Driven into oblivion:
The Toll of Conflict and Neglect on the Health of Mothers and Children in South Darfur

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

"The maternal and child health crisis unfolding in South Darfur is one of a magnitude I've never seen in my career. Pregnant women and women in labour are dying in shocking numbers from complications preventable with basic obstetric care. The conflict has led to shortages in lifesaving supplies, closure of services, and access barriers. Pregnant women and girls are presenting when it's already too late, if they present at all. Starving mothers lead to starving kids – all shamefully forgotten."

Noor Rijnberg, Médecins Sans Frontières Sexual and Reproductive Health Implementer, South Darfur, August 2024

Background

The consequences for women and children of close to a year and a half of violence and displacement in Sudan are disastrous[1]. With famine declared in Zamzam[2], North Darfur, women and children are already paying the price of hunger, with 4 million children[3] and 1.2 million pregnant & breastfeeding women[4] projected to suffer from acute malnutrition across the country this year. Conflict-related sexual and gender-based violence is pervasive, and services aimed at preventing and addressing its consequences barely exist. Amongst the 6.9 million people estimated at risk[5], women and girls are the most vulnerable – particularly in displacement settings. Sexual and reproductive needs remain largely unmet for over 2.5 million women and girls of reproductive age displaced since the beginning of the conflict.[6]

This crisis is particularly manifest in South Darfur – which hosts the highest number of internally displaced people in Sudan.[7] Médecins Sans Frontières (MSF) teams are grappling with one of the most acute maternal and child health crises the organisation is witnessing globally. As warring parties continue restricting humanitarian access – precipitating the collapse of essential healthcare – conflict-driven barriers disproportionately affect women and children's access to care. Heavy rains and floods have compounded the impact of the conflict on the crisis, particularly following the collapse of the Mornei bridge in August 2024[8] – cutting off South Darfur from its lifeline to Chad. In the activities and programmes MSF supports – which cover a fraction of needs across the state – maternal mortality and child nutrition indicators have turned red.

The situation in South Darfur is a snapshot of what is likely unfolding at dreadful proportions across war-torn and isolated areas of Sudan. Hidden from general view, millions of forgotten mothers and children are suffering from the brutal effects of violence and neglect. A coordinated humanitarian scale-up – supported by commensurate funding and access – is urgently required to contain the crisis. Without it, mothers and children will continue dying at unprecedented rates and remain trapped in inextricable cycles of malnutrition – with far-reaching generational repercussions.

1 MSF Report, "A War on People: The Human Cost of Conflict and Violence in Sudan", July 2024
2 Famine Review Committee confirmed presence of IPC Phase 5 – Famine conditions in Zamzam camp on August 1st, 2024.
3 UNICEF Sudan, "One Year of Brutal War in Sudan", April 2024
4 UNFPA Sudan, "One Year of War in Sudan", April 2024
5 UNFPA Sudan Emergency Situation Report #15, August 2024
6 Ibid.
7 IOM Sudan Mobility Overview report, July-August 2024. South Darfur was reported as the state with the highest number of internally displaced estimated at 1.8 million for August 2024.
8 MSF Press release, 27th August 2024

Executive Summary

Women and children are bearing the brunt of the full-blown war on people raging across Sudan. In South Darfur, a severe maternal health crisis is unfolding and has gone largely unnoticed, while child malnutrition has been aggravated to emergency levels. Based on medical data from MSF-supported programmes and nutrition screenings, combined with testimonies from patients and healthcare providers, this report reveals the direct and indirect ways in which the conflict is affecting the health of mothers and children in Darfur – with potential long-term repercussions for their wellbeing.


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Key messages and findings

The maternal health crisis in South Darfur is one of the most acute MSF is seeing globally. Pregnant women, mothers and newborns are dying at alarming rates from preventable and treatable health complications. From January to mid-August 2024:

- 46 women have died of pregnancy-related complications in MSF-supported facilities. This represents 40% of the total number of maternal deaths reported across MSF Operational Centre Amsterdam (OCA) operations globally in 2023 (n=115)
- Maternal deaths have increased by more than 50% across the two maternity services MSF supports[9] 1 out of 30 women died from pregnancy or birth-related complications after being admitted to the Nyala Teaching Hospital maternity ward in July 2024
- Almost 1 out of 5 newborns with sepsis admitted in MSF-supported neonatal services did not survive, with 48 newborns dying from preventable and treatable infections

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Malnutrition has exceeded emergency thresholds, affecting children most acutely. Thousands of people are on the brink of starvation and risk of death – with the full extent and scale of the crisis largely hidden.

- More than 1 out 3 children aged 6-23 months screened for malnutrition in three Nyala localities in August 2024 was acutely malnourished (32.5%), well beyond the WHO emergency threshold of 15%; the 8.1% of the children screened had severe acute malnutrition (SAM). In one of the localities screened, the SAM rate was higher than 10%"
- Over 9,600 malnourished children[10] – 2,395 of them severely acutely malnourished – urgently require nutrition supplies. We know that accurate data is in short supply due to the crisis; needs in reality are likely much higher than reported
- 12.5% of pregnant and lactating women and girls screened in a nutrition survey in April 2024 were acutely malnourished, which has implications for their children including increased risk of malnutrition, stunted growth and impaired development
- Acute malnutrition rates have rapidly escalated in Nyala since MSF's last nutrition survey in that area in April 2024

Conflict is driving the maternal and child health crisis in South Darfur, deepening cycles of hunger, poor health and preventable suffering.

- Women and children are dying from preventable and treatable conditions and complications. Displacement, violence, supply shortages and conflict-related access barriers are underpinning the crisis
- Warring parties and affiliated armed groups continue to block or restrict access to lifesaving aid – choking the scale-up of the humanitarian response. The crisis is not only a byproduct of conflict – it is also deliberate and man-made
- Maternal and child health are strongly correlated, the former being a predictor of the latter. The crisis risks trapping families in protracted cycles of malnutrition, sickness and deteriorating health, and suffering more broadly

9 In absolute numbers. The number of patients has also increased, so this does not indicate potential deterioration in case fatality rates (data point not available).

10 Out of total of 29,5449 children 6-23 months of age screened

Calls to action

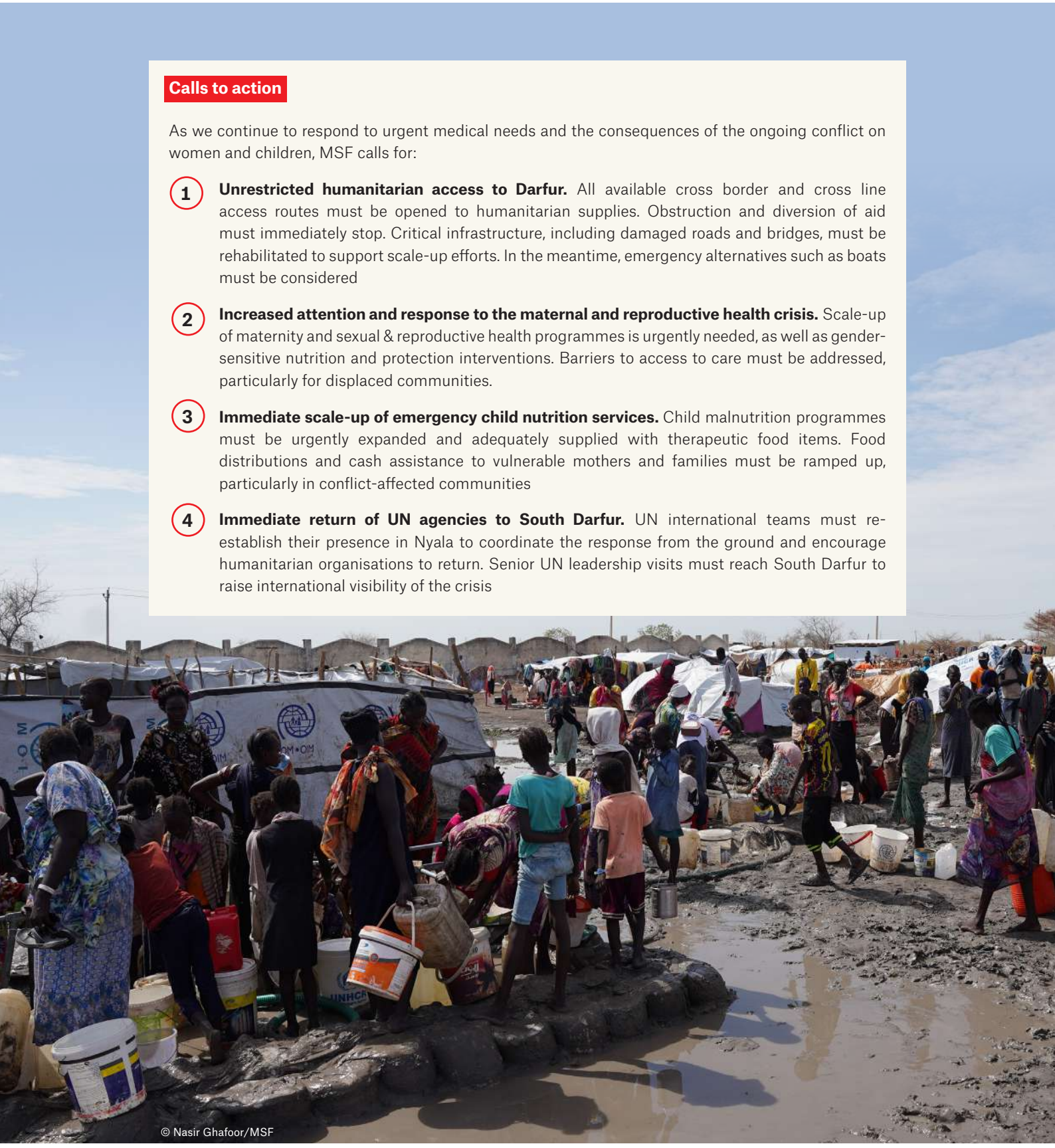
As we continue to respond to urgent medical needs and the consequences of the ongoing conflict on women and children, MSF calls for:

1. **Unrestricted humanitarian access to Darfur.** All available cross border and cross line access routes must be opened to humanitarian supplies. Obstruction and diversion of aid must immediately stop. Critical infrastructure, including damaged roads and bridges, must be rehabilitated to support scale-up efforts. In the meantime, emergency alternatives such as boats must be considered

2. **Increased attention and response to the maternal and reproductive health crisis.** Scale-up of maternity and sexual & reproductive health programmes is urgently needed, as well as gender-sensitive nutrition and protection interventions. Barriers to access to care must be addressed, particularly for displaced communities.

3. **Immediate scale-up of emergency child nutrition services.** Child malnutrition programmes must be urgently expanded and adequately supplied with therapeutic food items. Food distributions and cash assistance to vulnerable mothers and families must be ramped up, particularly in conflict-affected communities

4. **Immediate return of UN agencies to South Darfur.** UN international teams must re-establish their presence in Nyala to coordinate the response from the ground and encourage humanitarian organisations to return. Senior UN leadership visits must reach South Darfur to raise international visibility of the crisis



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MSF's sexual, reproductive and child health activities in South Darfur[11]

Since returning to South Darfur in January 2024, MSF has supported maternal health services in Ministry of Health hospitals and primary healthcare centres through rehabilitation of critical infrastructure, staff incentives, logistical and technical support, clinical supervision, medical supply, and running costs.

12,600 ante and post natal care consultations

1,258 neonatal care consultations

4,327 normal and complicated deliveries

2,473 C-section deliveries

1,282 family planning consultations

90 sexual and gender-based violence admissions

Donations of nutrition supplies to health structures

Mass immunization campaigns of children under 2 years

In Nyala Teaching Hospital, the MSF-supported maternity unit facilitates normal and caesarean deliveries and contraceptive services, and provides care to survivors of sexual and gender-based violence (SGBV), including prevention of sexually transmitted infections, provision of HIV post-exposure prophylaxis (PEP), and emergency contraceptives.

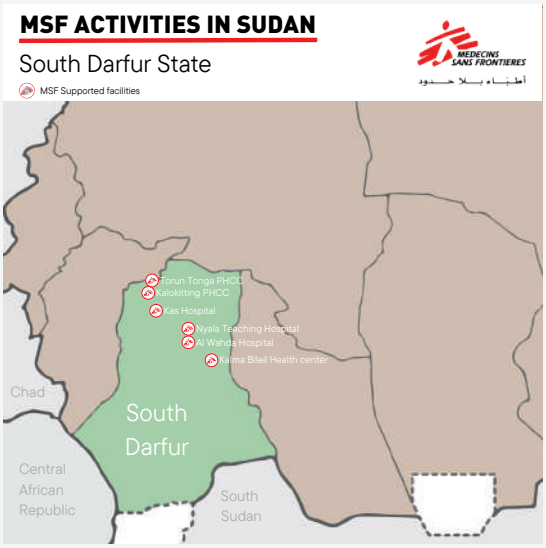
In Al-Wahda Hospital, MSF supports contraceptive services, and SGBV care through the provision of incentives and technical support to a 'confidential corner' within the clinic.

In Nyala's Bileil Primary Health Care centre, MSF supports ante- and postnatal care (ANC; PNC), normal births and contraceptive consultations.

In Kas Rural Hospital: MSF supports secondary healthcare and comprehensive emergency obstetric and neonatal care.

In the South Jebel Marra region, MSF is supporting three primary healthcare facilities (Kalokitting, Torun Tonga, and Dili) that provide ANC and PNC consultations, contraceptive services, and emergency referrals to Kas and Golo Hospitals.

In addition to support to these facilities, MSF is supporting women clinics in the Kalma IDP camp, Dreij and Otash IDP settings outside Nyala and will start supporting similar women-centered services in in the coming weeks to address the surging maternal mortality and sexual and reproductive needs across the state.



11 Data figures in this section are likely underestimates, as data was not systematically reported in the first months of operations. The figures reported cover the earliest period for which data was available after January 2024 or from the beginning of MSF presence and support to the facilities, and up to August 15th 2024. Kas and Nyala facility data collection started in February and March 2024 respectively, together with MSF programmes in these facilities.

How conflict is fueling South Darfur's sexual & reproductive, maternal and child health crisis

High maternal and neonatal mortality rates in South Darfur predate the conflict. Violence, displacement, and access barriers have, however, exacerbated the lack and quality of care for people with precarious health conditions or at risk of complications. Recent data from MSF-supported facilities shows the situation of mothers and children is rapidly deteriorating into a full-blown crisis, with pregnant women and mothers dying in unprecedented numbers.

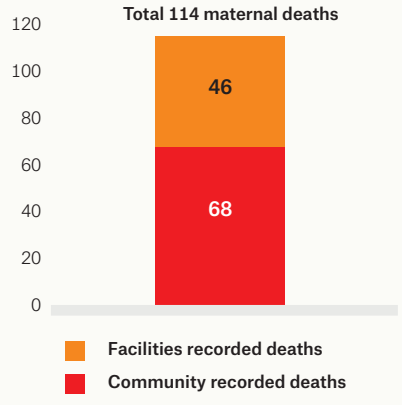
Maternal and neonatal deaths are on the rise

The maternal and neonatal health situation in South Darfur is amongst the most acute crises MSF is witnessing globally as a medical organisation – as maternal mortality numbers skyrocket against the backdrop of ever more stringent conflict-related barriers to access to care. Since MSF returned to Nyala in January 2024, progressively reopening activities in South Darfur, our team has documented a total of **114 maternal deaths** across supported facilities and within the community. The maternity services of Nyala Teaching and Kas Rural hospitals reported a total of 46 maternal deaths, and an additional 68 were reported to MSF teams during an assessment conducted in the IDP community in Nyala in April 2024.[12]

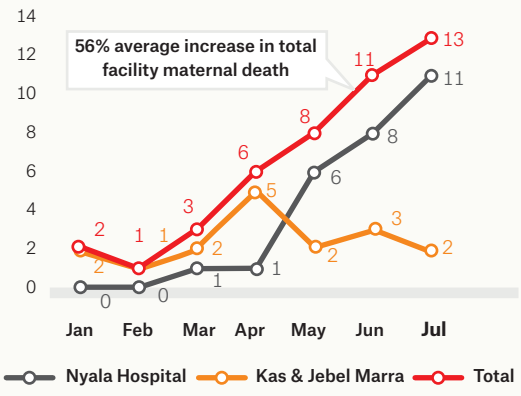
The number of maternal deaths observed in the few facilities and areas where MSF operates in South Darfur are particularly alarming when put into perspective. Over a period of less than eight months, and across two maternity services and an IDP community assessment, the number of reported maternal deaths (n=114) was higher than reported across all Western European countries in a year (n=110; 2020).[13] In MSF-supported facilities alone, women dying from pregnancy and childbirth-related complications (n=46) were near to half the number of maternal deaths reported across all MSF OCA's operations globally in 2023 (n=115).

Maternal deaths trends showed a staggering 56% increase across Nyala and Kas facilities from January to mid-August 2024. The Nyala Teaching Hospital has seen a particularly sharp and steady increase in women dying since March 2024. In July alone, 11 maternal deaths were reported out of 348 deliveries assisted, equating to a case facility rate (CFR) of 3.1%. Put differently, this means that **1 out of 30 women admitted to the Nyala Hospital maternity service died from pregnancy or childbirth-related complications** in July 2024. More women have died in this single maternity ward in a month than the average number of maternal deaths in the Netherlands on a yearly basis.[14]

Total maternal deaths reported in MSF-supported facilities and in Nyala IDP community, Jan-Jul 2024



Evolution in recorded maternal death in MSF-supported facilities, South Darfur, Jan-Jul 2024



12 MSF assessment in the IPD communities of Nyala conducted on the 24th and 25th of April 2025, with a recall period spanning January 2024 to the date of the assessment.

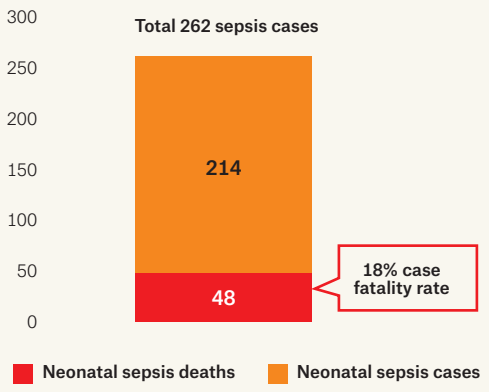
13 WHO report, Trend in Maternal Mortality 2000-2020, February 2023, page 32.

14 World Bank, Gender Data Portal, Netherlands. The average number of maternal death in the Netherlands per year in lower than 10 cases, for a population of 17.7 million people.

"I am in my 30s and gave birth three times. Each time my babies died. I gave birth at home and I experienced a urinary fistula. My mother had to sell her house for me to get care. We arrived at Al Wahda hospital late for my treatment because of the muddy roads here. I was lucky. A lot of pregnant women die before they reach the hospital. They are too late."

Female patient, South Darfur, August 2024

Total neonatal sepsis cases and deaths reported in MSF-supported facilities, Jan-Jul 2024



High mortality rates impact more than just mothers. Complications and mortality amongst neonates in both Nyala and Kas facilities are similarly alarming, with **262 cases of neonatal sepsis** during the first semester of 2024. Underlying causes include unsanitary cord care, as well as infections transmitted to the neonate as the result of deliveries conducted in supply and staff constrained settings and less than optimal sanitary conditions. The case fatality rate for neonatal sepsis[15] – which is treatable with adequate care – was 18% across both facilities, with 48 reported neonatal deaths from sepsis. That is close to **1 out of 5 neonates admitted for sepsis dying** from preventable complications when treated effectively and timely.

With MSF responding to only a fraction of the maternal and neonatal needs across the state, the true scale of the health crisis remains challenging to determine, and mortality is suspected to be much higher in areas where care remains out of reach for vulnerable and isolated communities.

Mothers and neonates are dying from preventable and treatable complications

The most prevalent causes of maternal death reported in South Darfur are preventable with timely access to skilled care including skilled birth attendants, recognition of complications and referral to emergency obstetric care, essential medications, and a clean delivery environment. The scale of women dying from infections and antenatal care health complications speaks to the critical lack of primary health services, medical supplies, and a severely constrained access environment.

Sepsis represented almost a third of maternal deaths reported. The high level of infections speak to women delivering in unsanitary environments, where basic items such as soap, clean delivery mats, and sterilised instrument are not available to community midwives. High Sepsis levels are also due to lack of access and timely treatment with antibiotics to treat infections and reflective of low access to perinatal care.

Unsafe induced abortions were also reported to cause maternal deaths, often due to the resulting infections. Of all cases of maternal deaths caused by sepsis in MSF-supported facilities, at least four were due to unsafe induced abortions. The number of maternal deaths from unsafe abortion are likely widely underreported due to stigma.

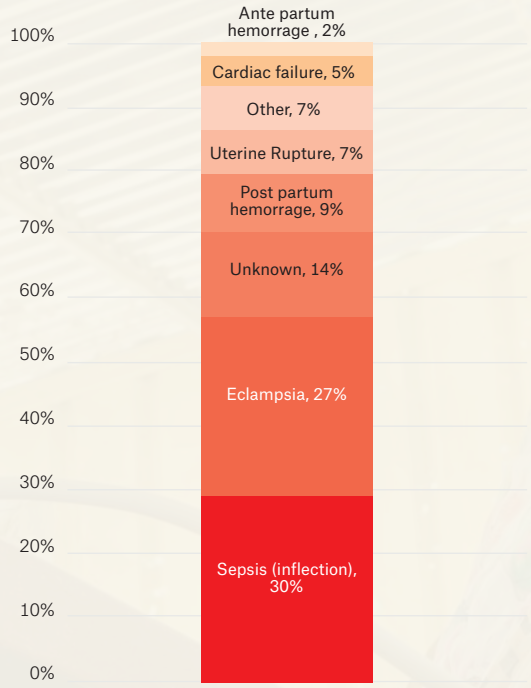
Eclampsia caused over a fourth of maternal deaths. High blood pressure in pregnancy can lead to seizures at the end of the pregnancy or during the post-partum and can be prevented with basic ante-natal care (ANC) and post-natal care (PNC). The compounding effect of limited ANC and PNC service provision, with constraints in accessing emergency services following the first convulsions leads to high and preventable eclampsia-driven maternal mortality rates.

Post-partum hemorrhage, the leading cause of maternal mortality globally, is particularly low in hospitals, as women are dying beforehand. With dysfunctional or inexistent referral systems, the number of post-partum hemorrhages reported are particularly low in proportion to other complications observed in the facilities. This likely indicates that women are dying before they reach the hospital due to delays and access constraints, and therefore not seen and reported in admissions.

15 MSF medical data, South Darfur. True numbers are likely higher due to gaps in data collection.

The rate at which women and children are dying from pregnancy and childbirth-related complications is exacerbated by conflict drivers – affecting services and supplies, increasing access challenges and barriers to care.

Cause of maternal deaths in MSF-supported facilities, %, Jan-Aug 2024



"I've observed unusual cases become very common since the war started: cases of babies who do not take mother's breast during the first hour of delivery, or babies who do not cry, or who have problem of oxygen, and cases of mothers who do not have milk."

Sudanese midwife, South Darfur, August 2024

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Violence, displacement, and obstruction of humanitarian aid are exacerbating the crisis

As in most conflicts, women and children are disproportionately affected – in particular in situations of mass displacement and preexisting fragile health systems. MSF teams engaging with pregnant women and mothers in the communities reported several underlying drivers to the crisis[16], including:

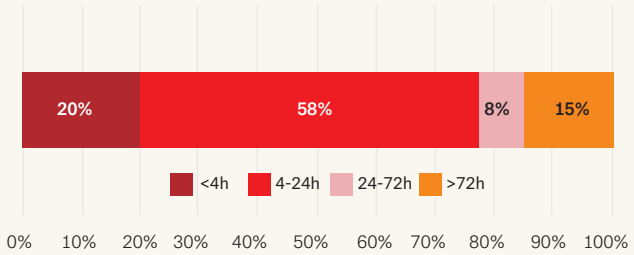
Malfunctioning maternal health structures: The conflict has led to the collapse of most of the health infrastructure and service provision, including some of the main hospitals and clinics of South Darfur. The new public Nyala Hospital for Women and Obstetrics, for example, was planned to open at the end of 2022[17], but was looted and vandalised during the first months of the conflict. It never opened its door to patients. Referral systems are lacking or dysfunctional and supplies scarce, impacting women's access to care in the facilities that remain open and operational.

Displacement: Fighting and insecurity in the Greater Darfur region has forced pregnant women to flee and seek refuge in overcrowded and under-resourced camps, where access to quality maternal healthcare is inexistent or severely limited. IDP camps in South Darfur have critical gaps in water, sanitation and hygiene (WASH) services, shelter, or non-food items, insufficient or non-existent transportation and referral options, forcing women to deliver in unsanitary environments, in turn increasing the risk of post-partum infections.

Sexual violence and lack of safe abortion care: MSF teams are seeing maternal deaths related to conflict-related sexual violence. The absence of commensurate care and protection services to respond to pervasive SGBV in Sudan is exacerbating the crisis.[18] With cases of rape resulting in unwanted pregnancies, women and girls have no alternative but to engage in unsafe abortion methods, potentially leading to life-threatening infections, internal organ injury and haemorrhage. Unsafe abortions are likely a leading cause of maternal death in South Darfur and remain critically underreported.

Access constraints[19]: MSF-supported facilities are reporting high numbers of late presentations amongst patients seeking emergency obstetric care. Women and girls present having developed critical complications, increasing their risk of death or severe and life-changing injury. Amongst maternal deaths reported in Nyala and Kas hospitals, **78% of women died in the first 24 hours following admission**.

Share of maternal death numbers, per time between presentation to the facility and death

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16 Focus groups conducted by MSF teams in South Darfur, over June and July 2024.

17 Sagia Press, 2022. Looting of the hospital and damage to the building were reported by MSF teams in South Darfur

18 MSF report, "A War on People: The Human Cost of Conflict and Violence in Sudan", July 2024

19 Insights collected from a testimony of MSF's sexual and reproductive health implementer, following her return from South Darfur, August 2024.


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"We had a pregnant patient from a rural area that waited 2 days to collect the money needed to get care. When she traveled to a healthcare centre, they had no drugs so she went back home. After 3 days, her condition deteriorated but again she had to wait 5 hours for transportation. She was already in coma when she reached us. She died from a preventable infection."

MSF Medical Team Leader, South Darfur, August 2024

Late presentations are often linked to access constraints, with patients reporting financial obstacles, availability of transportation, and insecurity as the main drivers delaying arrival to facilities. These underlying causes are closely intertwined, and include:

- **Costs of maternal care and births**: The MSF-supported Nyala Hospital is one of the few facilities providing maternal services free of charge across South Darfur. Adequate prenatal, perinatal and postnatal care comes with a substantial financial burden ranging from SDG 50,000 to 150,000 [USD 27 – 80][20] for facility-based deliveries. Many women are opting for home births, driven by financial and access constraints, and remain isolated from emergency obstetrics and neonatal care services even if they experience complications. Additionally, hospitals trying to get up and running, such as Al Wahda, rely on cost-recovery from patients and their families to pay staff and provide services and struggle to scale up services without more sustainable financial support.
- **Cost and availability of transportation:** Travel costs to access facilities are another barrier. A trip from Kalma IDP camp to Nyala Teaching Hospital, for instance, costs SDG 8,000 (approximately USD 5), which is unaffordable for women battling with other survival priorities such as nutrition. This results in limited antenatal health-seeking behaviour and increases the risk of pregnancy complications. Women often resort to survival coping mechanisms to collect transportation money, by selling food, furniture, or relying on the community. In case of emergency, this leads to delays in accessing care, and late presentations to the maternity, which are directly correlated to increased maternal deaths. Nighttime transportation is reportedly not available in the IDP sites – making it almost impossible for women to reach a facility for safe delivery care and in case of a complication.
- **Insecurity and violence:** In focus groups, women reported limiting their movements, including for health reasons, during the farming months. Women often describe the period as the "sexual violence season", during which they are more exposed and vulnerable to sexual assault and rape as they travel to farmlands.

Critical shortages in medical supplies. Medical supply shortages remain a major challenge across Darfur. The frequency and quantity of supply to health programmes is insufficient to cover the needs, resulting in national and international non-governmental organisations (NGOs) often forced to operate with limited stocks of drugs and medical items. Supplies such as oxytocin or misoprostol, which are essential to stop post-partum haemorrhage, are lacking. Antibiotics shortages are also affecting the timely treatment of infections. In the community, essential clean delivery items and kits are not available to community midwives, increasing the risk of infection and maternal and neonatal sepsis in childbirth.

Deterioration in women's malnutrition rates. High rates of malnutrition and food insecurity among pregnant and breastfeeding women and girls drive higher rates of anaemia, which increases their risk of death from haemorrhage.[21]

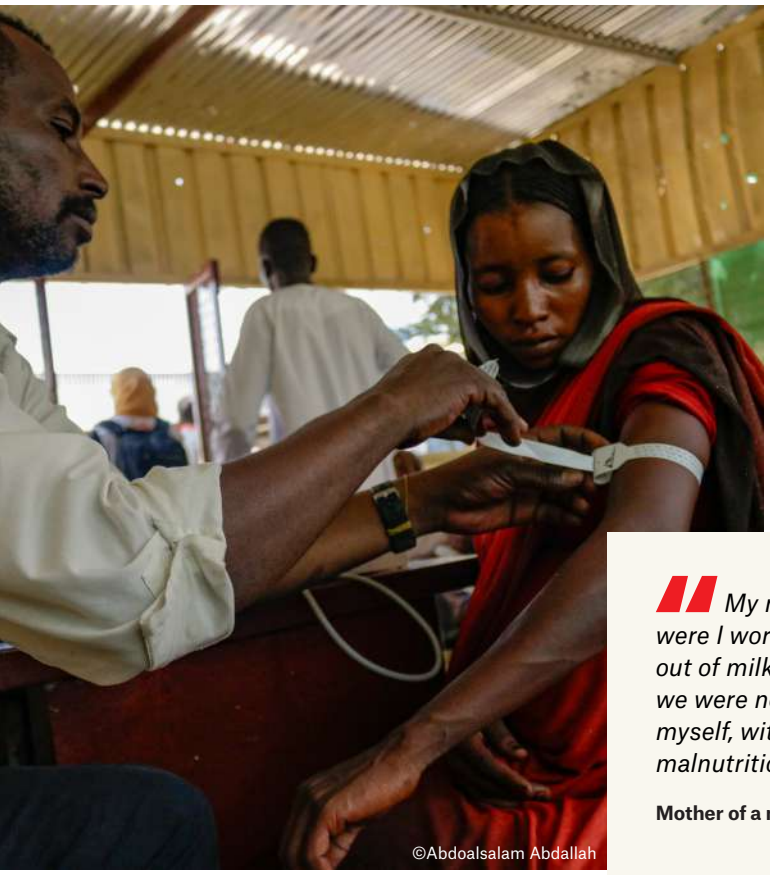
Conflict and its effect are undoubtedly fuelling the maternal health crisis in South Darfur – which in turn is exacerbating child health and malnutrition.

20 Focus group discussion, South Darfur, July 2024

21 Lancet Global Health. "Maternal anaemia and the risk of postpartum haemorrhage: a cohort analysis of data from the WOMAN-2 trial", August 2023

Children at risk of starvation: The effects of the conflict and maternal health crisis on malnutrition

MSF teams are witnessing alarming child malnutrition rates in South Darfur, comparable to those already reported by our teams in Zamzam camp in North Darfur.[22] While the full extent of the crisis remains hidden, thousands of children are on the brink of starvation in Nyala localities alone. Child hunger closely follows maternal health – both compounded by conflict dynamics. Maternal and child health and nutrition must be jointly addressed to avoid deepening longer-term cycles of hunger, sickness and preventable suffering.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Child malnutrition rates have crossed all emergency thresholds[23]

In August 2024, MSF, in collaboration with the Ministry of Health and UNICEF, carried out a catch-up immunisation campaign in the localities of Nyala North, Nyala South and Shattaya. A concurrent **MUAC malnutrition screening of over 29,550 children** aged 6-23 months was conducted in primary health care centres and outreach sites as a follow-up to a previous survey in April 2024.[24] Although the results cannot be generalised to the broader paediatric population,[25] concerning levels of malnutrition were confirmed: **9,601 children – 32.5% of all children screened – were found to be suffering from acute malnutrition** (GAM)**.** Of these, **2,395 children – 8.1% of children screened – had severe acute malnutrition (SAM)**. In Shattaya, SAM rates were over 10%.

The global acute malnutrition prevalence amongst children screened (32.5%) was twice above the World Health Organization's (WHO) >15% emergency threshold for GAM.

> *"My mother or sister have to bring my child to the market were I work so I can breastfeed him. But I started running out of milk because I don't eat well. My baby got a fever, but we were not able to pay for medication. Without food for myself, without medicine for him, my child developed severe malnutrition."*
>
> **Mother of a malnourished patient, South Darfur facility, August 2024**

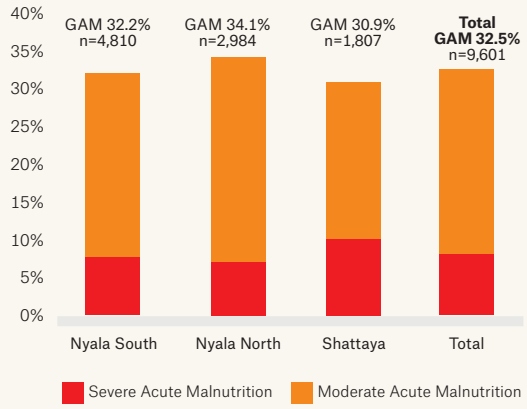
22 MSF Press release, 13 September 2024. Results from a screening in September in Zamzam camp, North Darfur, showed 34% GAM prevalence including 10% SAM among the children under five years of age screened as part of an immunisation campaign.

23 MSF epidemiological report, "Mass mid-upper arm circumference screening in Nyala, South Darfur, Sudan, August 2024

24 Relief Web, 'South Darfur starts vaccination campaign in one third of the state', April 2024.

25 Results might be affected by selection biases. Children underwent MUAC screening only if they presented for vaccination and were assessed as requiring catch-up vaccination. They are therefore not a representative sample of children in Nyala. While the effect of this bias is somewhat mitigated by the total collapse of routine immunisation across the state, age-eligible children with better or earlier access to healthcare may be more likely to have been vaccinated in the first catch-up vaccination activity in April before supplies were exhausted.

Mass screening mid-upper arm circumference (MUAC) of children aged 6-23 months, in Nyala North, Nyala South, and Shattaya localities, conducted August 2024



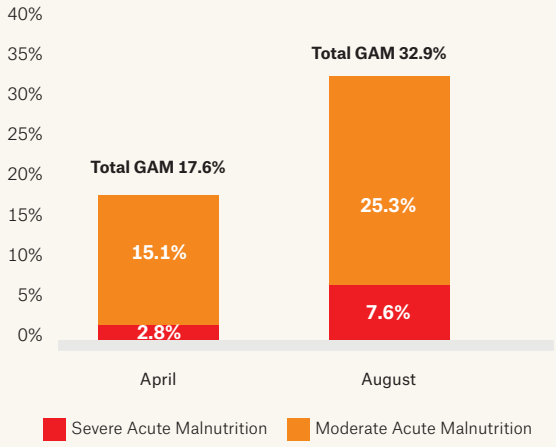
Out of **29,559 children aged 6-23 months** screened:

9,601 were acutely malnourished

of which

2,395 were severely acutely malnourished

Mass screening mid-upper arm circumference (MUAC) of children aged 6-23 months, in Nyala North and South localities, conducted in April and August 2024

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Aside from the acute malnutrition absolute number resulting from the screening, the results likely indicate a rapid deterioration in malnutrition levels since a similar assessment was conducted by MSF in April 2024. In Nyala South and Nyala North GAM prevalence was 17.6% in April vs. 32.9% in August, with SAM rates 2.8% vs. 7.6% respectively over the same period.

The MSF figures can only paint a partial picture of the crisis. The 9,600 acutely malnourished children identified through the MSF screening are at risk of health complications, or of deteriorating into more severe forms of malnutrition if not treated effectively and immediately. Severe acute malnutrition is a strong predictor of mortality, with the risk of death nine times higher among children with SAM compared to their well-nourished counterparts.[26] In Nyala alone, **at least 2,395 children under two years of age are therefore at the brink of starvation and death** without an adequate intervention.

26 Olofin I, McDonald CM, Ezzati M, Flaxman S, Black RE, Fawzi WW, Caulfield LE, Danaei G; Nutrition Impact Model Study (anthropometry cohort pooling). Associations of suboptimal growth with all-cause and cause-specific mortality in children under five years: a pooled analysis of ten prospective studies.

Conflict, maternal health and nutrition: inextricable determinants of long-term health and hunger crises

Malnutrition rates among young children are directly related to the maternal health crisis, and to the impact of conflict on access to obstetric care and nutritious food in a region already prone to high malnutrition prevalence.[27]

The conflict has exacerbated pre-existing vulnerabilities in the health system, with warring parties restricting and diverting the supply of lifesaving humanitarian aid.

In South Darfur for example, there had been no vaccines distributed in 2023 until MSF supported the transportation, cold chain and distribution of UNICEF supplies to Nyala in March 2024.[28] Nutrition programmes are running low on ready-to-use therapeutic food (RUTF) and therapeutic milk for their cohorts of children with severe acute malnutrition, causing local partners to struggle to maintain activities. At the beginning of September 2024, MSF teams in Nyala reported critical shortages of therapeutic milk – with complete stock-outs in F75 and F100.[29] Drip-fed nutrition supplies arrive to South Darfur only to be instantly absorbed, barely making a dent into the required humanitarian response.

The crisis has been further compounded by torrential rains, flooded crossing points and critical roads and bridges being washed away. The collapse of the Mornei bridge in West Darfur – bridging the only route connecting Central and South Darfur with Chad – left millions of people unable to receive supplies arriving from the Adré border crossing.

Across the country, 1.2 million pregnant and breastfeeding women and girls (PBWG) are projected to suffer from acute malnutrition this year.[30] In the MSF survey conducted over February and March 2024, **12.5% of PBWGs showed acute signs of malnutrition**.[31] This can lead to intra-uterine growth restrictions, premature deliveries, low birth weight, or lack of breastfeeding. This increases risks of acute and chronic malnutrition among children, making them more vulnerable to disease and infections, such as cholera, pneumonia, and malaria – illnesses that weaken the immune system and in turn contribute to, or exacerbate, malnutrition.


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27 Abu-Fatima O, Abbas AAG, Racalbuto V, Smith L, Pizzol D. Child Undernutrition in Sudan: The Social and Economic Impact and Future Perspectives. Am J Trop Med Hyg. 2020 Dec 21

28 MSF OCA internal briefing note, May 2024

29 MSF internal situation report, August 2024.

30 UNFPA Sudan, "One Year of War in Sudan", April 2024

31 MSF OCA internal nutrition survey, April 2024. Amongst pregnant and lactating women, the overall unweighted acute malnutrition prevalence was 12.5% (95% CI: 7.8 – 19.5). The acute malnutrition prevalence was 17.0% (95% CI: 8.6– 31.0) in Beliel IDP camp, 5.1% (95% CI: 1.2 – 19.1) in Otash IDP camp, 11.1% (95% CI: 2.5 – 38.3) in north Nyala, and 16.7%, (95% CI: 6.0 – 38.6) in south Nyala. A total of 157 PLW were screened, out of a 1,498 females aged 15 to 49 years surveyed.

> *"The mother of the twins died from severe bleeding, leaving behind 8 other children. My husband and I try to take care of them. Their father is away with the war, and we don't earn enough to feed them milk, so they got malnourished. Now we're 13 in the house with the adopted kids. We're struggling, eating porridge and sauce with a bit of salt, little or no oil, and green leaves."*
>
> **Caretaker, South Darfur facility, August 2024**


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The public health significance of Sudan's conflict-driven maternal and child health crisis extends beyond immediate health risks. Maternal death is also a strong predictor of child malnutrition and overall poor child health. Studies show that **surviving children under six months had a 35 times higher risk of dying**[32] compared to children whose mother survived. Sick and dying mothers often leave pre-existing children at higher risk of being unvaccinated, malnourished, unschooled or facing protection risks such as child labour, marriage or exploitation. This also adds burden on replacement caregivers, increasing the mouths to feed, and impacting other children and members of the household.

Increased mortality and malnutrition among pregnant and breastfeeding women and their children affects long-term developmental, including stunted growth, cognitive impairments, and diminished educational and economic potential.[33] Maternal and child health crises have far-reaching societal repercussions, trapping women, children and their families into cycle of protracted hunger, poverty, poor health, and suffering spanning generations.

32 Nguyen, D.T.N., Hughes, S., Egger, S. et al. Risk of childhood mortality associated with death of a mother in low-and-middle-income countries: a systematic review and meta-analysis. BMC Public Health 19, 1281 (2019).

33 Black, Robert E et al. Maternal and child undernutrition and overweight in low-income and middle-income countries. The Lancet, Volume 382, Issue 9890, 427 - 451

MSF calls for action

The maternal and child health situation in South Darfur is alarming yet widely neglected, demanding a coordinated and adequate response from all relevant stakeholders. To alleviate further suffering and save lives at risk, MSF is calling:

Parties to the conflict to:

- Cease violence against civilian populations, particularly violence impacting women and children
- Urgently facilitate unimpeded access of humanitarian and medical supplies and personnel to Darfur, through all possible routes, including cross border and cross line routes
- Cease the obstruction, diversion, retention, or blockage of humanitarian trucks and supplies

Ministry of Health to:

- Urgently restore emergency referrals and ambulances services to functioning health services
- Facilitate community-based sexual and reproductive health programs and outreach, and work with all humanitarian organizations in scaling up interventions to reduce maternal and neonatal mortality
- Collaborate with WHO to open Nyala's Maternity and Women Obstetrics Hospital and support other maternity and sexual and reproductive health services
- Work with international and national partners to alleviate the malnutrition crisis, increasing emergency stabilisation nutrition programmes and inpatient therapeutic feeding capacity
- Ensure financial access barriers to care are reduced, and affordable or free access to emergency maternal and neonatal care in some facilities in South Darfur
- Consider establishing a women's and maternal health working group, to improve coordinated interventions between national and international organisations

Humanitarian actors:

- Increase and strengthen support to basic and comprehensive obstetric and neonatal care, including obstetric surgery
- Design integrated maternal and women-sensitive approaches to nutrition, WASH and maternal healthcare
- Deploy emergency teams to address the nutrition crisis, focusing initially on Nyala and IDP sites
- Urgently scale up sexual and gender-based violence care and protection interventions, prioritising multi-purpose cash assistance, mental health and psychosocial support, and employment programmes for women

International donors and diplomatic community to:

- Increase emergency funding to maternal health, nutrition programs, and gender-sensitive protection and water, sanitation and hygiene activities
- Translate into action commitments to localise the response through flexible funding to a plurality of humanitarian actors able to quickly support health structures
- Accept and manage the degree of risk that enables the humanitarian response to scale up, and that accounts for the scale of the crisis
- Allocate funding to the rehabilitation of critical access infrastructure, including water systems, roads and bridges – with the Mornei Bridge in West Darfur as the immediate priority

UN Country leadership:

- Prioritise maternal health and child nutrition in the upcoming humanitarian response plan and ongoing activities
- Accelerate the return of UN staff and agencies to Darfur and the establishment of the hubs and spokes approach; fill the space that exists with dedicated expert capacity directly managing the humanitarian response, not only remotely
- Encourage agencies to proactively engage, seek and support local partners, including less formalised mutual aid groups, to add capacity to scale-up efforts; find proactive ways of making more of the pooled country fund reach smaller NGOs and other community-based organisations on the ground
- Consider accelerating high level visits of senior UN staff to Darfur and raising the visibility of the maternal health crisis

UNFPA to:

- Urgently scale up supply of obstetrics medical items, including oxytocin, misoprostol, and clean delivery kits, other emergency medicines on the Minimum Initial Service Package (MISP), as well as antibiotics, magnesium and family planning commodities; improve last-mile distribution networks.
- Increase cooperation with the MoH for training and supplying community midwifes, and increasing community outreach and health promotion programmes
- Re-establish presence of international teams and staff in Nyala to coordinate the maternal health emergency response, shifting from remote to direct management

UNICEF to:

- Urgently scale up nutrition programs and increase supplies of RUTF and therapeutic milk
- Find creative ways to ensure supplies reach areas in Darfur where routes remain affected by flooding or infrastructural damage (e.g. Mornei bridge), by using boats for example
- Scale up gender-sensitive WASH programming, initially prioritising Nyala IDP sites
- Re-establish presence of emergency response teams and senior staff in Nyala to coordinate the nutrition emergency response, shifting from remote to direct management

WFP to:

- Assess the damage to the Mornei bridge and rehabilitate access. In the meantime, consider creative alternatives to transport supplies to isolated areas of Darfur
- Scale up the pace and rations of food distribution, and increase cash-for-food interventions
- Re-establish presence of emergency response teams and senior staff in Nyala to coordinate the nutrition emergency response, shifting from remote to direct management

WHO, in coordination with relevant agencies such as UNOPS and UNDP to:

- Provide immediate financial, logistical and coordination support to the Ministry of Health to rehabilitate and open the Nyala Hospital for Women and Obstetrics
- Provide support, including financial incentives, financing of running costs, and technical trainings to Ministry of Health maternity units and comprehensive emergency obstetrics and newborn care services in maternity hospitals in Nyala
- Strengthen facility and community based maternal and perinatal death surveillance and response
- Re-establish presence of emergency response teams and senior staff in Nyala to coordinate the health emergency response and shift from remote to direct management

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