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Invisible mothers in fragile systems: rethinking maternal and newborn health governance for internally displaced populations in conflict-affected eastern DRC

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Abstract

Background

Governing maternal and newborn health (MNH) in contexts experiencing protracted crisis represents a major health systems challenge. In eastern Democratic Republic of Congo, recurrent conflict has caused massive displacement, severely affecting access to care for women and newborns. Building on prior political economy analyses, this study examines how policy content, implementation processes, and humanitarian dynamics shape the governance and delivery of MNH services for internally displaced persons (IDP) in North Kivu province, particularly following the resumption of armed clashes in October 2022.

Methods

A descriptive case study was conducted in Goma and surrounding areas, combining a document analysis (2012–2023) and 22 semi-structured interviews with key actors from health authorities, civil society, international humanitarian agencies, and healthcare providers. Using Walt and Gilson's health policy triangle, the analysis assessed both the content and coherence of MNH policies, as well as their implementation for IDPs living in formal camps, informal sites, and host communities in Goma city and its outskirts.

Results

Findings show that access to MNH services for IDPs is primarily shaped by institutional visibility, with eligibility for humanitarian assistance depending on the administrative identification of displacement sites. Formal camps benefit from greater coverage, while informal camps and IDPs integrated into host communities remain largely invisible to humanitarian mechanisms. This occurs in a context marked by the absence of MNH-specific policies for IDPs and highly fragmented governance, dominated by emergency-driven humanitarian interventions aligned with partners’ mandates and funding priorities rather than long-term national planning, with the state playing a largely administrative and regulatory role. Host communities’ perceptions of IDPs oscillate between solidarity and social fatigue. Despite an incomplete service package and reliance on short-term funding, providers caring for IDPs demonstrate resilience in adapting general MNH guidance to IDP needs despite the absence of dedicated policies.

Conclusion

In the absence of MNH-specific policies for IDPs, fragmented and emergency-driven governance shapes access to care through implicit mechanisms of humanitarian eligibility. Integrating MNH for IDPs into national policies, linking humanitarian and development approaches, and strengthening support for health personnel are essential to achieving equitable and sustainable care.

Background

Maternal and newborn health (MNH) remains a global public health priority and is central to the Sustainable Development Goals. However, progress remains uneven, particularly in contexts of armed conflict and systemic fragility, where women and newborns bear the brunt of protracted crises (1, 2). In the Democratic Republic of Congo (DRC), and more specifically in the province of North Kivu, the combination of chronic instability, massive population displacement, and a weak health system has severely compromised access to essential MNH services (1–3). The national maternal mortality ratio is an estimated at 427 deaths per 100,000 live births in 2023, while neonatal mortality rate reached 25 deaths per 1,000 live births in 2023 (4, 5). These figures mask significant regional disparities: in conflict zones, institutional maternal and neonatal deaths are significantly higher, exacerbated by the collapse of supply chains and the disruption of the continuum of care (6). In addition, there is poor mortality reporting for deaths that occur in the community (7).

For more than three decades, the DRC has experienced one of the world's most complex humanitarian crises, marked by recurring cycles of violence and displacement. In 2023, approximately 6.9 million people were internally displaced, with the second largest internally displaced persons (IDP)- population in Africa after Sudan (8, 9). Affected by prolonged instability and recurrent flare-ups of violence, due to his high instability, North Kivu province alone accounts for nearly 37% of these displaced persons (9). These flare-ups occur against a backdrop of protracted, low-intensity conflict that has eroded over time state governance, access to care, and contributed to the gradual permanent presence of humanitarian actors as long-term service providers rather than temporary emergency responders (6, 10, 11) (See Text Box 1 for a detailed description of the most recent resumption of conflict around Goma).

Since October 2022, armed clashes between the M23 rebel movement and the DRC Armed Forces have triggered recurrent waves of displacement in North Kivu, with repeated shifts in frontlines and sustained humanitarian consequences. After nearly a decade of relative inactivity, the movement resumed hostilities initially in interior territories of the province (particularly Rutshuru, Masisi, Walikale and Nyiragongo). Fighting first affected rural and semi-rural areas before progressively expanding toward major population corridors and the outskirts of Goma, the provincial capital.

Between late 2022 and 2024, cycles of escalation, ceasefire attempts, and renewed clashes generated successive waves of displacement, with large numbers of civilians fleeing again toward Goma and surrounding areas. This dynamic led to a growing concentration of displaced populations in and around the city, while insecurity and access constraints persisted in peripheral and semi-rural zones.

In January 2025, humanitarian reports documented intensified fighting and further M23 advances, resulting in the control of Goma by the rebels, additional displacement, disruption of essential services, and constraints on humanitarian response capacity. By December 2025, renewed offensives and heavy fighting continued to fuel population movements and insecurity along main corridors, including in the neighboring province of South-Kivu, worsening humanitarian needs and destabilizing the entire eastern region of the DRC.

Text Box 1. Most recent resumption of conflict and displacement around Goma (6, 10, 12, 13)

While some displaced persons find refuge in camps recognized by the authorities and humanitarian partners, many settle informally in precarious shelters or discreetly integrate into surrounding urban communities (14, 15).

In a context where urban health infrastructure is already saturated, the massive influx of displaced persons is putting additional pressure on health facilities, resulting in resource shortages, staff overload, and social tensions (3, 16). At the same time, IDPs living outside formally recognized camps and registered in humanitarian databases remain largely excluded from free healthcare or social targeting schemes, despite having healthcare needs that are comparable to, or even greater than, those of populations living in formal camps (15).

Building on our previous political economy analysis, which revealed competing priorities in resource allocation, governance issues, and the negative impact of conflicts on health systems on MNH prioritization (1), the present study set out (i) to assess the content and coherence of MNH policies and humanitarian guidelines in addressing the MNH needs of local host communities, IDPs living in formal camps, and IDPs settled outside those camps in and around Goma, capital of North Kivu Province; and (ii) to analyze the implementation processes and challenges of MNH policies for IDPs in this area since the onset of the armed clashes currently observed in North-Kivu since October 2022. This research aims to highlight the reality of “invisible mothers” in a fragile health system and to identify institutional, political, and human levers that can promote more inclusive and resilient MNH governance in a protracted crisis.

Methods

Study design and setting

This research draws on a single descriptive qualitative case study, conducted as a Health Policy Analysis of MNH governance for IDPs in North Kivu province, in eastern DRC. The approach combined documentary analysis and key informant interviews (KII) to examine the formulation/coherence, and implementation of MNH policies and interventions for IDPs in a context of prolonged conflict.

The study focused on the city of Goma and its surroundings, which have been the main reception area for IDPs since fighting resumed in October 2022. Within this setting, IDPs are distributed across both urban sites (located within or immediately around the city), and peripheral sites situated on the outskirts along semi-rural or insecure axes outside Goma's urban core. This geographical focus allows an examination of the dynamics of governance and the modalities of access to healthcare in an urban environment under severe humanitarian pressure.

Data collection and participants

1. Documentary analysis

A targeted literature review was conducted to identify how MNH for IDPs is addressed across policy, humanitarian, and implementation frameworks.

With the first major rebel insurrection event occurring in April 2012 in North Kivu (11), we chose to limit the review to documents published between January 2012 and December 2023, with the exception of a few earlier texts considered for context. Searches were conducted using a combination of electronic databases (PubMed and Google Scholar) and institutional websites. Search terms included combinations of *maternal health, newborn health, internally displaced persons, IDPs, DRC, Kivu, conflict, and humanitarian response*. Documents were included if they addressed MNH, health service delivery, or humanitarian coordination in displacement-affected settings in the DRC. Both English- and French-language documents were considered.

The search yielded four main categories of documents reviewed for analysis:

- National and provincial health plans (National Health Development Plan, SRMNEA-Nut Plan, North Kivu health operational action plans);
- Humanitarian guidelines from the health cluster and UN agencies (OCHA, UNFPA, UNICEF, WHO);

- Implementation reports from international and local non-governmental organizations (NGOs);
- Scientific articles on MNH and IDPs in the DRC.

From the reviewed documents, we extracted information using a structured tool to capture how MNH for IDPs is addressed. Extraction focused on three domains: (i) policies and processes (policy content and implementation), (ii) stakeholders and organizations (actors involved and their roles and practices), and (iii) contextual events (conflict and displacement dynamics shaping MNH responses). Particular attention was paid to whether documents explicitly addressed IDPs and differentiated between those living in formal camps and those residing outside camps. This information was then used to: (i) inform the selection of key informants, (ii) contextualize the analysis of key informants interviews (KIIs), and (iii) triangulate the findings from the KIIs with documented policies and programmatic practices. Particular attention was paid to the presence or absence of MNH services provisions differentiating IDPs living in formal camps and those living outside camps.

Categorization of displacement sites:

In this study, the categorization of displacement sites aligns with the operational distinctions commonly used in the DRC's humanitarian coordination (17–19). This classification was used for data collection and analysis to examine how the visibility of IDPs (that is, their formal identification within coordination and planning mechanisms) conditions access to humanitarian assistance, including MNH services. We therefore distinguished between:

- Formal camps: organized sites, officially identified by provincial authorities and humanitarian coordination mechanisms, where IDPs are typically registered, assigned to specific implementing partners, and included in response plans.
- Informal camps (or spontaneous sites): unplanned or initially unidentified and unstructured gatherings of IDPs, established often on community, private, or church land.
- IDPs outside camps: displaced persons housed with host families or integrated into host communities, generally not registered in humanitarian databases and not assigned to implementing partners. .

2. Interviews with key informants

Semi-structured KIIs were conducted during the first two weeks of January 2025. Participants were identified through an exploratory stakeholder mapping informed by the desk review and completed with support from a key informant from the North Kivu

Provincial Health Division. Respondents were purposively selected, and recruitment continued according to the logic of theoretical saturation, up to a final total of 22 interviews. They were divided into five categories:

- Health Providers (n = 5): primary and secondary care providers and managers in Goma's health zones. These providers work with Health Centers, General Referral Hospitals, Health Zones Central Offices, and Medical Clinics attached to displacement camps;
- Civil Society Representatives (n = 6): representatives of secular, Catholic, and Protestant organizations, civil actors representative of displacement sites, and civil actors engaged in equity and human rights advocacy;
- Provincial government authorities (n = 4): Staff from the Provincial Health Division, National Reproductive Health Program, provincial government, and the Ministry of Social Affairs, Humanitarian Action, and National Solidarity;
- Central Government Authorities (n = 3): representatives from the National Reproductive Health Program, Ministry of Social Affairs, Humanitarian Action, and National Solidarity, and the Department of Family and Specific Group Health; and
- International humanitarian partners (n = 4): representatives from WHO, UNFPA, UNICEF, and Première Urgence Internationale.

The interviews were conducted in-person by senior researchers (RB, PM, GN, CCZ, and CM) from the School of Public Health of the Université Catholique de Bukavu (UCB), in either French or Swahili depending on participants' preferences. All researchers were fluent in both languages. Interviews followed a semi-structured guide based on the health policy analysis Triangle by Walt and Gilson (20). This framework, which examines the content, context, actors, and process of health policies, was adapted to the context of MNH in displacement settings. The work of Gilson et al. (21) on the respective roles of authorities and practitioners, as well as that of Buse et al. (22) on interactions and power relations between actors, further guided the formulation of questions relating to governance, coordination, and leadership. Contributions from the literature on IDP health (14, 23) enabled the integration of dimensions specific to living conditions, vulnerability, and equity of access.

These studies helped shape out six themes aligned with the study's objectives (Table 2).

Table 2
Study themes driven from study objectives and aligned with the health policy analysis triangle (20)

Objective	Theme	Description	Health Policy Analsyis Triangle Component
Objective 1: Assess Content and Coherence	Policy implementation and service management	Examines how well MNH policies align with service delivery practices across different IDPs settings, ensuring that policies are coherent and effectively designed.	Policies and Process
	Authorities' perception of the problem	Explores how the perceptions of local and national authorities shape the coherence and content of MNH policies.	Stakeholders and Organizations
	Type of shelter and healthcare accessibility	Investigates how different IDP shelters impact the accessibility and consistency of MNH service delivery, reflecting on policy content and process.	Policies and Process
Objective 2: Analyze Implementation Processes and Challenges	Geographic and urban influence	Assesses how urban and geographic factors challenge the implementation of MNH services.	Context and Events
	Conflict and precarity	Analyzes how ongoing conflict and instability impact the implementation and challenges of delivering MNH services.	Context and Events
	Popular narrative influence	Looks at how societal narratives and public perceptions influence MNH policies and the actions of stakeholders.	Stakeholders and Organizations

Analytical approach

The six pre-defined themes guided the interview guide development and the codebook for the analysis. The codebook was applied to the data in Dedoose software (24), with other sub-codes generated inductively during analysis. The authors formulated sub-themes

aligned to both the pre-existing and generated codes, which led to categorizations that expanded beyond the original themes. In light of these new sub-themes, the original six themes were refined into five coherent thematic areas: (i) fragmentation of governance, (ii) equity among IDPs, (iii) continuity and quality of care, (iv) contextualization and resilience of staff, and (v) inclusion and community perceptions.

Document review and interviews were triangulated throughout the analysis. Where inconsistencies arose between formal coordination mechanisms described in documents and actors' reported experiences, these were interpreted as gaps between institutional design and implementation.

Reflexivity

The research team brought together researchers from the UCB, based in South Kivu province, DRC, and international researchers from the International Rescue Committee. Despite these researchers being employed by an international NGO, the researchers involved in the study do not have roles that are responsible for service provision in DRC or elsewhere. Study leadership by locally-based researchers facilitated access to institutional actors, a better understanding of the security context, and fluid communication with respondents. The contribution of international researchers provided analytical distance and an external perspective on the dynamics of humanitarian governance and intervention coordination.

Given the possibility of interpretative bias linked to the proximity of local researchers to the study site, the team put in place several mitigation mechanisms: triangulation of sources, cross-methodological strategies between UCB and International Rescue Committee researchers, and peer validation of emerging themes and the analytical approach at each stage of coding.

The unstable security situation also shaped the data collection methods, requiring continuous adjustments in planning, mobility, and flexibility in the way interviews were conducted. For instance, interviews were scheduled only after security clearances were confirmed. Field activities were concentrated to limit exposure, and interview logistics (timing and location) were adapted when movements became constrained, while preserving the depth and scope of the discussions. The team maintained ethical vigilance toward participants and affected communities.

Ethical considerations

Before each interview, participants received clear information about the study's objectives, confidentiality, and their right to withdraw. Free and informed written consent

was obtained by all participants before each interview. All members of the research team hold international CITI Program certification for research involving human subjects. The study protocol received ethical approval from the Ethics Committee of the UCB under number UCB/CIES/PB/02B/2025 as well as the International Rescue Committee Institutional Review Board (GR 1.00.018). The data were anonymized and used exclusively for scientific purposes, in accordance with the ethical principles of research and participant rights.

Results

The results of our study are organized around five themes generated from the analyses. As introduction, the text box 2 summarizes the political and institutional framework of MNH for IDPs in the DRC, as revealed by the literature review.

The literature review shows there is no specific national policy governing MNH for IDPs in the DRC. Current guidelines are based on general frameworks such as the 2019–2022 SRMNEA-Nut Integrated Strategic Plan and its 2022–2026 extensions, which promote universal access to care, without distinction between IDPs and host populations. Free childbirth, which has been gradually implemented since 2023 in certain pilot areas, is part of a Universal Health Coverage approach, does not include a specific mechanism for reaching IDPs. On the humanitarian front, successive Humanitarian Response Plans recognize that more than 80% of displaced persons live outside camps and that healthcare provision remains largely dependent on ad hoc interventions by partners. Furthermore, the incomplete implementation of the Kampala Convention (the African treaty for the protection of the rights of IDPs) limits the integration of IDPs' right to health into national sectoral policies. While UNHCR's 2021–2025 public health strategy encourages IDP inclusion in national systems, this policy remains largely unimplemented in the DRC.

Text Box 2. MNH policies for internally displaced persons in the DRC (18, 19, 25–27) .

Before presenting the five themes, it is important to highlight a cross-cutting observation that emerged strongly across all interviews: a general consensus around the imperative of a sustainable return to peace. Across all categories of respondents, peace was seen as an essential condition for restoring not only the quality and continuity of healthcare services, but also social cohesion, which has been undermined by the war. Several respondents describe a sense of "social fatigue" and exhaustion in the face of the prolonged conflict in eastern DRC, along with a deep desire to regain the stability needed to rebuild services and restore community.

"You know, we need peace because without peace as a priority, it's difficult. Peace really is the first requirement!" (International Partner-02)

"The solution is peace. North Kivu needs peace. Because once we have peace, all these displaced people will stay at home and there will be no problem accessing healthcare."

(Provincial Government-03)

"What they say, what we say, and what I also say is that the war must end. That's all we ask for. We just want peace, and when we have peace, that's all. Just peace." (Civil Society-05)

Theme 1: Stakeholder dynamics: A fragmented health response under pressure

The humanitarian response relies on a multitude of actors (e.g. international agencies, local and international NGOs, government authorities, and community structures) organized around formal coordination mechanisms such as health clusters, technical working groups, and inter-agency response planning processes. These platforms facilitate information exchange, priority setting, and intervention coordination. However, their effectiveness appears to be hampered by overlapping roles, security constraints limiting movement, and the limited capacity of state authorities to exercise effective leadership.

Planning and logistical organization for IDP health services are largely carried out by NGOs and technical partners, with the state primarily playing a normative and strategic role through the Provincial Health Division. This normative role is administrative and regulatory (approvals, oversight, and formal coordination). Operationalization relies heavily on donors and international technical partners present in the field, who provide logistical support, support for human resources, and medical supplies. This external dependence, combined with administrative slowness, undermines the sustainability of services: free healthcare, a central element of the health response, remains dependent on humanitarian funding, which is often unstable and time-limited. As a result, prolonged delays in supply, recurrent shortages, and a weak capacity to develop specialized services are common.

"We tell ourselves that (the government) must end the war, but we don't really trust it. It is the NGOs that are there to transport the sick to other hospitals, and if there are costs involved, I think it is the NGOs that pay, not the government." (Civil Society-06)

The implementation of interventions follows the progressive identification and registration of displacement sites, which conditions how health services are organized and deployed. When displacement sites are formally identified by provincial authorities and humanitarian coordination mechanisms, they are integrated into operational planning, including logistics, infrastructure support, and service delivery arrangements. This process relies on close coordination between political and administrative authorities in North Kivu and international humanitarian partners.

In practice, international partners play a central role to service delivery within camps: they directly provide prenatal and obstetric care, set up temporary infrastructure, organize medical transport, and supply essential inputs, effectively compensating for the state's limitations. However, their role is not without tensions, with some respondents reporting a lack of transparency in resource management, communication problems, or questionable practices in the field. For example, certain international partners reportedly choose to collaborate directly with private health facilities and local NGOs, without going through the state regulatory framework. Similarly, government respondents criticized the lack of collaboration among international partners, local private and religious-owned health facilities, and state authorities, further weakening policy effectiveness. The result is an overall inconsistency in the response. Some respondents justified the lack of collaboration from international partners with government actors by highlighting the government’s administrative delays and bureaucratic procedures that can take several months and push many of these actors to operate outside state mechanisms due to the urgency of need. The avoidance of administrative red tape means having to work without formalization by the central government.

"But it is also true that there are (international) NGOs that parachute in, especially in the east where you come from. There are even many NGOs that are not known at this level here [in Kinshasa, central government of DRC]. As a result, we sometimes have no control over what they do." (Central Government-01)

"... we can say that 30% of (international) NGOs collaborate and 70% do not... they know that by going through the state, there will be several principles that they will not comply with, so they prefer to provide assistance without going through the state." (Provincial Government-02)

Local authorities unanimously recognize the severity and urgency of the crisis. Forced to act urgently without sufficient resources, they often adopt ad hoc responses (e.g. mobile clinics, partial free access, purchase of ambulances) which, although essential, struggle to provide a lasting response to the scale of the needs. A chronic lack of resources and insecurity, prevents actors from developing a structural and sustainable response, increasing dependence on the humanitarian system and perpetuating fragmented management of MNH needs.

"...That is why, during our discussions [between provincial government and various health sector actors], we argued that the operation of these camps for displaced persons should have a specific status because there was a large population that exceeded the management capacity of a Chief Medical Officer. So we argued that these sites should have a specific status. This request has not yet been implemented, but (the head of the

North Kivu Provincial Health Division) is already working on it with the provincial governor." (Provincial Government-03)

As the respondent above suggests, a proposed “specific status” would place large displacement sites under the administrative supervision of the Provincial Health Division rather than a single Health Zone, given that their population size exceeds the usual managerial scope of a Health Zone team. This would shift service organization to the provincial level.

Theme 2: Equity among IDPs

Access to MNH services for IDPs is uneven and closely linked to the degree to which displacement situations are identified and integrated into humanitarian coordination and planning mechanisms.

Although respondents agree that, in principle, care should be provided equally to displaced persons and host communities, they reported significant disparities in practice.

* IDP camps officially formally identified and integrated into MNH coordination mechanisms benefit from a stronger and more regular presence of humanitarian organizations. These camps are linked to one or more health facilities or mobile clinics offering free MNH services and receiving more consistent supplies of medicines and equipment.

- IDPs sheltered in informal camps may also access humanitarian assistance, including the MNH services, but usually only after these sites are identified and mapped within humanitarian coordination systems. This is done often through the effort of local NGOs and civil society organizations that play a key role in making such sites visible to authorities and international partners.
- IDPs staying with host families or integrated into urban communities often remain outside these coordination and planning frameworks. Lacking formal identification as IDPs, they are often excluded from humanitarian interventions, including MNH associated free-care schemes. This results in heavy financial costs, as these IDPs are compelled to rely on out-of-pocket payments for healthcare. In addition, they may be mistakenly considered to be systematically supported by host families, which further contribute to their exclusion. This misperception exacerbates their vulnerability, as actual care remains uneven and sometimes non-existent. Consequently, camp registration become, for many IDPs, a de facto requirement to access humanitarian aid and subsidized MNH care.

"There are some organizations, such as the World Food Program and the Red Cross, that also take into account displaced persons living with host families. But the government has not yet taken a position on identifying and assisting them. It considers those in the camps to be more vulnerable than those in host families." (Provincial Government-02)

Theme 3: Quality, continuity of care, and inadequacy of care packages offered

While MNH was the primary focus of this study, respondents often described challenges related to quality and continuity of care in a more holistic manner, reflecting broader health system constraints that directly affect MNH service delivery. Despite the efforts of the actors involved, the continuity and quality of care remain precarious.

In peripheral areas, care is provided by health facilities that have often been looted or destroyed and operate with limited resources. Specialized or emergency services are rare. Recurring shortages of medicines and medical equipment undermine the quality of care and expose patients to additional risks. Alternative solutions, such as mobile clinics or advanced sites, provide partial support but are not sufficient to meet the scale of need and are sometimes forced to withdraw when the security situation becomes too dangerous.

"...our health zone is no longer functional, even the health zone central office team has fled... all the equipment that was intended for reproductive health has remained in the village... we have difficulty accessing that place..." (Health Provider-03)

In urban areas, one of the major obstacles identified is the chronic undercapacity of the health system to cope with exponentially increased demand due to regularly insufficient human, material, and financial resources. Healthcare provision is partial, often reduced to emergency interventions or limited and discontinuous primary care. Specialized services, particularly advanced obstetric care, are often unavailable, overwhelmed, or difficult to access due to the challenges of transporting patients amid ongoing insecurity. This leads to a high dropout rate from care pathways and preventable deaths among displaced communities.

"Imagine a health area like this one, which used to have a population of 20,040 and where we had to treat 200 or 300 patients per month. Now the population is 450,000... Now we are forced to treat 2,000 to 3,000 patients per clinic... It is the same staff who used to treat 300 patients, and it is this same staff who now treat 3,000 patients..." (Health Provider-01)

"...you will find, for example, in the Goma health zone, that the number of displaced persons exceeds 400,000, so [populations from] more than two health zones are spilling over into one health zone..." (Provincial Government-03)

Apart from disrupting maternal and neonatal care, the armed conflict also affects other aspects of reproductive health, such as the management of menstrual health for displaced adolescent girls. Beyond physical care issues, several respondents emphasized the need to integrate an appropriate psychosocial dimension, particularly for MNH services for displaced persons living outside camps or in informal settlements. Trauma related to conflict and displacement, although widespread, is still poorly addressed in interventions. Addressing these specific psychosocial needs is therefore identified as a key factor in improving access to and effective use of services.

"... they come in traumatized and insecure... They would come and stay in front of the door for two or three hours. I pass by and she's still there, and I ask her what I can do for her, but she doesn't say anything. Sometimes she cries, and when I see her crying, I think to myself, 'There's a problem here, I need to talk to her...' We need training on how to welcome them and help them, because when you have a lot of problems, it's difficult to express yourself." (Civil Society-05)

Theme 4: Contextualization of MNH policies and resilience of health personnel

The functioning of MNH services relies on human resources that have been weakened by conflict and underfunding. Healthcare workers, most of whom are unpaid or underpaid and receive no social security coverage from the state, nevertheless continue to perform their duties. Healthcare workers are supported by external partners and many continue to work, "out of a sense of vocation," despite being exhausted by difficult working conditions. This situation leads to gradual demotivation, exacerbated by the overload caused by the influx of displaced persons and the lack of material resources to provide quality care. In peripheral areas, when it becomes too dangerous to remain at their posts, some health care providers are forced to abandon their jobs, further disrupting services.

Faced with these constraints, efforts to contextualize MNH policies are gradually emerging. Providers and humanitarian organizations are striving to maintain a certain level of functionality despite challenges, adapting strategies to the unstable security context, using available resources, and demonstrating great flexibility in the face of constant pressure and major logistical challenges. For example, the preferred use of local or displaced human resource, particularly for community health worker recruiting, promotes the acceptability of services and reduces local tensions. Mentoring initiatives, training for midwives operating in humanitarian contexts, and rapid assessments in crisis situations, often supported by international partners, aim to strengthen skills and improve services. Mechanisms such as maternal and neonatal death audits and the development of strategic plans for displaced persons are beginning to be integrated into institutional practices. These initiatives do not reflect formal changes in national MNH policies; rather,

they stem from adaptations made at facility and Health Zone levels, often supported by international partners. Maternal and neonatal death audits are typically conducted by the Health Zone Central Office under the supervision of the Chief Medical Officer, with financial and technical support from partners, including through performance-based funding. These processes help facilities and providers adjust their daily practices to address the specific needs of displaced populations, even in the absence of dedicated national guidelines. Nevertheless, the limited availability of qualified personnel, combined with the lack of structural support from the state and temporary nature of external funding, limits the possibilities.

"...most of the displaced people who come from the south speak Kinyarwanda. So it's best to work with healthcare providers who come from facilities in the south... We insist to donors such as UNFPA that the first people they recruit for these clinics must be displaced healthcare providers or nurses, because if we take someone (...) who does not speak Kinyarwanda, they will not be able to cope easily." (Provincial Government-04)

Theme 5: Inclusion mechanisms and community perceptions of IDPs

The sudden demographic pressure on urban centers caused by the influx of IDPs has led to perceptions among the local population that range from solidarity to social exhaustion. Host communities, particularly in Goma, often complain about increased pressure on land, food resources, and essential services.

"There are (displaced persons) who were better off (financially) and rented houses. They live there with their families, independently of the camps, but still are registered in the camps [and therefore can benefit from humanitarian aid] even though they live normally in society." (Civil Society-01)

At the same time, a degree of empathy remains, expressed through community camp management mechanisms involving local actors as site presidents, neighborhood leaders, and community organizers. These actors are involved in mediation, communication, and aid distribution, although internal tensions and/or external pressures can sometimes create disorganization or overlapping responsibilities.

Health professionals share these perceptions, warning of overburdened structures, and demotivated staff. Civil society respondents and health workers have identified local communication mechanisms (e.g. town criers, community relays, local campaigns) as essential for maintaining links with displaced persons and facilitating their identification, integration, and referral to services. In contrast, the role of the media is described as marginal in terms of influencing public policy and the social integration of displaced

persons. The media tends to focus their attention only on specific health incidents or security issues, without actively engaging in broader advocacy for IDPs.

Efforts to promote equitable access to care include explicit non-discrimination strategies, priority triage in health facilities, and community recruitment that takes into account the linguistic and cultural diversity of beneficiaries. Particularly vulnerable groups, including people with disabilities, pregnant adolescents, survivors of sexual violence, teenage mothers, people living with HIV, and tribal or linguistic minorities, sometimes benefit from tailored measures such as priority access to care or specialized equipment, once identified.

"... Similarly, for the deaf and dumb, we must recruit people who can speak their language..." (Provincial Government-04)

"In any case, everyone is treated equally (in health facilities); there is no difference between indigenous people and displaced persons. Everyone is protected in the same way." (Health Provider-01)

Nevertheless, these initiatives do not always eliminate discrimination, which persists in various forms: the unequal distribution of resources, latent inter-communal tensions, insufficient inclusive measures, and physical inaccessibility of health facilities for people with reduced mobility. In addition, some respondents expressed the need for more specific awareness-raising among health personnel on forms of inclusion towards displaced persons from different community backgrounds.

"Well, there are times when (displaced women) are marginalized... they find a long queue... they don't wait and go home, which is how they often lose their lives." (Civil Society-04)

"There are tribes that are in the majority... they will occupy all the positions... they even distribute two kits to a single woman [belonging to the same tribe as them] ... the others who are underrepresented will get nothing." (Civil Society-06)

Discussion

Our study examines the governance and delivery of MNH services for IDPs in North Kivu province, Eastern DRC, with a focus on identifying the institutional, humanitarian dependence, and contextual factors that shape these dynamics.

The results reveal a high degree of fragmentation in health system governance in conflict-affected areas. These governance challenges must be understood within the specific conflict dynamics of North Kivu, where a decades-long, low-intensity conflict marked by recurrent flare-ups, territorial contests between armed groups, and chronic insecurity has

progressively eroded state presence and operational capacity (11). Such instability limits the ability of provincial and district health authorities to plan, supervise and finance services, and creates a structural vacuum that external humanitarian actors are compelled to fill. This prolonged reliance on international partners reinforces the asymmetry between state actors, private facility owners (essentially faith-based health facilities) and international actors, and contributes to the patterns of fragmented governance observed.

Although stakeholder discussion platforms provide theoretical frameworks for consultation, their effectiveness remains constrained by insecurity, weak state leadership, and near-total financial dependence on external partners. As a result, coordination remains more formal than functional, with planning often reactive rather than strategic.

These patterns are widely described in fragile settings. The WHO notes that coordination in protracted humanitarian contexts tends to prioritize immediate response over institutional strengthening and system sustainability (28). Kruk et al. (29) emphasize the importance of legitimate and operational leadership to connect emergency aid with long-term public health objectives. In such contexts, the state often becomes a “symbolic actor”, limiting itself to formal regulation while private providers and NGOs assume responsibility for sustaining essential service delivery (30, 31).

This dynamic also shapes the governance of MNH services for IDPs. Our literature review shows that there is currently no national policy specifically governing MNH for IDPs in the DRC. While broader frameworks addressing internal displacement and humanitarian response exist, MNH for IDPs is not articulated through a dedicated health policy. Existing guidelines remain limited to general frameworks, such as the SRMNEA-Nut plan and free childbirth services, without targeted provisions for displaced populations. As a result, MNH care for IDPs is largely delivered through humanitarian programming, characterized by ad hoc interventions and short-term funding cycles, consistent with patterns observed in other conflict-affected settings (18, 19, 32). More broadly, while some countries have adopted general internal displacement policy frameworks (33), clear examples of MNH-specific policy integration for IDPs remain rare in the literature.

While humanitarian presence compensates for state failings and ensures service continuity, it also maintains structural dependency that undermines local system reconstruction. The coexistence of multiple actors, each pursuing short-term measurable objectives (e.g., mobile clinics, free services, kit distribution), fosters “project-based governance” (34, 35), where decisions are negotiated rather than guided by coherent needs assessment. This dynamic, already described for MNH in the general population (1), is particularly concerning for IDPs, whose extreme vulnerability amplifies the consequences of fragmented and reactive service provision.

Regarding access to MNH services, inequalities also exist within displaced populations themselves, with hierarchical access to humanitarian aid shaped more by institutional visibility than actual vulnerability. This pattern echoes documented mechanisms of exclusion in protracted displacement settings. Drawing on Spiegel's work (23), we note that administrative management of camps tends to structure humanitarian resource allocation, producing forms of "humanitarian eligibility" among displaced groups, in line with Zetter's analysis of how bureaucratic labels shape access to assistance (36). In the DRC, these dynamics are amplified by weak civil registration systems (37) and absent targeting mechanisms, rendering many displaced persons "statistically invisible". Access to healthcare depends on mobility, road safety, or proximity to humanitarian service delivery points, all of which are factors beyond the control of these vulnerable populations.

This observation calls for re-examining two fundamental paradigms of healthcare provision in crisis contexts: the humanitarian approach, focused on targeting based on urgency, and the public health approach, based on universal coverage. The structural tension between these two approaches contributes to keeping IDPs outside the scope of protection and care. It is therefore necessary to rethink health in humanitarian contexts by designing mechanisms that reconcile rapid response required by emergencies with the inclusivity necessary for public health. This revision would involve broadening "humanitarian eligibility" beyond formal camps to also include host families and communities in aid and monitoring mechanisms. Such a shift aligns with the principles of *area-based approaches*, increasingly promoted in urban humanitarian settings, which prioritize geographic coverage over population status and aim to reach all affected residents, whether displaced or hosts, within a defined area (38). Longer term, this approach would align with the principles of the "Leaving No One Behind" (39), placing MNH at the intersection of emergency response, universal health coverage, and sustainable development.

Our analyses show that despite visible efforts by humanitarian actors and local health structures, the continuity and quality of MNH services remain severely compromised. This reflects broader patterns observed in crisis-affected settings. A 2021 systematic review (40) identified supply chain disruptions, limited clinical supervision, and inadequate staff training as major barriers to effective care delivery in humanitarian contexts. Similarly, Kruk et al. (41), emphasize that poor-quality health systems cause more deaths than lack of access alone, highlighting that access without quality is insufficient. In our context, however, IDPs face a double burden: not only is quality of care compromised, but access itself remains severely constrained.

Our results show that beyond issues of quality, the package of care offered to IDPs remains insufficient. In a context of weak government coordination, the multiplicity of actors and funding sources fragments rather than strengthens the response. The

proliferation of vertical projects organized around single services or disease-specific priorities (MNH, nutrition, HIV, etc.) often leads to partial service delivery, while cross-cutting dimensions such as menstrual hygiene management, family planning continuity, and psychosocial support remain inadequately addressed. This systemic lack of coherence aligns with findings by Truppa et al. (42), who show that in conflict settings, the abundance of actors can paradoxically contribute to disorganization and poorly aligned interventions. Similarly, other authors (29, 30) emphasize that quality and comprehensiveness depend on service integration within a coordinated system, rather than the accumulation of fragmented sectoral responses. Thus, although we acknowledge that all interventions are relevant in an emergency context (because every need is critical for an IDP), the fact remains that their collective effectiveness depends on coordination within a framework of continuity and complementarity of care (43).

Our findings highlight health workers as both the backbone and a key vulnerability of the health system. Despite extremely challenging conditions (low or absent pay, excessive workloads, insecurity), many providers remain in place, driven by professional commitment or supported through local coping mechanisms and external aid. However, literature on fragile health systems shows that short-term humanitarian incentives, such as temporary bonuses, have limited impact without sustainable institutional support (44). In this context, the resilience of health personnel reflects not system strength but a fragile equilibrium compensating for institutional gaps. Innovative local strategies, such as community-based recruitment and mentoring, temporarily mitigate disruptions by strengthening acceptance and continuity of care. Similar adaptations have been observed in fragile settings such as Ethiopia and South Sudan, where intrinsic motivation and community support helped maintain minimal service provision despite systemic instability (30, 45, 46). However, this resilience remains precarious, as staff exhaustion, turnover, and service disruption increase when external support declines. Ensuring sustainability therefore requires institutionalizing these adaptive practices and strengthening formal support mechanisms, including adequate remuneration, psychosocial support, supervision, and security protections.

The perceptions of host communities in urban areas like Goma toward forced cohabitation with IDPs oscillate between humanitarian solidarity and collective weariness in an already fragile environment. This ambivalence reflects broader social fatigue and a desire for lasting peace, which emerged as a cross-cutting theme across interviews. Similar patterns have been documented in contexts such as South Sudan and the Central African Republic, where mass displacement simultaneously generates mutual aid and pressure on limited local resources (47–49).

In prolonged displacement settings, cohabitation gradually becomes normalized, and frustrations increasingly relate to the inability of local systems to adapt to sustained

demographic pressure. Studies from Bukavu and Maiduguri similarly show that, over time, displacement becomes embedded in urban life, shifting expectations toward institutional responsibility rather than the displaced populations themselves (14, 50).

Regarding access to healthcare, our findings show that “humanitarian eligibility” leaves IDPs outside camps marginalized despite comparable or greater needs than those in camps. This selection mechanism creates assistance gaps also documented in Nigeria and Syria (51, 52). Jacobs & Kyamusugulwa (2018) further demonstrate in Bukavu that socio-economic status shapes how displaced households navigate urban integration (50) : those with resources settle and lose their IDP status, while the poorest remain in prolonged precarity. Similar dynamics are observed in Goma, where socio-economic vulnerability and administrative visibility jointly determine access to free MNH services.

The inclusion efforts observed in our study (non-discrimination strategies, priority triage, linguistic or cultural adaptation) illustrate a clear desire for equity, particularly among health personnel. However, their effects remain limited by system fragmentation and weak institutional monitoring. As highlighted in 2012 by a multiple case study conducted in resource-constrained settings (53), inclusive approaches produce tangible effects only when supported by stable intersectoral coordination and strong political commitment.

Beyond healthcare access, perceptions of IDPs and inclusion practices raise broader concerns about social cohesion. Patterns of mutual aid, rivalry, and withdrawal are reshaping relations in host communities, reflecting deeper tensions in a social fabric already weakened by prolonged conflict. Across interviews, a consistent message emerged: lasting peace is seen as a prerequisite for restoring both health system functionality and trust between communities. This aligns with growing calls for integrated approaches linking public health and peacebuilding (54, 55), underscoring that rebuilding health systems is inseparable from restoring social cohesion.

Study limitations and context of research

This study has certain limitations that should be considered when interpreting the results.

First, data collection took place in a context of instability, limiting the observation of continuity of care over time. Fieldwork was completed just a few days before a major security turning point in Goma and North Kivu: the takeover of the province by the M23. According to humanitarian reports released in the days that followed (56), this event caused further displacement and the closure of many facilities. These developments, which occurred after the data collection, do not invalidate the structural dynamics identified, but invite us to interpret the results as a snapshot of a system already under pressure.

Second, despite the triangulation between categories of actors (civil society, service providers, authorities, partners), the limited availability of certain respondents, particularly government officials, may have restricted the comparative depth between decision-making levels.

Finally, interviews with central-level government actors revealed limited familiarity with the operational realities of MNH services for IDPs in eastern DRC, which constrained the detail they could provide. This reflects a broader gap in information flow between central and field levels in prolonged crisis.

Conclusion

This study highlights the structural fragmentation and humanitarian dependence of the health system in conflict-affected areas of eastern DRC, and their impact on access to and quality of maternal and neonatal care for IDPs. In the absence of a specific MNH policy framework for IDPs, the health response is shaped by humanitarian logic: reactive, temporary, and focused on emergency management rather than continuity of care. While this dependence ensures a minimum level of services, it also perpetuates fragmented governance where planning relies on external actors rather than public institutions. The analysis further reveals marked inequalities in access driven by administrative, geographical, and security factors, reinforcing “humanitarian eligibility” as an implicit criterion for prioritization.

Addressing these inequities requires explicitly integrating MNH for IDPs into national policies and implementation frameworks that extend beyond formally recognized camps. Strengthening state stewardship, aligning humanitarian support with long-term system objectives, and sustaining frontline health workers are essential to move from emergency-driven provision toward more equitable and resilient MNH systems.

Abbreviations

DRC
Democratic Republic of Congo
IDP
Internally Displaced Person
OCHA
(United Nation’s) Office for the Coordination of Humanitarian Affairs
SRMNEA-Nut
Reproductive, Maternal, Newborn, Child and Adolescent Health and MNH MNH:Maternal and Newborn Health
UNHCR

United Nations High Commissioner for Refugees
WHO
World Health Organization

Declarations

Ethics approval and consent to participate.

Before each interview, participants received clear information about the study's objectives, confidentiality, and their right to withdraw. Free and informed written consent was obtained by all participants before each interview. All members of the researcher team hold international CITI Program certification for research involving human subjects. The study was conducted in accordance with the principles of the Declaration of Helsinki (57). Ethical approval was obtained from the *Comité Institutionnel d'Éthique de la Santé* (Institutional Health Ethics Committee) of the Université Catholique de Bukavu, Democratic Republic of Congo (reference number: UCB/CIES/PB/02B/2025), as well as from the International Rescue Committee Institutional Review Board (reference number: GR 1.00.018). All data were anonymized and used exclusively for scientific purposes, in accordance with ethical standards and the protection of participants' rights.

Consent for publication

Not applicable

Availability of data and materials

De-identified qualitative data generated and analyzed during this study cannot be made publicly available due to confidentiality considerations and the sensitive conflict-affected setting. The interview guides and codebook are available as supplementary materials.

Competing interests

The authors declare that they have no financial and non-financial competing interests.

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Authors' contributions

RB, PM, MM, KSC, AA, PS and NK conceived the study design and data collection tools. GB supported design of methods and data collection preparation. RB led the data collection and analysis. CCZ, PM, GN, CM, MM and GB assisted in data collection and

analysis. RB led the manuscript preparation, assisted by MM and CCZ. MM, PS, KSC, AA, and NK have substantively revised the manuscript and provided critical feedback. All authors read and approved the final manuscript.

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