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GENDER & HEALTH

GLOBAL FINANCING FACILITY (GFF): GENDER & REPRODUCTIVE, MATERNAL, NEWBORN, CHILDREN AND ADOLESCENT HEALTH AND NUTRITION

Cordaid

WHAT IS THE GLOBAL FINANCING FACILITY?

The Global Financing Facility is a country-led partnership that helps governments prioritise and scale up investments in **Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH-N)**.

Launched in 2015, the GFF strengthens service delivery systems to save lives, drive progress toward Universal Health Coverage (UHC), and helps countries achieve the Sustainable Development Goals (SDGs). The GFF plays a **catalytic role** by helping countries **bring together domestic and international funding and expertise** to finance proven health priority areas for **women, children, and adolescents**.

Because strong **primary health care (PHC)** is widely seen as the foundation of universal health coverage (UHC), the GFF supports countries to strengthen PHC, so essential services (like **maternal care, infant nutrition, and contraception)** reach people who are most at risk, including during crises and infragile and conflict-affected situations. In short, the GFF helps countries turn plans into results by using financing and partnerships to make PHC stronger and more equitable.

It is a **multi-donor trust fund** launched in **July 2015**. It is **managed by the World Bank** and funded by governments and private foundations. The Netherlands is a donor and a member of both the Investors Group and the Trust Fund Committee, the two governing bodies of the GFF.

COMMON GENDER-RELATED BARRIERS IN RMNCAH-N

Limited decision-making power and control over money

Many women cannot decide on their own health care or family planning, or lack money/permission to seek care. Globally, out of 68 UNFPA reporting countries, an estimated 44 per cent of partnered women do not have the power to make informed decisions about health care, sexuality, and contraception.

Time and access constraints

Even when services are available, women often have less time and flexibility to travel to clinics and wait for care because they carry most unpaid care work. Globally, women perform 76.2% of total hours of unpaid care work, spending on average 4 hours and 25 minutes per day on it compared with 1 hour and 23 minutes for men.

Harmful social norms and stigma

Globally, 12 million girls marry before the age of 18 each year. The harmful effects of child marriage extend across generations, negatively affecting child and maternal health, hindering economic progress, and restricting women's productivity and earnings. Girls who marry young or become pregnant early often drop out of school, have limited knowledge about reproductive health, and face higher risks of complications and death in childbirth.

Stigma around adolescent sexual and reproductive health limits young girls' access to services, both information and commodities (e.g. contraceptives). In some communities, pregnancy and childbirth are treated mainly as a "woman's duty", so families may underestimate the need for regular check-ups, skilled birth attendance and rapid care when complications arise. When births occur without appropriate skilled support or referral pathways, risks for mothers and newborns increase.

AFRICA

YOUTH GROUPS TRANSFORMING HEALTH FOR WOMEN AND GIRLS

Across several Sub-Saharan countries, youth groups are playing a growing role in shaping health services for women and girls. Working together with the GFF country platforms, young people are not only service users but also active participants in planning, monitoring and accountability processes.

Youth-led organisations have contributed to identifying barriers such as stigma around adolescent sexual and reproductive health, discrimination by providers, and lack of confidentiality in facilities. By participating in national health dialogues and monitoring service delivery, they have helped ensure that adolescent-friendly services are reflected in investment plans and reforms.

In some countries, youth representatives sit on national or sub-national health platforms, contributing to discussions on service package design, quality of care, and outreach strategies. Their engagement has strengthened community feedback mechanisms and improved responsiveness to the needs of adolescent girls.

This approach addresses systemic barriers, including the under-representation of youth voices in decision-making, limited accountability for quality of care, and the persistence of stigma in sexual and reproductive health services.

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Limited access to contraception and information

When women and adolescent girls cannot access a full range of contraceptive methods or respectful counselling, unintended pregnancies and closely spaced births increase risks for mothers, newborns and children. Globally, an estimated 257 million women who want to avoid pregnancy are not using safe, modern contraception, and where data is available, nearly a quarter of women cannot say no to sex.

Adolescents face additional barriers, including stigma, judgment from health workers, myths about side effects, and cultural norms around virginity, marriage and childbearing. Evidence from sub-Saharan Africa shows that married adolescent girls are less likely to use contraceptives than unmarried girls, partly due to expectations to prove fertility after marriage. A review also found that adolescents often rely on media or peers for contraception information, while myths, gender norms, education and socio-economic status limit access and use.

Access to information is also increasingly shaped by digital access: in low- and middle-income countries, women are 14% less likely than men to use mobile internet, leaving 885 million women unconnected, reducing access to health information, service navigation and referrals.

Sexual and Gender-Based Violence (SGBV) and underreporting /tolerance

SGBV reduces care-seeking and undermines health and safety. Worldwide, 1 in 3 (30%) of women have experienced physical and/or sexual violence by an intimate partner or sexual violence by a non-partner (or both). In GFF-supported countries, the GFF gender roadmap notes evidence that where GBV is accepted/tolerated, women are less likely to use skilled birth attendants and timely/full antenatal care.

Mistreatment and discrimination in facilities

Poor treatment during childbirth (verbal abuse, neglect, denial of care, non-consented care) discourages women from delivering in facilities or returning for follow-up care. A WHO-led study across four countries (Ghana, Guinea, Myanmar and Nigeria) found more than one-third of women experienced mistreatment during facility childbirth. Moreover, health workers may discriminate against unmarried and young women.

ZIMBABWE

IMPROVING QUALITY AND ACCESS THROUGH RESULTS-BASED FINANCING

Zimbabwe's Health Sector Development Project (2011–2024) used results-based financing (RBF) to expand access to and improve the quality of maternal and child health services. The programme was implemented by Cordaid, in partnership with the Government of Zimbabwe, and co-financed by the World Bank, later including the Global Financing Facility. It has since continued as a Cordaid-led initiative.

The project began in two rural districts and was gradually scaled up before expanding nationwide. Under the RBF model, health facilities received funding linked to performance indicators, including antenatal visits, facility deliveries, and child immunisations. Village health workers were engaged to strengthen outreach, community demand, and reporting systems.
Reported results include more than 1 million women accessing antenatal care, with 1.39 million completing four or more visits, over 1.1 million facility deliveries, and approximately 958,000 children completing essential immunisations.
By linking financing to service delivery outcomes and strengthening frontline services, the project reduced financial barriers, improved the quality of care, and increased utilisation of maternal and child health services.

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HOW THE GFF INVESTS IN GENDER EQUALITY

The GFF supports 36 countries to analyse how **gender inequality holds back progress** in women's, children's and adolescents' health.

Key action areas to address the **system-level barriers** include:

- **Analytical + technical support:** Generate and use country-specific analysis showing how gender inequality affects RMNCAH-N outcomes, especially through quality of care, health financing, and the health workforce, so investment cases and reforms target the real bottlenecks.

- **Gender-responsive monitoring + data:** Invest in monitoring and data systems (including routine systems and equity-disaggregated reporting)that can regularly track gender equality indicators relevant to RMNCAH-N, and use community-level inputs/feedback to capture women's and adolescents' experience of care.

- **SRHR within UHC reforms:** Support policy and program reforms that integrate sexual and reproductive health and rights into universal health coverage, including service package design, workforce reforms, and legal/policy reforms that remove barriers for women and adolescents.

- **Stronger local gender expertise in country platforms:** Bring national gender equality actors (women's organisations, youth groups, gender experts) into country platforms and strengthen local capacity for gender monitoring and evaluation, so priorities and accountability reflect lived barriers.

- **Women's and girls' leadership:** Support system reforms and processes that empower women and girls as leaders in investment-case design, implementation, and monitoring at country and global levels, so decision-making and spending priorities become more gender-responsive.

- **Beyond-health sector action:** Strengthen engagement beyond the health sector to shift key gender levers in social protection, education, infrastructure, and employment, recognising that many constraints on women's and girls' health sit outside clinics.

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REMAINING CHALLENGES AND RECOMMENDATIONS FOR DECISION MAKERS

Limited involvement of men and boys

- Design male-inclusive health education campaigns to promote shared responsibility in family planning, antenatal care, and child health;
- Incorporate gender-transformative approaches in community outreach that challenge harmful masculinity norms and promote caregiving roles for men;
- Train male community leaders and peer educators to advocate for respectful maternal and adolescent health practices.

Persistent gender norms and social stigma

- Implement culturally sensitive gender norms programming in schools, community centres, and through media, focusing on delaying marriage and promoting girls' education;
- Scale up adolescent-friendly health services that ensure confidentiality, respect, and non-discrimination (with youth input in design and evaluation);
- Use social and behaviour change communication strategies to normalise girls' and young women's access to contraception and reproductive care.

Underreporting of SGBV

- Integrate SGBV screening and referral protocols into all maternal and adolescent health services;
- Train health workers on survivor-centered care and legal referral pathways;
- Support confidential, safe reporting systems and strengthen links between health, legal, and protection sectors to respond to SGBV.

Limited leadership roles for women

- Expand mentorship and career advancement pathways for women in health policy, leadership, and service delivery roles;
- Enforce gender parity targets in national health committees, boards, and local governance structures.

NIGER

LEGAL REFORM AND COMMUNITY ACTION TO PROTECT GIRLS

In Niger, reforms addressed legal and social barriers limiting adolescent girls' access to reproductive health services. With support from the World Bank and the Global Financing Facility, Niger reformed its legal framework to allow married adolescent girls to access family planning services without being accompanied by a parent or husband.

Alongside legal reform, community and school-based initiatives were introduced. Through the SWEDD project, 50 Child Protection Committees were established across several regions to prevent early marriage and support girls' wellbeing. These committees bring together community members, including health workers and local leaders, to address harmful norms.

Secondary school girls also gained access to school health clubs providing reproductive health education, including information on teenage pregnancy, sexually transmitted infections, and gender-based violence.

This combined approach of legal reform, community engagement and education directly addresses barriers linked to adolescent stigma, early marriage, and restricted access to sexual and reproductive health services.

ABOUT CORDAID

Cordaid is a value-based international development and emergency relief organisation, based in the Netherlands with offices in 14 countries. We work in and on fragility and support communities in their efforts to improve health care, education, food security, and justice. Where disaster strikes, we offer humanitarian assistance.

Cordaid is deeply rooted in the Dutch society with more than 260,000 private donors. The Christian values of human dignity, justice, compassion and care for the planet guide us in our work. Cordaid is a founding member of Caritas and CIDSE, and member of the ACT Alliance.

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