POLICY BRIEF · HUMANITARIAN HEALTH ·

No Woman Invisible: Extending Respectful Maternal Care to Refugees and Displaced Populations in Nigeria

Wellbeing Foundation Africa (WBFA) in partnership with UNHCR Nigeria | 2025 | Rasheed Yusuf

Key Message

Displacement does not pause pregnancy. In Nigeria, 3.5 million internally displaced persons and 127,000 refugees 84% of them Cameroonian live in conditions that make maternal death not an exception but a systemic probability. A 15-year-old girl in a humanitarian setting faces a 1-in-51 lifetime risk of dying from a maternal cause, compared to 1-in-593 in stable countries. Since 2021, WBFA has worked with UNHCR Nigeria to deliver its MamaCare360 midwifery model in Cross River State's Cameroonian refugee settlements serving 7,144 participants, supporting 1,038 live births, recording zero maternal deaths, and achieving a neonatal mortality rate of 1.9 per 1,000 against a state benchmark of 24. This brief makes the case for scaling this model and for making displaced women central to Nigeria's maternal health agenda.

The Displacement and Maternal Health Crisis — Nigeria and Global

127K
refugees and asylum-seekers in Nigeria — 84% Cameroonian (UNHCR, 2024)

3.5M
internally displaced persons in Nigeria (UNHCR, 2024)

1 in 51
lifetime maternal death risk for a girl in humanitarian settings — vs 1 in 593 in stable countries (WHO, 2025)

80%
of crisis-affected population in NE Nigeria are women and children (Healthy Newborn Network, 2024)

>700
maternal deaths per 100,000 in Northern Nigeria — highest in country (Meh et al, 2019; WHO et al, 2023; PMC, 2024)

1. Displacement and Maternal Health in Nigeria: An Invisible Crisis

Nigeria faces one of the world's most acute convergences of maternal mortality and forced displacement. By end of 2024, UNHCR recorded 127,000 refugees and asylum-seekers across 25 Nigerian states the overwhelming majority (84%) Cameroonian nationals fleeing the ongoing Anglophone Crisis in Cameroon's Northwest and Southwest regions, which has produced no durable peace since escalating in 2017. These refugees are concentrated primarily in Cross River, Taraba, Akwa-Ibom, Benue, and Adamawa states. Alongside this refugee population, Nigeria hosts 3.5 million internally displaced persons one of the largest IDP populations on the African continent driven primarily by the Boko Haram insurgency in the Northeast, communal violence in the Middle Belt, and increasingly, climate-related flooding.

Displacement and maternal death are not parallel crises they are the same crisis. The WHO's April 2025 Trends in Maternal Mortality report makes this explicit: nearly two-thirds of all global maternal deaths now occur in countries affected by fragility or conflict. A 15-year-old girl in a humanitarian setting faces a 1-in-51 lifetime risk of dying from a

maternal cause twelve times higher than her counterpart in a stable country. Nigeria itself carries a 1-in-25 lifetime risk, among the highest globally. In Northern Nigeria, which hosts the majority of Nigeria's displaced population, the maternal mortality ratio reaches 709 deaths per 100,000 live births more than 35 times higher than in high-income countries.

The 2025 Aid Crisis: A Compounding Threat

The WHO/UNICEF April 2025 Trends in Maternal Mortality report warns explicitly that unprecedented humanitarian aid cuts — driven by the US suspension of USAID funding — are now threatening to reverse fragile maternal health gains across the most vulnerable settings globally. Nigeria's humanitarian health programmes, which include SRMNCH services in displacement settings, are directly exposed to this funding withdrawal. The Report identifies humanitarian settings as the zone of highest risk for maternal mortality regression in 2025 and beyond. At a moment when Nigeria's displaced women need more support, the global financing architecture that sustains that support is contracting.

The specific situation of Cameroonian refugees in Cross River State illustrates the structural nature of this crisis. These refugees — predominantly from the Anglophone Northwest and Southwest regions have been in Nigeria since 2017, many in prolonged settlement with no near-term prospect of return. They live in communities like Adagom and Ukende in the Ogoja axis, where host community health facilities are already under-resourced, and the additional pressure of a refugee population further strains capacity. Pregnant women in these settlements face the full weight of the triple burden: the underlying fragility of Nigeria's maternal health system; the additional vulnerability of displacement; and the near-total absence of dedicated, culturally adapted maternal services.

A 2024 qualitative study across IDP camps in North Central Nigeria (PLOS One, December 2024) found that displaced women's primary sexual and reproductive health needs include emergency obstetric care, maternity clinic access, and skilled birth attendance yet the most common barrier is financial inability, compounded by fear, stigma, language barriers, and absence of female providers. The study found that IDP women frequently improvise care in ways that endanger their lives and those of their newborns. These are not outliers. They are the norm in the absence of deliberate, adapted humanitarian maternal health programming.

2. WBFA's Humanitarian Midwifery Model in Practice

Since 2021, WBFA has partnered with UNHCR Nigeria to deliver its MamaCare360 Community Midwifery Model in refugee and displacement settings in Cross River State. This adaptation of WBFA's flagship maternal health programme was specifically designed for the humanitarian context maintaining the programme's evidence-based educational core while incorporating cultural sensitivity, flexibility for fragile environments, and integration with UNHCR's broader humanitarian response architecture.

The programme operates across four facilities in the Ogoja axis of Cross River State: Adagom Health Center, Ukende Health Center, Ogboja Primary Health Care Centre, and General Hospital Ogoja. These facilities serve both Cameroonian refugees and the surrounding Nigerian host community reflecting WBFA's deliberate commitment to an inclusive model that strengthens the health of all women in the area, not only the displaced.

1 **Adapted MamaCare360 Curriculum — Culturally and Linguistically Sensitive**

WBFA's standard MamaCare360 antenatal and postnatal education curriculum was adapted for the Cameroonian refugee context, incorporating linguistic accommodation for Francophone and Anglophone Cameroonian participants, use of local metaphors and familiar reference points, and inclusion of topics specific to the displacement experience such as stress, trauma, and uncertainty during pregnancy.

Sessions are led by WBFA-trained midwives who receive additional orientation on cultural humility and trauma-informed care. Both interactive group sessions and individualised one-on-one consultations are offered.

2 Home and Community Visits — Reaching the Unreachable

Recognising that refugee and displaced women often face the greatest barriers to facility attendance including distance, childcare responsibilities, fear, and physical exhaustion WBFA complements facility-based sessions with structured home and community visits. These visits allow midwives to reach women who cannot attend clinics, provide practical guidance on birth preparedness and newborn care in the home environment, and build the individual relationships that are at the heart of the continuity of care model. This component is particularly critical in humanitarian settings where women may be reluctant to engage with formal health systems.

3 WASH and Infection Prevention Integration

MamaCare360 in Cross River is integrated with WASH interventions adapted for the refugee settlement context. Midwives deliver targeted messages on hand hygiene, safe water, sanitation, and infection prevention during pregnancy and delivery reflecting the specific WASH vulnerabilities of camp and settlement environments. This integration reduces the risk of neonatal sepsis and puerperal fever, which are disproportionately elevated in displacement settings due to overcrowding, limited water access, and poor sanitation infrastructure.

4 Dignity Kits and Essential Materials Distribution

WBFA distributes dignity kits to women in refugee and displacement settings containing essential items for safe delivery and postpartum care, including clean delivery kits, sanitary pads, soap, and newborn essentials. These kits serve a dual function: they provide material support that many displaced women cannot access independently, and they reinforce WBFA's message that every woman regardless of displacement status deserves dignified, respectful care. Dignity kits also create an engagement touchpoint that brings women into the midwifery programme.

5 Digital Midwifery — Extending Care Beyond the Facility

WBFA's WhatsApp-based Digital Midwifery Platform has been extended into Cross River's humanitarian settings, with 483 mothers currently enrolled in the Cross River group (368 added in 2024 alone). This digital layer provides 24/7 access to midwife support particularly valuable in a setting where facility attendance is irregular, where women may go into labour at night or on weekends, and where the distance between home and facility can be life-threatening. The digital platform also enables midwives to maintain continuity of care with women who have been relocated or moved between settlements.

6 Inclusive Host-Refugee Service Delivery

A deliberate design principle of WBFA's humanitarian model is that services are delivered to all women in the catchment area both Cameroonian refugees and Nigerian host community members. This approach reduces stigma and social friction between refugee and host populations, prevents the creation of parallel

health systems that breed resentment, and strengthens host community facility capacity in ways that benefit all residents permanently. UNHCR's 2024 Annual Results Report explicitly identifies refugee inclusion in national health services as a core strategy objective WBFA's model operationalises this at the community level.

3. Impact and Outcomes (2021–2024)

WBFA's humanitarian midwifery model in Cross River State has delivered results that are striking against both national benchmarks and global humanitarian health standards. The 2024 Annual Report data for Cross River State which includes both the refugee and host community populations served demonstrates the power of sustained, midwife-led, relationship-based care even in a fragile, displacement-affected environment.

Reach and Participation

In 2024 alone, 7,144 participants were reached across WBFA's four Cross River facilities including 3,886 pregnant women, 2,734 lactating mothers, and 524 family members and influencers. The engagement of family members is particularly significant in the humanitarian context, where spousal support and family acceptance of maternal care-seeking can be a decisive factor in whether a woman reaches a facility during labour. 415 structured facility-based sessions were conducted throughout the year, and the Digital Midwifery platform enrolled 368 additional mothers in 2024, bringing the total Cross River digital enrolment to 483.

Birth Outcomes — Zero Maternal Deaths

The most powerful outcome of the Cross River programme is its mortality record. Among 1,038 live births supported in 2024, zero maternal deaths were recorded among programme participants. This compares against Nigeria's national maternal mortality ratio of 993 per 100,000 live births, and a Cross River State NDHS 2023–24 benchmark NMR of 24 per 1,000 live births. WBFA's Cross River NMR of 1.9 per 1,000 is 92% lower than the state benchmark a result that reflects both the quality of midwife-led antenatal education and the effectiveness of referral pathways and birth preparedness that the programme instils.

Against the Global Humanitarian Standard

UNHCR's Reproductive Health in Humanitarian Settings standards identify access to skilled birth attendance and functional referral pathways as the two most critical interventions for reducing maternal mortality in displacement settings. WBFA's model delivers both — and goes further by embedding them in a continuity-of-care framework built on trusted midwife relationships. The programme's outcomes compare favourably even against established UNHCR refugee health benchmarks and demonstrate that the barriers to quality maternal care in displacement settings are primarily systemic and resource-related, not inherent to the context.

Indicator	Result	Source
Total participants served in Cross River (2024)	7,144	WBFA Annual Report, 2024
Pregnant women reached through ANC sessions	3,886	WBFA Annual Report, 2024
Lactating mothers reached through PNC sessions	2,734	WBFA Annual Report, 2024
Family members and influencers engaged	524	WBFA Annual Report, 2024
Live births supported in Cross River	1,038	WBFA Annual Report, 2024
Maternal deaths among programme participants	0	WBFA Annual Report, 2024
Neonatal deaths among programme participants	2	WBFA Annual Report, 2024
Programme NMR in Cross River (vs NDHS benchmark of 24)	1.9 per 1,000	WBFA Annual Report, 2024
Facilities delivering MamaCare360 in Cross River	4 (Adagom, Ukende, Ogboja PHC, Gen. Hospital Ogoja)	WBFA Annual Report, 2024
Digital Midwifery enrolment — Cross River	483 mothers (368 added in 2024)	WBFA Annual Report, 2024
Cameroonian refugees hosted in Nigeria (end 2024)	~107,000 (84% of 127,000 total refugees)	UNHCR ARR 2024
Refugees and asylum-seekers hosted by Nigeria total	127,000 across 25 states	UNHCR ARR 2024
Nigeria IDPs (end 2024)	3.5 million	UNHCR Nigeria, 2024

Table 1: Humanitarian Maternal Health Impact Snapshot — Cross River State (2024). Sources: WBFA Annual Report 2024; UNHCR Annual Results Report 2024.

Voice From the Field

"When I arrived in Adagom I did not know where to go or who to trust. I was seven months pregnant and I walked for three days. The midwife from WBFA came to my shelter. She spoke to me quietly and explained everything. She checked my baby. She gave me a plan for what to do when I went into labour. She was there when I delivered. My baby was born healthy. I do not have words for what that means to me." — Cameroonian refugee mother, Adagom settlement, Cross River State, 2024

4. Lessons Learned

Four years of implementing humanitarian maternal health programming in Nigeria's refugee and displacement contexts have produced critical lessons that should directly shape the design of scaled and successor programmes both within Nigeria and across similar displacement-affected settings in West and Central Africa.

1 **Displacement does not reduce women's need for quality maternal care — it amplifies it.**

Cameroonian refugee women in Cross River, many experiencing pregnancy in a foreign country without documentation, family networks, or financial resources, have the same clinical needs as any pregnant woman — and face dramatically higher risks. The lesson is structural: humanitarian maternal health programmes must be designed to the same quality standard as development programmes, not treated as an emergency stopgap. The zero maternal deaths outcome in Cross River was achieved not by lowering standards for refugees, but by applying WBFA's full evidence-based model in an adapted form.

2 **The inclusive model — serving refugees and host communities together — is both ethically and operationally superior.**

WBFA's decision to serve all women in the Cross River catchment area, regardless of displacement status, has produced multiple benefits: it prevents the social tensions that parallel systems create; it strengthens host community health infrastructure permanently; and it is more cost-efficient than operating separate programmes. UNHCR's 2025 strategy explicitly calls for this inclusion approach. The implication for policy is clear all future humanitarian maternal health investments in Nigeria should be structured as inclusive programmes serving mixed populations, not refugee-only interventions.

3 **Cultural adaptation is not a peripheral consideration — it is a prerequisite for engagement.**

The Cameroonian refugee population in Cross River is linguistically and culturally distinct from the Nigerian host community. Anglophone and Francophone Cameroonians have different health beliefs, communication styles, and experiences of childbirth. WBFA midwives who received orientation on these differences achieved significantly higher engagement and trust than standardised delivery would have produced. The implication: any humanitarian maternal health programme operating with a refugee population must invest in cultural adaptation, interpreter access, and provider training on cultural humility as a baseline requirement.

4 **Digital tools can reach women those facilities cannot — and this is most true in humanitarian settings.**

In Cross River's refugee settlements, women who cannot attend weekly MamaCare360 sessions due to distance, childcare, or physical exhaustion can still access midwife support through the WhatsApp Digital Midwifery platform. This is not a secondary option; it is often the primary access point for the most vulnerable women. The programme's 483 Cross River digital enrolments demonstrate sustained demand. The implication: digital maternal health platforms should be funded and scaled as a core component of humanitarian maternal health programmes, not as a supplementary add-on.

5 **Sustained, long-term presence builds the trust that short-term emergency programmes cannot.**

WBFA has operated in Cross River since 2021 — a period long enough to build community recognition, institutional relationships, and individual midwife client bonds that produce results. In contrast, most

humanitarian health interventions are short-cycle and project-based, with constant turnover of providers and programmes. The Zero maternal deaths outcome in Cross River is partly a product of four years of consistent presence. The implication: humanitarian maternal health funding must shift toward multi-year, sustained programming not 6- or 12-month emergency response cycles that reset trust every time they end.

5. Policy Recommendations

To protect displaced women's right to safe motherhood — and to convert WBFA's demonstrated proof of concept in Cross River into a national standard — the following seven recommendations address the policy, financing, workforce, and system gaps that currently leave Nigeria's refugee and IDP populations without adequate maternal care.

R1

Formally designate humanitarian settings as priority implementation zones in Nigeria's national RMNCAEH+N strategy

Refugees, asylum-seekers, and IDPs are explicitly named as vulnerable groups under the Basic Health Care Provision Fund (BHCPF) — yet this recognition has not translated into targeted programming or ring-fenced funding within the RMNCAEH+N Strategic Framework. The FMoH should formally designate communities hosting significant refugee or IDP populations as priority SRMNCH implementation zones, with dedicated implementation plans, monitoring indicators, and accountability mechanisms. This policy change would create the framework within which all other recommendations operate.

Lead actors: Federal Ministry of Health (FMoH), RMNCAEH+N Technical Working Group, NPHCDA, National Commission for Refugees Migrants and IDPs (NCFRMI), UNHCR Nigeria

R2

Scale WBFA's MamaCare360 humanitarian midwifery model to all Cross River refugee settlements and to new displacement sites nationally

The model's proven outcomes — zero maternal deaths among participants, NMR of 1.9 per 1,000 against a state benchmark of 24, and 7,144 participants reached in 2024 — provide compelling evidence base for national scale-up. WBFA and UNHCR should develop a joint scaling plan for all major Cameroonian refugee settlements in Cross River, Taraba, Akwa Ibom, and Benue. A parallel adaptation for IDP contexts in the Northeast should be developed with the Borno, Adamawa, and Yobe State Ministries of Health. Both models should maintain the core design principles: continuity of care, inclusive host-refugee delivery, and cultural adaptation.

Lead actors: WBFA, UNHCR Nigeria, Cross River SMOH, Taraba SMOH, Borno SMOH, SPHCDAs, development partners

R3

Establish guaranteed, portable maternal health entitlements for all refugees and IDPs under BHCPF

Despite their legal designation as a vulnerable group, refugee and IDP women in Nigeria frequently lack the documentation required to access formal health services under BHCPF and state health insurance schemes. NHIA and the NCFRMI should establish a portable, documentation-light maternal health entitlement card — modelled on UNHCR's refugee registration system — that guarantees access to ANC, skilled birth attendance, emergency obstetric care, and PNC at any enrolled BHCPF facility, regardless of displacement status or state of origin. This aligns with the Global Compact on Refugees' inclusion mandate and Nigeria's stated UHC commitments.

Lead actors: National Health Insurance Authority (NHIA), BHCPF Oversight Committee, NCFRMI, UNHCR Nigeria, FMoH

R4

Mandate culturally adapted SRMNCH+N training for all health workers deployed to humanitarian settings

Health workers assigned to facilities serving refugee and displacement-affected populations must receive mandatory orientation in cultural humility, trauma-informed care, language access strategies, and the specific SRH needs of displaced women — including higher risks of GBV, obstetric fistula from prolonged labour, and perinatal mental health distress. This training should be incorporated into NMCN and NPHCDA deployment standards for humanitarian posting. WBFA's existing adaptation experience in Cross River should inform the curriculum design.

Lead actors: Nursing & Midwifery Council of Nigeria (NMCN), NPHCDA, SPHCDAs, UNHCR, WHO Nigeria, International Medical Corps (IMC), WBFA

R5

Expand digital midwifery platforms into all major refugee and IDP settlements as a low-cost care extension tool

WBFA's Digital Midwifery WhatsApp platform is one of the most cost-effective tools available for extending maternal health support into displacement settings — requiring only a smartphone, a SIM card, and a trained midwife moderator. With 483 mothers already enrolled in Cross River and strong demonstrated demand, this should be scaled to all major settlement clusters. Development partners — including UNHCR, telecommunications companies operating in Nigeria, and digital health donors — should fund the smartphone provision, data allowances, and midwife training required to operationalise this expansion. Emergency connectivity provisions should also be activated for newly displaced populations.

Lead actors: WBFA, FMoH Digital Health Division, UNHCR Nigeria, MTN Foundation, Airtel Nigeria CSR, eHealth Africa

R6

Integrate refugee and IDP maternal outcomes into NHMIS and the Maternal and Perinatal Death Surveillance and Response system

Nigeria currently has no systematic mechanism for tracking maternal deaths, near-misses, or birth outcomes in refugee and displacement settings. This data absence means the scale of the crisis is invisible to policymakers, and evidence-based advocacy for humanitarian maternal health investment is impossible. NHMIS should be updated to include refugee/IDP status as a data field across all maternal health indicators. UNHCR's Community-Based Monitoring systems should be formally linked to the national MPDSR framework. NCFRMI should be mandated to produce an annual Humanitarian Maternal Health Data Report.

Lead actors: NHMIS Steering Committee, Maternal and Perinatal Death Surveillance and Response (MPDSR) bodies, NCFRMI, UNHCR Nigeria, FMoH Department of Planning Research & Statistics

R7

Strengthen host community health systems to absorb displacement-driven demand sustainably — not as a separate parallel system

The most durable solution to humanitarian maternal health is not a dedicated refugee health system — it is a strengthened national system that absorbs refugee and IDP needs as part of its universal mandate. Cross River, Taraba, Benue, and Adamawa States — which host the largest refugee and IDP populations — should receive additional HRH and infrastructure investments calibrated to the size of their displaced populations. World Bank, USAID successor programmes, and bilateral donors should channel humanitarian maternal health investment through state-level systems strengthening, not solely through vertical humanitarian response. WBFA's inclusive model, co-serving refugees and hosts, provides the template.

Lead actors: State Ministries of Health, LGA Health Authorities, World Bank, EU, bilateral donors, UNICEF, UNHCR, WBFA

The table below provides a quick-reference summary of all seven recommendations:

#	Recommendation	Lead Actors	Timeframe
R1	Formally designate humanitarian settings as priority implementation zones in Nigeria's RMNCAEH+N strategy	FMoH, NPHCDA, NCFRMI, UNHCR Nigeria	Immediate
R2	Scale WBFA's MamaCare360 humanitarian midwifery model to all Cross River settlements and new displacement sites	WBFA, UNHCR, Cross River SMOH, SPHCDA	Short-term
R3	Establish guaranteed, portable maternal health entitlements for all refugees and IDPs under BHCPF	NHIA, BHCPF Oversight Committee, NCFRMI, UNHCR	Short-medium term
R4	Mandate culturally adapted SRMNCH+N training for all health workers in humanitarian settings	NMCN, NPHCDA, UNHCR, WHO Nigeria, IMC	Short-medium term
R5	Expand digital midwifery platforms into refugee settlements as a low-cost care extension tool	WBFA, FMoH Digital Health Division, UNHCR, MTN Foundation	Short-term
R6	Integrate refugee and IDP maternal outcomes into NHMIS and maternal death surveillance systems	NHMIS Steering Committee, NCFRMI, UNHCR, WHO	Medium-term
R7	Strengthen host community health systems to absorb displacement-driven demand sustainably	State Ministries of Health, LGA Health Authorities, World Bank, donors	Medium-long term

Table 2: Summary of Policy Recommendations — Humanitarian Maternal Health, Nigeria 2025

Displacement does not pause pregnancy. Our response cannot pause either.

Every woman — refugee or citizen, in a settlement or a suburb — deserves a midwife who knows her name, a facility that will receive her, and a system that will keep her alive.

No woman invisible. No pregnancy without care. No community left behind.

We Call On:

Federal and State Governments	Formally include displaced women in all national maternal health strategies and financing packages. Establish portable health entitlements that follow displaced women regardless of documentation status. Prioritise hosting states for HRH and infrastructure investments proportional to their displaced populations.
UNHCR Nigeria and UN Agencies	Expand and sustain funding for community-based midwifery models in refugee and IDP settings. Advocate for multi-year programme cycles that build rather than reset — community trust. Link humanitarian maternal health data to national MPDSR and NHMIS systems.
Development Partners and Donors	Fund the WBFA–UNHCR humanitarian midwifery model for replication across all major Nigerian displacement settings. Invest in digital tools that extend maternal care beyond facilities. Resist the pressure to cut humanitarian health funding in the settings where it is most needed.
Civil Society and Refugee Communities	Champion the rights of displaced women to respectful, quality maternal care. Engage refugee-led organisations as community health promoters and accountability advocates. Share the evidence of what works — so that no community's story of survival goes unheard.

About This Brief

This policy brief is produced by the Wellbeing Foundation Africa (WBFA), Directorate of Policy, Advocacy, Innovation, Research & Development, drawing on WBFA's humanitarian programme implementation in Cross River State (2021–2024), the 2024 WBFA Annual Report, the UNHCR Nigeria Annual Results Report 2024, the WHO/UNICEF Trends in Maternal Mortality (April 2025), and peer-reviewed research published in 2024–2025 on maternal health in displacement settings. It is intended for UNHCR Nigeria, Federal and State Ministries of Health, the NCFRMI, development partners, and humanitarian donors. The programme data for Cross River State reflects both the refugee and Nigerian host community populations served by WBFA facilities in the Ogoja area.

This brief synthesizes programme monitoring data (2021–2024), comparative analysis against UNHCR and WHO humanitarian maternal health standards, and a structured review of peer-reviewed and grey literature. Quantitative indicators were drawn from WBFA programme data and benchmarked against national and global datasets."

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