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MATERNAL AND CHILD HEALTH SERVICES IN POLYCLINICS DURING WARTIME

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War shatters every layer of society, but its most insidious devastation often unfolds far from the front lines—in the quiet collapse of routine health services. Among the most vulnerable casualties are pregnant women, new mothers, and young children. In times of active conflict, polyclinics—the backbone of primary and outpatient care in many health systems—become both a lifeline and a fragile frontline institution, struggling to sustain maternal and child health (MCH) services against a tide of destruction, displacement, and fear.

The Polyclinic Under Siege A polyclinic, by design, is a hub of comprehensive, non-residential care. It combines general practice, specialist consultations, diagnostics, immunization, antenatal care, family planning, and pediatric services under one roof. In peacetime, it offers continuity and accessibility, especially for women and children who rely on its proximity, affordability, and integrated services. War upends every one of these attributes.

The physical infrastructure of polyclinics is often directly targeted or caught in the crossfire. A 2025 multi-country analysis documented a total of 4,289 attacks on healthcare across five conflict-affected countries using WHO surveillance data, with an even higher tally of 5,454 from the Safeguarding Health in Conflict Coalition database (Druce et al., 2025). In Ukraine alone, the World Health Organization has verified more than 1,300 attacks on health-care facilities since the full-scale invasion began (WHO Regional Office for Europe, 2025). A damaged polyclinic means not just the loss of a building but the destruction of cold chain equipment for vaccines, sterilisation units for safe deliveries, laboratory capacity for prenatal screening, and essential medicines. Even when the structure remains standing, electricity, water, and heating often do not—making basic infection prevention or the storage of oxytocin and insulin impossible.

Human resources hemorrhage. Doctors, midwives, and nurses flee violence alongside their patients or are themselves displaced. Those who stay face impossible workloads, personal trauma, and the constant threat of injury or death. A facility that once saw 50 antenatal visits a day may suddenly have only one midwife and a handful of volunteers, seeing patients by torchlight in a basement shelter.

The Unbroken Chain of Care – Why Continuity Is a Matter of Life and Death

The calculus of maternal and newborn survival is unforgiving. A pregnancy cannot be postponed for a ceasefire, and a baby due during bombardment will not wait for peace. Interruptions to antenatal care mean that hypertensive disorders, gestational diabetes, and malpresentations go undetected. Anemia and malnutrition, rampant in displacement, compound risks. The absence of skilled birth attendance and emergency obstetric referral turns a complication into a death sentence. Globally, countries classified as conflict-affected have an estimated maternal mortality ratio (MMR) of 504 deaths per 100,000 live births—over five times higher than the MMR of 99 in non-conflict, non-fragile countries (UNFPA, 2024a). In 2023 alone, an estimated 160,000 women died from preventable maternal causes in fragile and conflict-affected settings, accounting for six in ten maternal deaths worldwide (UNFPA, 2024a).

For children, the breakdown of routine services is a cascade of silent killers. Missed vaccination appointments trigger outbreaks of measles, polio, and diphtheria in

already malnourished populations. Without growth monitoring, acute malnutrition goes unnoticed until a child presents with medical complications. Common childhood illnesses—diarrhea and pneumonia—become fatal when oral rehydration salts and antibiotics run out, and caregivers fear the journey to a clinic.

Adaptation and Resilience: How Polyclinics Morph into Lifelines Despite the odds, healthcare workers and communities adapt in extraordinary ways. The polyclinic's physical site may no longer be safe or accessible, but its functions migrate and morph.

Decentralization and Mobile Outreach When patients cannot come, services go to them. Mobile MCH teams, often assembled from the surviving staff of a polyclinic, travel to informal settlements, metro stations, or basement shelters. In Sudan, for example, the United Nations Population Fund (UNFPA) has deployed 56 mobile health teams across 11 states, offering reproductive health services and gender-based violence protection in war-affected areas (UNFPA Sudan, 2023). These teams carry portable ultrasound devices, essential medications, vaccines in solar-powered coolers, and, critically, registers to track high-risk pregnancies. A tent in a collective center becomes a temporary antenatal clinic, ensuring that a woman receives her tetanus toxoid shot and her weekly fetal heart rate check.

Telemedicine and Hotlines Where infrastructure allows, the wartime polyclinic extends through phone lines and internet connections. Midwives run 24/7 hotlines for pregnant women to report danger signs—bleeding, reduced fetal movement, severe headache—and receive immediate triage advice. Postpartum depression screening and breastfeeding support shift to virtual consultations. Pediatricians guide mothers through managing fever at home when a hospital visit is too dangerous, reserving referrals for the most critical cases. This remote tethering maintains a clinical relationship that can rapidly pivot to an in-person visit if a safe window opens.

Integrated Service Delivery and Simplified Protocols Conflict forces brutal simplification. Polyclinics adopt "one-stop-shop" visits where a woman coming for a child's vaccination also receives her own postpartum checkup, a supply of contraceptives, and a mental health screening. The conventional schedule of multiple

antenatal visits may be compressed into a few focused contacts, emphasizing the highest-impact interventions: iron and folic acid supplementation, blood pressure measurement, syphilis testing, and birth preparedness planning. For children, the Integrated Management of Childhood Illness (IMCI) becomes the backbone, with community health workers trained to assess, classify, and treat or refer using minimal equipment.

The Midwife and Nurse as Bedrock In wartime polyclinics, the role of midwives and community nurses expands dramatically. They become ultrasound technicians, mental health counselors, malnutrition screeners, and vaccinators. Supportive supervision and task-sharing mean that a single skilled provider can manage a caseload that would have been unthinkable in peacetime. A study in Malawi found that stakeholders perceive task-sharing antenatal ultrasound scanning with trained midwives as having a positive impact on continuity and quality of care, specifically enabling early detection of complications and improving women's birth preparedness (Manda-Taylor et al., 2022). Their intimate knowledge of the community allows them to locate defaulters, address vaccine hesitancy exacerbated by misinformation in crisis, and detect the early signs of domestic violence, which surges in displacement.

The Hidden Burden: Mental Health and Protection Maternal and child health in war is inseparable from mental health. The polyclinic visit may be the only non-violent, supportive contact a pregnant woman has in weeks. Post-traumatic stress, anxiety, and depression are rampant, directly impacting pregnancy outcomes and parenting capacity. Embedded mental health and psychosocial support within polyclinics—whether through trained midwives offering "psychological first aid" or dedicated counselors—is a critical adaptation. Screening for gender-based violence and linking survivors to safe spaces must become a standard part of every MCH encounter, not an afterthought.

The Way Forward: Protecting the Sanctuary The international humanitarian community has developed frameworks—the Minimum Initial Service Package (MISP) for reproductive health in emergencies, the Sphere standards, the Baby-Friendly Spaces model—but their implementation requires concrete, sustained action. The MISP, for instance, is a coordinated set of lifesaving priority activities designed to prevent excess

maternal and newborn morbidity and mortality, among other objectives, and is to be implemented at the onset of every humanitarian emergency (Inter-Agency Working Group on Reproductive Health in Crises, 2018).

- Physical protection: Health facilities must be explicitly off-limits to attack, in line with International Humanitarian Law. UN Security Council Resolution 2286 (2016) strongly condemns acts of violence against medical personnel and facilities, demanding that all parties to armed conflict respect and protect them. Yet a decade later, these obligations are systematically breached, with over 4,500 health facilities damaged in conflicts around the globe since 2016 (Safeguarding Health in Conflict Coalition, 2025).

- Supply chain corridors: Reliable resupply of reproductive health kits, midwifery supplies, ready-to-use therapeutic food, and cold chain equipment through negotiated humanitarian corridors is non-negotiable.

- Flexible financing and support: Donors and governments must allow programmatic flexibility, so a grant intended for a brick-and-mortar polyclinic can be repurposed to support mobile teams, generator fuel, or telehealth credit for midwives.

- Investment in local health workers: They are the last mile and the first responders. Salaries, safety, psychosocial support, and trauma care for staff themselves keep the service alive.

A wartime polyclinic is more than a medical outpost. It is a symbol of normality and hope, a place where a mother hears her unborn child's heartbeat for the first time despite the distant thunder of shelling, where a child receives a vaccine that protects them from a killer disease even as the world around them disintegrates. Defending these services is not merely a health imperative; it is a profound commitment to the idea that even in humanity's darkest hours, the most vulnerable lives are worthy of protection, care, and the promise of a future.

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