EQUAL
EVIDENCE & IMPACT FOR MOTHERS & NEWBORNS LIVING IN CONFLICT

UNDERSTANDING FACTORS THAT FACILITATE OR HINDER THE PRIORITIZATION OF MATERNAL AND NEONATAL HEALTH PROGRAMS AND POLICIES IN DRC

POLICY BRIEF

BACKGROUND

The recurrence of armed conflict over the past three decades in the Democratic Republic of Congo (DRC) has had a heavy impact on the health sector, with North and South Kivu provinces among the most severely affected. While progress has been made with 85% of all deliveries now assisted by skilled health personnel,[1] other indicators for maternal and newborn health (MNH) outcomes remain low with 547 maternal deaths per 100,000 live births (2020);[2] 26 neonatal deaths per 1000 live births (2022);[3] and 28 stillbirths per 1000 births (2021).[4]

Given the complex political and economic environment, a deeper understanding is needed of the factors that influence MNH policy design, implementation, and resource allocation in conflict-affected areas of the DRC. This brief outlines a recent political economy analysis (PEA) led by the Université Catholique de Bukavu (UCB) and the International Rescue Committee (IRC) – partners in the EQUAL research consortium – to examine the diverse political, economic, and health system factors that influence MNH decision making and prioritization in North and South Kivu provinces in eastern DRC. With this information, the consortium aims to identify opportunities to accelerate progress toward improved health outcomes for women and newborns living in conflict-affected communities.

SUMMARY

- As part of the EQUAL Research Consortium, UCB and the IRC conducted a political economy analysis examining MNH policy, practice, and financing in DRC.
- Diverse stakeholders shape DRC's MNH sector, with donor funding often driving program implementation. While private health sector play a key role delivering MNH services, challenges persist in regulating private providers, particularly in crisis zones.
- While MNH is perceived to be a high political concern, policy implementation is hindered by resource constraints and competing priorities. Policies developed at the central level are difficult to adapt for the eastern provinces given pervasive insecurity and inadequate budget, complicated by frequent changes in health system leadership.
- Acute crises like epidemics, conflict, and natural disasters disrupt MNH decision-making, funding, and service delivery. Health providers in conflict-affected areas sometimes establish mechanisms for peaceful coexistence with rebel militias to ensure continuity of care.
- Gender, religious, and cultural norms influence MNH prioritization and care-seeking behaviors. Cultural preferences for male education and traditional beliefs contribute to a shortage of female staff in MNH service delivery and decision-making.

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STUDY OVERVIEW

This PEA sought to understand the factors that facilitate and/or hinder the prioritization of MNH by government and other key stakeholders and to assess the influence of conflict and fragility on decision-making in the eastern provinces impacted by protracted crisis. This included exploring the diverse power dynamics impacting MNH, while also unpacking the complexity of policymaking spaces that involve multiple stakeholders each with their own priorities, perceptions, and capacities. It also sought to analyze the influence of contextual factors like conflict, epidemics, and natural disasters on MNH policy and practice in the DRC.

Study location

This PEA was conducted at the national, provincial, and local levels to take into account the decentralized organization of DRC's health system. North and South Kivu provinces have been affected by decades of conflict and insecurity resulting in high rates of maternal and newborn mortality.[5] The consortium is conducting other studies in these locations including assessments of facility-based quality of care and of community-based maternal and perinatal death surveillance and response systems.

EQUAL PROJECT OVERVIEW

Funder: UK International Development from the UK government

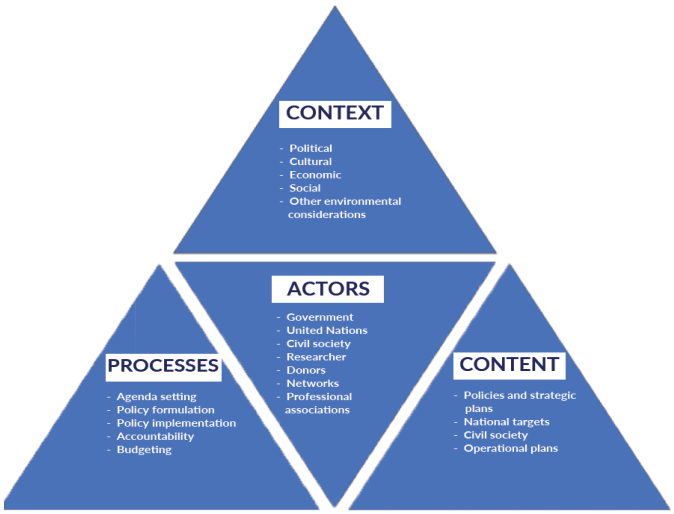
Length: July 2021 – April 2026

Locations: DRC, Nigeria, Somalia, and South Sudan

Partners: Institute of Human Virology Nigeria, International Rescue Committee, Johns Hopkins Center for Humanitarian Health, Somali Research and Development Institute, and Université Catholique de Bukavu.

Study design

This was a descriptive case study conducted between October 2022 and August 2023.[6] UCB executed a desk review examining relevant scientific papers published in peer-reviewed journals and official MNH related documents from the DRC government and technical partners. This included policies, programs strategic plans, annual reports, and other PEAs. 24 key informants were interviewed including high-level government officials from the Ministries of Health, Planning, and Budget at the national level; health technicians form different programs and offices of the MoH at national and provincial levels, and Health Zones managers at the health zone level. Non-governmental informants included representatives from bi-lateral and multi-lateral cooperation institutions engaged in MNH in DRC, researchers from several universities in DRC, and local North and South Kivu civil society organizations.



Health Policy Triangle, Walter & Gilson (1994)[7]

The study was guided by the Health Policy Triangle, a conceptual framework commonly used to assess policy content, policy-making processes, the overall institutional, political and social context, and the role of policy actors – including their values and interests, social networks, and power dynamics – in shaping policy outcomes.[7]

A thematic analysis was conducted with a deductive approach with four themes inspired by the framework: policies and processes, stakeholders and organizations, events and context, and gender and inclusion.

Results

The study findings are outlined below, structured based on the predominant themes that surfaced through the research.

Diverse stakeholders are involved in MNH policy, practice, and financing in the DRC, each possessing distinct interests, perspectives, and agendas.

- While the national MoH holds primary decision-making power, international partners play a vital role in planning and implementing DRC's MNH policies, with execution often dependent on donor funding, and therefore aligned with donor priorities.
- As public health care structures often struggle to provide quality MNH services, the role of private health sector actors has rapidly expanded. These include faith-based organizations, which have become key partners in the provision of essential health services in the DRC.
- The fragility of the state authority in crisis zones weakens the power of local health managers to regulate private providers. In turn, some private providers take advantage of the governance constraints and operate outside of the law, providing low-cost and potentially lower quality care to vulnerable women.

While MNH is perceived to be a high political concern in the DRC, prioritization and implementation is hindered by factors including competing emergencies, ongoing armed conflict, and resource constraints.

- Frequent changes in health system leadership disrupt the sector's stability, diminishes staff motivation, and leads to a high turnover of professionals with the specialized knowledge and skills needed to address MNH challenges.
- Policies and guidelines aimed at reducing preventable maternal and newborn deaths are developed at the central level and sometimes face challenges being adapted for effective implementation in the eastern provinces which are marked by pervasive insecurity.
- DRC's national health budget does not accurately reflect available resources or need, leading to insufficient financing for MNH due to factors exacerbated by insufficient government revenue, corruption and financial mismanagement, delayed revenue collection, and a large informal economy.

Ongoing crisis and insecurity plague North and South Kivu provinces, severely impacting MNH services and outcomes.

- In the DRC, acute crises such as epidemics, wars, or natural disasters severely disrupt decision-making and funding for MNH services, exacerbating resource limitations and negatively impacting service delivery. Additionally, major humanitarian events lead to temporary healthcare system disruptions, allowing unlicensed providers to establish illegal parallel structures that may persist beyond the immediate crisis.
- In crisis-affected communities, access to public healthcare facilities is sometimes limited by geographic and security obstacles, in addition to the cultural and religious barriers described by stakeholders.
- Health providers working in areas of North and South Kivu affected by armed conflict are sometimes faced with the need to establish mechanisms for peaceful coexistence with rebel militias. This is for their own safety and to help ensure the continuity of MNH care.
- Eastern DRC has experienced numerous humanitarian, political, security, and environmental crises. While these crises have helped mobilize resources and stakeholders, the focus is primarily on immediate relief rather than long-term development.

Gender, religious, and cultural norms impact MNH in DRC including prioritization, care seeking behaviors, and access to diverse healthcare providers.

- DRC remains a patriarchal society with resource and decision-making power remaining with men. This can affect timely access to healthcare for women and ultimately MNH outcomes.
- Persistent cultural preferences for educating male children over females, combined with security concerns, contribute to a shortage of competent female staff in MNH services in the DRC, leading to gender disparities and limited female representation in MNH decision-making positions.
- Traditional beliefs, social and religious norms, and language barriers hinder the success of MNH interventions, with some communities favoring traditional practices and practitioners over modern medicine.

RECOMMENDATIONS

FOR GOVERNMENT:

1. Include MNH care in humanitarian response plans and disaster risk reduction strategies to ensure the continuity of care throughout different phases of a crisis.
2. Provide financial protection or accessible, pro-poor healthcare systems in areas where there is limited access to public healthcare.
3. Introduce and enforce legislative mechanisms to better regulate the private health sector and to discourage unlicensed activities, particularly in times of emergency.

FOR CIVIL SOCIETY/INGOS:

1. Identify and cultivate political champions for MNH to ensure it remains a top priority with sustainable commitment across government levels and ministries.
2. Implement flexible community-based strategies that increase access to care and empower women living in crisis-affected communities to have more choice in care seeking behaviors.

FOR DONORS:

1. Ensure MNH investments are flexible in order to effectively address the diverse contexts and constraints that exist in DRC.
2. Empower the DRC government to take ownership of the MNH agenda, resource allocation, and management by dedicating resources to strengthen the skills and capacities of local health managers and authorities.
3. Prioritize local engagement and partnerships to ensure MNH interventions align with local needs and priorities. This requires establishing flexible funding mechanisms to swiftly respond to changing MNH needs and crises.

FOR RESEARCHERS – more research is needed on:

1. Gender mainstreaming mechanisms in DRC and their potential impact on improving MNH, especially in the context of health system strengthening through Universal Health Coverage (UHC).
2. How healthcare systems can effectively capitalize on policy windows during crises to drive sustainable MNH improvements amidst challenging circumstances.

FOR ALL ACTORS:

1. Leverage the influx of funds during crises to strengthen the health system including rehabilitating health infrastructures and encouraging community ownership.
2. Provide more comprehensive support to health care personnel working in the conflict-affected regions through safety and security training, psychosocial support, and timely payment.
3. Facilitate collaboration between modern and traditional providers to expand the research of essential health services and bridge gaps in access and coverage without undermining quality of care.

For more information visit www.EQUALresearch.org and contact Rosine Bigirinama (rosine.bigirinama@ucbukavu.ac.cd) or Equal@rescue.org

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