Birth Justice Country Mapping

Insights Report & Recommendations

comotion × GLOBAL FUND FOR WOMEN

Executive Summary

This Birth Justice Country Mapping Insights Report presents a comprehensive desk review and stakeholder-informed analysis of the maternal and newborn health (MNH) and birth justice landscape across five countries: Ethiopia, Kenya, Malawi, Nigeria, and Sierra Leone. These countries were shortlisted from the FCDO priority list using criteria including maternal mortality ratios, policy environment alignment, e.g., Every Woman Every Newborn Everywhere (EWENE)/Collaborative Advocacy Action Plan(CAAP) participation, political stability, and implementation feasibility.

This report forms the second phase of the project. Following initial country scoping, the project undertook a desk review and stakeholder consultation to assess the landscape of maternal and newborn health and civic mobilisation across five shortlisted FCDO priority countries. The purpose of this report is to inform the **selection of two countries** for deeper engagement in the next phase, including a **Movement Mapping and Analysis Process (MMAP)** and the **formation of appropriate and relevant in-country Birth Justice governance structure**. These next steps will focus on building national ecosystems of feminist organisers, movement leaders, and policy advocates with the potential to drive systemic change. This report does not offer a comprehensive mapping of all actors or needs, but rather provides a comparative entry point into country contexts, rooted in feminist analysis and community voice.

The recent discourse and practice around MNH has remained largely technical, often focusing on governmental or institutional actors; these dynamics are not incidental - they are structural . This report (and the broader project) intentionally aims to surface and center the lived experiences of women, girls, and marginalized communities, particularly through the perspectives of grassroots groups, who are often pushed to the margins of agenda-setting and systems influence. Key findings indicate that the shortlisted countries exhibit significant maternal health challenges, including high maternal mortality ratios, policy gaps, and funding constraints exacerbated by the

reduction of international aid—particularly due to the dismantling of USAID. The report examines grassroots advocacy efforts, political stability, and engagement by civil society organizations and feminist networks in shaping MNH policies. Despite the presence of national accountability mechanisms such as the Every Woman Every Newborn Everywhere (EWENE) acceleration plans, Collaborative Advocacy Action Plans (CAAP) and Global Financing Facility (GFF) frameworks based on country strategies, there is a disconnect between grassroots priorities. None of the five countries surface indicators on reducing obstetric violence, increasing safe abortion care, banning Female Genital Mutilation (FGM), reducing Gender-Based Violence (GBV) in their respective national health agendas.

Across contexts, there is limited use of the "birth justice" frame, but widespread relevance of its principles: safe abortion access, respectful maternal care, and SRHR integration. Civic mobilisation remains low in most countries, with Kenya and Nigeria showing the highest latent potential for movement-building. Rural, displaced, and marginalised communities remain excluded from policy influence, and faith-based actors wield significant influence—sometimes progressive, sometimes obstructive.

The findings recommend prioritizing **Kenya and Nigeria** for further intervention, given their strong existing networks of civil society organizations and ongoing efforts to bridge advocacy with policy action. Strengthening grassroots organizations and ensuring that women-led advocacy groups shape national priorities is essential for addressing persistent MNH/birth justice challenges. Additionally, the report emphasizes the need to mitigate the adverse effects of funding cuts by mobilizing domestic resources and innovative financing strategies to sustain birth justice advocacy and health service provision.

Methodology

A desk review was undertaken to dig deeper into all the shortlisted parameters through the following activities:

1. **A review of published data** and information from respected sources relevant to the parameters.

2. **Discovery interviews** were conducted with the knowledgeable and experienced staff members of global and local organisations. A list of over 50 key organisations working within the space of sexual reproductive, maternal and newborn health/ birth justice advocacy and service provision was prepared in collaboration with Global Fund for Women.

3. **Analysis generated for 5 countries through Global Fund for Women's Social Movement (SM)Index tool.** The SM-Index analysis is based on publicly available protest data (via ACLED and other sources) used to detect birth justice and related feminist agendas. The protest data are used as proxy indicators for feminist agendas.

4. **Media Mapping:** Leveraging AI tools to map the news media landscape in the countries in question. We used Sprout Social Listening and Inoreader -a web-based content and RSS feed reader which compiles news feeds from online sources matching specific keywords for the user. We created a customised feed based on keywords such as ***maternal health, health system, midwives, community health workers, childbirth, maternal mortality, birth justice, maternal morbidity and birth equity***.

5. **Literature Review:** We used an AI deep research tool to source relevant research - peer-reviewed publications, grey literature such as NGO reports, government publications, and think tank reports, conducted in the last five years for the five countries, that might contradict or corroborate our findings.

Key Insights

1. Disconnect Between National Strategies and Community Realities

While all five countries have a mix of formal MNH strategies and policy frameworks (e.g., EWENE, CAAP, GFF mechanisms), grassroots actors consistently report being excluded from agenda-setting. National frameworks tend to focus on technocratic solutions such as service delivery or system reform rather than rights-based frameworks prioritising lived experience. As such these frameworks often fail to reflect lived realities such as obstetric violence, abortion stigma, GBV and health needs of refugees and other marginalised groups. Many CAAPs prioritize institutional goals (e.g., financing or data) but overlook fundamental rights-based demands like safe abortion care or respectful maternity services.

Multiple interviewees noted that maternal health is still "owned" by health professionals and global development actors, not communities. This disconnect is particularly visible in countries like Kenya and Nigeria, where well-resourced policy frameworks exist but remain disconnected from the demands of youth-led, feminist, or community-based actors. In Fos Feminista's terms, maternal health is still largely led by "briefcase boys"—external professionals with limited accountability to local actors.

It is useful to note that all five countries face challenges related to FGM and unsafe abortion related mortality and morbidity and yet there is no data or targets that have surfaced in either EWENE, GFF or CAAP priorities.

Countries where the above insight was applicable:
Ethiopia, Kenya, Malawi, Nigeria, Sierra Leone

2.

Donor Dependency Undermines Sustainability and Advocacy Power

In all countries, maternal health is highly dependent on donor funding—particularly from the U.S., EU, and Gates Foundation. Funding cuts, especially to USAID programs, have devastated health systems, reduced civil society engagement, left many grassroots actors without operating budgets and many citizens without access to essential health services. Some actors have reluctantly accepted funding from anti-rights or conservative faith-based groups to survive.

The Beginnings Fund which promised to provide a ray of hope in the above context will focus on Malawi, Rwanda and Tanzania in its first round and investments in these countries will be closely aligned to their respective EWENE acceleration plans and CAAP priorities, thus, missing the opportunity to align investments to community needs as these are not reflected in EWENE or CAAP priorities.

Countries where the above insight was applicable:
Kenya, Malawi, Nigeria, Ethiopia, Sierra Leone

3.

“Birth Justice” Framing Has Limited Resonance Locally

While “birth justice” is a powerful unifying term, it is rarely used or recognised by in-country actors, who prefer technical language (e.g., RMNCH, SRHR, maternal mortality). Feminist framing is often avoided due to political risk, donor dynamics, or cultural resistance—especially in rural and conservative regions. To mobilise more support, campaigns must adapt language while preserving transformative intent.

Countries where the above insight was applicable:
Malawi, Nigeria, Kenya, Sierra Leone, Ethiopia

4.

Grassroots Mobilisation Remains Sparse But Latent Energy Exists

Despite high maternal mortality, protest data and media analysis show few women-led mobilisations explicitly focused on MNH. However, strong networks exist in adjacent fields (GBV, femicide, youth SRHR), offering strategic entry points to frame maternal health as a justice issue within existing movements.

Countries with high latent potential:
Kenya, Nigeria

Countries with low MNH mobilisation:
Malawi, Sierra Leone, Ethiopia

5.

Structural Inequities Deepen Urban–Rural and Regional Gaps

Across all countries, regional inequalities are stark. Services are more accessible in capital cities and urban areas, while rural or conflict-affected zones suffer from poor infrastructure, weak supply chains, and health worker shortages. In Ethiopia, interviewees noted the destruction of over 1,000 health posts in conflict zones. In Sierra Leone, climate-related disease burdens and infrastructure collapse exacerbate MNH risks.

These disparities aren't just geographic—they're also structural. Local organisations in remote areas struggle to access funding, internet, or policy spaces. As a result, the burden of maternal mortality is heaviest where civil society is least empowered to respond.

Political instability (e.g., in Northern Nigeria, Northern Ethiopia) and conservative cultural norms further marginalise these regions from advocacy and service delivery opportunities.

Countries where the above insight was applicable:
Ethiopia, Nigeria, Kenya, Sierra Leone

6.
Faith-Based and Traditional Leaders Are Double-Edged Influencers

Faith leaders play outsized roles in shaping norms around maternal and reproductive health—both as gatekeepers and allies. In some contexts, they lead campaigns for safe abortion or adolescent SRHR (e.g., Malawi's Religious Leaders Network for Choice); in others, they reinforce stigma and restrict civic space. Engaging this group strategically is essential.

Interviewees stressed the importance of sustained relationship-building in these contexts. The success of networks like the Religious Leaders Network for Choice in Malawi shows that shifting the narrative within religious spaces is possible—but it requires patient, locally grounded strategies.

Countries where the above insight was applicable:
Malawi, Ethiopia, Nigeria, Sierra Leone

7.

Civil Society Engagement Remains Symbolic and Under-Resourced

Across the five countries, technical working groups and policy platforms exist—but civil society's role within them is often symbolic. Civil society organisations—especially women-led CBOs—believe that while they are often invited into policy processes, it is for validation, not for agenda-setting. Community health workers (CHWs), midwives, and grassroots women's groups are rarely recognised as strategic stakeholders despite their central role in service delivery and mobilisation. TWGs and CAAP processes are often donor-driven, technically complex, and exclude informal, rural, or youth-led actors. Even in well-structured coalitions (e.g., HENNET in Kenya), grassroots power remains fragile.

Interviewees in Kenya, Malawi, and Ethiopia highlighted a critical need for **capacity-building in budget advocacy, policy influence, and resource mobilisation**. CHWs in Kenya, for example, operate through community health units and report drivers of maternal mortality—but their voices are not formally embedded in health system decision-making.

Additionally, limited core funding and donor-imposed metrics hinder civil society participation. In many cases, INGOs act as intermediaries between local CSOs and government—creating bottlenecks to direct influence and perpetuating dependency.

Countries where the above insight was applicable:
Kenya, Nigeria, Ethiopia, Malawi

8.
Anti-Rights Forces Are Gaining Influence

There is increasing visibility and funding for anti-rights groups using “family values” rhetoric to roll back SRHR progress. With SRHR advocates underfunded and fatigued, these actors are gaining traction in national forums and policy spaces. The 2025 Pan-African Family Values conference in Nairobi exemplifies this threat.

Countries where the above insight was applicable:
Kenya, Nigeria, Malawi

9.
Media Visibility Does Not Equate to Community Representation

Awareness campaigns (e.g., PIH/Vlogbrothers in Sierra Leone) generate attention but often don’t reflect the needs and priorities of local actors. Campaigns like What Women Want are unique in their focus on centring individual priorities at the core of health campaigning. Media narratives are frequently donor- or government-led, leaving grassroots organisers invisible. There is a need to shift visibility and storytelling infrastructure to community leaders and frontline workers.

Countries where the above insight was applicable:
Sierra Leone, Kenya, Nigeria, Ethiopia

10.
Refugees, Displaced Women, and Climate-Affected Populations Are Overlooked

Despite high numbers of displaced persons and refugees (e.g., Nigeria's 3.1M IDPs, Kenya's refugee camps), there is little to no integration of these populations' needs into MNH frameworks like CAAP or EWENE. This represents a major blind spot in national planning and donor prioritisation.

Countries where the above insight was applicable:
Nigeria, Kenya

Recommendations and Next Steps

Based on the findings of this landscape analysis, and based on the project's imperative to support movements that are already operational, more matured, and with a strong degree of organizing history, we recommend moving forward with **Kenya** and **Nigeria** as the two focus countries for the next phase of the Birth Justice Initiative.

Both countries demonstrate:

- **Strong maternal health ecosystems** with active networks of SRHR advocates, midwives, youth-led organisations, faith based groups and extensive networks of grassroots actors.

- **Existing momentum in advocacy efforts** around issues aligned with birth justice—including SRHR, respectful maternity care, safe abortion and GBV

- **Health Policy Infrastructure**, given their participation in CAAP, EWENE, and GFF processes, as well as the visibility of civil society in health governance platforms, both countries have clear accountability mechanisms for targeting their health advocacy efforts.

- **Latent or emerging civic energy**—with Nigeria and Kenya recording the highest numbers of women-led protests among the countries mapped.

Critically, both contexts offer space to test and co-develop community-rooted, rights-based approaches to maternal and newborn health that can serve as blueprints for broader regional learning. The next phase of work will focus on deepening this engagement through a Movement Mapping and Analysis Process (MMAP) which will provide evidence for decision-making on appropriate in-country governance structure and a grantmaking model. These processes will centre local leadership and ensure that strategy development is grounded in the lived realities and visions of communities most affected by maternal injustice.

UK International Development

Partnership | Progress | Prosperity

This project was funded by
UK International Development.