MSF
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Left behind in crisis: Escalating violence and healthcare collapse in South Sudan

SOUTH SUDAN © DIEGO MENJIBAR

MEDECINS SANS FRONTIERES

Contents

List of acronyms

BHI	Boma Health Initiative
BPHNS	Basic Package of Health and Nutrition Services
CMR	Clinical management of rape
GF	Global Fund
HNRP	Humanitarian Needs and Response Plan
HPF	Health Pooled Fund
HSTP	Health Sector Transformation Project
IDP	Internally displaced people
IHL	International Humanitarian Law
IOM	International Organization for Migration
ITFC	Inpatient therapeutic feeding centre
ITN	Insecticide-treated bed nets
MoH	Ministry of Health
NGO	Non-governmental organisation
NHP	National Health Policy
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OHCHR	Office of the United Nations High Commissioner for Human Rights
OPD	Outpatient department
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
SGBV	Sexual and gender-based violence
SMC	Seasonal malaria chemoprevention
SPLA/IO	Sudan People's Liberation Army-in-Opposition
SSPDF	South Sudan People's Defence Forces
TB	Tuberculosis
TC	Transit Centre
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, sanitation and hygiene
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

Acknowledgements: MSF wishes to acknowledge all its staff and patients in South Sudan.

In memoriam

This report is dedicated to the memory of the 31 MSF staff killed by violence since 9 July 2011, in South Sudan.

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Introduction

In 2025, South Sudan saw a sharp escalation in political tension, violence and insecurity, worsening an already severe situation marked by extremely limited access to healthcare and services. Clashes between government and opposition forces, and non-state armed groups, particularly in Upper Nile, Jonglei, Unity, Central Equatoria and Warrap states, involved clashes, airstrikes and attacks on civilians on a scale not seen since the revitalised peace agreement was signed in 2018. This comes at a time when international interest and support are already declining.

MSF has been working in what is now South Sudan since 1983, and the country remains one of the organisation's largest operations. Present across six states and two administrative areas, MSF fills critical gaps in healthcare services. In 2024, teams treated over 800,000 people in outpatient consultations and 84,800 patients who needed hospitalisation.

Health services in South Sudan are stretched to breaking point. In all the locations in which MSF works, teams are confronted with the devastating impact on communities of a chronically underfunded health system. Many primary care facilities are non-functional with frequent stockouts of essential drugs, including malaria treatment, and chronic delays in staff payments. Hospitals are neglected, and patients needing life-saving surgery or emergency maternal care have few options. Although gaps in healthcare pre-date the extensive 2025 funding cuts, reduced support has compounded and exposed deep-rooted structural failures, and is likely to exacerbate this trend.

Conflict is driving further gaps in health delivery. Challenges in delivering healthcare are even more acute in conflict-affected regions, especially those outside of government control. Many health facilities have closed, staff have fled, and insecurity and access challenges restrict delivery of supplies to the few remaining facilities. More agile humanitarian support is imperative to ensure access to healthcare in these communities.

Targeted attacks on health facilities and staff are increasing. There has been an extremely concerning increase in attacks on civilians and health facilities by all parties to the conflict, particularly in the Equatorias and Upper Nile. In 2025, MSF alone experienced eight targeted attacks on its staff and facilities, forcing the closure of two hospitals in Greater Upper Nile and the suspension of primary care activities in Jonglei, Upper Nile and Central Equatoria.

Large parts of the country are experiencing overlapping crises. Conflict, large-scale displacement, flooding and disease outbreaks all contribute to further straining already stretched services. In 2025, in addition to regular

projects, MSF opened 12 emergency projects in response to cholera, malaria peaks, flooding and displacement because of violence, compared with five in 2024. These emergencies are interconnected, driven and exacerbated by longstanding gaps in basic services, including health and water, sanitation and hygiene (WASH) services.

This report documents persistent and worsening barriers to healthcare at a time of deteriorating humanitarian conditions in South Sudan. Drawing on testimonies from MSF patients, caretakers and staff in areas where the organisation operates, and case studies on malaria, cholera and the Sudan crisis, the report challenges the growing normalisation of crises affecting women, men, boys and girls in South Sudan.

Photo: **Children and caretakers at the pediatric inpatient ward, Old Fangak.**
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REPORT METHODOLOGY

This report provides a snapshot of key medical and humanitarian concerns in South Sudan in 2024 and 2025. The report is informed by MSF routine medical data and interviews with 26 community members, patients, caretakers and staff (primarily South Sudanese), conducted across MSF projects between September and November 2025.[1] The design of some medical operations has changed during this period, while other projects have been forced by conflict and insecurity to close. Community member interviews were conducted with interpreters; staff interviews were in English. All quoted individuals consented to having their testimonies included.[2]

Given South Sudan's rapidly changing and volatile environment, some contextual factors may have shifted since data collection and writing.

A SHIFTING CONTEXT IN 2025: MEDICAL AND HUMANITARIAN CONSEQUENCES

The escalating violence in 2025 followed mounting tensions in 2024 linked to the long-running power struggle between President Salva Kiir and First Vice-President Riek Machar.[3] Increased tensions and clashes between the government-led South Sudan People's Defence Forces (SSPDF) and the Sudan People's Liberation Army-in-Opposition (SPLA/IO), and non-state armed groups erupted across Upper Nile, Jonglei, Unity, Central Equatoria and Warrap states. By November 2025 an estimated 320,000 people had been newly displaced within South Sudan,[4] adding to the 2.2 million internally displaced people (IDPs) already living in formal and informal displacement sites since previous years of civil war.[5]

MSF teams have treated hundreds of people wounded by violence in 2025, including women and children. An estimated 190,000 people have also fled South Sudan for neighbouring countries, including Ethiopia, Uganda, the Democratic Republic of Congo and Sudan,[6] while over one million have been displaced into South Sudan by the ongoing war in Sudan.[7]

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1 Coincidentally, all caretakers and patients interviewed were female and all medical staff were male. This reflects wider trends in who accesses services and current medical staff profiles in South Sudan.

2 Interpreters worked hard to capture participants' comments, but a direct translation was not always possible. Quotes presented throughout this report have been changed for clarity only, or to protect participants' anonymity.

3 Rivalry between South Sudan's two main leaders plunged the country into civil war in 2013, and there have been ongoing outbreaks of violence between forces loyal to each ever since. Machar and Kiir both seek to stoke dissent and exploit ethnic identity as part of their rivalry.

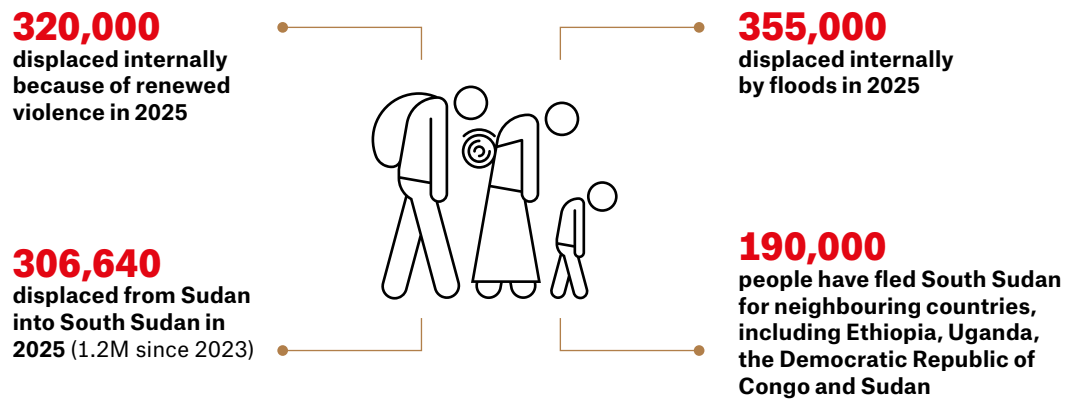
4 United Nations Office for the Coordination of Humanitarian Affairs (OCHA) (14 October 2025), South Sudan: Humanitarian Snapshot (September 2025).

5 OCHA (November 2023), South Sudan: Humanitarian Needs and Response Plan 2024.

6 UNHCR (11 November 2025), South Sudan Situation: Core 02 Nov 2025.

7 UNHCR, Sudan Situation [Accessed 13 November 2025].

Figure 1
Internal and cross-border displacement in 2025



Displacement figures as of October 2025.

The war in Sudan, now entering its third year, continues to strain South Sudan's fragile health system. Main areas of entry and transit, including Renk and Malakal in Upper Nile State, are severely overcrowded with people living in dire conditions and lacking adequate food, clean water and shelter. A cholera outbreak that started in Sudan in August 2024 rapidly spread across the border, exposing alarming gaps in WASH infrastructure and healthcare in South Sudan. By October 2025, the outbreak in South Sudan had claimed over 1,500 lives.[8]

The worsening situation in South Sudan follows years of conflict, declining international interest and chronic underfunding for both health and humanitarian responses; major UK Aid cuts in 2022 left around 200 facilities,[9] including eight major hospitals, unsupported, and severe funding cuts in 2025 compounded this.

In early 2025, the United States of America — which funded 55 per cent of South Sudan's 2024 humanitarian appeal — announced a suspension and subsequent termination of many humanitarian contracts. Subsequent donor reductions changed the global funding landscape for 2025 and beyond. The resulting drastic 'reprioritisation' of the Humanitarian Needs and Response Plan (HNRP) reduced the number of people targeted for assistance from 5.4 to 2.9 million,[10] despite an estimated 9.3 million people — 70 per cent of the population — being in need.

8 WHO (31 October 2025), Weekly Situation Update on Ongoing Health Emergency Events in South Sudan.

9 This was due to significant reductions in healthcare financing for the multi-donor Health Pooled Fund (HPF).

10 OCHA (15 April 2025), Re-prioritized Humanitarian Needs and Response Plan (HNRP).

Climate-related hazards have deepened existing health barriers and inequities. By the end of October, severe flooding across Jonglei, Unity and Upper Nile states had displaced around 355,000 people[11] and impacted an estimated 144 health facilities, destroying livelihoods, increasing the risk of water-borne diseases and compounding barriers to healthcare.

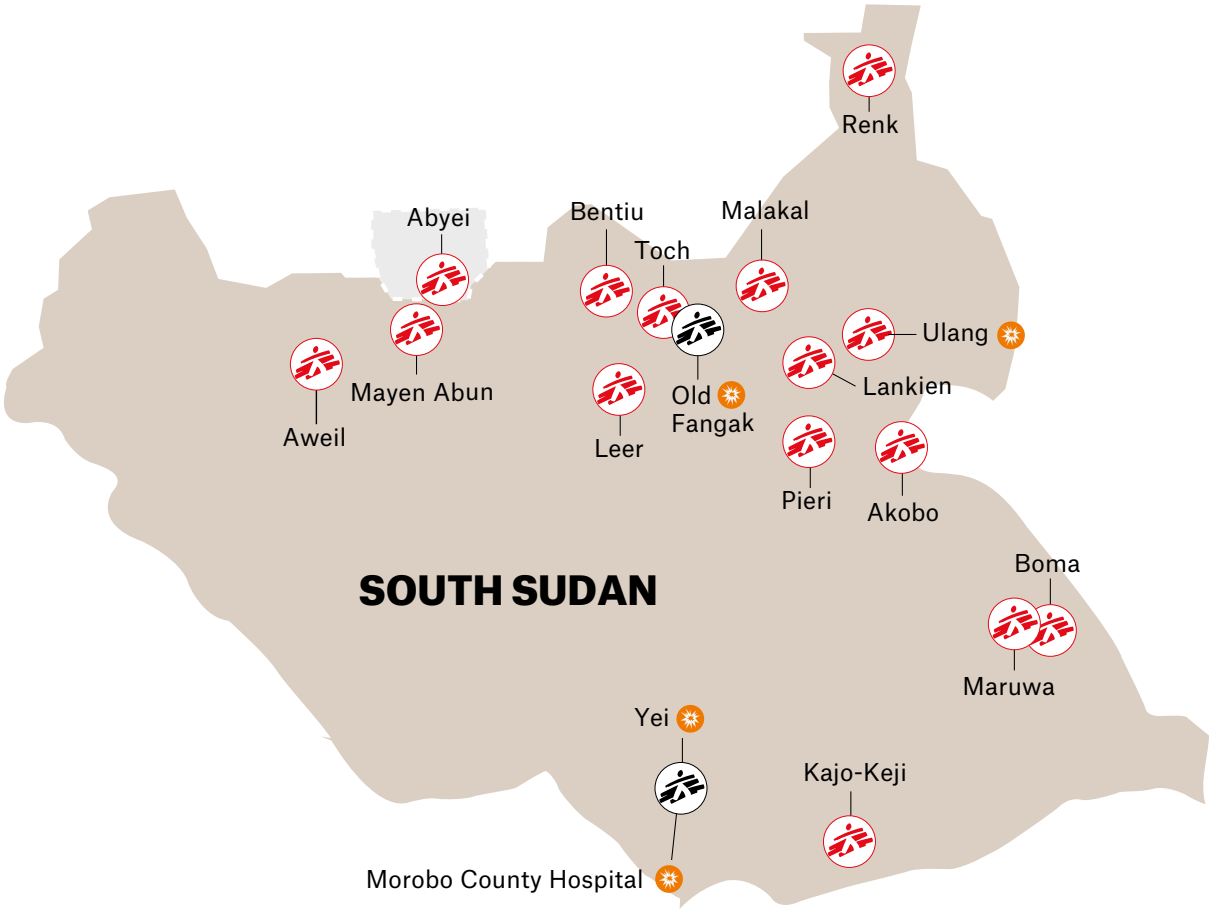
MSF activities in South Sudan

MSF runs standalone health services, supports existing Ministry of Health (MoH) facilities and opens emergency health responses across the country as needs arise.

11 Facilities impacted sourced from the WHO Weekly Situation Update on Ongoing Health Emergency Events in South Sudan, 31 October 2025. Numbers displaced by flooding sourced from: OCHA (31 October 2025), South Sudan: Flooding Situation Flash Update No. 9

Photo: **The MSF integrated community case management team in Abyei.**
© SEAN SUTTON / PANOS PICTURES

Figure 2
MSF regular projects in 2025

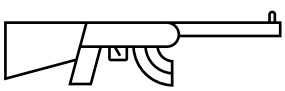


Locations with ongoing MSF medical activities, as of November 2025

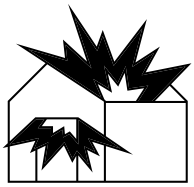
MSF projects that have been closed or suspended due to violence and conflict in 2025

Attacks on MSF staff and or facilities in 2025

The maps and place names used do not reflect any position by MSF on their legal status



Targeted attacks on staff and facilities in 2025:
Old Fangak Hospital (bombed), **Ulang Hospital** (looted), **2 MSF boats** returning to Ulang from Nasir Hospital (attacked), **Morobo County Hospital** (attacked), **Yei** (3 kidnappings).



Clashes between government and opposition forces, and non-state armed groups, particularly in Upper Nile, Jonglei, Unity, Central Equatoria and Warrap states, **involved clashes, airstrikes and attacks on civilians** on a scale not seen since the revitalised peace agreement was signed in 2018.

Health services stretched to breaking point

South Sudan's healthcare system is dangerously fragile. Over 80 per cent of services are provided by non-governmental organisations (NGOs), and just 1.3 per cent of the national budget is allocated to health — far below the 15 per cent target pledged by African Union countries in 2001. When facilities lose international support, they quickly become non-functional.[12]

Healthcare delivery is structured into community, primary, secondary and tertiary levels of care, although tertiary services are essentially non-existent.[13] The government's National Health Policy (NHP) 2016-2026 and Health Sector Strategic Plan 2023-2027 provide the overall vision for the health sector, including delivery of a Basic Package of Health and Nutrition Services (BPHNS). Chronic underinvestment and neglect, however, plus fragmentation among the MoH, NGOs, and multiple other donors (including the Global Fund (GF), providing disease-specific funding for HIV/AIDS, tuberculosis (TB) and malaria, and Gavi, the Vaccine Alliance, which supports the MoH and other partners to provide and deliver vaccines) have left huge gaps, and universal health coverage targets are far from being achieved. Many of the country's 1,395 health facilities are non-functional due to violence, floods, and lack of staff or drugs and supplies and fail to deliver effective or consistent care.[14]

The Health Sector Transformation Project (HSTP), a multi-donor-funded (including the World Bank (WB)) project launched in July 2024 to support basic health and nutrition services and emergency preparedness, is South Sudan's principal mechanism for (mainly primary) healthcare delivery. Led by the government and implemented in collaboration with the World Health Organization (WHO), United Nations Children's Fund (UNICEF) and implementing partners, it planned to support 1,158 facilities across 10 states and three administrative areas over three years, but, due to funding constraints, will support only 816 facilities until 2027.

12 WHO (2024), Health Pooled Fund Phase 3: Final Assessment.

13 At the community level, in 2017, the government launched the Boma Health Initiative (BHI) — a nationwide strategy to improve access to essential health services at village (or 'boma') level. Meanwhile, tertiary care is the most specialised level of care, including referral and teaching hospitals, yet is extremely limited in South Sudan. MSF projects support the BHI, primary care facilities and hospitals. This report focuses on primary and secondary care, including state, county and teaching hospitals.

14 The Republic of South Sudan, MoH (February 2025), Health Sector Transformation Project (HSTP) (draft).

The project has faced severe delays in essential medical supply delivery and staff payments since inception, and even if fully implemented would leave significant gaps, particularly in secondary care and specialist services, including trauma care. The transition towards greater domestic health system ownership has lacked the necessary investment and support.

Chronic underinvestment in health and inadequate service provision means South Sudan has some of the worst health indicators globally. Malaria, HIV/AIDS and TB are leading causes of morbidity and mortality. Maternal, neonatal and under-five mortality rates are unacceptably high and well above global targets - women and children continue to die from preventable causes. Food insecurity and malnutrition are widespread, and increases in conflict, cholera, food gaps and the closure of nutrition services in 2025 mean these are expected to reach critical levels, especially in Jonglei, Unity and Upper Nile states.[15]

PRIMARY HEALTHCARE UNDER-RESOURCED AND UNDER PRESSURE

Across all MSF's operational areas, the primary care system is struggling to deliver even basic services. Many primary healthcare facilities, including those at the community level — Primary Health Care Units (PHCUs) - that refer to primary health care centres (PHCCs) for more comprehensive treatment, are closed or lack staff and drugs to deliver consistent and effective care.

Many facilities, including those supported by the HSTP, are non-functional and frequently experience stockouts of malaria drugs, diagnostic tests and essential supplies, compounded by staff shortages and chronic delays in payments of incentives and staff salaries. Essential medicines, including antimalarials and antibiotics, often run out within weeks, despite orders being designed to last four months. Quantities are often not based on existing population estimates and need. The situation in non-HSTP facilities is often far worse, as they receive less support.

> People pretend they are doing something — but anything you do should be seen by the naked eye. People say there are facilities there but in fact you don't see anything. They have a big space, they say: we are operating doing this, we are doing that. Even if you go to their registers, you don't see anything. The funding might be involved, but the management is poor.
>
> *Nurse, MSF staff, Toch PHCC, October 2025*

15 IPC (4 November 2025), South Sudan: Acute Malnutrition Situation for September - November 2025 and Projections for December 2025 - March 2026 and for April - July 2026.

HSTP drug and commodity supplies, for July-October 2025 were only ordered in September 2025, and are not expected to arrive until late 2025 or in 2026. This includes malaria drugs, which will only arrive after the peak malaria season is over. Limited communication around supply issues including with health actors outside of the HSTP, impacted coordination and preparation. Staff working in these health facilities were last paid in June, undermining motivation and quality of care.

> The staff of the [MoH], we are facing a lot of challenges within the work area here in the facility. We are helping 800 or 900 people per week. But at the end of the month, our expected salary is not even equivalent to what we can use to support our families. But we devote ourselves to the community.
>
> *MoH staff incentivised by MSF, Toch PHCC, October 2025*

> The management is poor because of the delay in medication and staff payment. Sometimes the staff, they relax, because this payment is not on time.
>
> *Nurse, MSF contract, Renk County Hospital, September 2025*

> Second is the human resources gap, there are no well-trained staff, who are capacitated and with appropriate supervision to know what the gaps are. Those who are working under the MoH — irregular payments is one of the factors as well that I believe contributes to a decrease in the motivation of the staff working there. They move to other areas to find different services.
>
> *Clinical Officer, MSF contract, Ulang, October 2025*

In Bulukat transit centre, Upper Nile, where MSF ran a mobile clinic for South Sudanese returnees and refugees from Sudan between July 2023 and November 2024, over half of patients seen by MSF in October 2024 were from the host community, as nearby facilities in the area lacked medical supplies and staff incentives were delayed.

The lack of functioning facilities forces people to seek treatment in private clinics and pharmacies — unaffordable for many — or to travel long distances, including to MSF facilities, often at significant cost[16]. In Twic County, some patients walk a full day to reach MSF services; in other hard-to-reach areas affected by floods and violence, people travel several hours, including by boat.

16 MSF (May 2025), Deadly Gaps: Don't turn away from saving lives.

> I came from Aweng to Mayen Abun, it was one day walking alone with my child. It was far, it was raining, and it was a difficult journey. First, I took a ride in motorbike until Turalei, then I walked. But I prefer to endure this journey than to see my child become worse. First, I went to a health facility [PHCU] in Aweil, but they didn't have all the needed medications. I didn't have enough money to purchase them. That's why I had to come to Mayen Abun hospital.
>
> *Female Caretaker (child admitted to inpatient therapeutic feeding centre (ITFC)), Mayen Abun PHCC, September 2025*

> My priority is my children's health. I'm worried MSF will leave someday, because if it wasn't for MSF, my children would not be alive today. In my experience, the MoH is different, services are not the same, we don't always find the services or medications at MoH facilities. They ask us to buy the medications, but we don't always have enough money to buy all medications requested. Sometimes, if I'm sick, I must choose to use the money to buy food for my children and not the drugs for myself.
>
> *Female Caretaker (child admitted to ITFC), Mayen Abun PHCC, September 2025*

> I came here because my child is sick. The child has fever and diarrhoea. I travelled from Keurdeng, it took one hour. There is a small health facility [in Keurdeng], but it does not have all the medication — sometimes they finish supplies very fast. I took the child to the health centre, but there was no medication.
>
> *Female Caretaker (child admitted to inpatient department), Toch PHCC, October 2025*

> People tell us when they need to choose between food and buying medications, they have to choose food. And we hear that a lot from patients who live far and need chronic care, as for HIV and TB. They don't find free medications near home, then they choose to stay near home to find some work and buy food for them and the families. They only come to us in late stages.
>
> *MSF staff, Mayen Abun, September 2025*

In Warrap State, the host community, IDPs from previous conflicts, and people displaced by the war in Sudan all travel long distances to access MSF facilities in Twic County. The number of women seeking antenatal care here increased by 43 per cent (11,596 to 16,550) between 2024 and 2025, largely attributable to gaps in services elsewhere, as well as to MSF's distribution of mosquito nets.

Sexual and gender-based violence (SGBV) is widespread, but heavily underreported due to stigma, fear and limited access to care. Although it is a core component of primary care, fewer than 30 per cent of facilities provide SGBV care, and there is a severe shortage of staff trained in the clinical management of rape (CMR) nationally; basic psychosocial support is also insufficient.[17] Between January and September 2025, around 2,200 survivors of sexual violence received comprehensive care across Bentiu, Leer, Lankien and Pieri, and 5,600 survivors received basic care and referral at the community level. Most cases are women, and over 40 per cent are under 19. Numbers likely under-represent the true scale of SGBV. Many arrive too late for effective prophylactic treatment; between 2018 and 2024 in MSF projects in Jonglei and Unity states, only 25 per cent of SGBV survivors accessed services within the 72-hour window necessary to receive comprehensive care.[18] In Malakal, only 40 per cent of patients arrived within this window from January to July 2025.

17 OCHA (December 2024), South Sudan: Humanitarian Needs and Response Plan 2025.

18 MSF internal analysis: A Seven-Year Retrospective Analysis of Sexual and Gender-Based Violence (SGBV) Characteristics and Trends among Survivors accessing care at MSF health facilities in South Sudan (2018-2024).

Photo: **MSF staff visit a discharged patient from Mayen Abun hospital. Both staff are walking through the field to reach the house of the patient.**
© PAULA CASADO AGUIRREGABIRIA

Gaps in primary care significantly affect secondary services. In many MSF-supported hospitals, patients seek treatment for conditions that should be treated at the primary level. In Abyei Administrative Area, MSF's Ameth-Bek Hospital — the only functioning secondary care facility — is increasingly overwhelmed by referrals. In May, the emergency room received over 800 cases in just a few weeks that would normally be handled in primary care where they are easily treatable, including malaria and diarrhoea.

SECONDARY HEALTHCARE AND REFERRAL GAPS

Secondary care — including county, state and teaching hospitals — is sorely lacking across South Sudan. Hospitals, not initially planned to be supported under the HSTP, were left with insufficient resources and ambiguous staffing and supply arrangements. Less than 10 per cent of HSTP-supported facilities provide secondary care, leaving major gaps in referral and emergency surgery services and maternal and reproductive healthcare.[19] Existing hospitals are often overcrowded, and experience regular shortages of critical supplies and staff; referral pathways (including ambulance services) to secondary care are often non-existent, causing dangerous delays.

> "I walked for two days to arrive here; I was alone with my baby. It's been three weeks we are here at the hospital. In Akak there's a [PHCU], but they don't have services for newborns. I first went there, but they told me they didn't have the services I needed. Where I live there are many needs, no hospital, especially for pregnant women and delivering babies. I hope my child will recover soon and that we can return home for me to take care of my children. I'm worried in any case that my children may get sick later and that we don't find healthcare services for us. The travel from there to here is difficult and I fear we may not survive it next time.
>
> *PHCC, Female Caretaker (child on neonatal ward), Mayen Abun, September 2025*

> "On this ward we have 21 beds — this is not enough for the numbers of patients. Some days, two pregnant women might share a bed. We know it is not good for two women to share a bed, for the health of the children. Those who are referred from a distant place; it is complicated. There was one lady who was referred; they took her to a private clinic, then they referred her

19 From available resources shared on the HSTP, 48 of 816 facilities are secondary healthcare facilities.

here to Renk. When she arrived, the head of the child had been out for three days. When she delivered, the child was already dead.

MSF-incentivised Midwife, Renk County Hospital, September 2025

Where hospitals exist, a shortfall in specialised staff, such as surgeons and gynaecologists, critically disrupts patient care. Delays of several months in paying staff incentives, already perceived as too low,[20] undermine motivation and ultimately the quality of care.

> “It is challenging when we come to work at night, and there are nurses who do not work. As the midwives, we give the medication and do deliveries and do everything. Our nurses before would just come to sleep, and they would not want to wake up. Since MSF came, they are better — it is not like before. If you are working together at night, they keep working. They were paid, but it is delayed by months, so now MSF can incentivise them, so they are happy.
>
> *MSF-incentivised Midwife, Renk County Hospital, September 2025*

MoH hospitals rely heavily on volunteers. In Renk County Hospital, this includes individuals working on the maternity ward who should be incentivised under the HSTP and in June 2025, 54 hospital staff abruptly lost NGO support due to funding cuts, leaving severe gaps in maternity care. MSF’s paediatric ward saw increased critical neonatal admissions in 2025; mostly low-birth-weight newborns linked to poor antenatal care and unattended births. MSF began supporting the maternity department with incentives and supplies in September.

Key state-level secondary care and referral hospitals, such as Aweil and Bentiu State Hospital, face critical shortages in medical supplies, specialised staff, including surgeons, and functional infrastructure. Malakal Teaching Hospital, the main surgical referral hospital in Upper Nile State, had no consistent surgical capacity from July 2024 until March 2025; and closed temporarily due to strikes over incentives payments in November and December 2024. Aweil State Hospital, which lost funding due to cuts in 2022, continues to struggle with supply, staff and equipment shortages, severely limiting its capacity to function as the main referral facility in Northern Bahr el Ghazal.

20 Official letter from MoH on 30 October 2025: Notification on delays in the arrival of supplies and disbursement of incentives.

County hospitals face similar challenges, especially as many are not recognised as hospitals. The Mayen Abun facility in Twic County is regarded by the MoH as a hospital, but receives staffing and supplies designed for a PHCC. The county hospital in Yuai, Uror County, lacks sufficient staff and surgical capacity, and refers patients to MSF primary care facilities in Pieri or Lankien; complicated cases must be flown to the closest acceptable operating theatre in Bentiu, almost 300 km away in Unity State.

Renk County Hospital, also supported by the HSTP, is the only secondary care facility in the county supporting local and displaced communities, including refugees and returnees from Sudan. It lacks sterilisation capacity and faces frequent surgical equipment, staff and medication shortages. 180 women deliver in the hospital each month and key supplies like oxytocin are often lacking in the maternity unit, and women sometimes have to share beds, putting both mother and baby at risk. Monthly admissions to the paediatric ward increased from 90 in 2023 to over 200 in 2025, mainly for severe malaria, severe pneumonia and diarrhoea.

Poorly managed, overcrowded and under-resourced outpatient departments (OPDs) lead to unnecessary, preventable deaths, and long wait times deter some patients from accessing care promptly, which further burdens already busy MSF-supported emergency departments.

> “I saw a child in the OPD that was in a bad condition, but they did not prioritise, and the child died. This is what I would like to comment. It was very painful. All the cases that are critical should be on one side, away from those who are not in a critical situation.
>
> *Mother on maternity ward, Renk County Hospital, September 2025*

> “This OPD is under the MoH. They had a rupture of essential medication, which happened so often, this leaves the patients, in the community, with no choice. When they come, MSF we receive them, and we will triage them... the staff who were working on secondary care, exclusively for inpatient care, now there is another need, and the needs are too high.
>
> *Clinical Officer, MSF contract, Ulang Hospital, October 2025*

Conflict and attacks on healthcare: ‘crisis within a crisis’

In 2025, South Sudan saw its sharpest escalation in armed conflict since the revitalised peace agreement was signed in 2018. Clashes between government forces, opposition groups and non-state armed groups have escalated since February, particularly in Upper Nile, Jonglei, Unity, Central Equatoria and Warrap states.

Nearly 2,000 civilians were reportedly killed across the country in violent clashes and indiscriminate airstrikes by September (a 59 per cent increase from 2024), and over 320,000 people were newly displaced.[21]

Between January and June 2025, MSF treated over 740 people for violence-related injuries across Jonglei and Upper Nile states, including gunshot wounds, burns from bombings, and knife injuries. In Malakal, MSF treated 141 trauma patients, including women and children, between April and November, many with gunshot wounds.

South Sudan remains among the top five most dangerous places in which to deliver humanitarian assistance. Fatalities among aid workers were already higher by November 2025 than during all of 2024; all victims were South Sudanese.[22]

In flagrant violation of International Humanitarian Law (IHL), 2025 also saw a sharp increase in attacks on health facilities by all parties to the conflict, particularly in the Equatorias and Upper Nile. The resulting collapse of services impedes lifesaving care and blocks humanitarian medical agencies from delivering assistance.

South Sudan urgently needs an agile medical and humanitarian response capable of responding to the needs of affected communities, particularly in areas affected by conflict. MSF teams continue to adapt medical programmes as the context evolves, but escalating violence and increasing attacks on health facilities and humanitarian workers pose significant challenges.

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21 Office of the United Nations High Commissioner for Human Rights (OHCHR) (26 September 2025), South Sudan: Türk alarmed by deteriorating human rights situation amid rising violence and political tensions; UNHCR (11 November 2025), South Sudan Situation: Core 02 Nov 2025.

22 Aid Worker Security Database, South Sudan: Aid worker security incidents, 2025, Humanitarian Outcomes, https://aidworkersecurity.org.

Attacks on MSF facilities and staff in 2025 left at least 400,000 people in extremely hard-to-reach areas without access to medical care.

ESCALATING CONFLICT AND ACCESS CONSTRAINTS

While conflict dynamics vary across the country, rising insecurity is severely disrupting health services and humanitarian access across conflict-affected regions.

In Upper Nile State, violent clashes between the SSPDF and Nuer militia began in February 2025 in Nasir, with heavy aerial bombardment, resulting in numerous civilian casualties and the displacement of tens of thousands of people, both within the county and into Ethiopia. MSF teams across the border in Ethiopia treated 217 war-wounded people fleeing the violence between February and March.

> People struggled, particularly the family members, by carrying the patient across. It may take them almost seven to ten days to reach the Ethiopian exit and then if they have the resource, they can facilitate to reach Ethiopia or to go to Akobo. It was quite challenging. Especially for women and children, there were no delivery services.
>
> *Clinical Officer, MSF contract, Ulang County, October 2025*

By March 2025, most humanitarian organisations in Ulang, Nasir and Longechuk counties had suspended their activities; all health facilities along the Sobat Corridor from Doma to Mandeng were forced to close by April. While some health staff working in HSTP-supported facilities reportedly tried to relocate services into areas where people had been displaced, HSTP partners were unable to access these areas with medical supplies.

Humanitarian access is being further restricted by different parties to the conflict, making it difficult, and in some cases impossible, to deliver medicines and healthcare to all communities. In Upper Nile, it wasn't until July that MSF teams could regain access to parts of Nasir County. In Lankien, MSF teams must, for the first time, request SSPDF's permission to land its aircraft, impeding the arrival of medical staff and supplies into the territory and potentially feeding perceptions of politicisation of aid, as well as delaying urgent medical referrals. Patients requiring immediate lifesaving medical intervention may already wait up to 48 hours for an MSF flight to be cleared in order to reach an operating theatre.

Photo: **MSF hospital in Old Fangak, South Sudan, after being deliberately bombed on 3 May 2025.**
© MSF

DIRECT ATTACKS ON HEALTH FACILITIES

Attacks on health facilities have been noticeably increasing, with eight attacks on MSF staff and facilities taking place in 2025.

In April, dozens of armed men stormed and looted MSF's 60-bed hospital in Ulang - one of the only secondary care facilities in the area — and forced its closure. Over 100 patients, including trauma patients with gunshot wounds, pregnant women, and children, were receiving critical treatment at the time.

This attack was part of a broader pattern of insecurity affecting healthcare in the area. In January, two clearly marked MSF boats carrying six staff were attacked while returning to Ulang after delivering medical supplies to Nasir County Hospital, forcing MSF to suspend all outreach activities in the region.

> "This looting affected us a lot; medical supplies were taken, and some equipment was destroyed. It was really difficult. The town was evacuated, and because MSF was the main backbone providing quality healthcare in the corridor — not only in Ulang but also Nasir by extending the [outreach] programme, it was very difficult.
>
> *Clinical Officer, MSF contract, Ulang County, October 2025*

In May, MSF's hospital in Old Fangak was bombed by two gunship helicopters, killing at least seven people and injuring 27, including four MSF staff. The pharmacy and recently-stocked medical supplies were destroyed, and the hospital was forced to close and teams relocated. MSF had treated

over 220 patients with violence-related injuries between January and the hospital's closure.

In June, the MSF-supported Morobo County Hospital was attacked and looted, and two ambulances burned. Following the abduction of one of its staff members, MSF was forced, not for the first time, to suspend its activities in Yei River and Morobo counties in August.[23]

RISING VIOLENCE DENIES COMMUNITIES ACCESS TO LIFESAVING CARE

The closure of health activities due to attacks and insecurity has disastrous consequences for communities with already limited access to healthcare.

In 2025, the closure of the Ulang hospital left an estimated 150,000 people without care. Old Fangak Hospital was the only functional facility for over 110,000 people living in remote, flood-prone areas with limited medical access. The suspension of activities in Yei and Morobo left 150,000 people without access to essential services between August and November 2025. From November 2025, MSF will provide emergency and maternity support to Yei Civil Hospital, but outreach activities — a lifeline for communities living in remote areas — will not resume.

Old Fangak town is now at the centre of overlapping crises that reflect the country's broader challenges; staff describe communities as "facing a crisis within a crisis". Sustained aerial assaults since May 2025 have displaced over 38,000 people.[24] and, by August, the town was completely submerged by flooding. After the May attacks, MSF launched medical activities in Toch, where a primary care facility had closed because of US funding cuts. In addition to facing many-hour journeys by canoe or boat to access services; fears of violence are now creating further barriers to care.

> "Challenges accessing healthcare are not only means of transport but also conflict. There are those who live far and fear coming here — especially in this crisis. People who are staying in New Fangak and Pigi county — to reach here might get scared on the way. They might meet the army along the way. For now, they have stopped [the conflict]... but people could fear bombing.
>
> *MSF Nurse, Toch PHCC, October 2025*

23 MSF (May 2024), A lifeline for remote areas cut off from healthcare in South Sudan.

24 Fews Net (5 August 2025), Extremely high acute malnutrition levels underscore the risk of Famine in Upper Nile State.

In Ulang and Old Fangak, MSF teams lost access to over 1,000 patients with chronic diseases, including HIV/AIDS and TB. Potential stigma makes identifying and retaining patients challenging, and the disruption of care also increases the risk of transmission and drug resistance. In Old Fangak, displacement following violence and flooding meant 500 of the 638 HIV patients remained unaccounted for by October, and others died. In Ulang, patients must now cross into Ethiopia for vital treatment.

> “Some people were displaced to small islands to survive, far places, not affected by floods. It has increased the default rate for our patients, for them to come to the facility it costs a lot to hire a canoe. The death rate has increased. We tried to follow up in June, we received a lot of information from outside, Mr X is no longer here, Mr X passed away. That makes seven [deaths], since the incident. But I don’t know for those who exceed the defaulting rate stage, those who missed their appointments, those who we lost to follow-up, those who totally defaulted — I don’t know how they are.
>
> *Nurse, MSF contract, Toch PHCC, October 2025*

Photo: **People standing outside the MSF hospital gate in Old Fangak after fleeing their flooded homes, August 2025.**
© MSF

> Now currently after the suspension of the activity, it has become a very imminent challenge because in the corridor, MSF is the only organisation providing HIV services. When MSF left due to the suspension of activity it was quite challenging because these individuals could not access any services.
>
> *Clinical Officer, MSF contract, Ulang, October 2025*

Communities living along the Sobat River-corridor, Upper Nile State, lost access to maternity services, chronic disease treatment, and referral systems for those needing emergency care because of violence. Medical staff were also displaced from MSF's Ulang hospital by ongoing violence, witnessing the impact of the loss of health services on populations they previously supported.

> Following the aerial bombardments, the teams moved to another area. I was put as the medical focal point. There was no option, leaving that woman there, with sepsis — we know as a clinician what the main outcome will be without appropriate treatment. We understood the feelings of the family who brought her in, they did not expect this mother to die. For us, having the skill, but there is nothing to use on the patients — it was a very tragic story. We were based in the grounds [of the PHCC] because we evacuated to Mandeng, and we stayed there while we waited for communication. Then aerial bombardments happened, and we had to leave the area.
>
> *Clinical Officer, MSF contract, Ulang County, October 2025*

Elsewhere, insecurity has reduced access to services, despite severe needs. In March, MSF was forced to reduce its support to outreach activities in Malakal, compromising access to quality care and referrals. This led to a 50 per cent drop in admissions of children for malnutrition compared with 2024, with similar reductions across other departments.

Case study

Malaria: response exposes persistent health service gaps

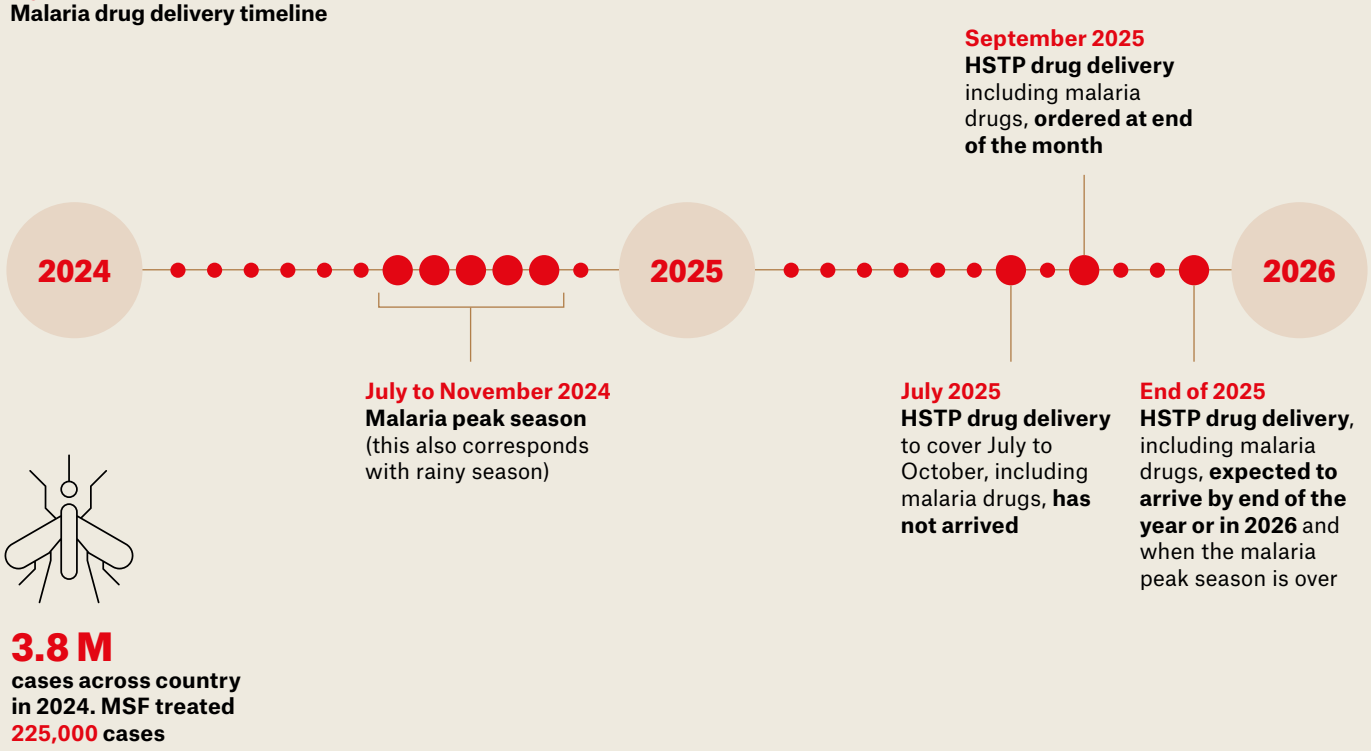
Malaria remains the leading cause of morbidity and mortality in South Sudan, accounting for 30–50 per cent of deaths, according to the WHO; particularly among children under five and pregnant and lactating women. In 2024, there were 3.8 million cases across the country, with annual peaks during the rainy season.[25] Diagnostics, treatment and prevention methods are frequently missing or inconsistently applied, and MSF teams continue to treat hundreds of thousands of patients: 225,000 in 2024, and similarly high numbers in 2025, despite increased insecurity and reduced access to care.

The high disease burden reflects wider healthcare barriers and inconsistent rollout of prevention tools, including seasonal malaria chemoprevention (SMC) and insecticide-treated bed nets (ITNs). MSF provides SMC ahead of the peak malaria season to protect children under five, who are the most at risk of complications and death from malaria, in particularly impacted counties, including Twic and Aweil. In flood-affected and insecure areas, such as Fangak County, communities resort to improvising mosquito nets from fabric or empty sorghum (grain) bags to prevent malaria transmission.

> “Some people have mosquito nets for prevention, but some do not have them. If they get to the hospital, we normally give out medication. But during this season it is very hard because of stagnant water everywhere, it is very hard to prevent mosquitoes from biting. The main thing we normally give is medication, tell them to go to bed earlier. They can go to bed earlier so mosquitoes cannot bite them, that is what we normally tell them. It can improve a bit, but it cannot change completely.
>
> *MSF Nurse, Toch PHCC, October 2025*

25 WHO (December 2024), Malaria in South Sudan: Past, Present and Future.

Figure 3
Malaria drug delivery timeline



The malaria response has again exposed persistent supply challenges. HSTP drugs for July-October 2025 were only ordered in September, causing nationwide stockouts during peak malaria season. Facilities in Kajo-Keji, Yei, Morobo, Twic, Aweil and Abyei Special Administrative Area were left for months without supplies. While some priority areas received delayed 'buffer stock', others were left without.[26] Yambio State Hospital admitted around 20 children a day for severe malaria between June and August, with its last supply of antimalarials arriving in April. MSF, though not present in this hospital, supported the transportation of drugs in September.

Between January and September 2025, MSF treated over 116,100 uncomplicated malaria cases (those which can be treated in the community or primary care facilities). Patients often travel long distances due to a lack of local facilities, medication or staff, and some PHCCs refer patients to MSF because they lack supplies.

26 The buffer stock is the leftover balance from previous cycles of drug supply procurement.

> A mother brought her child, who was later diagnosed with cerebral malaria. On arrival at the hospital, it was quite challenging, fever and continuous seizures. This was caused by delay, because those in the inland village — it is not just that they are very far, there are no health services available in some areas that can initiate early management before transferring the patient. This is challenging and it was very sad. It not only affected the mother — it also affected the staff, because seeing this situation over and over again. It is also having a big impact on resources, because those patients arriving later means more resources will be directed to this.
>
> *Clinical Officer, MSF contract, Ulang, October 2025*

Photo: Mother and daughter in an IDP camp, Mayen Abun.
© PAULA CASADO AGUIRREGABIRIA

Delays in effective treatment, combined with low immunity in young children and pregnant women, cause many uncomplicated cases to progress to severe malaria. These cases require hospitalisation and sometimes blood transfusions; challenging in under-resourced settings. Without timely treatment, the disease can quickly become deadly. By September 2025, MSF teams had treated 6,680 people with severe malaria. In Aweil, 2,245 severe cases by September represented 51 per cent of all malaria admissions. HSTP-supported facilities in Renk reported malaria drug stockouts ahead of the peak season, and the number of children admitted for severe malaria more than doubled between August and September 2025, from 55 to 137.

> We have so many cases of malaria and pneumonia. The reasons [patients] have severe malaria is because, for those who are coming from far, they get sick but there is nowhere for them to be seen or get given treatment. If malaria has not been treated within 24 hours, it will get worse and from there the child will have fever and then convulsions. From there it will become complicated.
>
> *MSF Nurse, Renk County Hospital, September 2025*

Conflict further restricts malaria care. In 2024, MSF treated 23,500 malaria patients in its Old Fangak Hospital, with data showing increasingly prolonged malaria peaks over the past three years. Before its forced closure in May 2025 and before peak season, hospital teams had already treated 2,300 cases.

Photo: **A patient sits next to a wall of the new malaria ward at Aweil State Hospital.**
© ISAAC BUAY

Case study

Cholera outbreak: displacement and gaps in multisectoral response

Since October 2024, South Sudan has faced its largest cholera outbreak on record.[27] A cholera outbreak declared in neighbouring crisis-affected Sudan in August 2024, quickly reached Renk, South Sudan — the main entry point for refugees and returnees from Sudan.

With a timely response, the outbreak should have been contained in Renk, but it spread to Malakal, Bentiu, Aweil and the capital, Juba, in just days. The outbreak is ongoing a year later; over 95,000 cases and more than 1,500 deaths have been reported.[28] No one should die from cholera, but without rapid access to healthcare it can be fatal.

Between October 2024 and October 2025, MSF responded to cholera in all its projects, and opened additional emergency interventions, including in Juba, treating over 35,000 patients across nine states; over a third of all cases reported nationally. Almost 15,000 patients required hospitalisation. A specialised cholera treatment unit was opened at Renk County Hospital,[29] treating 500 patients by August 2025.

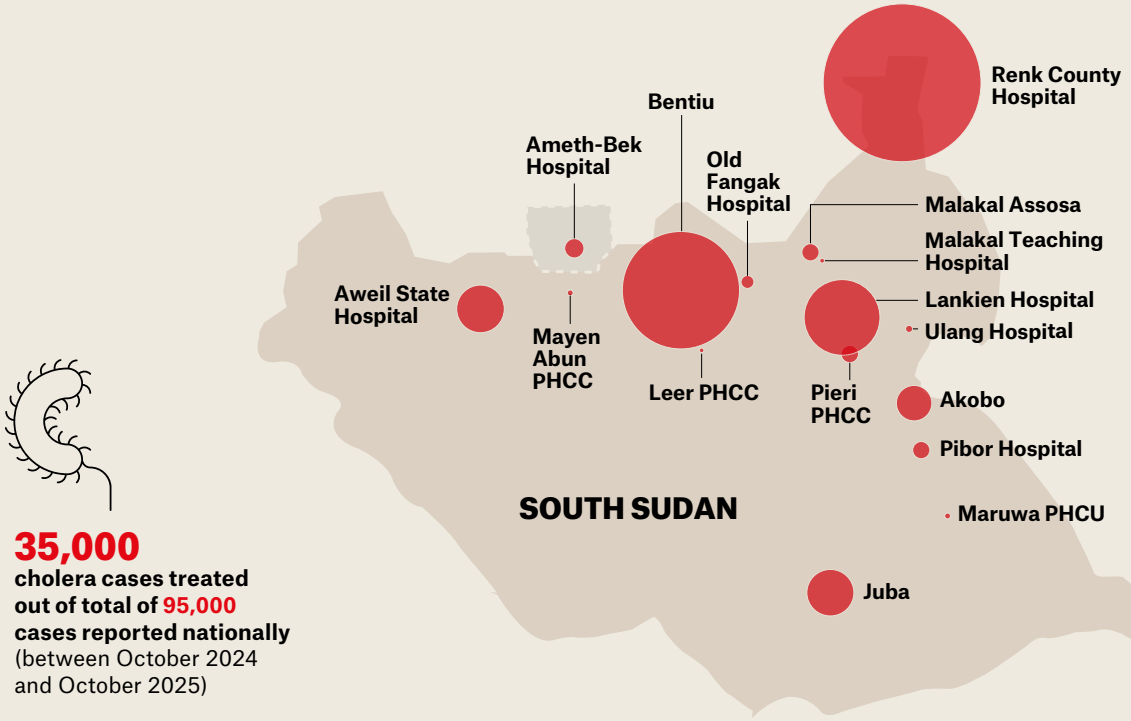
Rapid spread was driven by population movement — including displacement due to violence — limited surge capacity and chronically under-resourced WASH services. By November 2024, cholera had reached Malakal, Upper Nile State; a major transit point for new arrivals from Sudan. MSF teams ran two treatment centres in Malakal County, treating 646 patients between November 2024 and February 2025. In Bentiu, MSF ran various oral rehydration sites and operated 250 cholera beds across its specialised treatment centre in the IDP camp and support to the MoH in Bentiu State Hospital until August. This period saw almost 7,000 cases, with 3,240 patients hospitalised.

27 WHO (29 August 2025), Cholera — Multi-country with a focus on countries experiencing current surges.

28 WHO (31 October 2025), Weekly Situation Update on Ongoing Health Emergency Events in South Sudan.

29 As cholera cases began declining, MSF handed over to the MoH in April 2025, but continued to provide light support.

Figure 4
MSF response to cholera outbreak that started in 2024



35,000
cholera cases treated out of total of 95,000 cases reported nationally
(between October 2024 and October 2025)

> The first case we received had also travelled from Upper Nile, from Malakal. The communities move, they came from Malakal, with no symptoms. They came to see their other family members. When they arrived, the same day, they came to the hospital with symptoms — watery diarrhoea and vomiting and severe dehydration. Based on our clinical assessment they were admitted.
>
> *Nurse, MSF contract, Bentiu, November 2025*

In Ulang, fighting in March 2025 forced 30 cholera patients to flee the MSF hospital, risking death themselves and further spread of the disease. When looting forced the hospital to close in April, the cholera response was also disrupted.

> There was cholera when the looting happened, there were a lot of deaths described as related to cholera. It became difficult as this war was going on, there were a lot of casualties, with MSF helping referrals for those in need.
>
> *Clinical Officer, MSF contract, Ulang County, October 2025.*

Areas were already vulnerable to waterborne disease outbreaks. South Sudan's WASH sector is chronically underinvested, with recent funding cuts exacerbating the situation.[30] Displacement sites are often particularly neglected. In Bentiu IDP camp and informal displacement sites around the town, which host thousands of people, devastating floods in 2021, the influx of refugees from Sudan since 2023 and the reduction in essential WASH funding have contributed to a deteriorating situation[31].

> "This year was a bad year — there were a lot of things coming in — cholera came into the camp. NGOs scaled down their activities because there were funding cuts, so the gap was bad regarding sanitation. There was open defecation because the latrine facility in the camp was not functional. This increased the rate of transmission in the camp. Outside the camp there was the same issue — most of the community are drinking direct from the river, which is also contaminated because they practice open defecation.
>
> *Nurse, MSF contract, Bentiu, November 2025*

Fangak County, affected by severe flooding in 2024 and 2025, lacks latrines and clean water; people are forced to drink contaminated floodwater shared with animals. Between January and May 2025, before the Old Fangak hospital was closed following an attack, MSF teams treated 860 cholera cases.

> "We have just finished with cholera — I am not saying it will go completely — because the sanitation services are not in place. So, WASH and prevention can improve the lives of people in Toch. Now we have one and a half weeks without cases of cholera. Before we had patients on and off.
>
> *MSF Nurse, Toch PHCC, October 2025*

MSF supports the MoH through emergency interventions, including a 100-bed specialised cholera treatment centre in an IDP camp in Juba, treating 2,800 patients between December 2024 and February 2025. In Malakal, MSF donated supplies to MoH facilities and supported vaccination campaigns, including in Mayom County, Lankien and Pieri.

30 UNICEF (16 September 2025), Humanitarian Situation Report N 7.

31 An MSF survey carried out in August 2024 revealed critical gaps in sanitation, water availability, hygiene practices and solid waste management; a 2021 survey highlighted a deteriorating situation.

> It was only MSF that was responding, almost responding alone. The other hospitals they had planned but I think they lacked resources, human resources — staff and medical supplies. Most of the patients came from Rubkona and Bentiu town — it was really a high influx of patients. It was a lot of pressure on the staff; the 50- to 75-bed capacity was overwhelmed until we reached 150 beds. Patients were referred from different facilities to our facility. This increased transmission between communities because there was a lot of movement between facilities, and areas.
>
> *Nurse, MSF contract, Bentiu, November 2025*

Vaccination is essential in prevention and containment efforts. Campaigns were delayed, largely due to insecurity, logistics and slow disbursement of funds. In Juba, MSF reached nearly 120,000 people through reactive cholera vaccination campaigns from December 2024 across various displacement sites. While reactive campaigns to outbreaks are essential, preventive campaigns in hotspot areas are also necessary. Despite recent declines in cholera cases, risks remain high due to flooding (especially in Unity, Jonglei and Upper Nile states), continued displacement and chronic under-investment in preventive measures. Hepatitis E — already a recurring public health concern in South Sudan — has surged and overlapped with cholera in parts of the country; Renk declared an outbreak in 2025.

Photo: **The MSF health promotion team is conducting an informative session with community leaders at an IDP camp in Malakal, empowering them to help safeguard their communities against the outbreak.**

Case study

Sudan crisis: additional strain on already stretched basic services

The arrival of over one million refugees and returnees from Sudan into South Sudan since April 2023 has overwhelmed the already weak health system, especially in Renk and Abyei Administrative Area.[32] Renk County, and specifically the Joda crossing, has received around 80 per cent of returnees and arrivals. The war in Sudan continues to displace populations, and around 500 people continue to arrive daily, including through non-official border crossings, where the population is believed to have increased by 100,000 since the beginning of the war.[33] Individuals arrive without belongings after travelling for several weeks on dangerous journeys, many having experienced violence, extortion and/or SGBV. MSF teams have supported new arrivals with mental health needs related to trauma, separation and loss.

Before the conflict in Sudan, health facilities in South Sudan relied on specialist services in Sudan. Despite the ongoing civil war, which has killed tens of thousands of civilians and decimated infrastructure and services, MoH-run departments in Renk County Hospital continue to refer patients to Sudan for treatment. Some patients choose to make the journey themselves, knowing treatment for certain conditions cannot be provided in Renk or South Sudan.

> “Some people used to go to the private clinic when they had money, to avoid the crowds in the hospital here. That is why most people used to go there. If you don’t have money, you will come to the hospital and wait for a long time. Even then, there are some tests that they cannot do here, and they will send you outside, and sometimes you cannot get the medicine. They will tell you: come tomorrow or come another day. If you are lucky, you will get it. There are a lot of people who have been referred from here to Sudan.
>
> *Mother on maternity ward, Renk County Hospital, September 2025*

32 UNHCR (9 September 2025), Sudan Situation Map Weekly Regional Update - 08 Sep 2025.

33 Accurate population figures are challenging, and the last census for Renk was conducted in 2008.

> I went to Sudan with my brother, because he has kidney problems, a week ago, and I heard about cholera cases in Sudan. He left for Kosti, to get dialysis. He was in South Sudan, and they diagnosed the problem and said they do not have the services here.
>
> *Male Refugee, Gosspami, September 2025*

> My brother has joint pain and diabetes and needs treatment. He has not managed to see a doctor in South Sudan. He was receiving treatment for diabetes, but now he must pay.
>
> *Female Refugee, Gosspami, September 2025*

Renk has seen a rise in mental health needs, as facilities in Sudan, including for psychiatric care, continue to be destroyed. There were 165 new admissions for MSF mental health services between January and July 2025. This was compounded by funding cuts in early 2025, which forced actors providing essential psychotropic medication for refugees and returnees in Renk and where MSF referred patients, to suspend activities.

> As the war has not stopped, people are still coming, and the number of mental health consultations is still going to go up. We need psychiatric care in Renk, we don't know how long other agencies will be operational, what are their challenges — it is hard for us to predict their next move.
>
> *MSF staff, Renk County Hospital, September 2025*

Abyei Administrative Area, a politically contested and unstable border zone, has also received large numbers of refugees and IDPs, mainly from Kordofan and Darfur. Many people travel for one to two weeks or more to receive medical treatment in MSF's Ameth-Bek Hospital. Between January and September, MSF provided surgical care to 1,240 patients, including those with violence-related injuries. Overcrowding forced some patients to sleep outside the hospital between treatments and while awaiting follow-up care.

Reception facilities for new arrivals into South Sudan have failed to meet needs. Transit centres (TCs), designed for 72-hours stays, host well beyond their capacity — one in Renk, planned for 3,000 people, was home to over 9,000 by September 2025. People live in dire conditions; lacking access to food, shelter and adequate WASH services. The World Food Programme (WFP) provides only minimal, short-term assistance; around one meal a day for two weeks. The conditions raise significant protection concerns and heighten the risk of disease outbreaks. In June 2025, MSF supported measles vaccination of 2,800 previously unvaccinated children aged 6-14 years in the TC and unofficial sites, after seeing a spike in cases in Renk County Hospital.

> When it is raining the water comes in here and it is difficult for me. If I could have two plastic sheets to build something, it would be better for me and the children. For me and my daughter, we are just the two of us, no one is supporting us. If we can go to another location out of this place, I will go. But I am not willing to go to back to Sudan anymore.
>
> *Female Refugee, Transit Centre 2, September 2025*

In Abyei, most new arrivals have settled in the Amiet market area and a former TC. Amiet market, historically a trade hub and home to 1,000 people, has become a sprawling informal settlement of around 50,000, approximately 80 per cent of whom are Sudanese. The United Nations High Commissioner for Refugees (UNHCR) halted registration in early 2025 and withdrew its operational presence in Abyei in June, due to funding cuts. With basic services virtually non-existent, the lack of latrines and clean water have resulted in widespread cases of waterborne diseases, including cholera and hepatitis E.

Photo: **A group of women collects water at a designated point set up by MSF in Jerbana, where the lack of water is the main issue for the population.**

Onward transportation from Renk and Abyei to refugee camps or other parts of the country has been slow and insufficient to meet demand. Due to funding cuts and insecurity, the International Organization for Migration (IOM) suspended onward transportation in Renk in early June 2025, resuming limited transfers in September for only around 500 individuals a week. Travel from Renk to Malakal takes three days by boat, and is dangerous, sometimes even deadly. Transfers from Abyei were already delayed and poorly managed, further complicated by the rains and the June 2025 cholera outbreak.

> The main challenge for us here is the issue of transportation, we are here but we want to go to a different location. The situation in terms of food here is very difficult for me and for my family. The shelter we have here is difficult, during the rain.
>
> *Female Returnee, Transit Centre 2, September 2025*

Overcrowded conditions in TCs push new arrivals to settle in other areas, where health services are often already stretched. In Gosspami village, Renk, the population has increased from 1,000 to around 20,000 since April 2023; most are refugees. MSF now supports primary care for both the host community and new arrivals, with around 4,000 consultations a month; upper respiratory tract infections, watery diarrhoea and urinary tract infections are the main morbidities.

> Some of the adults are weak, they need food. We don't have money to buy food. There are some people who have not received plastic sheeting, since they arrived. We need food like lentils and oil... In this season there are a lot of mosquitos and there is no food, this can cause malaria and disease. These are the needs of the community, I am not speaking for myself, this is for the whole community.
>
> *Male Refugee, Gosspami, September 2025*

Conclusion

In 2025, the sharp escalation in violence deepened South Sudan's humanitarian crisis, with large parts of the country now experiencing overlapping shocks: conflict, economic pressures, climatic changes (evidenced by severe and recurrent flooding), disease outbreaks and large-scale displacement. MSF experienced eight targeted attacks on its staff and facilities — clear violations of international and humanitarian law — while access constraints continue to undermine healthcare delivery and effective humanitarian response efforts.

Despite growing needs, international interest in South Sudan, and corresponding financial donor support, continue to decline, often accompanied by narratives promoting development rather than emergency support. Government funding for health also falls woefully short of need. The primary mechanism for national healthcare provision is critically under-resourced, unable to ensure consistent medical supplies, support secondary care or respond to recurrent and overlapping public health emergencies.

Against this bleak backdrop, the persistent gaps in public healthcare and basic services, and the resulting deaths from preventable and treatable diseases, particularly among women and children, risk becoming dangerously normalised and accepted as the status quo. As South Sudan enters its fifteenth year of independence, without a shift in approach, increased investment in health and humanitarian programming, and real accountability for delivering services, communities will continue to bear the brunt of these crises.

CALLS TO ACTION

The worsening humanitarian crisis in South Sudan needs urgent international prioritisation: populations face overlapping crises, and the current response is failing to meet the rising needs across the country.

- International donors to South Sudan must maintain presence and funding commitments; the humanitarian situation is only likely to deteriorate further in 2026. Existing limited funding should be directed to ensure it has a real impact on communities.
- The protracted nature of humanitarian needs and longstanding challenges in delivering aid should not be used by donors to excuse or normalise the acute gaps in the response that are evident across the country.

- Funding and investment in health and basic services must be prioritised, as major gaps are having a devastating impact on communities.

- A scaled-up multi-sectoral response is essential, including the urgent prioritisation of access to proper and dignified WASH services, due to challenges posed by waterborne diseases.

Shortcomings in existing health projects, including the Health Sector Transformation Project (HSTP), need to be urgently addressed. Despite being overstretched, the HSTP remains a major lifeline for healthcare in much of the country.

- Donors to the HSTP including WB, UK, Canada, EU, Gavi, the Vaccine Alliance, GF, USA, UAE and others, must honour their funding commitments to the project.

- Health facilities need support on the ground, not just on paper. The MoH, WB, UNICEF and WHO must ensure the timely delivery of basic drugs and supplies — including for malaria, which continues to be the leading cause of morbidity and mortality — and the payment of staff salaries. Clear and timely communication around funding, supply and staff shortages is needed to ensure continuity of care and coordination with other health organisations.

- Donors must consider investing in a more comprehensive package of care, including secondary care — currently neglected — particularly for surgery, emergency maternal care and referrals.

- The Government of South Sudan must scale up its national budget allocations for health, in line with its Abuja Declaration commitment of allocating 15 per cent to health. Budgetary constraints jeopardise efforts to support facilities and ensure the sustainability of healthcare delivery across the country.

At the same time, a shift in approach is also needed to deliver assistance more effectively in South Sudan, especially in conflict-affected areas.

- In many parts of the country, pre-existing gaps in healthcare delivery are being exacerbated by conflict, insecurity and access constraints. Despite this, delivery models have not changed.

- More agile and humanitarian approaches to delivering healthcare are urgently required in these areas, especially in regions not under government control, to ensure all communities have access to care.

Humanitarian access, protection of civilians, and respect for health facilities must be guaranteed across South Sudan.

- All parties to the conflict, including the SSPDF, SPLA-IO and non-state armed groups, must ensure the protection of health facilities and their staff in line with International Humanitarian Law (IHL). Safe passage must be guaranteed for medical referrals, the delivery of medical supplies and humanitarian aid, as well as the movement of health and humanitarian staff.

- All parties to the conflict must ensure the protection of civilians. The use of airstrikes and incendiary weapons in populated areas poses a grave threat to civilians and critical infrastructure. Under IHL, all parties have an obligation to respect and protect civilians and avoid the use of indiscriminate or disproportionate force.

- Donors, regional actors and the government must reaffirm commitments to humanitarian protection, ensure accountability for attacks on health infrastructure, and enable neutral humanitarian assistance regardless of ethnicity, political affiliation, or location.

Photo: **Welmar and Ahamed Mahad, outside the transit centre in Renk, under the makeshift tent where they have been living for over a month.**
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MEDECINS
SANS FRONTIERES