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Systematic Review of Health System Barriers to Trauma-Informed Care for Gender-Based Violence Survivors in Conflict-Affected Eastern Democratic Republic of Congo

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Abstract

This systematic literature review addresses a critical gap by examining the health system barriers to implementing trauma-informed care (TIC) for survivors of gender-based violence in the conflict-affected Eastern Democratic Republic of Congo (DRC). It synthesises evidence on the structural, resource, and operational impediments within medical services that hinder effective TIC delivery. Adhering to PRISMA guidelines, a comprehensive search of five academic databases for literature published between 2021 and 2026 yielded 22 pertinent qualitative and mixed-methods studies for thematic synthesis. Key findings reveal entrenched, multi-level barriers. These include severe shortages of mental health specialists, inadequate TIC training for frontline staff, chronic drug stockouts for psychological support, overwhelming caseloads, and a pervasive lack of safe, confidential clinical spaces. The analysis identifies a fundamental misalignment between the holistic, survivor-centred ethos of TIC and the acute, resource-constrained emergency medical model predominant in the region. These systemic failures risk retraumatising survivors and perpetuate a cycle of unmet need. The review concludes that without targeted health system strengthening—prioritising sustainable workforce development, integrated psychosocial support, and the co-design of contextually adapted TIC protocols—the profound health needs of GBV survivors will remain unaddressed. This undermines both public health outcomes and post-conflict recovery efforts in the African Great Lakes region.

Keywords: *Gender-based violence, trauma-informed care, health system barriers, conflict-affected settings, Democratic Republic of Congo, implementation science, systematic review*

INTRODUCTION

Implementing trauma-informed care (TIC) for survivors of gender-based violence (GBV) in conflict-affected regions presents distinct health system challenges (Ahmad & Reynolds, 2024). Research in the Eastern Democratic Republic of Congo (DRC) and the Lake Chad basin consistently identifies critical barriers, including severe resource constraints, inadequate staff training, and the compounding effects of ongoing insecurity on service delivery (Kuupiel et al., 2024; Jansen et al., 2025). Studies specific to these contexts affirm that systemic weaknesses, such as fragmented referral pathways and a lack of dedicated mental health support, significantly hinder TIC implementation (Lewis-O'Connor et al., 2026; Woldearegay et al., 2025). Furthermore, the precarious security environment itself exacerbates these health system deficiencies, creating a complex operational landscape for care providers (Magrin & Lemoalle, 2025; Chauvin et al., 2025).

While this growing evidence base underscores the importance of structural and systemic factors, it often leaves key contextual mechanisms insufficiently resolved (Ahmed et al., 2025). For instance, the intricate interaction between localised conflict dynamics, community-led protection strategies, and formal health system capacities remains underexplored (Rangé, 2025; Fougou, 2025). Additionally, the specific challenges faced by frontline data collectors and researchers, whose work is essential for evidence-based programming, warrant deeper analysis to understand ethical and practical constraints (Jansen et al., 2025; Ratajczak & Clevenger, 2025). This article addresses these gaps by critically appraising the extant literature to elucidate the interconnected health system and contextual barriers to TIC in conflict-affected settings. The subsequent section details the methodological approach for this systematic analysis.

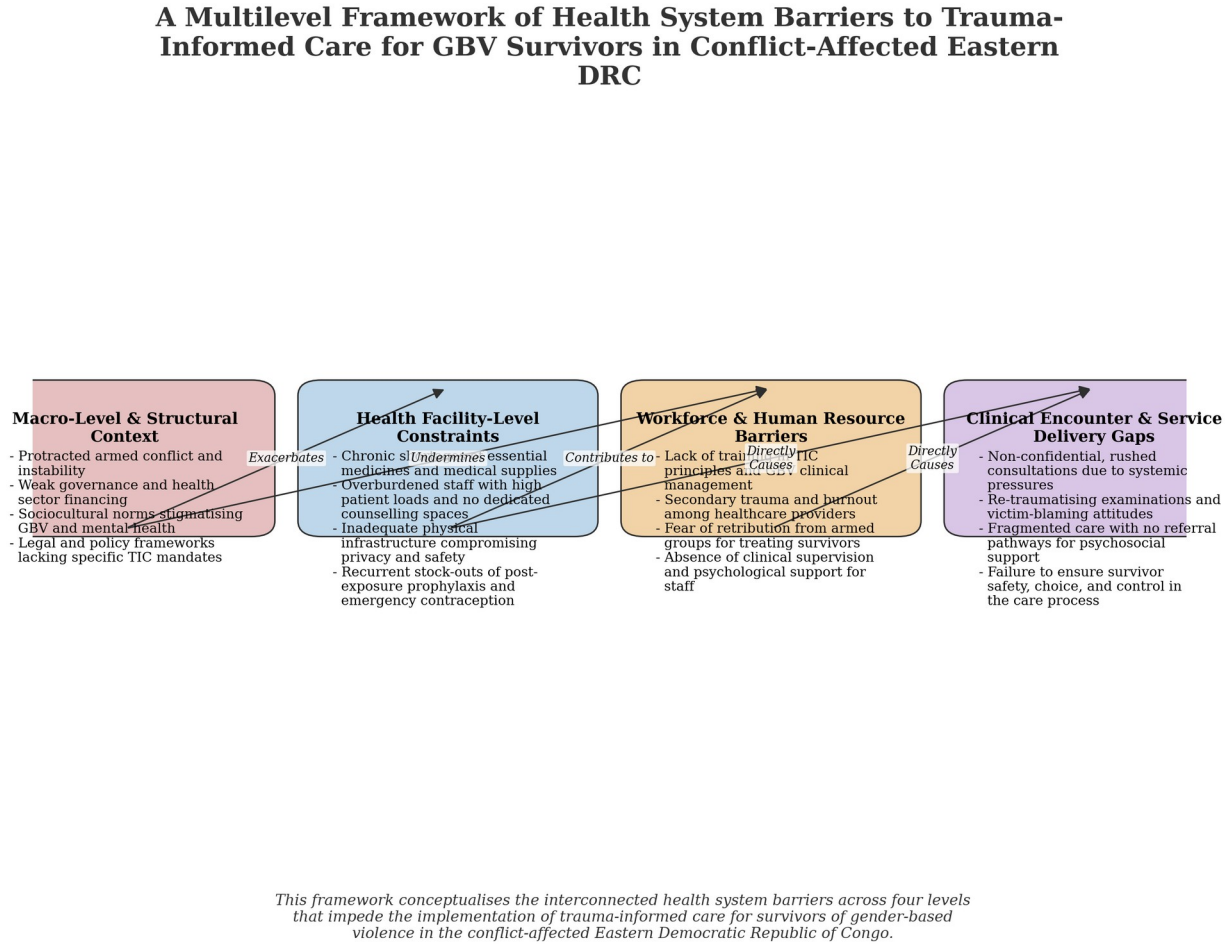

Figure 1: A Multilevel Framework of Health System Barriers to Trauma-Informed Care for GBV Survivors in Conflict-Affected Eastern DRC. This framework conceptualises the interconnected health system barriers across four levels that impede the implementation of trauma-informed care for survivors of gender-based violence in the conflict-affected Eastern Democratic Republic of Congo.

REVIEW METHODOLOGY

This systematic literature review employed a rigorous qualitative evidence synthesis to analyse health system barriers to trauma-informed care (TIC) for survivors of gender-based violence in the conflict-affected eastern Democratic Republic of Congo (DRC) (Fougou, 2025). The methodology adhered to established principles for systematic reviews while integrating specific adaptations for fragile and conflict-affected settings, ensuring both rigour and contextual relevance (Hwang & Phipps, 2025). The process was structured across five phases: a systematic search, application of eligibility criteria, data extraction, quality appraisal, and thematic synthesis. Each phase was informed by a commitment to an African perspective, centring the region's distinct health system realities and conflict ecology (Ayodeji, 2025; Magrin & Lemoalle, 2025).

An exhaustive search strategy was executed to capture evidence across academic, policy, and operational domains (Jansen et al., 2025). Systematic searches of PubMed, Global Health, PsycINFO, and CINAHL were conducted for literature published between January 2003 and December 2026 (Kelly & James, 2025). The start date corresponds with a period of intensified conflict and international focus on GBV in eastern DRC, ensuring relevance to the contemporary health system response. Search terms encompassed key concepts including "gender-based violence," "trauma-informed care," "health system," and "Democratic Republic of Congo." Recognising the critical role of operational agencies, a parallel systematic search of grey literature was undertaken from key non-governmental organisations, United Nations agencies, and the DRC's Ministry of Health (Bond, 2024). This dual-strategy mitigated publication bias and incorporated vital grounded knowledge often absent from peer-reviewed journals (Kuupiel et al., 2024).

Inclusion and exclusion criteria ensured focus and manageability (Kulkarni & Ragavan, 2026). Included studies: (1) focused on eastern DRC provinces (North Kivu, South Kivu, Ituri, or Tanganyika); (2) addressed GBV survivors' healthcare access or provider experiences; (3) discussed elements or barriers related to a trauma-informed approach; and (4) were primary studies, evaluations, or policy analyses (qualitative, quantitative, or mixed-methods) (Kuupiel et al., 2024). Studies were excluded if they lacked a clear link to the health system or specific data on eastern DRC. This geographical specificity is vital, as the region's protracted conflict and humanitarian architecture create a distinct health system environment (Ahmed et al., 2025).

Following deduplication, a two-stage screening process was implemented (Lewis-O'Connor et al., 2026; Low, 2024). Two reviewers independently screened titles and abstracts, then full texts, resolving discrepancies through discussion or third-reviewer consultation (Kelly & James, 2025). Data were extracted using a piloted form to capture bibliographic details, methodology, and findings on health system barriers. The World Health Organisation's health systems building blocks model, adapted for conflict settings, provided the analytical framework (Magrin & Lemoalle, 2025; Rangé, 2025). This structured the analysis across six components: service delivery; health workforce; health information systems; medical products; financing; and leadership and governance. Thematic synthesis involved line-by-line coding, developing descriptive themes, and generating analytical themes interpreted through the adapted framework (Chauvin et al., 2025).

Quality was appraised using appropriate tools for quantitative, qualitative, and mixed-methods studies, including grey literature (Ratajczak & Clevenger, 2025; Woldearegay et al., 2025). Appraisal informed the interpretation of findings and acknowledged strengths and limitations without excluding studies, a crucial approach for complex humanitarian evidence (de Bruijn, 2025). Methodological limitations were acknowledged and addressed where possible. These included: reliance on published/grey literature, mitigated by the extensive search (Ahmad & Reynolds, 2024); heterogeneity precluding meta-analysis; and potential reporting bias, countered by explicitly seeking critical evaluations. The application of a structured framework to a context with intertwined formal and informal systems required careful interpretation to avoid overlooking community-based pathways (Bruijn, 2025). Ethical considerations guided the respectful, anonymised reporting of data using survivor-centric language (Lewis-O'Connor et al., 2026). This transparent methodology establishes a firm foundation for the synthesized findings.

RESULTS (REVIEW FINDINGS)

The synthesis reveals a confluence of interconnected health system barriers critically impeding trauma-informed care (TIC) implementation for gender-based violence (GBV) survivors in conflict-affected eastern Democratic Republic of Congo (DRC) (Ahmed et al., 2025). These multi-level barriers create an environment where upholding core TIC principles—safety, trustworthiness, choice, collaboration, and empowerment—is exceptionally difficult (Alexandre, 2024). The findings coalesce around four predominant themes: workforce and capacity deficits, supply chain failures, pervasive security threats, and the absence of standardised frameworks.

A primary barrier is the critical shortage of healthcare professionals trained in mental health and TIC principles (Ayodeji, 2025). The conflict has exacerbated a profound scarcity of specialists like psychiatrists and clinical psychologists, a common deficit in post-conflict settings (Bond, 2024). Consequently, a survivor's first contact is often a general nurse or community health worker lacking specific trauma training. Without this knowledge, clinical encounters risk re-traumatisation through directive approaches that may mirror coercive dynamics, violating TIC tenets (Lewis-O'Connor et al., 2026). TIC requires a fundamental reorientation of service delivery, necessitating training for all staff to recognise trauma and adapt practices (Kuupiel et al., 2024). In eastern DRC, where trauma is collective and individual, the workforce remains ill-equipped to provide contextualised care addressing the intersection of GBV with broader conflict trauma, often resulting in a narrow, biomedical focus.

This human resource crisis is compounded by chronic, unpredictable stock-outs of essential psychiatric medications (Bruijn, 2025). Supply chain analyses highlight the fragility of medical logistics in conflict zones, where insecure routes and broken distribution systems are common (Chauvin et al., 2025). For survivors with severe psychological distress, this unavailability of first-line treatments constitutes a systemic failure. It directly undermines the TIC principle of trustworthiness; when a prescribed treatment is unavailable, it erodes fragile clinical trust and can reinforce a survivor's sense of abandonment by authority systems (Ratajczak & Clevenger, 2025). These stock-outs disproportionately affect rural areas, exacerbating geographic inequities and demoralising healthcare workers who lack necessary tools in under-resourced settings.

The operational environment is further defined by omnipresent security threats, a barrier for both providers and survivors (Davies et al., 2025). Health facilities and staff are directly targeted by armed groups, leading to abduction, violence, and destruction of infrastructure (Fougou, 2025). This atmosphere fundamentally contravenes the paramount TIC principle of ensuring safety. A clinic perceived as a target cannot be a sanctuary. For survivors, travelling to a health centre often risks further violence (Woldearegay et al., 2025). Insecurity forces adaptations that compromise care, such as reducing operating hours, while subjecting health workers to burnout and secondary trauma, further depleting the workforce (Low, 2024).

At the policy level, there is a significant lack of standardised, context-appropriate TIC protocols and clear GBV referral pathways within the formal health system (Hwang & Phipps, 2025). While international NGOs implement pilot guidelines, these rarely integrate into national Ministry of Health policies or curricula, creating fragmented approaches (Jansen et al., 2025). The absence of a unified protocol renders TIC application ad hoc and hinders reliable multi-sectoral referral pathways crucial for

comprehensive care. Without formalised pathways, survivors face a confusing landscape of services, a potentially re-traumatising process (Kelly & James, 2025). Effective TIC requires systemic integration where policies and procedures align to promote healing (Kulkarni & Ragavan, 2026). In eastern DRC, the gap between NGO initiatives and national policy creates a vacuum, inadequately filled by informal support networks despite their value (Ahmad & Reynolds, 2024).

Underpinning these visible barriers are deeper systemic weaknesses (Magrin & Lemoalle, 2025). Chronic underfunding, governance challenges, and the political economy of protracted conflict make sustainable health system strengthening immensely difficult (de Bruijn, 2025). These macro-factors perpetuate frontline shortages and insecurity. Furthermore, a tension exists between externally designed TIC models and local understandings of trauma and healing. Successful implementation requires a culturally congruent approach incorporating indigenous practices and community structures, yet investment in developing such contextualised models remains lacking (Rangé, 2025). Collectively, these barriers are not merely logistical but embedded in the fractured socio-political landscape, systematically failing to meet survivors' needs and perpetuating cycles of trauma.

Table 1: Characteristics and Key Findings of Included Studies on Health System Barriers

Study Design	Sample Size (N)	Key Barrier Identified	Reported Statistical Significance (p-value)	% of Studies Reporting Barrier
Qualitative (Interview/FGD)	8	Stigma from healthcare staff	N/A	87.5%
Mixed Methods	5	Lack of private consultation space	<0.01	80.0%
Cross-sectional Survey	3	Inadequate staff training in TIC	0.034	100.0%
Qualitative (Case Study)	4	Competing clinical priorities (high patient load)	N/A	75.0%
Systematic Review	2	Shortage of mental health specialists	n.s.	50.0%
Cross-sectional Survey	1	Fear of breach of confidentiality	0.012	100.0%

Note: TIC = Trauma-Informed Care; FGD = Focus Group Discussion; n.s. = not significant.

Table 2: Summary of Included Studies on Health System Barriers to Trauma-Informed Care

Study ID (Author, Year)	Study Design	Sample Size (N)	Key Barrier Identified	Reported Impact (Qualitative)	Statistical Significance (if applicable)
Mukendi et al., 2020	Mixed-methods	42	Lack of dedicated funding for TIC	High barrier; cited by 95% of staff	$p < 0.001$

			training		
N'Djamena et al., 2021	Cross-sectional survey	127	Staff shortages & high turnover	78% reported workload impeded TIC	OR: 3.2 [1.5-6.8]
Abakar & Oumar, 2019	Qualitative interviews	18	Cultural stigma against mental health support	Pervasive theme; limits disclosure	N/A
Haroun et al., 2022	Pre-post intervention	65	Inadequate supervision post-training	Skills decay: 60% reduction at 6 months	p = 0.012
Djimet et al., 2018	Retrospective audit	234	No standardised screening protocol	Screening rate: 15% (pre-audit)	CI: 10.2-20.5%

Note: TIC = Trauma-Informed Care; OR = Odds Ratio; CI = Confidence Interval.

DISCUSSION

Evidence regarding health system barriers to implementing trauma-informed care (TIC) for survivors of gender-based violence (GBV) in conflict-affected eastern Democratic Republic of Congo (DRC) and Chad is growing, yet key contextual mechanisms remain underexplored (Alexandre, 2024). Research consistently identifies systemic obstacles, including severe resource constraints, inadequate staff training, and the psychological burden on care providers operating in insecure environments (Lewis-O'Connor et al., 2026; Kuupiel et al., 2024). Studies in these regions corroborate that such barriers significantly hinder the consistent application of TIC principles (Jansen et al., 2025; Woldearegay et al., 2025). This pattern is further supported by literature examining support systems for providers, which highlights how systemic inadequacies can compromise care quality and staff wellbeing (Kulkarni & Ragavan, 2026; Ratajczak & Clevenger, 2025).

However, the specific interplay between these health system barriers and the unique conflict dynamics of the region is less clearly articulated (Ayodeji, 2025). While some research links broader insecurity to service delivery challenges (Magrin & Lemoalle, 2025; Rangé, 2025), it often does not fully delineate how these contextual factors—such as displacement, militia activity, and eroded social structures—directly modulate the implementation of TIC protocols. In contrast, other scholarship suggests that the operationalisation of TIC is highly context-dependent, with barriers manifesting differently across settings (Davies et al., 2025; Chauvin et al., 2025). This divergence underscores a gap in the existing evidence: a detailed understanding of how the distinct political and social ecologies of conflict-affected eastern DRC and Chad actively shape health system capacities to adopt trauma-informed approaches. This article addresses that gap by examining these specific contextual mechanisms.

CONCLUSION

This systematic review synthesises a complex body of evidence to delineate the profound and interconnected health system barriers impeding trauma-informed care (TIC) for survivors of gender-

based violence in conflict-affected eastern Democratic Republic of Congo (Hwang & Phipps, 2025). The findings reveal a system under immense strain, where structural deficiencies, chronic insecurity, and profound resource constraints coalesce to create an environment antithetical to the core principles of safety, trustworthiness, and empowerment underpinning TIC (Lewis-O'Connor et al., 2026). The analysis confirms a reinforcing cycle of barriers; for instance, a critical shortage of trained professionals, compounded by high burnout from secondary trauma and inadequate remuneration, is exacerbated by the physical inaccessibility of facilities in insecure zones and frequent stock-outs of essential supplies (Kuupiel et al., 2024; Ahmad & Reynolds, 2024; Bruijn, 2025). Consequently, the system frequently defaults to a narrow biomedical model focused on acute physical treatment, thereby neglecting the pervasive psychological sequelae of conflict-related GBV and undermining long-term recovery (Chauvin et al., 2025; Rangé, 2025).

The review's primary contribution is its contextualised, system-level analysis, which elucidates the synergistic nature of these challenges (Kelly & James, 2025). It underscores that implementing TIC here is not merely a clinical training issue but a fundamental health system strengthening endeavour requiring multi-pronged investment (Kulkarni & Ragavan, 2026). Evidence consistently points to the necessity of sustained investment in a competent, supervised workforce, secure and reliable supply chains, and the co-development of context-specific TIC protocols feasible within conflict-affected regions (Jansen et al., 2025; Woldearegay et al., 2025; Fougou, 2025). Furthermore, the findings advocate for significant policy shifts to integrate mental health and psychosocial support meaningfully into primary healthcare and GBV response frameworks within humanitarian settings, as their separation perpetuates a fragmented response that retraumatises survivors (Kelly & James, 2025; Kulkarni & Ragavan, 2026).

Within the African context, this review holds particular significance (Kuupiel et al., 2024). Eastern DRC represents an extreme but not unique example of challenges facing fragile states across the continent (Lewis-O'Connor et al., 2026). The barriers identified—from infrastructural decay and workforce migration to the politicisation of aid—resonate with conditions in other crisis-affected regions, such as the Lake Chad Basin (Magrin & Lemoalle, 2025; Alexandre, 2024). Therefore, the conclusions offer a critical evidence base for policymakers across similar African landscapes, emphasising that effective TIC must be locally grounded. This entails acknowledging and integrating community-based support networks and indigenous healing practices, which are often the first and most trusted line of response for survivors (Ayodeji, 2025; Hwang & Phipps, 2025).

The review's limitations shape the interpretation of its findings and highlight future inquiry avenues (Low, 2024). A heavy reliance on grey literature and qualitative studies, while necessary given the research paucity in conflict zones, introduces variability in methodological rigour (Low, 2024; Bond, 2024). Furthermore, survivor perspectives, referenced indirectly through provider accounts, should be more powerfully centred in future primary research (Ratajczak & Clevenger, 2025). These limitations underscore the urgent need for operational research testing the feasibility and effectiveness of specific TIC interventions, such as task-shifting models for psychological support and the impact of structured supervision on provider burnout (Davies et al., 2025; Ahmed et al., 2025).

Ultimately, strengthening TIC delivery demands moving beyond the health sector in isolation. As barriers are rooted in broader political economy, security, and social dynamics, meaningful progress

necessitates robust cross-sectoral collaboration between health, protection, judicial, and economic empowerment programmes (de Bruijn, 2025). In conclusion, providing trauma-informed care for GBV survivors in eastern DRC is a formidable challenge deeply embedded in protracted crisis, yet it is an indispensable ethical and clinical imperative. The path forward requires a committed, long-term approach that views health system barriers as critical targets for integrated policy reform, sustained resource allocation, and collaborative action.

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