

16th October,2026

Subject: Open Letter to the Co-chairs and Members of the Joint Task Force on Reform of the Global Health Architecture

As the Joint Task Force prepares to finalize its interim report, we write with one message: the reform of the global health architecture will succeed or fail by whether it delivers for women, children and adolescents.

In 2023, an estimated 260,000 women died from complications of pregnancy and childbirth, 92% of them in low- and lower-middle-income countries. In 2024, 4.9 million children died before their fifth birthday. These are the populations the current architecture most often fails, and the first to lose services when financing contracts, as it has in 2025, when official development assistance fell 23.3%, with aid for reproductive health falling faster than for any other area of health.

The Task Force's evidence base names country ownership, comparative advantage, regional leadership and aligned financing as the themes on which reform initiatives converge. We agree with all of them. But the same synthesis contains no reference to women, children, adolescents or sexual and reproductive health and rights. We need to have current data with references to women ,children and adolescents from the different countries. Nineteen governments and a dozen institutions have already committed, in the Lyon Joint Political Declaration of 7 April 2026, to safeguarding SRHR within a reformed architecture. The interim report should not fall behind a commitment its own members have made.

The reform should ultimately be judged by what changes for people, not only by how institutions are reorganized. For women, children and adolescents, that means protecting essential services through the transition and ensuring that country ownership, regional leadership, aligned financing and greater efficiency translate into equitable access, stronger accountability and better health outcomes.

We therefore ask that the interim report:

- Name them explicitly. Women, children and adolescents, and sexual and reproductive health and rights, should be named in the interim report, not assumed within “equity,” “primary health care” or other broader categories.
- Protect financing through the transition. Essential WCAH and SRHR services, commodities, workforce, data systems and community accountability mechanisms should be safeguarded as financing is realigned behind country-led priorities, so that reform does not create new gaps in access or continuity of care.
- Make country ownership and integration deliver for WCAH and SRHR. Country-led priority-setting should translate into national benefit packages, health-system plans, financing and monitoring frameworks that explicitly include essential WCAH and SRHR services. As the architecture moves toward greater integration, primary health care and universal health coverage, these priorities should become more accessible and sustainable, not less visible, accountable or adequately financed.

- Measure whether the reform delivers for women, children and adolescents. Progress on country ownership, regional leadership, aligned financing and greater coherence should be assessed not only through institutional or financial measures, but by whether the reform improves equitable access to quality WCAH and SRHR services and outcomes, particularly for underserved populations.
- Guarantee representation and accountability. Women-led, youth-led, community and Global South organizations should have a meaningful role in the reformed architecture's governance and accountability, with progress tracked using data disaggregated by sex, age, income, geography, disability and context.

None of these asks requires new institutions or new mandates. They require the reform to be explicit about who it must serve, what must be protected through the transition and how success will be measured. We ask the Task Force to ensure that women, children and adolescents, and their health and rights, are visible in the architecture from design through implementation and accountability.

Signed,

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