resources, and whose needs are treated as urgent. Across health systems, deep power imbalances continue to reinforce neoliberal, colonial, capitalist, patriarchal, racist, and ableist structures that systematically disadvantage people, especially girls, women, and marginalized communities.[2] These power imbalances commodify care, undervalue frontline and community health workers, undermine sexual and reproductive health and rights, and exclude those most affected from decision-making. In doing so, they erode public trust and strip autonomy, dignity, and safety from both those seeking care and those providing it.[3]

International human rights law is clear: States have a legal obligation to respect, protect, and fulfill everyone's right to the highest attainable standard of physical and mental health and well-being, including SRHR.[4] A feminist approach insists that this obligation must be fulfilled in ways that center those most affected by injustice, strengthen public systems, redistribute power and resources, and make health systems accountable to the people they serve.

Achieving "health for all" requires justice-oriented transformation. It requires transforming the structures, norms, and power relations that determine whose health is prioritized, whose knowledge counts, who makes decisions, and who is left behind. Feminist health systems offer a roadmap for this transformation: they center dignity, care, bodily autonomy, equity, collective voice, and the leadership of women, girls, gender-diverse people, health workers, and marginalized communities.[5]

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2 Eger H, Chacko S, El-Gamal S, Gerlinger T, Kaasch A, Meudec M, et al. Towards a feminist global health policy: power, intersectionality, and transformation. PLOS Global Public Health. 2024;4(3):e0002959. Abimbola S, Pai M. Will global health survive its decolonisation? The Lancet. 2020;396(10263):1627–1628. Mofokeng T. Reclaiming sexual and reproductive rights through a decolonial lens. Health and Human Rights. 2025;27(1):91.

3 Kentikelenis A, Rochford C. Power asymmetries in global governance for health: a conceptual framework for analyzing the political-economic determinants of health inequities. Global Health. 2019;15 (Suppl 1):70. doi:10.1186/s12992-019-0516-4. Morgan R, Ayiasi RM, Barman D, et al. Gendered health systems: evidence from low- and middle-income countries. Health Research Policy and Systems. 2018;16(1):58. doi:10.1186/s12961-018- 0338-5.

4 International Covenant on Economic, Social and Cultural Rights, art. 12, 16 December 1966 (hereinafter ICESCR Art. 12); Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), UN Doc. E/C.12/2000/4 (hereinafter CESCR GC 14); Committee on Economic, Social and Cultural Rights, General Comment No. 22 on the right to sexual and reproductive health (Art. 12), UN Doc. E/C.12/GC/22 (hereinafter CESCR GC 22).

Grounded in the Melbourne Declaration, this Charter calls on States and the wider global health and gender equality ecosystem to rebuild health systems as public goods and as essential to fulfilling their human rights obligations. It calls for health systems that challenge inequality, uphold rights, and meet the needs of everyone, especially those most often excluded from care and decision-making.

What is a feminist approach to health systems?[6]

A feminist approach to health systems centers human rights, gender justice, intersectionality, and public accountability. It recognizes that health is shaped not only by services, but also by power: who has access to care, who makes decisions, whose knowledge is valued, how resources are distributed, and whose bodies and lives are treated as worthy of protection.

Feminist health systems protect the right to the highest attainable standard of physical and mental health, including comprehensive SRHR and bodily autonomy.[7] They provide respectful, compassionate, person-centered care across the life course. They address the social and structural determinants of health, including gender inequality, racism, poverty, ableism, colonialism, violence, climate injustice, migration status, and discrimination based on sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC).

Feminist health systems are designed with and for the people most affected by injustice. They redistribute power, resources, and decision-making toward communities, civil society, feminist movements, and health workers. They dismantle colonial, patriarchal, racist, ableist, and other oppressive structures in health governance, financing, research, care, and knowledge production. They ensure universal, equitable access to quality care, medicines, and health technologies.

They also value the people who make care possible. This means addressing the gender pay gap, recognizing paid and unpaid care work, protecting and fairly compensating health workers, and ensuring women and marginalized health workers can lead and shape the systems in which they work.[8]

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5 CESCR GC 14.
6 The Charter offers a working definition of feminist health systems, co-created with feminist, health, and gender equality communities, and will continue to evolve through collective learning, advocacy, and implementation.
7 Starrs AM, Ezeh AC, Barker G, et al. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. The Lancet. 2018;391(10140):2642– 2692. doi:10.1016/S0140-6736(18)30293-9.
8 Eger H. Feminist Global Health Policy: Addressing Health Inequalities through an Intersectional Perspective. Springer; 2023. ISBN: 978-3-658-43497-7.

Feminist Principles of Health Systems	Call to Action on State Obligations
The Right to Health Health systems are grounded in the right to the enjoyment of the highest attainable standard of physical and mental health. They are designed to provide integrated, people-centered care across the life course.[9]	States must respect, protect, and fulfill the right to the highest attainable standard of physical and mental health,[10] by enshrining these rights in law,[11] guaranteeing universal access to comprehensive services and information, and ensuring participatory, people-centered care.[12]
Intersectionality and the Structural Determinants of Health[13] Health systems recognize gender as a structural determinant of health and address overlapping systems of oppression that shape access to care, including race, ethnicity, class, disability, age, and SOGIESC.[14] They remove barriers to bodily autonomy, information, and services; center those most affected; and ensure research and data reflect their realities.[15] Health	States must legally recognize intersecting forms of discrimination based on race, ethnicity, class, disability, age, and sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC) and their compounded negative impact on health.[17] States must prohibit discrimination and adopt and pursue policies and programmes designed to eliminate such occurrences.[18] States must adopt gender-transformative approaches

9 ICESCR Art. 12; CESCR GC 14, para. 21; World Health Organization. Framework on integrated, people-centred health services. UN Doc. A69/39. 2016; paras. 14–15; Nabyonga-Orem J, Asamani JA. Ensuring the right to health along the life course. The Lancet Global Health. 2022;10(12):e1689–e1690.
10 ICESCR Art. 12; CESCR GC 14, paras. 1–5; Beijing Declaration and Platform for Action, para. 89.
11 CESCR GC 14, paras. 33, 36–37.
12 Committee on the Elimination of Discrimination against Women. General Recommendation No. 24 on Women and Health (Art. 12), UN Doc. A/54/38/Rev.1. 1999; para. 31(a) (hereinafter CEDAW GR 24); World Health Organization. Framework on integrated, people-centred health services. UN Doc. A69/39. 2016; paras. 14–15.
13 The term "structural" is used here because these determinants operate at a macro level and are not modifiable by individual behavior. They are shaped by the allocation of resources, power, prestige, and discrimination in society, resulting in social stratification. See Solar O, Irwin A. A conceptual framework for action on the social determinants of health. WHO Discussion Paper; 2010. Structural and social determinants of health are also understood here to encompass commercial determinants, including private sector actors, market forces, and corporate practices that shape health outcomes, consistent with the World Health Organization definition of commercial determinants and The Lancet Series on Commercial Determinants of Health. For the foundational framework on health equity through action on social determinants, see World Health Organization. Closing the gap in a generation: health equity through action on the social determinants of health. 2008.
14 ICESCR, Art. 12; Committee on Economic, Social and Cultural Rights. General Comment No. 20 on Non-Discrimination in Economic, Social and Cultural Rights (Art. 2, para. 2), UN Doc. E/C.12/GC/20. 2009; para. 32 (hereinafter CESCR GC 20); United Nations Office of the High Commissioner for Human Rights. Born Free and Equal: Sexual Orientation, Gender Identity and Sex Characteristics in International Human Rights Law. 2nd ed. New York and Geneva: OHCHR; 2019.
15 CESCR GC 14, paras. 3, 11; CESCR GC 20, para. 17; CESCR GC 22, paras. 5, 8, 30; Committee on the Elimination of Discrimination against Women. General Recommendation No. 28 on the Core Obligations of States Parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination against Women, UN Doc. CEDAW/C/GC/28. 2010; para. 18 (hereinafter CEDAW GR 28).
17 CEDAW GR 28, para. 18; CESCR General Comment No. 20 para. 32.
18 CEDAW GR 28, para. 18.

systems are gender-ransformative: they challenge the power structures and norms that produce health inequities, redistribute resources and opportunities, and ensure equal representation and decision-making at all levels.[16]	that actively challenge and reshape gender norms, power structures, and harmful expressions of masculinity that restrict health access, influence health risks, and perpetuate health inequities across health systems.[19]
Anti-Colonialism and Decoloniality Health systems are anti-colonial and decolonial[20] in governance and practice. They recognize colonialism and racism as forms of discrimination linked to patriarchal control, oppression, and the control of sexuality.[21] They actively dismantle, rather than reproduce, colonial power structures.[22]	States must recognize and address colonialism and racism as forms of discrimination, including the enduring legacies of colonial and extractive structures of health systems.[23] States must eliminate barriers rooted in colonialism and racism by reforming laws, policies, financing, and governance structures to center the leadership, local knowledge, and decision-making authority of affected communities, Indigenous peoples, and the most impacted by colonial health inequities.[24]
Respectful Person-Centered Care Across the Life Course Health systems guarantee timely, compassionate, and person-centered care	States must respect, protect, and fulfill the right to health across the life-course by ensuring accessible, affordable, acceptable, and quality health services for all individuals

16 CEDAW Articles 5(a), 12; CEDAW GR 24, paras. 6, 9, 12b, and 14; CESCR GC 22, paras. 8, 27, 30.
19 CESCR GR 22, paras. 8, 27, 30.
20 Mehjabeen D, Patel K, Jindal RM. Decolonizing global health: a scoping review. BMC Health Services Research. 2025;25(1):828. doi:10.1186/s12913-025-12890-8.
21 CESCR GC 20, paras. 7–9; CEDAW GR 39, paras. 20, 24, 30; ICESCR, Art. 1; UN General Assembly. United Nations Declaration on the Rights of Indigenous Peoples, UN Doc. A/RES/61/295. 2007; Art. 23 (hereinafter UNDRIP); UN General Assembly. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng: Sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic, UN Doc. A/76/172. 2021.
22 Barcham M. Decolonizing public healthcare systems: designing with Indigenous Peoples. She Ji: The Journal of Design, Economics, and Innovation. 2022;8(4):454–472. doi:10.1016/j.sheji.2022.10.004; UN General Assembly. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng: Sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic, UN Doc. A/76/172. 2021.
23 Committee on the Elimination of Racial Discrimination. General Recommendation No. 37 on Equality and Freedom from Racial Discrimination in the Enjoyment of the Right to Health (Art. 5(e)(iv)), UN Doc. CERD/C/GC/37. 2024; para. 1 (hereinafter CERD GR 37); Committee on the Elimination of Discrimination against Women. General Recommendation No. 39 on the Rights of Indigenous Women and Girls, UN Doc. CEDAW/C/GC/39. 2022; paras. 7, 20, 24, 30 (hereinafter CEDAW GR 39); UN General Assembly. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng: Racism and the right to health, UN Doc. A/77/197. 2022; UN General Assembly. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng: Sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic, UN Doc. A/76/172. 2021.
24 UNDRIP, Art. 23; International Labour Organization. Convention No. 169 Concerning Indigenous and Tribal Peoples in Independent Countries, adopted June 27, 1989, entered into force Sept. 5, 1991, 1650 UNTS 383, Art. 2 (hereinafter ILO Convention 169).

across the life course. They respond to people's distinct needs, rights, dignity, evolving capacities, and agency at every stage of life, from childhood and adolescence through adulthood and older age.[25] They remove structural and legal barriers, including third-party authorization requirements, that obstruct access to care.[26]

at every life stage.[27] This includes guaranteeing age-appropriate, gender-responsive, and rights-based services, from comprehensive sexuality education and adolescent-responsive care, to maternal, newborn, and sexual and reproductive health services, to care for aging populations, including mental health and long-term care. States must respect, protect, and fulfill the right to respectful, dignified care across the life-course, ensuring that all individuals can access services that uphold dignity, privacy, informed consent, and freedom from harm, coercion, and violence in all health settings.[28]

Sexual and Reproductive Health and Rights[29]

Health systems uphold SRHR, bodily autonomy, and the right of every person to make free and informed decisions about their sexuality and reproduction.[30] They provide comprehensive, confidential, rights-based, and people-centered SRH services across the life course, free from coercion, discrimination, stigma, and violence.[31] They pay particular attention to adolescents, who face acute barriers including criminalization, stigma, third-party authorization requirements, and denial of confidential care. Health systems must be designed with

States must respect, protect, and fulfill SRHR by guaranteeing universal access to comprehensive, quality SRH services, information, and education, and ensuring autonomy, informed consent, and non-discrimination in all aspects of care across the life-course.[34] States must ensure that SRH services are confidential, rights-based, and free from coercion, discrimination, stigma, and violence in all health settings.[35] States must guarantee adolescents' right to access SRH information and services without third-party authorization, ensuring health systems are designed with and for young people as

25 CEDAW GR 24, para. 2; World Health Organization. Framework to implement a life course approach in practice. Geneva: WHO; 2025. ISBN: 978-92-4-011257-5; White Ribbon Alliance. Respectful Maternity Care Charter: The Universal Rights of Women and Newborns. Washington, DC: White Ribbon Alliance; 2019.
26 World Health Organization. Framework to implement a life course approach in practice. Geneva: WHO; 2025. ISBN: 978-92-4-011257-5.
27 ICESCR Article 12; CESCR General Comment No. 14.
28 CEDAW GR 24, para. 2; ICCPR Arts. 7 and 17.
29 Starrs AM, Ezeh AC, Barker G, et al. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. The Lancet. 2018;391(10140):2642–2692. doi:10.1016/S0140-6736(18)30293-9.
30 CESCR GC 22, para. 1; CEDAW, Art. 16; CESCR GC 22, paras. 5–7, 13–17; World Health Organization. Framework on integrated, people-centred health services. UN Doc. A69/39. 2016; paras. 14–15; UN Fourth World Conference on Women. Beijing Declaration and Platform for Action, UN Doc. A/CONF.177/20/Rev.1. 1995; paras. 94–96 (hereinafter Beijing Platform for Action).
31 CECSR GC 22 para. 5.
34 CESCR Art. 12; CESCR GC 22 paras. 33.
35 ICCPR Arts. 7, 17; CEDAW GR 24.

and for young people as rights-holders, respecting their evolving capacities, agency, and right to informed decision-making.[32] They must dismantle structural, legal, and social barriers so services are available, accessible, acceptable, and high-quality for all.[33]

rights-holders, respecting their evolving capacities, agency, and right to informed decision-making.[36] States must dismantle all structural, legal, and social barriers to SRH care, including criminalization, ensuring services are available, accessible, and acceptable, and high quality for all, with particular attention to those facing intersecting forms of discrimination.[37]

Disability Justice

Health systems are accessible, inclusive, and grounded in universal design. They ensure that persons with disabilities, especially girls and women with disabilities facing intersecting forms of discrimination, can enjoy the highest attainable standard of physical and mental health without discrimination.[38] This includes accessible facilities, transportation, information, and communication; sign language interpretation; accessible formats and assistive technologies; reasonable accommodations; disability-specific services; comprehensive mental health care; and support for autonomy, free and informed consent, and full respect for the legal capacity for persons with disabilities.[39]

States must ensure that health systems are designed according to universal design and are fully accessible in practice, including accessible infrastructure, information, communication, and digital services, as well as sign language interpretation and other communication support.[40] States must guarantee equal access to the same range, quality, and standard of health care, including sexual and reproductive health services, disability-specific services, and comprehensive mental health care.[41] States must also respect the autonomy, will, and preferences, of persons with disabilities, ensure free and informed consent, and uphold legal capacity on an equal basis with others through appropriate decision making.[42]

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32 CRC, Arts. 12, 14; Committee on the Rights of the Child. General Comment No. 20 on the Implementation of the Rights of the Child during Adolescence, UN Doc. CRC/C/GC/20. 2016; paras. 11, 18–20, 59 (hereinafter CRC GC 20); CESCR GC 22, paras. 18, 28, 30, 44, 48, 49(f); CEDAW GR 24, para. 23.
33 CESCR GC 14 para. 12; CESCR GC 22 para. 49(c).
36 CRC GC 20; CESCR GC 22 para. 40.
37 CESCR GC 22 para 34-36; CEDAW Art. 2.
38 Committee on the Rights of Persons with Disabilities, General Comment No. 3 on Women and Girls with Disabilities (Art. 6), UN Doc. CRPD/C/GC/3 (Nov. 25, 2016), para. 2 (hereinafter CRPD GC 3); Convention on the Rights of Persons with Disabilities (Dec. 13, 2006), Art. 25 (hereinafter CRPD)
39 CRPD Art. 25(a, b, d); CRPD GC 3 para. 2, 64b;
40 Committee on Economic, Social and Cultural Rights, General Comment No. 5 on Persons with Disabilities, UN Doc. E/1995/22 (Dec. 9, 1994), para. 34 (hereinafter CESCR GC 5).
41 CRPD Art. 25.
42 CRPD Art. 25(a, b, d);

Mental Health Health systems recognize mental health and psychosocial well-being as essential to the right to health. [43] They address structural drivers of distress, including gender inequality, violence, poverty, and discrimination, while ensuring quality, rights-based, community-based care.[44]	States must ensure the right to mental health as an essential component of the right to health, with accessible, quality, rights-based services integrated within health systems, free from discrimination, coercion, and abuse.[45] States must address social determinants affecting mental well-being, including gender inequality, violence, and poverty.[46]
Conflict, Crisis, and Humanitarian Emergencies Health systems are neutral, impartial, rights-based, and able to remain functional and accessible during armed conflict, occupation, siege, and genocide.[47] Medical facilities, health workers, and humanitarian personnel are protected under international humanitarian law and must never be targets of attacks. [48] The diversion of public resources toward militarization undermines the right to health and disproportionately harms girls, women, and marginalized communities who depend most on health systems.[49] Health systems actively address the gendered dimensions of conflict, including sexual and gender-based violence (SGBV), reproductive violence, and the destruction of sexual and reproductive	States must ensure that health systems remain functional, accessible, and impartial during armed conflict, occupation, siege, and humanitarian emergencies, while upholding their core obligations under the right to health.[51] States must respect and protect medical facilities, health workers, and humanitarian personnel, and ensure accountability for attacks and other violations of international humanitarian and human rights law.[52] States must ensure that military expenditure does not compromise the resources required to fulfill the right to health.[53] States must also ensure that health systems address the gendered dimensions of conflict, including sexual and gender-based violence, reproductive violence, and the disruption or destruction of sexual and reproductive health services, and ensure

43 ICESCR Art. 12.
44 CRPD Art. 19, 25.
45 ICESCR Art. 12; UN General Assembly, Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, UN Doc. A/RES/46/119 (Dec. 17, 1991), Principles 1.3 and 1.4.
46 CESCR GC 14, para. 11; CEDAW GR 28, para. 18.
47 UN Security Council, Resolution 2286 on the Protection of Medical Care in Armed Conflict, UN Doc. S/RES/2286 (May 3, 2016) (hereinafter UNSC Res. 2286)
48 Ibid.
49 Committee on the Elimination of Discrimination against Women, General Recommendation No. 30 on Women in Conflict Prevention, Conflict and Post-Conflict Situations, UN Doc. CEDAW/C/GC/30 (Oct. 18, 2013), paras. 50-51, 52 c-d (hereinafter CEDAW GR 30); UN Secretary-General (António Guterres), The Security We Need: Rebalancing Military Spending for a Sustainable and Peaceful Future, United Nations Office for Disarmament Affairs (Sept. 9, 2025).
51 ICESCR Art. 12; CESCR GC 14 para. 34; CEDAW GR 30 para. 2; UNSC Res. 2286.
52 UNSC Res. 2286.
53 CEDAW GR 30 paras. 50-51, 52 c-d.
54 Rome Statute, Art. 8 war crimes; CEDAW GR 30 para. 35.

health services, which international humanitarian law recognizes as war crimes and crimes against humanity.[50]	accountability where such acts constitute violations of human rights law, international humanitarian law, or international criminal law.[54]
Refugees, Internally Displaced People, Migration, and Statelessness Health systems are inclusive, rights-based, and non-discriminatory. They ensure equitable access to health services for all displaced persons, migrants, asylum seekers, refugees, and stateless persons regardless of legal status, nationality, or documentation.[55] They recognize and respond to the specific needs of women, girls, and gender-diverse people on the move, including risks of gender-based persecution, SGBV, trafficking, and denial of reproductive health services.[56] Health systems ensure migrant women have access to essential health services including sexual and reproductive health care, free from discrimination, exploitation, and retaliation.[57]	States must ensure health systems provide equitable, non-discriminatory access to health services for all displaced persons, migrants, asylum seekers, refugees, and stateless persons regardless of legal status, nationality, or documentation, removing all obstacles to access and applying a gender-sensitive approach throughout the displacement cycle that identifies and responds to the specific needs of women, girls, and gender-diverse people including gender-based persecution, SGBV, trafficking, and denial of reproductive health services.[58] States must ensure migrant women including undocumented workers have access to essential health services and SRHR free from discrimination, exploitation, and retaliation, guaranteeing emergency care regardless of immigration status.[59]
Climate and Environmental Justice Health systems are climate-just, gender-responsive, and resilient. They anticipate and respond to climate and environmental	States must ensure affected communities (particularly women and girls) and health workers' equal and meaningful participation in the design and monitoring of climate

50 CESCR GC 22 para. 30; CESCR GC 14 para. 34; Rome Statute of the International Criminal Court, art. 8 (July 17, 1998), 2187 U.N.T.S. 90 (hereinafter Rome Statute); CEDAW GR 30 para. 35.
54 Rome Statute, Art. 8 war crimes; CEDAW GR 30 para. 35.
55 Committee on the Elimination of Racial Discrimination. General Recommendation No. 30 on Discrimination against Non-Citizens, UN Doc. CERD/C/64/Misc.11/rev.3. 2004; para. 36 (hereinafter CERD GR 30); CESCR GC 14, para. 12; CESCR GC 20, para. 30; Committee on the Elimination of Discrimination against Women. General Recommendation No. 32 on the Gender- Related Dimensions of Refugee Status, Asylum, Nationality and Statelessness of Women, UN Doc. CEDAW/C/GC/32. 2014; para. 7 (hereinafter CEDAW GR 32); World Health Organization, International Organization for Migration, and Office of the United Nations High Commissioner for Human Rights. International Migration, Health and Human Rights. 2013.
56 CEDAW GR 32 paras. 8, 11, 14-15, 34.
57 Committee on the Elimination of Discrimination against Women, General Recommendation No. 26 on Women Migrant Workers, UN Doc. CEDAW/C/2009/WP.1/R (Dec. 5, 2008) (hereinafter CEDAW GR 26).
58 ICESCR Art. 12; CESCR GC 14, para. 12; CESCR GC 20, para. 30; CEDAW GR 32, paras. 7, 11, 14-15; CERD GR 30, paras. 7, 29, 36.
59 CEDAW GR 26; CERD GR 30, para. 34; International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, art. 28 (Dec. 18, 1990) (hereinafter ICRMW).

hazards,[60] address disproportionate impacts on marginalized communities,[61] and ensure that SRHR and essential services remain accessible, high-quality, and equitably delivered during climate-related crises.[62]

response. States must also ensure that all policies, legislation, plans, programmes, budgets and activities related to climate and disasters are grounded in human rights and equality, with priority for the most marginalized groups of women and girls.[63] States must ensure sexual and reproductive health services remain accessible during climate crises and must include women and marginalized communities in all disaster preparedness, planning, and response. [64]

Health Workforce

Health systems recognize the essential contributions of a predominantly female workforce, including midwives, nurses and physicians, community health workers, informal health workers, and students, to health service delivery. Health workers are supported, empowered, protected, and fairly compensated, with access to high-quality education and training, and meaningful participation in decision-making at all levels.[65] Health systems address the gendered barriers of the health sector and care economy, including pay inequity, underrepresentation in leadership, discrimination, and the undervaluing of paid and unpaid health and care work.[66]

States must ensure all health workers, such as midwives, nurses and physicians, community health workers, informal workers, students, and youth, have fair wages, are provided a decent living, safe working conditions, and reasonable hours.[67] States must address the gender gaps in leadership and pay, ensure health workers' meaningful participation in health systems decisions, and guarantee equal opportunity.[68] States must also ensure that people from marginalized and rural communities can access health professional educational programs delivered using modalities that meet their needs.[69]

50 CESCR GC 22 para. 30; CESCR GC 14 para. 34; Rome Statute of the International Criminal Court, art. 8 (July 17, 1998), 2187 U.N.T.S. 90 (hereinafter Rome Statute); CEDAW GR 30 para. 35.
60 ICESCR Art. 12; CESCR GC 14, para. 11.
61 CEDAW Art. 2; Committee on the Elimination of Discrimination against Women, General Recommendation No. 27 on Older Women and Protection of their Human Rights, UN Doc. CEDAW/C/GC/27 (Oct. 16, 2010), para. 25 (hereinafter CEDAW GR 27) .
62 World Health Organization, Draft Global Action Plan on Climate Change and Health, UN Doc. A78/4 Add.2, Seventy-eighth World Health Assembly, Provisional agenda item 18.3 (May 15, 2025); Paris Agreement, art. 7(5) (Apr. 22, 2016) (hereinafter Paris Agreement).
63 Committee on the Elimination of Discrimination against Women, General Recommendation No. 37 on the Gender-Related Dimensions of Disaster Risk Reduction in the Context of Climate Change, UN Doc. CEDAW/C/GC/37 (Feb. 7, 2018), para. 8 (hereinafter CEDAW GR 37).
64 CESCR GC 14, para. 40; CEDAW GR 37, para. 26.
65 World Health Organization, Global Strategy on Human Resources for Health: Workforce 2030, pg. 18 (Geneva: WHO, 2016). ISBN 978-92-4-151113-1.
66 World Health Organization, Delivered by Women, Led by Men: A Gender and Equity Analysis of the Global Health and Social Workforce, Human Resources for Health Observer Series No. 24 (Geneva: WHO, 2019); World Health Organization, Global Strategy on Human Resources for Health: Workforce 2030 (Geneva: WHO, 2016). ISBN 978-92-4-151113-1.
67 ICESCR Art. 7; CESCR GC 23.
68 CESCR GC No. 14, para. 17); ICESCR Article 7(c); CEDAW Art. 11.
69 World Health Organization. Global Strategy on Human Resources for Health: Workforce 2030. Geneva: WHO; 2016. p. 18. ISBN: 978-92-4-151113-1.

Universal Health Coverage and Health Financing

Health systems ensure Universal Health Coverage (UHC), guaranteeing available, accessible, acceptable, and quality health services, including comprehensive SHR[70], for all people, regardless of gender, race, age, SOGIESC, disability, migration status, or socioeconomic status.[71] Health systems are equitably financed so that resources are raised, allocated, and spent in ways that eliminate financial barriers, prioritize historically marginalized communities, and support comprehensive, rights-based, universal care.[72]

States must ensure Universal Health Coverage by guaranteeing the right to health, including comprehensive sexual and reproductive health care that is available, accessible, acceptable and of good quality.[73] States must eliminate financial and non-financial barriers to health services, including sexual and reproductive health services; expand coverage; increase resources available for care; and ensure gender-responsive services that address intersecting forms of discrimination.[74] To fulfill their obligation to respect, protect, and fulfill the right to health and SHR, States must ensure equitable health financing with services affordable for all, using the maximum of their available resources, adequate budgetary resources for women's health comparable to men's, and prioritization of primary and preventive care benefiting the broader population.[75]

70 CESCR GC 22, paras. 7-10.
71 CESCR GC 14, paras. 18-27.
72 UN General Assembly, Resolution 78/4 on Global Health and Foreign Policy, UN Doc. A/RES/78/4 (Oct. 16, 2023), paras. 4, 36, 47, 83, 85, 87, 88-90; World Health Organization, Resolution WHA78.12 on Strengthening Health Financing Globally, Seventy-eighth World Health Assembly, Agenda item 13.3 (May 27, 2025)
73 CESCR GC 14, para. 30; OHCHR, Overview on Universal Health Coverage and the Right to Health; CESCR GC 22, paras. 12-21
74 CESCR GC 22, para. 31; UN General Assembly, Resolution 78/4 on Global Health and Foreign Policy, UN Doc. A/RES/78/4 (Oct. 16, 2023), paras. 4, 36, 47, 83, 85, 87, 88-90; CESCR GC 22, paras. 30-32; Office of the United Nations High Commissioner for Human Rights, Overview on Universal Health Coverage and the Right to Health (June 19, 2023)
75 ICESCR Art. 12; CESCR GC 22; CESCR GC 14, para. 12b, 19; CEDAW GR 24, para. 30.

Methodology

This Charter is grounded in binding international human rights law. Each principle was developed by reviewing a non-exhaustive list of treaties and authoritative interpretations, identifying their core requirements for health systems, and articulating them through a feminist, intersectional lens. The State obligations are drawn from treaty language and aligned with each principle. This approach translates existing legal commitments into concrete standards for feminist health systems.

The principles are based on **core international human rights frameworks** and their authoritative interpretations. Where a principle falls outside this framework, it may be drawn from a parallel legally binding instrument or from a non-binding but politically authoritative instrument, such as a declaration, agreement, or resolution. This is a non-exhaustive list of principles; sub-principles and emerging issues can be developed further.

The right to health, SRHR, and mental health are considered across the life course, drawing on the WHO framework to implement the life course approach in practice. This approach covers all stages of life and centers the person, rather than only the service or intervention being delivered. The Charter also uses the Guttmacher-Lancet Commission definition of sexual and reproductive health and rights, which offers a rights-based and comprehensive understanding of sexual and reproductive health across the life course. This definition serves as an interpretive framework, allowing the Charter to address SRHR issues that are not specifically named in the principles.

The Charter was co-created by a multidisciplinary consortium of gender equality and human rights advocates, health workers, and health systems researchers. It underwent extensive peer review by more than two dozen consortium partners. A virtual community validation activity, attended by several hundred participants — including researchers, midwives, advocates, program managers, and policy advisors — also helped refine the document. The Charter recognizes feminist and intersectional movements as central to shaping, advancing, and sustaining health systems transformation, including through collective agency, movement-building, civic space, accountability, and resistance to regression.

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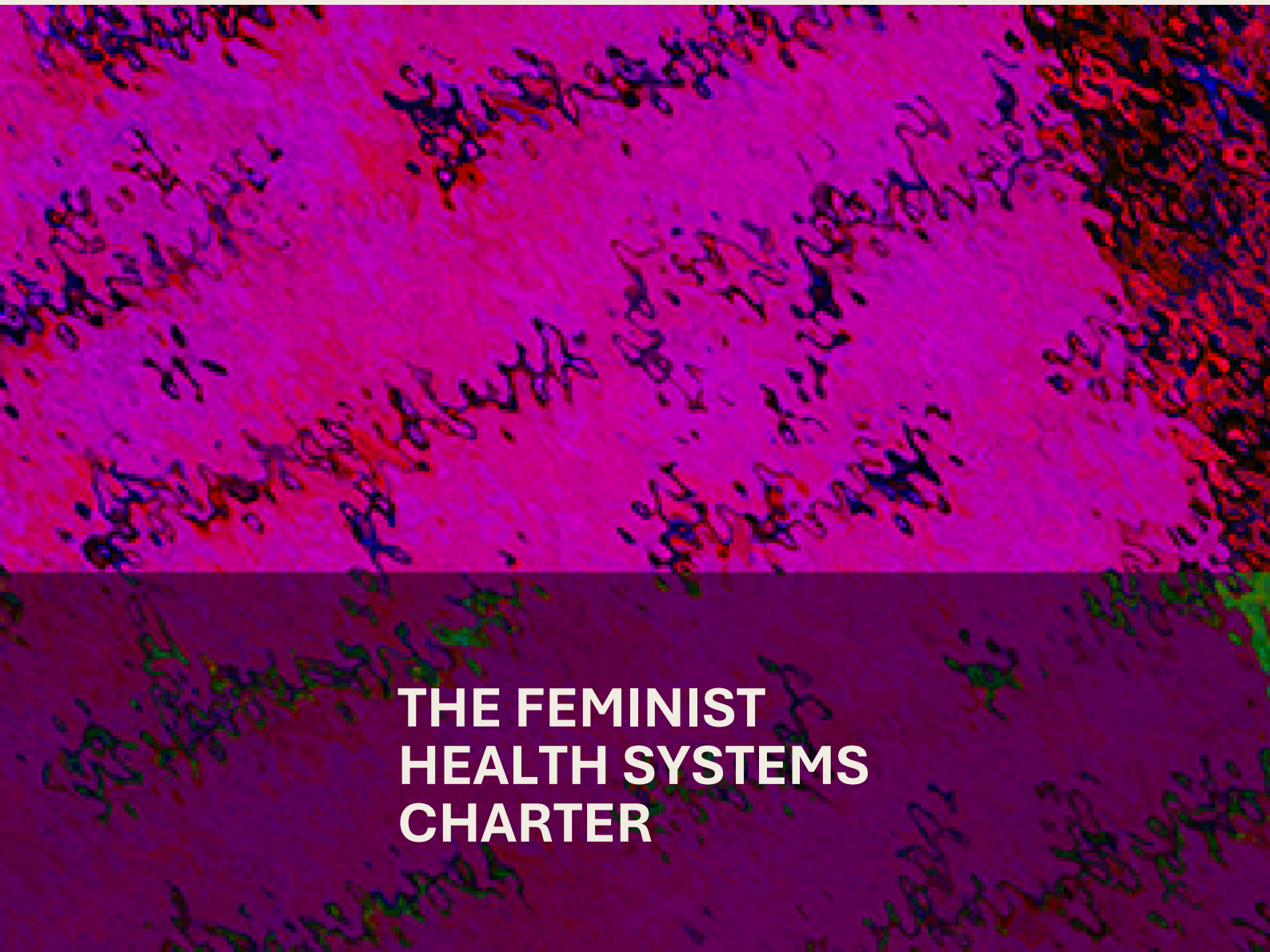

THE FEMINIST HEALTH SYSTEMS CHARTER