



The head midwife, a senior midwife, and a midwife from the Diffa Health District.



# Building the Bridge

How Community Matrones Are  
Connecting Women to Maternal Care  
in Conflict-Affected Niger

SEPTEMBER 2026

# The Problem

Niger faces one of the most complex humanitarian situations in the world, shaped by intersecting security threats, climate shocks, weak institutions, and deep socioeconomic challenges. Despite some progress, maternal health continues to be a significant public health concern in Niger. The estimated maternal mortality rate is 441 deaths per 100,000 live births (2021), significantly higher than the global average of 112.<sup>1</sup> In rural areas, 31% of women made at least four antenatal care (ANC) visits, compared to 46% in urban areas. Both of which still fall behind the global average of 65% of women attending at least 4 ANC visits.<sup>2</sup> These alarming indicators underscore the need for stronger public policies and collaborative interventions between the government and its technical and financial partners. Furthermore, Niger's contraceptive prevalence rate is among the lowest in Africa, at just 18.8%, reflecting deep barriers to family planning access and uptake.<sup>3</sup>

In the Diffa region — near the border with Nigeria and Lake Chad — these national challenges are amplified by a humanitarian crisis that has steadily deepened since 2015. Armed group incursions have driven large-scale displacement, swelling the region's population with internally displaced persons, refugees from Chad, and host communities all competing for severely limited services and resources. Discussions around reproductive health are taboo, access to contraception is extremely limited, and early marriage is widely accepted. In 2025, only 3% of the Diffa regional health budget was allocated to sexual and reproductive health (SRH).

The humanitarian situation has become even more complex due to the resurgence of armed attacks against civilians and the current authorities' restriction of humanitarian access through the imposition of military escorts in certain areas and the prohibition of access to others. The only health centers operating in the municipality of Diffa — a refuge for villagers fleeing attacks — close around 2 p.m. for security reasons, leaving women in labor without qualified staff. As a result, home births have increased due to these restrictions, often without any specialized assistance.

## What is a matrone?

In Niger, a matrone is a community birth attendant — a woman from within the community who has historically assisted with deliveries using traditional knowledge and practices. Matrones are deeply embedded in community life and are known and trusted by the families they serve. Each family typically has a matrone they turn to, and in contexts of insecurity where formal health services are unavailable after hours or altogether, matrones have long been the only form of birth support available to women. The PRET-SRHR project recognized this existing role and worked to formalize and strengthen it — transforming matrones from isolated traditional practitioners into trained, supervised, and recognized members of the broader health system.



The midwife from the Diffa Health District and the Reproductive Health (RH) Officer from the PRET project during a training supervision session for midwives.

1 World Health Organization, 2023: Niger Health Data Overview. Available: <https://data.who.int/countries/562>

2 UNICEF, 2026. Maternal and Newborn Health Disparities in Niger. Available: [https://data.unicef.org/wp-content/uploads/cp/maternal-newborn-health/maternal-and-newborn-health\\_NER.pdf](https://data.unicef.org/wp-content/uploads/cp/maternal-newborn-health/maternal-and-newborn-health_NER.pdf)

3 World Health Organization 2023: Maternal Mortality: the urgency of a systemic and multisectoral approach in mitigating maternal deaths in Africa. Available: [https://files.aho.afro.who.int/afahobckpcontainer/production/files/iAHO\\_Maternal\\_Mortality\\_Regional\\_Factsheet.pdf](https://files.aho.afro.who.int/afahobckpcontainer/production/files/iAHO_Maternal_Mortality_Regional_Factsheet.pdf)

## The Solution

The IRC's PRET-SRHR project (Partnering for Resilience to Emergencies through Transformation of Sexual and Reproductive Health Rights), funded by Swedish International Development Cooperation Agency (Sida) launched in the Diffa Health District in December 2023 to address these challenges and improve access to SRH care. Working across four Integrated Health Centers (CSIs) — Diffa Urban, Mamari Forage, Bagara, and N'Guel Kolo — the project set out to strengthen health systems, transform harmful social norms, and improve the resilience of communities to access SRH services even in fragile, conflict-affected settings.

To address the access challenges posed by insecurity and movement restrictions, PRET-SRHR built a deliberate strategy around matrones — community birth attendants already embedded in local life and trusted by families. Historically, matrones practiced traditional birthing techniques in isolation from the formal health system, sometimes even in competition with it. The PRET-SRHR project reshaped this dynamic by providing structured training to 80 matrones, enabling them to identify danger signs in pregnant women, women in labor, postpartum women, and newborns, and to refer them appropriately to health facilities.

These matrones were recruited by the heads of the four CSIs and within their respective health catchment areas, covering a total of 10 CSIs under the leadership of the Diffa Health District. The training significantly strengthened their knowledge and skills in recognizing and identifying complications during pregnancy, childbirth and the postpartum period, as well as danger signs in newborns and ensuring timely referral when necessary.

This initiative contributes to reducing risks associated with home deliveries and delays in seeking care. In addition to maternal and newborn health, the matrones received training on a wide range of sexual and reproductive health and rights (SRHR) services — including family planning, post-abortion care (PAC), and gender-based violence (GBV) prevention and referral. This breadth of training was not incidental; it was a direct response to the humanitarian context. In a setting where armed conflict restricts access to formal health facilities and closes health centers early, matrones represent one of the few consistent, trusted

points of contact through which women can receive accurate health information and be linked to services. Ensuring that their scope extended beyond delivery attendance to cover the full spectrum of SRHR was essential to reaching women whose options had been severely narrowed by insecurity. They also acquired communication techniques to effectively conduct community-based awareness sessions.

Monthly supervision visits by health center staff reinforced their skills and maintained the connection between community and facility level. Each matrone also received a monthly stipend as recognition of her role and contribution.

*“Every day, we (matrones trained by PRET-SRHR project) go directly into the communities to raise awareness among women, address their concerns, and encourage them to go to the health center quickly whenever needed. After childbirth, we continue our support by promoting good infant and young child feeding practices. The training we received from IRC gave us the skills we needed to better advise and support mothers. Today, we are seeing real change. Women are visiting the health center more often and keeping their consultation appointments. Beyond the training, IRC also provided us with essential equipment, including uniforms, soap, and work supplies, which allow us to carry out our work in better conditions. Today, the urban health center is cleaner, the reception of patients has improved considerably, and communities’ trust in health services has grown significantly.”*

**FATIMA, MATRONE IN DIFFA**

An emphasis on integrating matrones with the formal health system allowed them to serve as a bridge between communities and facilities and led to immediate and concrete results. In communities where health centers closed early due to security concerns, matrones ensured that births were attended, danger signs were identified, and referrals were made.

The program also invested heavily in strengthening the formal health system itself. Eighty-eight health workers were trained in Basic Emergency Obstetric and Newborn Care (BEmONC), the Minimum Initial Service Package (MISP) for SRH in Crisis Situations, Postpartum Hemorrhage prevention, maternal and perinatal death surveillance and response (MPDSR), family planning, and post-abortion care. Four training sessions were organized with the participation of

22 health workers from the four health centers. Health facilities were equipped with beds, mattresses, and other essential materials. Two health centers — Mamari Forage and N'Guel Kolo — were electrified through solar and generator installations, transforming the ability of health workers to conduct nighttime deliveries safely.

To address the deep sociocultural resistance that had long discouraged women from seeking formal care, the program conducted community awareness campaigns and organized roundtables with religious leaders, who were trained to lead outreach framing Islamic arguments in support of family planning and maternal health. This was essential groundwork as facilities needed to be places communities were willing to go in order for matrones to successfully refer women to health facilities.

## Approaching Key Challenges

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The operating environment made consistent supervision difficult. Security restrictions meant that IRC staff and health center workers could not always reach matrones for their monthly supportive supervision visits, and some communities remained entirely inaccessible due to the escort requirement. The program responded by building the capacity of local governance structures such as community health management committees (COGES) and accountability committees, to support monitoring in areas where external staff could not go. This meant that matrones were never entirely without oversight, even in the most constrained periods.

Perhaps the most instructive challenge was one of recognition. Historically, matrones had operated informally and without institutional status. PRET-SRHR aimed to change this by presenting the matrones' results within the continuum of care — including improved delivery conditions, systematic referral of at-risk pregnant women, and reduced mortality caused

by PPH. Additionally, PRET-SRHR advocated for their recruitment as nursing assistants, capitalizing on the skills they had acquired through the project. The monthly stipend, the formal training, the supervision relationship with health center staff, and the structured referral pathway all signaled that matrones were not peripheral to the health system but part of it. This shift in status matters for sustainability: matrones who feel recognized and included in the formal health system are more likely to continue their work after the project ends.

As Dr. Bohari Hamidou, Chief Medical Officer of Diffa District, described, *“the project's support helped turn the district's performance indicators green, with matrones now playing a central role in combating maternal mortality and promoting assisted deliveries.”* He emphasized that the behavioral change achieved in communities would outlast the project itself — even after medicines run out and staff are reassigned.

## Results and Impact

Between December 2024 and December 2025, the PRET-SRHR project achieved substantial progress across maternal and reproductive health outcomes. By the end of year two, 2,922 births had been attended by skilled health personnel in supported facilities — 81% of the three-year target — and 10,272 women had completed their first antenatal visit, reaching 76% of the three-year goal. An additional 309 women received comprehensive post-abortion care, representing 74% of the three-year target. These results reflect the matrone model working as intended: women who previously lacked skilled support at delivery were being seen, referred, and cared for, with matrones playing a central role in bridging the gap between community-level births and facility-attended deliveries.

Beyond facility-level outcomes, the matrones carried out extensive community sensitization work, reaching a total of 16,505 people across the four Integrated Health Centers. In a context where insecurity restricts movement and limits women's ability to access formal care, these interactions were often the only avenue through which women could receive SRHR information. Their outreach spanned the full continuum:

from antenatal care promotion and safe delivery encouragement, through family planning counseling and postnatal follow-up, to GBV prevention and referral.

- 4,038 women were sensitized on the importance of attending antenatal care
- 1,321 women in labor were encouraged to seek facility-based delivery
- 2,006 pregnant women received information on recognizing danger signs
- 3,585 women were informed about family planning services
- 2,072 women were reached on postnatal care
- 658 people were sensitized on GBV prevention and referral pathways.

PRET-SRHR earned formal recognition from the Diffa Health District, which awarded IRC an official certificate of appreciation for its contributions to service quality and community wellbeing. High-level supervision visits — including joint missions with the Minister of Health of Niger and the Governor of the Diffa region — underscored the program's visibility and institutional acceptance.



The Reproductive Health (RH) Officer for the PRET project at the Diffa Urban Community Health Center (CSI) during a field supervision visit with a midwife who was conducting an awareness-raising session for women who had come for family planning (FP) services at the Diffa Urban Community Health Center (CSI).

## The Way Forward

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The most significant and transferable legacy of PRET-SRHR in Niger is the matrone model and their operational collaboration with state health centers. By formalizing the role of community birth attendants within the health system — giving them training, supervision, recognition, and a structured link to facilities — PRET-SRHR demonstrated that task-shifting to the community level is not only possible in fragile contexts, but essential. In a region where insecurity closes health centers early, where military escort requirements limit humanitarian access, and where women have historically delivered at home without skilled support, matrones fill a gap that no formal health system expansion alone could address. Crucially, this model's value is not limited to maternity care. When humanitarian access is curtailed and facilities operate under severe constraints, the ability to provide accurate information and community-level referral pathways for family planning, post-abortion care, and GBV response is equally life-saving. Women in Diffa cannot easily reach a health center for a contraceptive consultation or to report GBV — but they can speak to their matrone. Training matrones across this full range of SRHR services recognizes a basic reality of humanitarian

response: where formal services cannot reach, trusted community actors must be equipped to do more.

Sustaining these gains will require continued investment from the Diffa Health District, the regional health directorate, and the government of Niger. Furthermore, expanding this approach to surrounding villages affected by armed violence will save more lives. Key questions must be addressed such as how the ongoing training and supervision of matrones will be financed, how will health centers maintain the equipment and infrastructure improvements, and how strengthened community governance structures continue to advocate for SRH services.

The program's experience also offers lessons for scale, as the matrone approach could be adapted and replicated in other fragile contexts across the Sahel. Where conflict closes health centers and insecurity cuts off formal care, the matrone model shows that collaboration between community actors and the formal health system can extend essential services to women who would otherwise be left without support. ■