Donor Policy Report

A Feminist Model for Funding Reproductive and Birth Justice

comotion × GLOBAL FUND FOR WOMEN

Preface

Global progress on maternal and newborn health has stalled, with preventable deaths increasingly concentrated among women, birthing people and newborns facing poverty, disability, adolescent pregnancy, humanitarian crises and climate-related vulnerability. Technical investments remain essential, but they are disconnected from community realities and priorities and will not achieve their full potential unless they are matched by investment in community power, respectful care, rights-based accountability and grassroots advocacy.

Funders can respond to this gap by reframing maternal and newborn health as a gender, rights and justice issue. Doing so strengthens grassroots movements, shifts funding decisions closer to impacted communities, and links lived experience to national and global policy agendas.

This report is intended for donors, philanthropic institutions, bilateral and multilateral agencies, global health funders and private foundations seeking practical ways to advance reproductive justice, maternal and newborn health equity, locally-led development and gender equality. The Birth Justice Initiative, with a focus on Kenya and Nigeria, offers a practical model for doing this: fund feminist, locally led and movement-informed grant-making that enables communities to define funding priorities, organise across constituencies, and influence policy and practice in maternal and newborn health. This approach can help translate policy commitments into tangible improvements for women, girls and other birthing people, as well as newborns and families.

Executive Summary

The Birth Justice Initiative demonstrates how feminist funding can strengthen maternal and newborn health outcomes by addressing the power, accountability and rights gaps that technical investments alone cannot solve. By funding grassroots advocacy, donors can help build the conditions for respectful care, equitable access and durable policy change.

Success will not be measured only by predefined policy outputs. It will be reflected in stronger movements, more inclusive funding decisions, clearer pathways from lived experience to policy influence, and health agendas that respond to the realities of those most affected by maternal and newborn mortality.

Recommendations for Donors

1. **Fund advocacy as a health intervention.** Resource law, policy, accountability, stigma reduction and community oversight as core components of maternal and newborn health (MNH) investment.

2. **Provide flexible, multi-year core support.** Move beyond short, restricted grants to enable grassroots organisations to plan for the long term, retain staff, respond to political opportunities and sustain long-term policy influence.

3. **Shift decision-making power.** Embrace participatory grant-making so communities most affected by poor outcomes define funding priorities, criteria and measures of success.

4. **Invest in historically marginalised leadership.** Prioritise sustained funding for rural organising, disability-led movements, youth leadership and other groups that are often excluded from mainstream funding and decision-making.

5. **Fund infrastructure for participation.** Resource the systems that make meaningful participation possible, including interpreters, transport, childcare where relevant, airtime and data, stipends, accessible venues and low-tech communication systems. These are essential investments that enable equitable participation.

6. **Support integrated agendas.** Allow movements to address MNH alongside sexual and reproductive health and rights (SRHR), gender-based violence (GBV), mental health, disability, economic justice and climate vulnerability.

7. **Adopt participatory learning.** Invest in evidence systems that centre grassroots actors and document how grassroots advocacy changes policy, practice, trust, accountability and access, without imposing extractive reporting burdens.

Context for This Work

- **Maternal mortality remains urgent:** WHO estimates that around 260,000 women died during and following pregnancy and childbirth in 2023, with most deaths preventable and concentrated in low and lower-middle-income countries. Source note: WHO maternal mortality fact sheet, 2025.
- **Newborn survival is still fragile:** UNICEF reports that 2.3 million newborns died in the first month of life in 2022, with around 6,300 newborn deaths every day. Source note: UNICEF maternal and newborn health programme page.
- **The policy fit is strong:** Donor commitments to gender equality, sexual and reproductive health and rights, health systems strengthening, locally led development and ending preventable maternal and newborn deaths create a clear opportunity. Birth justice sits at the intersection of these agendas by linking respectful care, accountability, community power and reproductive autonomy.
- **The political context is changing:** At the same time, coordinated anti-rights movements are increasingly challenging progress on gender equality and sexual and reproductive health and rights. Investing in locally led Birth Justice movements strengthens democratic participation, protects hard-won gains and builds community resilience against these regressive trends.
- **The Policy Problem:** Maternal and newborn health is still too often treated as a technical delivery challenge: build facilities, procure commodities, train providers and improve data. Yet communities describe a different reality. Fear of mistreatment, denial of consent, stigma around pregnancy outcomes, disability exclusion, gender-based violence, economic insecurity and weak accountability all shape whether people seek care and whether services are safe. (See project MMAP report). This creates a persistent disconnect between national policy ambition and investment and grassroots experience and priorities. Policies may name respectful care, equity and community engagement, but they often lack funded mechanisms for communities to influence priorities, monitor implementation or hold systems accountable.

> **Our country has very good policies. Our greatest undoing is implementation of those policies... Policies around healthcare financing for maternal health are not quite in sync with community realities.**
>
> FAITH MBEHERO, COUNTRY TECHNICAL ADVISOR, KENYA

The Birth Justice Initiative Model

The Birth Justice Initiative applies feminist funding practice to maternal and newborn health by combining participatory governance, movement mapping, flexible grant-making and adaptive learning. Its model is designed to shift power to those closest to the problem while strengthening the link between local priorities and policy influence.

- **Movement mapping:** A Movement Mapping Assessment Process was led by our in-country advisors who helped us ensure context specificity and wide reach amongst movement actors. Through this work, we engaged more than 320 grassroots and movement actors to identify priorities, funding gaps and pathways for advocacy across Kenya and Nigeria. The findings outlined in the report show that community priorities are broader and more integrated with adjacent or intersecting movement priorities than many traditional maternal and newborn health programmes. Grassroots actors do not separate maternal health from sexual and reproductive health and rights, gender-based violence, disability, mental health, economic justice, adolescent autonomy, rural exclusion or legal reform. They see these as part of the same continuum of risk, access and accountability.

> **Maternal care should be an integrated, uninterrupted system of services that needs to follow a woman and her newborn throughout her pregnancy experience, or childbirth, or postpartum period. Or, throughout her unwanted pregnancy experience, decision, choice, until the end.**
>
> IJIEOMA EGWUATU, COUNTRY TECHNICAL ADVISOR, NIGERIA

- **Participatory governance:** Movement Advisory Groups of 5-7 grassroots advocates and service providers in Kenya and Nigeria, representing diverse communities, issues and lived experiences, shape advocacy priorities, define funding criteria and make grant decisions.

- **Anchor partnerships:** Trusted feminist grant-making organisations, UHAI East Africa Sexual Health Reproductive Initiative (UHAI EASHRI) in Kenya and International Centre for Environmental Health and Development (ICEHD) in Nigeria bring the infrastructure required to manage in-country grant-making, support movement coordination and develop more trusted local relationships.

  In the context of this consortium, as more partners take on an active role in the project implementation (anchor partners, Movements Advisory Groups, in-country consultants), it is crucial to have clear roles and responsibilities among actors. The consortium has created a Roles and Responsibilities matrix that illustrates this clearly to facilitate implementation.

- **Flexible funding:** Multi-year, unrestricted grants support advocacy, organising and the real costs of movement work.

- **Learning for influence:** Evidence is generated with movements and used for advocacy, adaptation and donor learning.

Country Evidence: Kenya and Nigeria

In Kenya, national reproductive, maternal, newborn, child, and adolescent health (RMNCAH) policy commitments prioritise service quality, emergency obstetric and newborn care, surveillance and domestic financing. Grassroots actors affirm these goals but identify the lived experience of care as the missing link. Obstetric violence, stigma, mental health needs, adolescent exclusion and weak grievance systems undermine trust and reduce service uptake. Funding community-led accountability, legal literacy, youth leadership and county-level organising can help turn respectful care commitments into practice.

> **Sex worker-led groups are teaching each other harm reduction strategies—these are the real innovations that policy doesn't capture.**
>
> KENYAN YOUTH NETWORK ORGANISER

National indicators also conceal significant sub-national disparities. In Kenya, women living in rural and historically underserved communities face substantially higher risks of maternal death than those in Nairobi, reflecting inequities in transport, referral systems, workforce distribution and access to emergency obstetric care. Similar disparities exist across Nigeria, where maternal mortality and service access vary dramatically between states and between urban and rural communities. These differences reinforce the need for funding models that target community priorities rather than relying solely on national averages.

In Nigeria, national plans set ambitious targets for antenatal care and skilled birth attendance, while focusing on coordination, commodities, monitoring and financing. Grassroots evidence shows that women's experience of maternal health is inextricably connected to wider gendered issues including gender-based violence, unsafe abortion, mental health, poverty, disability exclusion and rural isolation. Funding integrated, multi-issue advocacy and low-tech rural mobilisation can help reach populations that formal platforms and data systems often miss.

Across both countries, the evidence points to the same conclusion: **health systems investments will have greater impact when paired with grassroots advocacy that builds trust, strengthens accountability and ensures that marginalised communities shape the agenda.**

> The community voices [allow people to] share and identify the gaps between the policy we have as a nation and the reality on ground... [The process] brought to bear the gaps—not just what we put together as policy but what is the reality people live with.
>
> OLUBUNMI (BUNMI) LAWAL-AIYEDUN, MARCH HEALTHCARE INITIATIVE, NIGERIA

Donor Value Proposition

For donors, the Birth Justice Initiative offers a practical model for connecting global health, gender equality, reproductive justice, governance and locally led development priorities. It complements investments in ending preventable maternal and newborn deaths by shifting decision-making power through resourcing the community leadership, advocacy infrastructure and accountability mechanisms needed to make health commitments credible, inclusive and locally owned.

> **They are there doing amazing work but nobody knows them, nobody listens to them because they don't have that financial muscle.**
>
> FAITH MBEHERO, COUNTRY TECHNICAL ADVISOR, KENYA

Community-led advocacy has the ability to strengthen government investment. Kenya and Nigeria, like other African Union Member States, committed through the Abuja Declaration to allocate at least 15% of national budgets to health. Birth Justice advocacy helps communities monitor these commitments, advocate for domestic resource mobilisation and ensure that public investment reflects local priorities.

DONOR CHALLENGE	BIRTH JUSTICE INITIATIVE RESPONSE	POLICY CONTRIBUTION
Technical investments do not always translate into utilisation or trust.	Fund community-led accountability and respectful care advocacy.	Improved uptake, quality and responsiveness of MNH services.
Marginalised actors are excluded from formal policy spaces.	Uses participatory governance and movement advisory structures.	Policy agendas reflect lived experience and equity priorities.
Short-term project funding weakens advocacy capacity.	Provides flexible, multi-year core support.	Stronger continuity in policy engagement and accountability.
Evidence is often extractive or disconnected from action.	Builds movement-owned learning and documentation.	Practice-relevant evidence informs adaptive implementation and donor learning.

Appendix

Aligning Local Realities to Global Agendas

Below is a **theoretical framework** that demonstrates hypothetical pathways from community priorities › identifying the root causes › the type of work or intervention we might expect to fund › outputs › policy outcomes. It could be helpful in connecting the dots between the work and the type of policy outcomes donors expect.

PRIORITIES FROM MMAP →	STRUCTURAL DRIVER →	COMMUNITY-LEVEL WORK →	PATHWAY TO INFLUENCE →	POLICY / SYSTEMS IMPACT
Obstetric violence; disrespect, abuse, denial of consent during childbirth	Normalisation of mistreatment; weak grievance systems; biomedical dominance	Birth companion programmes; maternal storytelling forums; legal literacy sessions; watchdog groups	Aggregated testimonies → engagement in RMNCAH TWGs; CAAP advocacy on respectful care; grievance reform proposals	Enforcement of respectful maternity care standards; accountability mechanisms operationalised
Criminalisation and stigma around abortion, miscarriage, pregnancy outcomes	Restrictive laws; provider fear; moral stigma	Legal literacy campaigns; safe referral networks; harm reduction education; public education messaging	Evidence to policy platforms; normalise PAC advocacy; engage abortion law reform conversations (where feasible)	Increased PAC funding; administrative clarity; gradual legal reform dialogue
Mental health trauma linked to GBV, unsafe abortion, obstetric violence	Mental health excluded from MNH frameworks	Healing circles; trauma counselling; youth safe spaces; survivor-led advocacy	Integration advocacy into RMNCAH plans; adolescent health agenda engagement	Mental health integrated into MNH packages; psychosocial budget lines
Exclusion of women and girls with disabilities from SRHR services	Physical inaccessibility; provider discrimination; lack of disability data	Disability-led audits; accompaniment; sign language peer networks; inclusive leadership pipelines	Advocacy for disability-disaggregated data (CAAP Goal 5 in Kenya); national inclusion standards	Disability inclusion in service standards; accessible infrastructure requirements
Youth excluded from decision-making spaces; tokenism	Technocratic governance; donor gatekeeping	Youth leadership training; mentorship networks; youth-led forums	Formal representation in TWGs/MCP; policy briefs authored by youth	Institutionalised youth participation; youth-responsive health services strengthened

PRIORITIES FROM MMAP	STRUCTURAL DRIVER	COMMUNITY-LEVEL WORK	PATHWAY TO INFLUENCE	POLICY / SYSTEMS IMPACT
LGBTQ+ exclusion from SRHR services	Criminalisation; stigma; security risks	Safe referral mapping; chaperone systems; confidential provider networks	Non-discrimination advocacy; inclusion in service guidelines	Reduced denial of care; strengthened inclusive protocols
Rural communities marginalised from movement leadership and funding	Urban NGO dominance; centralised policy processes	Rural organising hubs; transport stipends; local radio; town criers; offline mobilisation	Increased rural representation in Movement Committees & CAAP platforms	Decentralised decision-making; stronger county/state engagement
Fragmented advocacy (GBV, MNH, abortion, disability siloed)	Donor silos; vertical funding models	Multi-issue coalitions; cross-sector convenings	Integrated advocacy agendas presented to national frameworks	Policy coherence across SRHR, GBV, MNH & mental health
Poverty driving unsafe abortion, GBV, maternal mortality	Economic inequality; lack of social protection	Livelihood groups; cash support; skills training; savings circles	Link economic justice evidence to national poverty & adolescent agendas	Greater integration of economic support into SRHR programming
Unsafe abortion contributing to maternal mortality (10%)	Restrictive abortion law; poor PAC coverage	Public narrative campaigns; provider engagement; PAC awareness	Link evidence to MNH mortality reduction commitments	Increased PAC coverage; funding allocation improvements
Deep mistrust in public facilities	Abusive treatment; language barriers	Service charters; community oversight forums; complaint tracking	County-level advocacy; integration into respectful care agenda	Improved service trust; accountability mechanisms
Disability-led groups under-resourced and under-recognised	Funding concentration among formal NGOs	Leadership grants; direct funding to disability-led orgs	Movement Committee representation; donor model reform	More equitable funding distribution; stronger disability voice in policy
Climate shocks affecting pregnancy outcomes	Climate vulnerability not integrated into MNH planning	Community climate-health storytelling; disaster preparedness networks	Advocacy linking climate adaptation & maternal health	Climate-resilient MNH planning integrated

By Comparison: More technocratic advocacy agendas

As a useful and again purely theoretical framework for comparison purposes, below is a more technocratic advocacy approach. What is interesting about it is you can immediately see how the type of advocacy that would usually be 'funded' is not the type of work that would resonate with the movements working on these issues at a local level. It demonstrates the gap that needs to be bridged.

MMAP FINDINGS (GRASSROOTS INSIGHT)	EXISTING POLICY / FRAMEWORK ALIGNMENT	ADVOCACY PATHWAYS	POTENTIAL POLICY OUTCOMES
Disrespect and abuse during childbirth; weak grievance mechanisms	National Respectful Maternity Care (RMC) Guidelines; RMNCAH Investment Framework; UHC quality standards	Monitor enforcement of RMC standards at county level; document cases and expand awareness of the issue; engage County Health Committees; push for functional grievance systems	Stronger enforcement of RMC; improved quality-of-care indicators; increased facility trust and uptake
Adolescent mothers face stigma and denial of care	National Adolescent Sexual and Reproductive Health (ASRH) policies; RMNCAH acceleration commitments	Advocate for adolescent-responsive budgeting; integrate adolescent representatives in health planning forums; track non-discrimination compliance	Reduced adolescent maternal mortality; improved service utilisation among adolescents
Women with disabilities excluded from maternity services	Disability Act; UHC equity commitments; national inclusion frameworks	Conduct facility accessibility audits; advocate for disability-inclusive service standards; integrate disability indicators into monitoring systems	Operationalisation of disability inclusion within MNH; improved equitable access
Transport and referral gaps in marginalised counties	National emergency referral strengthening (including m-mama); RMNCAH county plans	Use MMAP data to identify underserved counties; monitor dispatch and facility readiness; advocate for sustained county budget allocations	Reduced second delay (delay in reaching care); measurable reduction in preventable maternal deaths
Fragmented maternal and newborn advocacy actors	National RMNCAH coordination platforms	Support coalition-building; integrate newborn and maternal actors; link grassroots evidence to national technical working groups	More coherent national advocacy voice; stronger influence on RMNCAH review cycles

Executive Brief for Donors

To ensure we are building ethical, trust-based alliances, we have to ground them in clear principles. You will find these in your workbooks.

IJIEOMA EGWUATU, COUNTRY TECHNICAL ADVISOR, NIGERIA

Purpose

To present the Birth Justice Initiative as a fundable model for strengthening grassroots advocacy, respectful care and accountability within maternal and newborn health systems in Kenya and Nigeria.

Why this matters now

Global progress on maternal and newborn survival has slowed, while women, other birthing people and newborns in marginalised communities continue to face preventable harm. Technical health investments alone cannot close this gap where people experience disrespect, stigma, exclusion, weak grievance systems and limited power over policy decisions.

Donor fit

The Initiative supports priorities shared by many donors, including ending preventable maternal and newborn deaths, advancing women's and girls' health and rights, strengthening grassroots movement leadership, promoting gender equality, improving health systems and supporting locally led development. It translates these commitments into practical grant-making and advocacy infrastructure.

The model

BJI combines movement mapping, participatory governance, flexible multi-year funding, anchor partnerships and movement-owned learning. In Kenya and Nigeria, this enables grassroots organisations to shape funding priorities, advocate for respectful care, monitor accountability and bring lived experience into policy spaces.

Donor case

Funding grassroots advocacy increases the likelihood that health system investments translate into trust, uptake, quality and equity. It also strengthens local ownership, improves feedback loops and supports communities often missed by formal policy and data systems.

Recommended donor actions

Provide flexible core support for grassroots advocacy; fund participatory grant-making; invest in rural, youth, disability-led and marginalised community organising; support integrated MNH, SRHR, GBV and mental health agendas; and adopt learning approaches that are useful to movements as well as donors.

Bottom line

BJI gives donors a concrete route to fund the demand-side accountability and movement leadership required to make maternal and newborn health systems more respectful, equitable and effective.

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