



Female farmers in Tur, South Darfur, 2023 © Katie Whipkey

Sudan – Khartoum, Al Gezira, East Darfur, South Darfur

Rapid Gender Analysis

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Abbreviations

FHH	Female-headed households
FSL	Food security and livelihoods
GBV	Gender-based violence
IDP	Internally-displaced person
IGA	Income generating activities
(I)NGO	International non-governmental organization
IPC	Integrated food security phase classification
IPV	Intimate partner violence
MAM	Moderate acute malnutrition
MHH	Male-headed households
MHPSS	Mental health and psychosocial support
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PEP	Post-exposure prophylaxis
PwD	People with disabilities
RGA	Rapid Gender Analysis
RSF	Rapid Support Forces
SAF	Sudanese Armed Forces
SAM	Severe acute malnutrition
SDG	Sustainable Development Goal
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
USD	United States dollar
VSLA	Village savings and loan associations
WASH	Water, sanitation, and hygiene
WFP	World Food Program
WHO	World Health Organization

Executive Summary

On April 15, 2023, heavy clashes erupted between the Sudanese Armed Forces (SAF) and Rapid Support Forces (RSF) in Khartoum. The conflict has since expanded and involves more non-state armed actors. There has been a near total collapse of services in the most conflict-affected states, including the closure of markets, shops, healthcare centers, schools, and the outages of water, electricity, banking, and telecommunications infrastructures. The complexity of the situation sets the tone for rippling consequences that have been seen across the entire population, especially affecting already marginalized groups and those with pre-existing vulnerabilities (such as female-headed households and those with chronic health conditions). The purpose of the Rapid Gender Analysis (RGA) is to provide information about the different needs, capacities and coping strategies of women and men focusing on four states: Al Gezira, Khartoum, East Darfur, and South Darfur. The RGA gathered primary data from 121 participants in August 2023, and triangulated the findings against 90 secondary data sources.

Data from the RGA shows that **despite women taking on more income-generating responsibilities, they continue to have unequal decision-making rights within the household.** One of the biggest changes in gender roles has been the emergence of more women in the labor force. Men and women alike reported feeling that the only job opportunities currently available are for women. As such, women are increasingly working outside of the household to financially provide for their families. Despite this change, the division of household unpaid care work has not shifted; in most cases, the burden of caretaking for the family is shouldered by women and has only expanded since schools have closed. Therefore, while most women feel they have gained marginally more decision-making power within the household, it has been primarily related to caregiving tasks and making choices around pursuing different types of income-generating opportunities.

Similarly, **women are playing important roles in the humanitarian response, but they remain sidelined from humanitarian decision-making.** Many of the patriarchal norms that have been long-present in Sudanese culture that restrict women's agency and participation in the public sphere have continued. Namely, women within affected communities are not participating in humanitarian decision-making even though they have been on the frontlines of mobilizing quickly to address urgent needs for newly displaced families and women survivors of gender-based violence (GBV). Local groups such as women's and youth initiatives/networks are stepping in where possible to run

Key Findings

- **Food security and livelihoods (FSL):** Two-thirds of respondents said their primary means of earning income has changed (58% of male respondents, 51% of female respondents). As such, most people (81%) have reported reducing their food intake and/or changing the way they eat. Female-headed households (59%) are more likely to reduce food intake than male-headed households (47%).
- **Nutrition:** Most households (66%) are eating less diverse types of foods than before the conflict, and women (55%) have experienced a disproportionate change in eating less nutritious foods (compared to 33% of men). This may contribute to nutritional support being reported as the top health need of women and girls.
- **Health:** Nearly half (44%) of those who tried to access healthcare in July did not have the money to pay for it. The biggest challenge, however, is a lack of available medicines and treatments (66%), especially for the growing problem of malaria (53%). Displaced women especially are recognizing a growing mental health crisis amongst all, especially children, but only 10% of respondents note psychological support as a key health need. More men and women alike see reproductive health as a critical need, but mostly in East Darfur where emergency care from the conflict is not as pressing.
- **Water, Sanitation, and Hygiene (WASH):** Women are more likely than men to feel that water availability is low and that they face long wait times to fetch it. Most people have safe access to latrines (83%), and those that do not are more commonly men because women are using neighbors' facilities. Most women (61%) do not feel that their menstrual hygiene needs are being met.
- **Safety and Protection:** One-third of survey respondents, almost all of whom were in East Darfur and Khartoum, feel there has been an increase in sexual violence and rape of women and girls. Men, on the other hand, face greater risk of intentional killings and injury.
- **Participation:** Few households – though equally amongst men and women – have received any type of humanitarian assistance since the start of the conflict (16%) and even fewer have been consulted about their needs (11%) by any aid organizations.

volunteer-led, community-based services – including lifesaving health services since many international organizations have reduced their operations.ⁱ The localized efforts have been impactful especially as several issues related to **mismanagement of aid from multilaterals/INGOs** were raised by both male and female respondents. For instance, humanitarian aid decisions are being made unilaterally by camp managers – creating barriers to access for some already marginalized groups – causing the aid not to reach its intended recipients.

Sudan’s traditional culture of reciprocity and community cohesiveness has been a lifeline for many families, but bonds are weakening as resources are depleting. Families, friends, and strangers are sharing whatever they have (homes, food, water, clothes, etc.) with each other; sometimes ten or more families are living together in one house. However, as the conflict has extended for many months, respondents shared that many host and displaced families are growing wearier of the co-living arrangement as pressure is mounting on the host families. Some families are experiencing multiple displacements often from host families’ homes into collective shelters due to resource shortages or because of conflicts that arise within the household. In collective shelters, women and girls are more likely to face increased risks for GBV and insufficient basic facilities such as safe latrines.

Harmful and unsustainable coping strategies are being widely practiced to manage the impacts of the conflict. Most respondents (81%) reported reducing their food intake and changing the way they eat because of the conflict. Men were more likely than women to report a personal reduction in their eating habits, but reducing overall food intake is more common in female-headed households than in male-headed households. While most have not been experiencing water shortages to the same extent as food yet, men and women have still been forced to reduce their water use by compromising their hygiene habits, most commonly taking fewer showers and doing less cleaning. Men and women are searching for options to cope with a lack of cash and rising prices to buy food and non-food items including selling assets and borrowing money. Women are leaning more heavily on diversifying their income-earning strategies – both in formal and informal economies – and using their savings, whereas men are relying more on selling assets.

Key Findings by Sector

- **Food Security and Livelihoods (FSL):** Loss of income has been the most widely felt impact of the conflict across all states, and the shift in livelihoods has been the biggest change (77%), especially for men (58% of men compared to 44% of women). Many went from having a stable job to depending on savings, humanitarian assistance, support from relatives, or shifting to various types of daily labor. This has compromised food security; now, nearly half of the population is experiencing crisis levels of food insecurity.ⁱⁱ Women, pregnant and lactating women, female-headed households, rural households, people living with disabilities, and older persons (60+) are most susceptible to food insecurity.ⁱⁱⁱ Most households report a lack of income and safety risks as the main barriers to accessing food, rather than lack of food availability at markets.
- **Nutrition:** Malnutrition is an increasing problem in all states especially for children and pregnant and lactating women, which has only exacerbated pre-conflict levels that were already the highest globally.^{iv} Food supplements – in particular for moderate malnutrition and prevention of malnutrition – are not available, increasing the risks of compromised immune systems, vulnerability to disease, and starvation. Many feel that the most pressing health need of women and girls is nutritional support through increased food diversity and supplementations. Sourcing foods for nutritional diversification such as fruits, milk, meat, and vegetables has been increasingly difficult. Women of reproductive age suffer from higher levels of anemia and malnutrition that present risks for birth complications (such as hemorrhaging) and maternal and infant mortality.
- **Health:** Although the health system faced significant gaps before the crisis, it has become increasingly strained as a result of the conflict’s escalation, although the impact has varied by state. In Khartoum, just 16% of facilities are fully operational and in East Darfur, many of the village clinics have closed. While facilities remain open in Gezira, they are overcrowded and severely overstrained. Non-urgent needs such as pre-and post-natal care are being deprioritized at health facilities, causing Sudan’s maternal mortality rate to rise since the conflict. Medications and vaccinations are unavailable at a time when risks for diseases are spreading (e.g., malaria and cholera) and those with chronic conditions have gone without treatment, especially those with kidney disease, diabetes, and cancer. Women are experiencing the biggest gap in healthcare as fewer female medical staff are available, and many women are reluctant or even prohibited to be treated by male medical staff due to cultural

norms and practices. Also, women reported reduced health seeking behaviors due to safety fears of attack from armed actors who are often stationed outside of medical facilities. Burnout and safety risks for local medical teams are presenting significant challenges to sustained programming.

- **Mental Health and Psychosocial Support (MHPSS):** Women are much more likely than men to discuss the mental health crisis unfolding in Sudan. According to RGA data, women recognize their own psychological health is suffering, such as feeling more depressed and alone, but they show the most concern for the children who they feel are most affected. Many say that children’s personalities and behaviors have drastically changed since the start of the conflict. Men are also exhibiting indications of mental health challenges and increased stressors brought upon by their inability to provide for the household in traditional ways. Additionally, survivors of sexual violence and rape are in dire need of specialized support and there are indications of increased risk of suicide, especially amongst young women.
- **Water, Sanitation, and Hygiene (WASH):** Accessing water is challenging for most people (83%), and women are slightly more impacted by these challenges than men as it is the responsibility of women in Sudanese culture to fetch water for the household. The primary challenges are electricity cuts that halt service from pumps, long waiting times at water pumps, and far distances to fetch water. Water contamination is a growing problem, particularly in regions where there has been an influx of displaced families. In these areas, sanitation is suffering due to garbage piling up and latrines being overcrowded. Still, most people feel they have a safe latrine to use and a place to bathe. Men are slightly more likely to feel they do not have access to a latrine or place to bathe, largely due to women being more comfortable sharing facilities with neighbors. According to RGA data, women’s greatest hygiene need is menstrual products, whereas the community at large is in dire need of soap.
- **Safety and Protection:** Risks are increasing and differ between men and women. One of the biggest risks to young men, particularly in Khartoum, is accusations of working for one of the conflicting parties. Men and boys are being targeted and are being beaten, killed, or detained. The major risk to women and girls is gender-based violence. An estimated 4.2 million people are now in need of GBV services.^v Intimate partner violence (IPV), sexual violence and rape by armed actors are on the rise. Women and girls, particularly in Khartoum and East Darfur, fear being raped or kidnapped while traveling to the market or any location outside of their home. In response, some men and women (but more so women) are staying inside their home or shelter as much as possible, especially at night to protect themselves from armed actors.

Recommendations

Overarching: Women must be meaningfully incorporated into the humanitarian response to ensure aid delivery reaches those most in need and to elevate the capabilities of female leadership in moving toward a more gender equitable Sudan post-conflict. Addressing humanitarian needs goes hand-in-hand with nexus solutions that strengthen existing structures and prioritize cash-based assistance, promoting local solutions and resilience. A full list of recommendations can be found in the report.

- **Food Security and Livelihoods:** Launch income generating and livelihood diversification activities and cash-for-work programs as appropriate for the context and in consultation with local women’s groups to mitigate against perpetuating harmful norms. Target the most vulnerable populations such as pregnant women with life-saving food assistance and ensure that information regarding the availability of food assistance is accessible to the most vulnerable, including non-displaced residents hosting displaced families.
- **Health and nutrition:** Financially support the operation and staffing (including female professionals) of existing health facilities and nutrition centers and ensure the integration of reproductive health, GBV, and rape care and management. Establish safe and accessible mental health and psychosocial support services. Prioritize delivery of the most needed medications and treatments such as malaria, insulin, antibiotics, vaccinations for children, malnutrition supplements and treatments, and post-exposure prophylaxis (PEP) kits.
- **WASH:** Expand water access to communities experiencing shortages through water trucking and water filtration or chlorination resources to shorten the distances that women need to travel to fetch water and provide jerry cans for extended storage. Ensure that camps and collective shelters have sex-segregated latrines and bathing spaces and sufficient soaps and menstrual hygiene products.
- **Protection:** Ensure that all front-line humanitarian actors are trained in the basic concepts of psychosocial first aid around GBV, disclosures, and safe referrals and that information regarding GBV services and reporting mechanisms are made accessible to communities.

Introduction

Background Information

On April 15, 2023, heavy clashes erupted between the Sudanese Armed Forces (SAF) and Rapid Support Forces (RSF) in Khartoum. Death tolls vary across sources: official figures of documented deaths in hospitals in early September hit more than 1,265^{vi}, and counts by independent actors have reached nearly 7,500^{vii} in approximately the same time frame.

Initially, the conflict and its impacts, including civilian casualties, displacement and damage to civilian infrastructure was centered in Khartoum. The conflict has since expanded beyond Khartoum into large parts of the country, especially in urban centers and along major roadways,^{viii} and involves more non-state armed actors. Now, clashes have been reported in every state.^{ix} The Darfur states, especially West and South Darfur, have become a critical area of concern with armed attacks and shelling increasing daily.^x Frontlines are shifting regularly and control over territory is ever-changing,^{xi} making access to safety and basic needs and services increasingly difficult for civilians and for humanitarian organizations to negotiate delivery of life-saving assistance.

Indiscriminate attacks on civilian infrastructure (e.g., markets, hospitals, homes) are occurring and belongings of individuals and organizations – including humanitarian offices – are being looted across Sudan. There has been a near total collapse of services in the most conflict-affected states such as Khartoum and South Darfur, including the closure of markets, shops, healthcare centers, schools, and the outage of water, electricity, banking and telecommunications infrastructures.^{xii} The deteriorating socio-economic situation has triggered a breakdown in the rule of law and exacerbated intercommunal tensions.^{xiii} Further challenges are compounding including flooding during rainy season, outbreaks of epidemic diseases such as cholera and dengue fever, fuel scarcity, shrinking financial resources, and lack of working transportation systems.^{xiv}

Risks are growing as the volatile mix of political interests, ethnic tensions and alliances, access to arms, and inter-communal conflicts increase.^{xv} The complexity of the situation and the variety of conflicting parties sets the tone for rippling consequences that have been seen across the entire population. The conflict's impact on women and girls is severe as it has further curtailed their access to basic services and has placed them at greater risk for gender-based violence (GBV) and other protection concerns. Risks for men and boys are also increasing, including accusations of supporting opposite sides of the conflict triggering harm, arrest, and coercive recruitment efforts by parties to the conflict.

Rapid Gender Analysis Objectives

The purpose of the Rapid Gender Analysis (RGA) is to provide information about the different needs, capacities and coping strategies of women and men focusing on four states: Khartoum, Al Gezira, East Darfur, and South Darfur. It delivers essential information about – including the changes in – gender roles and responsibilities, capacities, and vulnerabilities derived from a variety of data sources. Building upon the findings of CARE's initial RGA Policy Brief¹ and the Initial Rapid Gender Assessment led by UN Women,² this analysis intends to inform humanitarian actors about the vulnerabilities as well as capacities of women and men, with the aim of shaping future programming and funding to be more responsive to diverse needs and opportunities.

The specific objectives of the RGA are:

- To address the gap in sex disaggregated data to provide information about gender dynamics, evolving roles and responsibilities and household and community decision making given the changes since the conflict broke out in Sudan in mid-April 2023.

¹ CARE. 2023. "Rapid Gender Analysis Policy Brief: Sudan Conflict Response, May 2023." Rapid Gender Analysis. <https://www.careevaluations.org/evaluation/rapid-gender-analysis-policy-brief-sudan-conflict-response-may-2023/>.

² UN Women. 2023. "Initial Rapid Gender Assessment Sudan - Geographical Coverage: White Nile, Blue Nile, Darfur, Red Sea, Khartoum States." UN Women Sudan Country Office. <https://reliefweb.int/report/sudan/sudan-initial-rapid-gender-assessment-geographical-coverage-white-nile-blue-nile-darfur-red-sea-khartoum-states>.

- To better understand evolving coping mechanisms across individuals, households, and organizations (especially women-led organizations).
- To develop a set of actionable recommendations for humanitarian response and program design related to the core sectors of CARE's programming (health, nutrition, WASH (water, sanitation, and hygiene), protection, and FSL (food security and livelihoods)) to ensure targeted and effective support is provided to meet the needs of the most crisis-affected individuals, especially women and girls.

Methodology

The RGA was built up progressively using a range of primary and secondary information to understand gender roles and relations and how they may change during a crisis. RGA uses the tools and approaches of Gender Analysis Frameworks and adapts them to the tight time-frames, rapidly changing contexts, and insecure environments that often characterize humanitarian interventions.

The research for this report was undertaken between July 1 - September 14, 2023, and primary data collection took place between August 9 - September 4, 2023. The RGA focuses on four states: Al-Gezira, Khartoum, East Darfur, and – to a lesser extent – South Darfur. These states were selected both because they are hotspots for the conflict and/or migration, and they are focus areas for CARE Sudan programming. The RGA tool was designed to be iterative and built upon as more information becomes available. Research methods included:

- **Secondary Data Review** of 90 sources in English and Arabic.
- **Key Informant Interviews** with 31 adults and elders (25 women (81%) and 6 men (19%)) in four states: Al Gezira (21 people, 68%), Khartoum (3 people, 10%), East Darfur (6 people, 19%), and South Darfur (1 person, 3%). The interviews were conducted remotely through the [Fatima tool](#).
- **Survey** with 90 adults (66 women (73%) and 24 men (27%)) in three states: Al Gezira (29 people, 32%), Khartoum (31 people, 34%), and East Darfur (30 people, 33%). The survey was conducted remotely by phone (75%) and in-person (25% in East Darfur only) using the [KoboToolbox](#). The survey represents 45% non-displaced residents, 43% internally displaced persons, 4% refugees, and 2% returnees. Of the displaced, 36% were displaced after April 2023 and the remainder were displaced before the most recent conflict began.

The research had several **limitations**, including:

- Limited sex and age disaggregated secondary data made it difficult to identify and target more vulnerable groups in the design of the methodology.
- Sample sizes were reduced and inconsistent across states due to the fluctuating security situation and access challenges. Thus, more information is available about Gezira state and less from the others, in particular South Darfur as respondents were not reached nor is recent secondary data available.^{xvi}
- Given remote data collection methods deployed, respondents in areas more remote and outside of cell phone service areas were excluded as well as those without phones. Data collection was limited to those for which the CARE team could access via telephone numbers.
- Internet and telephone connectivity in Sudan was unreliable during the data collection period and required a pivot to in-person data collection where the security situation allowed. Thus, sampling methodologies were interrupted due to access challenges.

Demographic Profile

Of Sudan's approximately 44 million people (with a 50/50 gender balance)^{xvii}, there are more than 500 ethnic groups speaking more than 400 languages and the vast majority (approximately 70%) identify as Sudanese Arabs. The remaining population consist of African groups including Fur, Beja, Nuba and Fallata. While nearly everyone adheres to Sunni Islam (97%), there are established Christian sub-sets particularly in the south and in Khartoum.^{xviii}

The number of people in need in Sudan has increased 57% since April 15, 2023, from 15.8 million to 24.7 million.^{xix} This includes at least 3.1 million women and 3.5 million acutely malnourished children under five.^{xx} As of October 5, approximately 5.4 million people in Sudan are displaced, 4.3 million of whom are internally displaced (up from 3.8 million pre-crisis).^{xxi} Disaggregated data by gender, age, and disability status since the start of the conflict is not available for those internally displaced and remains a major data gap in understanding the disproportionate impacts of the conflict across different groups. However, the majority of those in need before the conflict were women and children (57% and 55% respectively), and women were estimated to be the majority of internally-displaced persons (IDPs) (51%), refugees (52%), and returnees (52%).^{xxii}

While the majority of displacement from the conflict is internal (80%), 20% have moved across borders.^{xxiii} Those who are moving across borders are more commonly women (52%) and Sudanese nationals (66%). Of the recorded 1,208,886 people who have left Sudan, 40.3% went to Chad, 26.7% to Egypt, and 24.2% to South Sudan.^{xxiv} Sudan was also one of the top 10 refugee-hosting countries pre-conflict (about 926,000), most of whom were from South Sudan. An estimated 2.7% of the internally displaced (approximately 188,000 people) are non-Sudanese nationals,^{xxv} approximately 70% of whom are children and 16% adult women.^{xxvi} Many who remained in conflict areas are the most vulnerable, including children, people who cannot physically make the move due to mobility impairments, or those who cannot afford the cost of traveling.^{xxvii}

2008 national census data found that people with disabilities (PWD) represent 4.8% of the population. This rate was higher in rural areas compared to urban and more common in males (53%) than females (47%).^{xxviii} Again, data since the start of the conflict is not yet available, though it is likely to be higher as a result of conflict-related injuries. Sudan's population is relatively considered young: the median age in Sudan is just 18.3 years old and with 61% of its total population under the age of 24 and 41% younger than 14.^{xxix} The youthful population can be attributed to the country's high fertility rate (4.5 children per woman as of 2020)^{xxx} and low contraceptive use (8.3%).^{xxxi} Completion of lower secondary education has been higher in Sudan than compared to other sub-Saharan countries or low-income countries and was nearly gender equal (50% of girls and 51% of boys) in 2018. Adult literacy, however, has a wider gender disparity: 65% of men are literate and 56% of women.^{xxxii} This indicates a closing gap in the education of girls since the past generation, but has still not reached parity. Nearly one-quarter (22%) of married women are in polygamous marriages, with rates higher in rural areas (24%; 17% in urban areas).^{xxxiii}

Table 1: Population data on people in need nationwide and by state

Location	People in Need (millions, % increase from Nov. 2022 ^{xxxiv})	IDP registered (% of total IDPs) ^{xxxv}	Gender Disaggregation
Nationally	24.7m ^{xxxvi} (57% increase) of the 49.7m population; 50% women ^{xxxvii}	4,232,840	Pre-crisis, 57% of IDPs and 46% of refugees were women. No data available since the crisis.
Al Gezira	2.0m ^{xxxviii} (132.56% increase) of the 6.25m ^{xxxix} population	299,086 (7.1%)	No data available.
Khartoum	3m ^{xl} (58.73% increase) of the 9.4m ^{xli} population	49,000 (1.2%)	No data available.
East Darfur	0.83m ^{xlii} (35.57% increase) of the 1.3m ^{xliii} population	500,075 (11.8%)	No data available.
South Darfur	2.3m ^{xliv} (35.29% increase) of the 4m ^{xlv} population	488,003 (11.5%)	No data available.

Findings and Analysis

Gender Roles and Responsibilities

Division of (domestic) labor

Most respondents said that the conflict has not brought about any gender role changes in the division of unpaid care work within the household. Similar to before the conflict and in line with local social and cultural norms, women are still primarily responsible for the domestic labor within the household (e.g., childcare, cooking, cleaning, etc.). The family care burden shouldered by women has only expanded: schools have closed so mothers/female caretakers are minding the children without the support of educational institutions, and men are increasingly absent due to injury or loss during the conflict, conscription into armed groups, or migration in search of other livelihood options. In fact, of the surveyed households, their household composition has shifted toward more women including 50% more older women (60+) with disabilities, 31% more female children (<18), 13% fewer older men (60+), and 10% fewer men with disabilities compared to pre-crisis conditions. In a small number of households in Gezira, men are taking on more responsibilities that were traditionally reserved for women, including cleaning and water collection. While noted by only very few male and female respondents living in collective shelters, they explained that they all needed to step in to help in the difficult circumstances. Thus, this may not be a longer-term change, but rather a shift out of necessity while women are increasing their presence in the workforce outside of the home.

Earning income

In 2021, labor force participation for women and men was 29.1% and 68.1% respectively, which has been relatively unchanged for more than a decade.^{xlvi} Women's labor force participation is low due to social and cultural norms that restricted women's participation almost exclusively to the household. The question of who is now earning income generated the most discrepancies amongst survey and interview respondents, which indicates that who is earning income may be highly fluid. Of the surveyed households, men are most likely to be working by a small margin: 52% of men are earning income currently compared to 47% of women. Most male and female respondents reported that there is more paid work outside the home available to women than men currently, such as selling tea, cleaning houses, and doing laundry. However, a small number of male and female interviewees, primarily in Khartoum, conversely said that women have stopped working to protect themselves against safety risks when traveling outside of the home (e.g., sexual violence; see Safety & Protection section below). Women who are working are most likely to be respondents from East Darfur than the other states, which continues pre-conflict trends of East Darfur women being more active working outside of the home than women in most other states.^{xlvii} About 14% of boys reported to be contributing to the household income and about 7% of girls according to male and female respondents. More information is available in the livelihoods section below.

Decision-making within the household

Women who participated in this RGA reported having gained marginally more decision-making power within the household since the conflict started. Across all types of decisions surveyed,³ half of all female survey respondents reported more of a decision-making role than before the conflict; 22% reported less of a role, however, and the remainder were unchanged. The types of decisions where more women felt they now have more responsibility were primarily related to caregiving, including family caretaking and accessing healthcare, but also related to engaging in livelihood activities. Additionally, the growth of female-headed households (FHH) has also led to more women being required to step into the role as breadwinners and lead decision makers as more men are killed or separated from their families due to the conflict. For instance, another study found that in FHH, women are taking on more financial decision-making responsibilities by necessity that would otherwise be considered in the sphere of the husband; yet, when the household is male-headed, women's role around financial management is still largely unchanged^{xlviii} even though more women are contributing to the household income. This finding was validated by RGA data as well,

³ Women and men were asked about the extent of their decision-making related to buying/selling assets, managing cash/income, livelihoods, migration/relocation, healthcare, food/nutrition, and family caretaking, and whether or not this changed since the conflict.

although some suggested that as women earn more of the income, they have a stronger say in the decisions. Generally, though, male and female respondents both reported that decisions were made after joint consultation within the family (averaging approximately 47%), with men having the final say on central household issues (such as relocation). Despite some positive changes, many of the patriarchal norms that have been long-present in Sudanese culture that restrict women’s agency and voice have continued.^{xlix}

Capacity and Coping Mechanisms

“We welcome people coming from Khartoum, who are coming in cars that carry 250 people approximately. They come exhausted due to the long journey and tough route. Some get robbed on their way. They are suffering from the lack of food and water. We help with the local organization I work with; through the help of local volunteers, we provide nutritional support like rice, onions, oil, and others. We provide a ready-made meal first upon their arrival, anytime morning, evening, or night.” – *Female local civil society leader in Eldein, East Darfur*

Severely restricted economic resources and mobility for newly displaced women, men, boys, and girls has forced families to **rely heavily on support wherever they find it**. In fact, 12% (11% of male respondents, 25% of female respondents) say support from relatives or humanitarian aid is their *primary* means of income now. Sudan has a rich “traditional culture of reciprocity and community cohesiveness”, which has helped those who have been forced to flee violence find refuge.^l This culture was especially noted in Gezira and East Darfur by all, but especially female RGA respondents: families, friends, and strangers are sharing whatever they have (homes, food, water, clothes, etc.) with each other; respondents also reported that sometimes ten or more families are living together in one house. To date, most (67%) are still living with host families.^{li} There have been some external reports^{lii} as well as statements from respondents in East Darfur that communities are paying closer attention to the needs of women survivors of GBV by ensuring they have adequate shelter within families for protection. The Sudanese practice of *al-d’ara* has been a lifeline for some IDPs. This practice involves women placing food under a tree or outside of their homes for passersby to eat. Also, cash and in-kind donations from the public – raised by traders, cattle breeders, and women and youth organizations/groups – have been instrumental.^{liii}


However, as the conflict has gone on for many months, respondents shared that many host and displaced families are growing wearier of the co-living arrangement and are able to offer less support as their resources have become more strained. In Gezira, where most families have been displaced from Khartoum, some displaced families are experiencing multiple displacements often from host families’ homes into collective shelters as space and resources are depleting or as conflicts arise within the household. For instance, some women explained that men may feel uncomfortable staying with their wives’ families as it goes against cultural norms, and this may cause disagreements or tensions within the home. This weariness of hosting has not (yet) been reported in East Darfur, potentially due to families have not been displaced in the state for as long. Regardless, the women who are hosting displaced relatives are shouldering increased responsibility for unpaid care work for the growing size of the household, which includes preparing and serving food, supporting health needs, childcare, and other issues as that arise. This limits the space, resources, and time women have to address their personal needs.^{liv}



Loss of income or livelihood has been the most widely felt impact of the conflict across all states (77%; see livelihood section below). To cope, men and women are trying different ways of **earning income** (32%), **selling assets** (18%), and **borrowing money** (17%). While all such income generating coping mechanisms are similar across states, those in East Darfur were slightly more likely to report selling assets and those in Gezira were slightly more likely to borrow money. This is likely attributable to the heavily agricultural economy of East Darfur pre-conflict. By gender, more women (36% of female respondents / 25% of male respondents) and those in female-headed households (FHH) (49% of FHHs / 22% of male-headed households (MHH)) say they are finding different ways to earn income as a primary coping mechanism. The types of work women do differ greatly by state, with those in East Darfur engaging in farming, livestock, and trade whereas those in Gezira are working in offices or the public service. Only daily labor and tea selling were income generating activities practiced by women in all states. Proportionately more

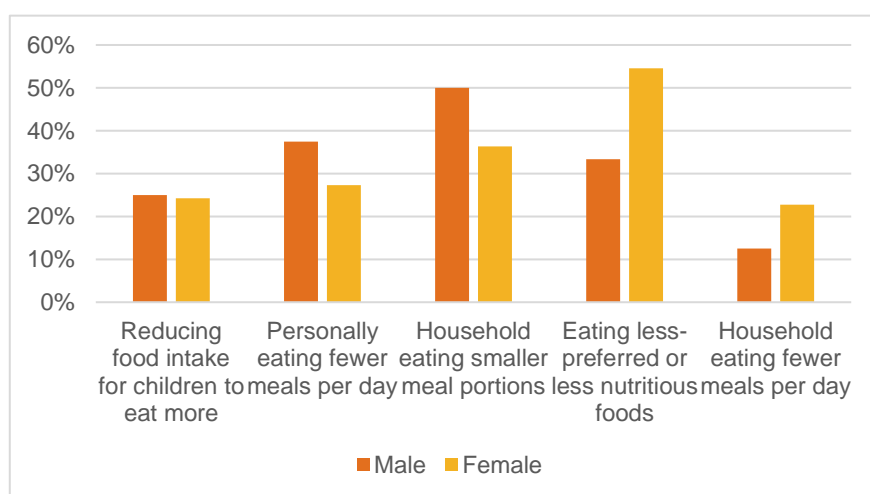
women reported using up their savings to meet their basic needs (29% of female respondents / 13% of male respondents) whereas more men reported selling their assets (25% of male respondents / 15% of female respondents). Given the patriarchal structures in Sudan that limit women’s ability to own assets, this is an anticipated finding.^{lv} As the conflict continues, both men and women will soon run out of these finite resources.

The majority of survey respondents (81%) reported that they and/or their family have **reduced their food intake and changed the way they eat** as a result of impacts from the conflict (see Figure 1). Men were more likely to report a personal reduction in their eating habits (60% of male respondents compared to 52% of female respondents), although reducing overall food intake is more common in FHH (59%) than MHH (47%), which was echoed in past assessments.^{lvi} Some female interviewees in Khartoum and Gezira said they have reduced their household’s meal intake to one meal per day. This could reflect the reality of cultural practices that women would eat less than men even before the conflict,^{lvii} so the difference in eating habits – in particular eating less – is being felt more by men.



81% of respondents reported a reduction of food intake since the conflict began

Figure 1: Key changes (>10%) in food consumption since the conflict by survey respondents



At least three-quarters of IDPs in Gezira in May 2023 could not access food independently due to a lack of financial resources; most relied solely upon **food donations** either from the local community or international actors.^{lviii} However, only 2% of respondents of this RGA survey reported relying upon food donations as a primary change in the way they eat. This may be because so few (17%) reported ever receiving food assistance and thus cannot rely upon it as a primary resource. Instead, alternative coping mechanisms are practiced including local barter economies to

exchange products in South Darfur^{lix} and sharing breastfeeding responsibilities across mothers to combat problems with lactation due to malnutrition in Gezira. While food scarcity was reported more problematic than water unavailability, people have turned to several types of coping mechanisms to also deal with **water shortages**. The main coping strategy of both men and women for the lack of water is taking fewer showers (42%). Many are also getting water from neighbors (29.5%), using less water for cleaning (16%), and using less for cooking (13%).

19% of survey respondents reported **relocating or migrating** since the conflict as a means of coping. Many families in Khartoum especially have relocated. Others particularly those with older parents, chose not to relocate or are still weighing the decision as the conflict continues to unfold.^{lx} More active coping strategies, especially related to protecting the physical safety of the family were reported by female respondents, include securing weapons (7%; reported only by women and almost exclusively in East Darfur) and having men sleep outside to protect their household (4%; reported only in Khartoum by women). Some male household heads remain highly resistant to strategies like taking up arms. As one man in Khartoum explained, *“It is difficult to resist an armed person. But I refuse to arm because it creates tribal conflicts.”*

“There is no one left in our neighborhood, there are only four families left.” - *Young female resident in Khartoum*

Access / Mobility

Most respondents (79% of male respondents, 71% of female respondents) feel safe moving without restriction within their neighborhood, including going to the market and health center, particularly in Gezira (92% of female

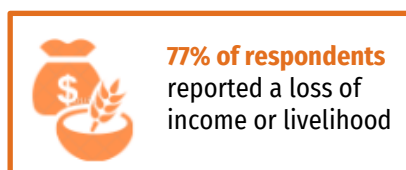
respondents, 80% of male respondents), but less commonly in East Darfur (67% of female respondents, 83% of male respondents) and Khartoum (50% of female respondents, 77% of male respondents). Traveling outside of their community, however, including going to the nearest town or another locality is less possible for most. There is a significant difference by state: mobility is open almost without restriction in Gezira state and those who report no movement possible are located mostly within Khartoum and, to a lesser extent, in East Darfur. However, some people (37%) report **staying inside** their home or shelter as much as possible to minimize their risk. This is a tactic more practiced by women than men (41% compared to 33%) and more common in East Darfur and Khartoum than Gezira, as conflict is not active in Gezira state.

Despite safety risks, women and girls have a strong cultural expectation that they must care for their families above all else, so they will travel alone if necessary to fulfill their responsibilities and address their basic needs. Indeed, girls are brought up to tolerate GBV so the risk of it often does not hinder their likelihood of traveling outside the home to perform their gender roles such as going to the market.^{lxi} As a survival strategy, girls especially are **traveling in groups** when they need to go out. Across the states, women were significantly more likely to report traveling in groups or with a male relative except in Khartoum, where a small number of men also reported traveling only in groups. A small number of women in Gezira reported being able to travel only in groups or with a male relative (regardless of whether travel is within or outside of the community). People living in all states said that they are no longer mobile in the evening or at night. In Khartoum, most said they stay indoors from 3pm, whereas East Darfur and Gezira, respondents said they stay inside from 7pm.

Services and Resources

Livelihoods

The top needs shared by men and women alike are cash (57%; 55% of female respondents, 67% of male respondents) and livelihoods (45.5%; 45% of female respondents, 42% of male respondents). While some women also named cash as their primary need over to livelihoods, no men named livelihoods as their primary need; rather, they focused on cash as their top need and livelihoods was their second or third priority reflecting the urgency in which they needed cash to address basic needs. This may also be due to the bank closures that have made accessing money increasingly difficult – including remittances, which are a major source of support for many Sudanese families, especially FHH and refugees.^{lxii} Liquidity of cash has severely constrained the local currency due to the closure of the Central Bank.^{lxiii}



Loss of income or livelihood has been the most widely felt impact of the conflict across all states (77%). Men more commonly identified it as their most significant change (58% compared to 44% of female respondents), but it is more evenly distributed amongst men and women's top three biggest changes. Men are more likely to identify this as their top change because most reported

that they had regular work before but can no longer find any work, including daily labor, since the conflict. According to RGA data, no one is earning any income in nearly one in ten households, particularly displaced or refugee households. This survey result is likely an underestimation of the true scale of unemployment, though, because even before the conflict unemployment was 16.6% nationally.^{lxiv} Both men and women reported that there are “no jobs”, despite their efforts to search and willingness to work. Employment opportunities have diminished with the closures of many businesses due to insecurity, major employers leaving the country, or a lack of goods to sell at shops.^{lxv}

Two-thirds of respondents (58% of male respondents, 51% of female respondents) said their primary means of earning income has changed (see Table 2). Some (37%) went from having a job that provided an income to depending on savings, humanitarian assistance, or support from relatives both inside and outside of Sudan whereas others who previously had stable jobs have shifted to various types of daily labor (38%). In Khartoum and South Darfur, fewer are seeking daily labor opportunities because they feel unsafe and because armed actors often prevent them from leaving their homes. There are many reports of children – especially boys – working in all states. In many cases, they are working alongside their parents.

Table 2: Livelihood impacts in Gezira, Khartoum, East Darfur, and South Darfur

Gezira	Khartoum	East Darfur	South Darfur
<p>More men (80%) experienced a change in their primary means of earning income compared to women (67%) in the state. Men went from daily labor to relying upon assistance, whereas women shifted from mostly public service and office roles to day labor or relying upon assistance as well. Some IDPs said that those who decided to flee first and move to Gezira were able to secure the limited jobs available with aid organizations. Those who arrived later have been left with few options. Women, more than men, look for work in the factories and in homes doing cleaning or laundry, and the men seek out jobs in construction or carrying items to the market. If successful, they earn only a very small wage. For instance, a factory job with long hours (6am-6pm) may only enable a worker to bring home 1,500SDG (\$2.50USD) for the day. As a result, people are not able to earn enough to provide for most of their needs and must depend upon remittances to get by.</p>	<p>Different from Gezira, more women have had to change their primary income earning options (89%) than men (69%). Before, women and men reported working in office jobs and markets. Now, much of the urban center has been deserted and the economic sector has collapsed in the state due to the duration and intensity of the conflict. This area formally thrived on a larger population of white-collar jobs,^{lxvi} but now employees and laborers cannot work since factories, markets, and office buildings are destroyed. Those who remain in Khartoum are no longer able to access their prior jobs and due to urban desertification, opportunities are not available for other livelihood opportunities such as petty trade.^{lxvii} The women who were in such roles before now go out each day in search of daily labor / odd jobs whereas men are largely not working to earn any income. The few whose primary means of accessing income remained unchanged are tea sellers and daily laborers.</p>	<p>East Darfur is an agriculture-dependent state for its livelihoods (84% of the population work in agriculture).^{lxviii} Women have historically been the main farmers and income-earners for their families. To date, farmers and laborers are less likely to report a change in their livelihoods. Still, the reliance people have on agriculture has been compromised. Now, there is a shortage of agricultural inputs due to supply issues, a lack of money to pay daily laborers, and a reluctance of farmers (typically women) to travel into the fields for safety reasons. Also, there used to be income-generating activities (IGA) supported by civil society. Those (development) jobs and projects ended and left many people without a source of income. Furthermore, there were many agencies where people could work but those opportunities are now few. In fact, far more RGA female respondents reported a change in income sources (58%) compared to male respondents (17%) in the state, most of whom had office jobs previously.</p>	<p>Women are often the primary agricultural laborers in the state and the breadwinners for their households.^{lxix} Since the conflict, however, there has been a reduction in available farming inputs (e.g., sorghum) and crops are being destroyed. These consequences of the conflict have negatively impacted the livelihood opportunities for female laborers.^{lxx}</p>

Food Security

More than 42% of the population (20,293,352 people) are experiencing crisis levels of food insecurity (IPC Phase 3+), and an additional 17 million are food stressed.^{lxxi} Estimates predict that 2.5 million *more* people than before the crisis are now **food insecure**.^{lxxii} The states with the most active conflict have the highest share of their population classified as IPC Phase 3+, including Khartoum (56%) and East and South Darfur (53%).^{lxxiii} Food is the top need indicated in UN OCHA situation reports in all of the focal states of this study except for South Darfur, which is non-food items.^{lxxiv} It is likely that food will also become the top need in South Darfur, as residents in Nyala reported that “hunger was approaching the ‘worst possible levels.’”^{lxxv} Similarly in Khartoum, respondents shared a fear of starvation and have learned to eat just one small meal a day with water. There are several groups that are more susceptible to food insecurity including women, pregnant and lactating women, female-headed households, rural households, PwD, and older people. Harmful gender norms about women eating least and last within a household^{lxxvi} perpetuate women’s food scarcity; 79% of women were not meeting minimum dietary requirements even before the conflict;^{lxxvii} female-headed households are more vulnerable to food insecurity (42%) compared to male-headed households (31%), and they also have a 10% lower food intake;^{lxxviii} and people with disabilities and older people typically rely on others for food.^{lxxix}

Households report a lack of income (31%) and safety risks (27%) as the main barriers to accessing food (not a lack of food in markets). The **cost of food** is a significant hindrance and the one described often by men and women alike. The high prices and lack of income are felt more by displaced persons (35%) than non-displaced (26%). In Gezira, food prices have increased by more than 50%,^{lxxx} and in Khartoum, inflation for basic goods has exceeded 160%.^{lxxxi} Similarly, the Greater Darfur area is experiencing some of the most extreme increases in market prices, including 100-150% increases from one year before.^{lxxxii} As a result, most respondents said they cannot afford to



buy food at the market. Reports from East Darfur even said that there is food in the markets that has expired because no one can afford to purchase it. Similar issues of food that is near expiration have arisen in Gezira as well.^{lxxxiii} Prices are likely to continue increasing with more displacement, but also due to the start of the rainy season, which will hinder transportation state-wide and nation-wide.^{lxxxiv}

Most (68%) of the survey respondents said there is still enough food in the markets. **Food unavailability** in markets was most challenging in Khartoum, where supplies are reported to be more scarce.^{lxxxv} Also, in Khartoum and South Darfur, local shops have closed due to insecurity, looting, a lack of goods to sell, or because they have been lost due to shelling or being burnt down.^{lxxxvi} Some foods are unavailable because of **disruptions to the supply chain**. Concerns are high about the ability to restock goods as transportation networks have been disrupted or closed completely.^{lxxxvii} Furthermore, access – financially and physically – to **agricultural inputs** is limited. Women experience more difficulties accessing production inputs (seeds, fertilizers, etc.) than men^{lxxxviii} despite the more active role they often play in farming in East and South Darfur.^{lxxxix} Limited inputs will reduce agricultural production and more deeply push the country into an acute food crisis,^{xc} especially rural households that depend on the ability to produce their own food. Some reports say this concern is coming into reality already in Gezira due to the high numbers of displaced families from Khartoum.⁴ As lean season has arrived, the needs are particularly stark.^{xcii} As most people in Sudan (Gezira and Darfur states included) rely almost exclusively on farming for both income and their own food consumption,^{xciii} needs are not being met with the influx of IDPs and the potential safety risks involved in cultivation and harvesting due to the conflict. Similarly, livelihood assets such as livestock have been negatively affected because of the impact from the conflict (e.g., the spread of diseases due to the destruction of livestock vaccine facilities in Khartoum).^{xciii}



Woman farmer selling her vegetables grown from the women's garden supported by CARE in East Darfur ©CARE 2023

Accessing markets differs by state. Men and women are near equally likely to say they do not face challenges accessing markets, except for market overcrowding (25% and 24% respectively). However, women struggle more with getting to the market due to the high cost of transportation (18% compared to 8% of men) and men feel more risks to their personal safety while traveling to the market (33% compared to 26% of women). Men risk being beaten by armed actors and women face the risk of being raped. There are also risks of being looted for cash and/or personal belongings on the way to and from the markets (see Safety & Protection below). Women explained that there is plenty of transportation available, but most cannot afford it and choose to walk instead. In East Darfur, people struggle during rainy season to reach the market due to road closures; this is unchanged from before the conflict started. The situation is very different in Khartoum and South Darfur, where accessing the market is extremely dangerous due to the volatility of the conflict. Respondents in Khartoum said that “*going to the market, you might die*”.

⁴ Some estimates say four million Khartoum families are now living in Al-Gezira state, though this number has not been verified formally. Source: UN OCHA. 2023. “Inter-Agency Rapid Assessment Report Al Gezira State (Greater Wad Medani, East Al-Gezira, Hassaheisa).” UN OCHA.

Nutrition

Malnutrition is an increasing problem in all states especially for children and pregnant and lactating women. Even before the crisis, Sudan had the highest rate of malnutrition globally, affecting 3 million children under the age of 5 (and 610,000+ with severe acute malnutrition (SAM)).^{xciv} The crisis has complicated this already fragile situation as it has disrupted aid – including nutritional supplements for 50,000 children suffering from SAM.^{xcv} Furthermore, a factory that produced 60% of all therapeutic food used by UNICEF and WFP to treat SAM and moderate acute malnutrition (MAM) respectively in Sudan, was burnt down.^{xcvi} Thus, OCHA estimates that there will be a 30% increase in the number of children with acute malnutrition in specific regions, particularly IDP hosting states.^{xcvii} Respondents are already feeling the consequences: they shared that food supplements – in particular for moderate malnutrition and prevention of malnutrition – are not available, making instances of malnutrition less treatable and becoming more extreme. Some are unable to cope, and respondents especially in East Darfur said that children are experiencing starvation.



A child receiving nutritional support in Sudan © CARE 2023

Furthermore, **nutrition services** are not currently available in most locations. Pregnant and lactating women as well as infants are most significantly affected, as they are not receiving the screenings and services needed to promote nutrition and health (e.g., counseling, breastfeeding promotion, micronutrient supplements, etc.).^{xcviii} In fact, both male and female survey respondents in all states, especially in Khartoum, felt that the top reproductive health need of women and girls is nutritional support (39% of female respondents, 56% of male respondents). Prior research has demonstrated a link between caregiving responsibilities and malnutrition of women and girls because they are meant to prioritize the nutritional needs of others above their own.^{xcix}

Therefore, as more women and girls are taking care of more families, they are likely to face a compounding nutritional crisis.

Building upon an existing problem,^c there is a severe **lack of food diversification**, which hampers proper nutrition.^{ci} Respondents reported that children and pregnant and lactating women are suffering from **anemia** due to poor nutrition. There are shortages of some food items such as oil, onions, wheat, rice, sugar, milk, fruit, and meat and the cash shortage has made it nearly impossible to eat a diverse and nutritional diet. Thus, eating less preferred or less nutritious foods was reported by 61% of survey respondents across all states and 66% reported they were eating less diverse types of foods since before the conflict. Many respondents shared that they are relying almost exclusively on legumes and millet. Respondents said the greatest needs are fruits (especially for children), milk (for lactating women and children), meat (for all, but especially for pregnant women), and vegetables. Non-food items such as charcoal and cooking fuel are also severely lacking. As a result, some people in Gezira and Khartoum report eating more raw foods.

Health Services

Even before the conflict began, Sudan's health system was strained. For instance, in 2021, the WHO scored Sudan at 44 on the Universal Health Coverage (UHC) index, placing Sudan at 162 of 188 countries ranked.⁵ The already poor health system has further collapsed since the onset of the crisis, especially as most facilities (more than 70%) in the conflict regions have **ceased operations**.^{cii} In Khartoum, most cannot safely access a health center and most health centers, even if operating, are damaged. As of May, 61% of health facilities in Khartoum have closed and just 16% remained fully operational.^{ciii} RGA respondents said that as of August, just two hospitals remain operational. In Gezira, respondents reported that they can still access health centers safely, although those in rural areas or outside

⁵ The Universal Health Coverage (UHC) index averages 14 measures of essential health service coverage including reproductive health, infectious diseases, non-communicable diseases, access to services, and more. Source: Global Health Observatory. 2023. "Coverage of Essential Health Services (SDG 3.8.1)." <https://www.who.int/data/gho/data/themes/topics/service-coverage> as cited in World Health Organization. 2023. "Annex 1. Country, Area, WHO Region and Global Health Statistics (of the World Health Statistics 2023)." The Global Health Observatory.

city centers struggle to reach facilities.^{cxiv} In East Darfur, larger health facilities are still operational, but smaller ones near villages have closed due to a shortage of medical supplies and electricity. In South Darfur, little data on health and nutrition is available since mid-April, making it difficult to confirm how many hospitals are still operational.

The healthcare facilities that remain open are **severely lacking supplies, equipment, and medicines**,^{cv} as most of these supplies were previously sourced through markets in Khartoum that have since been destroyed. Health system disruptions in Khartoum affect the entire country's access to medical supplies, lab tests, medicines, vaccinations, specialty care, and other elements of health provision. Specifically, the cold chain storage facility that stores nearly all vaccinations is no longer accessible.^{cvii} Doctors and nurses need reinforcement of medical and surgical materials to keep up with demand. There are reports of medical supplies being blocked in the roadways as they are being transported from Khartoum.^{cviii} As a result, the South Darfur Ministry of Health reported a critical shortage of medical supplies and medications in early August 2023;^{cxviii} such shortages were already a major issue in the state before the conflict.^{cxix}

Because of the closures, there is a problem with **overcrowding** (experienced by 42% of RGA respondents, especially in East Darfur and Gezira). In Gezira, for example, observations found that more than 30 people are sharing one room in many instances and, when indoor spaces are not available, patients are sleeping outside and at risk of snake and scorpion bites.^{cx} The vast closures of health facilities in Khartoum have increased the burden of Gezira's facilities. In fact, some Khartoum residents are traveling to Gezira for care.^{cxii} In East Darfur, the closure of smaller, more rural clinics in addition to the influx of IDPs has made the larger health centers full past capacity and there are reports of as many as three women staying in one bed.



Women in a health clinic in Sudan © CARE 2023

Not only does overcrowding negatively impact quality healthcare, but it also increases the risk of **infectious disease** spreading amongst the communities. Health facilities are seeing an increase in contagious skin diseases (scabies, tinea capitis and pedis, and heat rash), vector borne diseases (malaria), water borne diseases (dysentery), and mass food poisoning, and mumps (inside the camps).^{cxii} **Malaria** is one of the biggest concerns amongst respondents in all states, especially in East Darfur and Gezira. There are issues with both prevention and treatment as mosquito nets are not available nor is malaria medication. Residents report an abundance of pools of water where mosquitos are congregating as rainy season sets in. Early signs of outbreaks of diseases are starting, including cholera, flu, and typhoid. For instance, water and sanitation issues in Khartoum city have triggered warnings of a likely **cholera** crisis.^{cxiii} Assessing the state of the potential cholera crisis has been challenging, though, due to the closure of public health laboratories which has made testing for the disease impossible.^{cxiv}

Unlike many other food and non-food items where respondents say items are available but not affordable, most respondents across all states report that **medications and vaccinations** are not available in health centers nor in markets. Even prior to the conflict, many vulnerable populations such as those with chronic conditions and older people struggled to obtain the medication needed on a consistent basis.^{cxv} Now, these groups are almost always



Health workers talking in a pharmacy in Sudan © CARE 2023

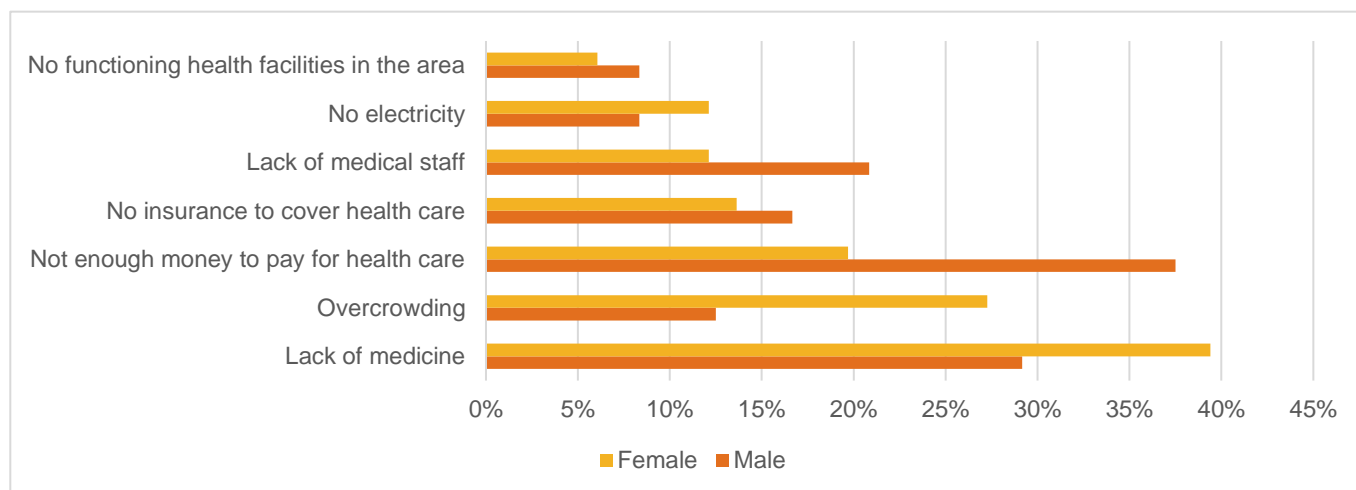
without routine medications.^{cxvi} Many medications that require cold storage such as insulin have been unavailable for a long time due to power cuts. This only compounds the shortage. The treatments and medications male and female respondents said were most needed are malaria treatment (53%), insulin (43%), malnutrition treatments (28%), psychological care (27%), kidney dialysis (20%), and pre- and post-natal care (19%). The top three needs are similar for men and women – though men see insulin as a greatest need instead of malaria – but the top needs change after that with a higher than the average proportion of men naming kidney dialysis, chronic disease treatment, and vitamins as critical health needs. Many other types of medications and treatments are

needed according to men and women, including antibiotics, pain killers, typhoid treatment, anemia treatment, blood pressure medication and cancer treatment.

Furthermore, the **limited local staff** are overwhelmed as they are caring for up to five times as many patients now as before, according to an RGA respondent. Many expatriate doctors in Khartoum left at the start of the conflict, and some female medical staff have been unable to return to work for safety reasons or because of childcare responsibilities at home. A small number of male and female respondents (equally) said the lack of female staff at health centers has been a key challenge for women to access healthcare. Some women in Sudan, due to religious beliefs and/or cultural norms, can only see female medical personnel.^{cxvii} Since the crisis, women health workers have had to stay home with their families and children which has left an even wider **gap in healthcare for many women**.^{cxviii} Also, doctors and health practitioners have become targets of threats and smear campaigns, particularly in Khartoum, which is making it harder for them to do their jobs and has led many to quit.^{cxix} This has only added to the staffing shortages. Infants and children in Khartoum have experienced increased vulnerability to health challenges, particular those living in orphanages.^{cxx} Similar issues have been reported in centers for older people, where residents have reportedly died due to lack of adequate care, food, and medicines.^{cxxi} In South Darfur, on the other hand, some hospitals have increased their capacities as they have been inundated with those injured or killed from the recent battles.^{cxvii} However, doctors note that patients are often unable to reach hospitals because of the ongoing clashes.^{cxviii}

Healthcare has become too **expensive** for most people. One person in Gezira said patients must pay a minimum of 3,000 SDGs (\$5 USD) to be seen. Then, treatments are an additional cost. For instance, in East Darfur, caesarean deliveries cost 200,000 SDGs (\$330 USD) and this cost is impossible for most, putting the lives of babies and mothers at risk due to delivery complications. People are opting not to seek healthcare now, even for chronic conditions, because it has become unaffordable. One respondent shared, *“I am afraid if I became sick or my children get sick. Where can I get money for treatment?”* In the past, people could use health insurance to manage costs. Since the conflict, health insurance schemes have stopped.

Figure 2: Key (>10%) health facility challenges experienced by survey respondents in Gezira, Khartoum, and East Darfur



Equally across all male and female respondents, half had to use a health facility in the past month (August 2023). However, more women needed to visit a health facility because they were sick but did not go (17% of female respondents, 8% of male respondents), and most were based in Khartoum (54%). Those who went to a facility experienced many challenges that align with those described (see Figure 2). The **challenges varied greatly by state** with the most noteworthy differences including: a lack of functioning facilities is much more problematic in Khartoum but overcrowding much less common as health seeking behaviors wane, and a lack of medicine is most often cited in East Darfur. These results demonstrate that there are some health service issues that are consistent nationwide including medication and supply shortages and growing medical costs, but some of the greatest variations across states are found within this sector, with available data indicating the direst needs in Khartoum. There are also some **significant differences by gender**, namely: men more frequently cite not having enough money to pay for care and insufficient medical staff, whereas women more often cite challenges with overcrowding,

lack of female staff and insufficient medicine. The differences could be due to the traditional role of men as the financial decision-makers in the household and thus, having greater awareness of the costs, whereas women traditionally take on the role of caretaker and are more likely to be the person in the household managing medications.

Mental Health and Psychosocial Support

Exposure to shelling, death, and destruction in the wake of such a sudden armed conflict has traumatic impacts on all who experience it.^{cxxiv} Many populations are experiencing secondary displacement, which triggers deeper psychological impacts.^{cxxv} Some respondents are sharing that older persons are recounting traumas repeatedly as they are struggling to process the reality of what is happening around them and/or are refusing to leave (either for personal or physical limitation reasons) conflict-stricken areas.^{cxxvi}

Men and women alike are manifesting their trauma in different ways. Women RGA respondents reported experiencing greater depression and fear, and many women are feeling more alone without their extended family and prior social connections. Widowed and divorced women are facing psychological stressors due to the collapse of the rule of law including children being taken back by their fathers or fathers not paying alimony.^{cxxvii} Also, women who lose their husbands due to death or injury often lose their agency to make independent choices. In past wars, widowed women have been forced to marry the closest male relative of their deceased husband.^{cxxviii} Both men and women RGA respondents shared that men are becoming more discouraged and therefore idle, and many men are no longer attempting to find work as much as they tried earlier in the conflict. There are reports in East Darfur of more men turning to drugs as a result. They elaborated that young men are most prone to drug use and violence has erupted, even between families, when the young men are under the influence of drugs. Some women in East Darfur and Khartoum reported that men decided to leave their families because of the humiliation of not finding work and the social and cultural pressures they faced as male heads of the household. Thus, one of the biggest changes since the conflict started has been the increase in FHH.

In Gezira, men and women alike feel that **children’s psychological wellbeing is the most affected**. Many say that children’s personalities and behaviors have drastically changed since the start of the conflict; they are more easily upset and act more aggressively. Many respondents shared stories of how loud noises and airplanes send children into a state of shock and fear and they are manifesting uncharacteristic signs of aggression and tantrums. Parents, especially mothers, feel lost about how to manage their children. Other assessments identified mental health as the most significant issue facing displaced children (68%).^{cxxix}

Another group with a critical need for psychological support are **rape and sexual violence survivors** (see section on Safety & Protection below). These survivors, who are typically women and girls, are not only traumatized from the experience, but they are also fearful that they may be or may become pregnant from rape and are uncertain how they will be able to physically and psychologically cope.^{cxxx} Additionally, others are experiencing psychological distress that comes from witnessing or hearing such acts being committed and harboring feelings of guilt for not being able to help.^{cxxxi} There is an increased risk of suicide if these survivors continue without treatment.^{cxxxii} There have already been some reports of increasing rates of suicide and/or self-inflicted harm amongst young women due to fears of being attacked and/or raped.^{cxxxiii} Prior to the conflict, there was already some evidence that young women in East Darfur were facing mental health challenges with a reported increase in suicide amongst girls – especially those being forced to marry at an early age.^{cxxxiv}



Women are more likely than men to note **mental health as a critical need**

Despite the critical nature of this need, only 10% of respondents – and almost exclusively by displaced women in Gezira – noted psychological support as a top need. This could be due to the greater familiarity with mental health issues of those who have been displaced from Khartoum, and the relative time and space to reflect on the consequences of the conflict on their mental health,

whereas those still in Khartoum and South Darfur are experiencing the physical dangers currently. **Women are much more likely than men to note mental health as a critical need**; they see a dire need for psychological support for others (particularly their children) but do not equally recognize or report this need for themselves.

Reproductive Health Services

Women survey respondents are much more likely than men to indicate reproductive health and family planning as critical health needs. Before the crisis, **maternal mortality** was amongst the worst worldwide with an estimated 270 women dying per 100,000 live births as of 2020^{cxv} even though most births (78%) were attended by a skilled medical professional (2013-2022).^{cxvii} Since the conflict in Khartoum, the areas surrounding the few remaining hospitals are controlled by armed actors and women feel it is too risky to access healthcare or seek medical attention even when they need services, including when they need to give birth. Pregnant women have reportedly been unable to seek medical care to address complications in advance of their birth (including nutritional deficiencies) and as a result face life-threatening consequences for both the mother and child such as hemorrhaging.^{cxviii} This is a major risk for the estimated 219,000 pregnant women in Khartoum^{cxviii} An estimated 7,982 pregnant women have been displaced as of May 9, and they have been left without obstetric and neonatal care and services while simultaneously increasing the physical and psychological stressors on their body.^{cxix} Similar issues are unfolding in South Darfur now as well, as armed actors are setting up bases on the grounds of health centers.

Respondents in East Darfur are also significantly more concerned about reproductive health, especially **pre- and post-natal care**, as a top health priority compared to respondents in other states (68% of all reporting it as a top need were from East Darfur). This was also the case for family planning services, where nearly 70% of women and girls historically were not able to access or utilize contraception in Sudan (2012-2019).^{cxl} The greater prioritization of these spheres in East Darfur could be influenced by the strong health and nutrition focused presence CARE has had in the state; thus, the knowledge of residents is likely higher about pre- and post-natal care than in other states that have not had the long history of awareness raising. Also, given the conflict is not as present in the state and fewer people are in need of emergency care, East Darfurians are more focused on routine health services. On the other hand, those in South Darfur are experiencing an urgent need for emergency care, so respondents said that pregnant women and those with chronic diseases are deprioritized, putting them at greater risk.



WASH

Water

Before the crisis, 17.3 million people were without access to a drinking water supply.^{cxli} These challenges have heightened since April and have become more widespread to include states that previously had better access to water and sanitation, namely Khartoum. This RGA confirmed that accessing water is challenging for most people (83% total; 83% of men, 89% of women).

Accessing water from a tap, which diminishes the water gathering burden for women, is the most common way water is accessed in all surveyed states: Gezira (65.5%), Khartoum (45%), and East Darfur (27%). Water tanks is the second most common source in Gezira (14%), Khartoum (32%), East Darfur (20%). When water is in a tank, it may only be refreshed after some days and in that period, some people are forced to go without water. As such, Gezira residents especially shared that they struggle to fill as many containers as they have to store it for the dry periods. Those living in schools must fill buckets, pots, or any other containers from the communal school tap; a separate assessment found that 62% of people lack sufficient water storage containers.^{cxlii} East Darfurians, compared to other states, are very diverse in how they access water including near equally turning to boreholes, water tanks, purchases from the store, from the tap, and other sources.

Because pumps rely upon electricity, water availability is most **inhibited by electricity and fuel cuts** (cited by 54% of respondents representing all states and living situations), which have been unstable since the start of the conflict. Gezira and Khartoum residents experience electricity cuts frequently and East Darfur residents to a lesser extent, which cuts off the pumps and their water sources. The water tanks that utilize solar powered generators have been more stable. Sometimes people need to turn to many different options to ensure they have what they need. One young man in Khartoum explained: *“Last week, there were rains. With each rain, the electricity was cut off for 4 or 5*

days. We cannot drink the piped water because it comes from a well and cannot be drunk without a filter.” In some densely populated areas of Khartoum, however, they have been without tap water for months.

Water availability is a big concern for women especially as they traditionally hold the responsibility of fetching it and using it for cooking, drinking, and hygiene.^{cxliii} According to RGA data, women are more likely than men (27% and 21% respectively) to feel that water availability is low and that they face long wait times to fetch it (32% and 25% respectively). As such, women (especially those in camps who experience longer waiting times on average) are also most affected by water shortages. Compared to the other states, women in East Darfur experience more challenges



Women and children collect water in shared collection site © CARE 2023

related to fetching water including long queue times (50%) and far distances (30%). This is unchanged from before the conflict, though, when one-quarter of East Darfur residents – mostly women – had to travel for more than one hour to fetch water.^{cxliiv} Similarly in South Darfur, most communities (90%) severely lacked access to nearby clean water. In fact, most (women and girls) had to travel for more than one hour to fetch water.^{cxliv} This puts women and girls at greater risk of GBV when traveling along the roads or forests for fetching.^{cxlvi} Thus, women in East Darfur shared that even though they continue to have water available, they are being more careful about how much they consume as a precautionary measure.

Water cleanliness is a problem noted equally amongst men and women (~22%), especially in Gezira. When water availability suffers, people, especially in rural locations, are more likely to drink from the same sources as animals and risk contracting (and spreading) waterborne disease.^{cxlvii} Water treatment is also currently insufficient, producing a dangerous combination of poor water and sanitation factors that is prompting a dire warning about cholera outbreaks.^{cxlviii} For instance, a woman displaced to Gezira shared, “*In the village of Musaed, they drink canal water contaminated with schistosomiasis. [...] I have seen children drinking contaminated water because there is no clean water with my own eyes.*” To combat unclean water, 16% of respondents – almost exclusive in Khartoum – reported purchasing clean water.

“Sometimes [we get water] from connections inside homes, or via pumps, or the Nile River during periods of conflict and power outages. Sometimes we buy it in two gallons for 500 pounds (\$0.83 USD), or you have to transport it from the Nile River on your own.”
– Male resident in Khartoum

Sanitation and Hygiene

Prior to April 2023, just 36.9% of the population nationwide used at least basic sanitation services.^{cxlix} Despite this figure, latrines are not a significant concern for most survey respondents (83%), as they reported having safe access to **latrines**. Similarly, nearly everyone reported having a safe place to **bathe** (92%). The few without, either had no bathing place to go or there was not a separate bathing area for males and females. Most of the few who did not have safe access to latrines are residents of East Darfur (19% compared to 10% in Gezira and 6% in Khartoum). There are some villages in East Darfur and Gezira where the latrine is far away from the school or camp, making it difficult to reach for many and impossible for some including older people and people with disabilities. Some camps/shelters do not have latrines available at all, so occupants (typically women) use latrines at neighbors’ homes or public facilities (e.g., mosques) during the day and are without access to facilities at night. Also, men more commonly cite challenges with accessing latrines (17% compared to 11% of women). The main reasons were because they did not have a latrine nearby to use or the infrastructure of the latrine collapsed due to the rainy season (which was reported in East and South Darfur and Khartoum). The higher rate of men reporting challenges is likely because they do not feel they have another option, whereas women are more likely to ask their neighbors to use theirs. Some women in East Darfur have formed groups with other women to travel to the latrines together during the day. In some camps, guards are out at night to protect women who need to use public latrines because there is no lighting available in the camps.

Due to the high rates of displacement, the main issue reported with latrines in Gezira and East Darfur is **overcrowding**. Also, when latrines are available, an observational assessment in Gezira found that 80% were not functioning due to water scarcity.^{ci} People are forced to wait for a long time as many families move through the queue to use the latrines. In one area, people reported that the latrines are often **overflowing**. These issues increase the likelihood of open defecation, which is dangerous for women and oftentimes impossible for people with disabilities, as it exposes them to risks to their personal safety. Similarly, in all states, the **cleanliness of the environment** is concerning to respondents who reported that they cannot get rid of waste. Before the conflict, Khartoum had some of the most reliable and clean WASH services in the country. However, with the extreme clashes occurring regularly throughout Khartoum city, trash is not being collected and corpses are being left indefinitely in the streets and are actively decomposing.^{cli} This, in addition to overflowing latrines, contributes to waterborne diseases for the whole community.

“There is nothing, no cotton, no pads nothing. Soon it seems like we are going to go back to more older ways of using a piece of cloth. Then people will be exposed to infections and who knows what else.” – *Female resident in Gezira*

There is a severe lack of personal hygiene products available nationwide, including soap, menstrual products, and diapers for babies. Respondents in all states are especially concerned about the unavailability and high price of **soap**. The majority of female respondents (61%) did not feel that their **menstrual hygiene** needs were being met. Where available, the price of menstrual hygiene products has skyrocketed. Due to these increasing challenges, many women and girls are preferencing the use of menstrual cloths instead.^{clii} In times where water is scarce, however, there is a risk of women and girls may be unable to clean the menstrual cloths, which can lead to negative health impacts.^{cliii} As such, women have reported using plastic bags or old fabrics to manage their periods. Many women respondents (36%) also recognized a need for a hygienic washing and/or disposal facility for the pads, which is currently lacking.

Safety and Protection

Physical Safety

Two-thirds of respondents felt there has been an **increase in security concerns** affecting women and/or girls since the start of the conflict, which is slightly higher than for men and boys (61%). Men are more likely than women to feel there have been increased safety risks for both women and girls (79% of male respondents, 66% of female respondents) and men and boys since the conflict (71% of male respondents, 61% of female respondents). Undoubtedly, death and injury are significant protection risks in a conflict. While the armed conflict is still ongoing in Khartoum and South Darfur, residents shared that they simply must “*adapt because there is no other choice*”. The most common safety concern for all is killing or injury accidentally by stray bullets. Men and boys are more likely, according to respondents, to be targeted for killings or recruited into the conflict. In East Darfur, they have seen a rapid spread of weapons and a growing presence of armed groups. One man shared, “*there has never been such a spread of firearms before.*”

One of the biggest risks to young men, particularly in Khartoum, is **accusations of working for one of the warring parties**. Men and boys are being targeted by an armed actor, facing verbal attacks and beatings, including with rifle butts, and sometimes killings or threats of killings.^{cliv} Respondents shared that it is vital to always carry documentation to prove your identity as protection. Therefore, the men and boys who had to flee without all of their documentation face increased safety risks. Furthermore, there are some families who are choosing to send girls out instead for necessities as a way to protect the boys from this risk. While it may minimize the risk to the boys, it puts girls at greater risk for rape or other injury.

Other major safety concerns include **theft** (40%) and **home invasion** (29%). Theft has been a growing problem since the start of the conflict: as people do not have means to provide for themselves, some (mostly young) men are turning to theft. In Khartoum, home invasions by armed actors are growing in frequency. Women who are survivors of such home invasions are being forced to meet the occupiers needs above their own, including by preparing food for them.^{clv} Sometimes, however, families are forced to leave their homes completely.^{clvi} In Gezira, on the other hand, since there has been such a large influx of displaced persons, people feel weary of each other

since they do not know each other yet. Some of the displaced families have shared stories of being **bullied** by the host community; some have even reported being physically attacked. Finally, improper water and sanitation facilities such as those **without locks or privacy and/or are located at far distances** from housing puts women and girls at risk of sexual violence.^{clvii} In Gezira and Khartoum, most communal facilities for displaced people do not have a shower or space to bathe privately, so women are showering in their rooms and men are going to the river. This is risky for women as they do not have a private and locked space. It is also risky for men because the river can be dangerous.

“From the beginning of the war, there was fear of repeated bombing, death, and injuries from stray and deliberate bullets. Nowadays, the fear of looting, theft, and rape has come to pass.” - *Male resident of Khartoum*

Gender Based Violence and Intimate Partner Violence

Research shows that GBV increases during times of conflict and women and girls⁶ see an increase in both the frequency and brutality of violence.^{clviii} Conflict weakens or severs the rule of law and compromises protective social norms and safety nets. Sudan is no exception. Past studies found that one in five Sudanese women have experienced sexual violence at the hands of partners or non-partners during times of conflict.^{clix} The GBV sub-sector estimates that 4.2 million people (up from 3.1 million pre-crisis) are now in need of GBV services,^{clx} but only 25% of GBV service partners are still operating.^{clxi}

Intimate partner violence (IPV) and domestic violence rates will likely climb as the conflict continues,^{clxii} as past studies have shown that during periods of conflict and economic hardship,^{clxiii} and as more women and men stay indoors together, IPV becomes a more significant risk. Survey respondents did not report an increase in IPV or domestic violence. However, a small number of respondents in Khartoum and East Darfur said IPV is a growing problem. They explained that because men cannot find work and there is not enough money in the house, there are more tensions and quarrels inside the home, and some say it is leading to more divorces.



One-third of survey respondents, almost all of whom were in East Darfur and Khartoum, feel there has been an increase in **sexual violence and rape** of women and girls (this risk was not named for men and boys). Sexual violence as a weapon of war inflicts pain and suffering on all involved – from the women who experience the violence to the men who must bear witness to the violence against their loved ones. For men, rape “humiliates and emasculates” the opposing group and triggers a sense of unfettered power amongst the perpetrating group.^{clxiv} For women, rape reinforces hierarchies where women are placed at the lowest level.^{clxv}

In Darfur and Khartoum, respondents said **that women and girls are being raped in the markets and along the road** on their way to the market. Young women, women living with disabilities, and refugee women are perceived to be those at highest risk to experience sexual violence.^{clxvi} Women and girls, even as young as 12 years old, are being raped or subjected to other forms of sexual violence by armed actors.^{clxvii} Young female refugees even prior to the conflict faced a high risk of sexual violence in their contexts (37% reporting such a risk), compared to young men (4% reporting the risk).^{clxviii} Also, displaced women living in camps are exposed to higher risk of GBV in settings with inadequate lighting and overcrowding.^{clxix} Respondents in Gezira said GBV is not a problem in their area despite overcrowding of camps. East Darfur, on the other hand, is experiencing a significant problem with rape in camps according to RGA respondents. Qualitative data highlighted the risks and prevalence of “illegal pregnancies” (pregnancy outside of marriage). Not only is this extremely dangerous and harmful for the girls, but it has rippling IPV effects for their mothers. There is a traditional belief in East Darfur that if a girl gets pregnant outside of marriage, the mother can be rightfully beaten because she is responsible for the daughter and therefore accountable for the family’s dishonor.

Treatment from sexual abuse was identified as a top need for women and girls by 10% of respondents, most of whom were displaced in camps since the conflict in East Darfur. There are insufficient rape kits available, and women are not able to access hospitals for treatment in a timely manner. Not only are these women survivors not receiving

⁶ Note: research does not discuss GBV against men and boys.

treatment, but they are also not able to seek justice and this creates a heavy psychological toll on survivors in addition to the physical impacts.^{clxx} Few rape cases have been officially reported^{clxxi} or documented.^{clxxii} Women (and men) in Sudan have historically **underreported** instances of GBV for a variety of reasons including stigmatization, reprisals, cultural norms around honor,^{clxxiii} and more access limitations because of the conflict (such as poor connectivity limiting access to reporting hotlines and insecurity limiting travel to health facilities for treatment).

Outside of formal spaces, women are using **informal channels to communicate** with each other for protection and response. Since April 15, women have been using social media to report incidents of rape and psychologists and medical personnel are offering free counselling to survivors. Civilian networks are also providing logistical information about safe routes, checkpoints, and emergency medical supplies to mitigate risks of sexual violence.^{clxxiv} These networks are sharing reports of rape via WhatsApp groups as well as information about pharmacies and clinics that can help the survivors. These groups feel that they can mobilize quickly because the use of sexual violence as a war tactic is not new for them.^{clxxv} However, poor internet connectivity, electricity outages, and fuel shortages hamper the informal network amongst women to make each other aware of risk areas and other issues.^{clxxvi}

Box 1: Sexual violence and rape in Khartoum

Khartoum is the hot spot of the conflict. One woman said, *“There is no safe woman in Khartoum.”*^{clxxvii} Reports of rape and abduction of women and girls is rising; some say that GBV cases have reached a record high.^{clxxviii} Women are exposed and vulnerable to opportunistic attack as they are spending longer hours outside the home sourcing necessities such as food and water, alone and without traditional familial or kinship support available.^{clxxix} For example, a 12-year-old girl who went to a shop just outside of her home was captured and raped in the shop while the shop-owner was being threatened at gunpoint.^{clxxx}

Reports have documented women being held under conditions of sexual slavery where armed men are taking turns raping them.^{clxxxi} Oftentimes, refugee and IDP women and girls are most vulnerable.^{clxxxii} The earliest whispers at the start of the conflict were that “foreign” women (namely Ethiopians, Eritreans, and South Sudanese) were being raped and Sudanese women were being spared.^{clxxxiii} Such reports have become more widely spread, indicating that women of non-Arab descent are most likely to be sexually assaulted or gang-raped. Some young Sudanese Arab-descent women shared stories of being told they are “safe” but, still, individual armed men have still committed sexual violence against them at gunpoint.^{clxxxiv} Also, young girls are being targeted with sexual violence, especially those in more vulnerable situations such as orphans.^{clxxxv}

Exploitation, Recruitment, and Kidnapping

Men and women in Khartoum and East Darfur report an increase in kidnapping, abduction, or trafficking of women and girls (13%). Young women are at risk of **kidnapping**, especially while migrating. For instance, East Darfur respondents shared that there have been reports of women being kidnapped who were traveling through the state during displacement. Some are being kidnapped for ransom (around 30 million SDG or 50,000 USD) from their families, others are being sold/trafficked, some for exploitation, and others are being used to care for combatants (e.g., emergency health care, cooking, cleaning, etc.). In South Darfur, there was a report that 24 displaced women and girls from Otash camp were kidnapped and raped.^{clxxxvi} Social media pages are launching dedicated to finding kidnapped women and girls.^{clxxxvii} Some women and girls in Khartoum have also been **abducted** in front of their families by the armed actors.^{clxxxviii} Also, because so many women and children who have fled Khartoum have lost access to their identification documentation, they are at increased risk for being **trafficked** with false promises of being transported to safety.^{clxxxix}

There is also perceived risk of men and boys being **abducted** or **recruited** through coercion by an armed actor (7%) in all states. This is a grave concern for boys and young men, though, especially as more and more are separated from their families in the process of displacement.^{cx} There have been reports of people going missing and young boys, especially those in the streets, being taken by groups in uniform.^{cxci} As tribes in South Darfur are increasingly aligning with specific armed actors, they are simultaneously encouraging young men to fight. This puts the lives of

young men at great risk.^{cxcii} This affects not only those disappearing and the young boys, but their whole families especially the mothers due to the severe stress they experience from losing a child.^{cxci}

Participation

Decision-making about Humanitarian Services

Few households have received any type of humanitarian assistance since the start of the conflict (16%) and even fewer have been consulted about their needs (11%) by any aid organizations. Based on RGA respondents, the likelihood was nearly equal amongst men and women for both. Those who have received humanitarian assistance and/or have been consulted on their needs are those living in camps or collective shelters in their respective locations (representing all surveyed states, although those consulted mostly represented Gezira). The recipients of aid mostly reported receiving food items.

Security and bureaucratic and administrative impediments are limiting humanitarian access and shrinking humanitarian space, especially in Khartoum and Darfur.^{cxci} With limited humanitarian resources and basic services available, there is a risk that already marginalized groups may face additional barriers accessing such aid. The most common challenge for men and women equally is a lack of information about the assistance available (~28% on average). Some women report that there are **discriminatory practices** by some aid distributors that favor certain groups over others, in particular men over women.^{cxci} Gezira residents who were not displaced feel disadvantaged because aid is only going to people in camps/shelters and is not recognizing their needs as hosts.

“We sit together and make decisions, but when the official is present, we all remain silent, because he always says: ‘I go to the organizations and the Commission and ask for help for you. He blesses us with the service he provides.’ He reminds us what he does to force us to obey him. So, people don’t talk in his presence. If someone speaks up, he will be answered: ‘If you don’t like the place, leave it.’” - *Woman displaced in a camp in Gezira*

Critically, several issues related to **aid mismanagement** were raised by both male and female respondents, including that humanitarian aid decisions are being made unilaterally and often the aid is not reaching its intended recipients. The group or committee managing the aid may prioritize it for their own family and friends (mostly in East Darfur) or for others in the community (mostly Gezira). In Gezira, multiple stories were shared about how those responsible for managing humanitarian assistance fell short in their duties (see Box 2 for an example). Several people in Khartoum reported that aid is being looted; as of June 2023, at least 25 NGO offices and warehouses had been looted in Khartoum alone.^{cxci}

Box 2: Camp corruption in Gezira⁷

“We got aid – which included flour, rice, and sugar – from some organizations. The organizations that distributed the relief took a signature or a picture from you to confirm the arrival, but the leadership of the camp met and decided to take the supplies and collect them in a warehouse. After three days had passed, we were still waiting for the supervisor to carry out the distribution. He came later and took a sack of sugar away in a small cart and said that there were some people in need in the neighborhood. We said that is no problem because we are all affected by war. After a day or two later, he came to distribute a kilo or two of sugar to each family. Then, he returned to take flour from the storage under the pretext of his desire to replace it with onions and oil. The supervisor asked us to collect some money to complete the meal. In five days after the aid arrived, we got one meal. The rest [of the days] we had to ask for help from other people who lived in the neighborhood, or we went out to work to bring food for our children. When we agreed to collect aid in the storage, we expected to get sugar and soap as well, and we did not expect all this to happen. There are some families who refused to give aid to the camp. They were then excluded from receiving aid, from collective meals, as well as from using cooking utensils.” – Female interview respondent in Wad Madani, Gezira

⁷ CARE has reported this case.

Survey respondents were evenly split – consistently across states – about whether they had the **opportunity to participate in humanitarian decision-making** in their communities or not; 84% of those who said they could not were women (representing 54.5% of all women surveyed), compared with 16% men (representing 29% of those surveyed). Women are more likely than men to not be permitted to participate in decision-making structures either by the local authority in charge (11% of women compared to 4% of men) or by their family (6% of women compared to 4% of men). The most common barrier for both men and women to participating was not knowing about the meetings, except in Khartoum where it is a lack of structures currently in place to facilitate humanitarian assistance.

Local women’s and youth groups and networks

Contrary to traditional gender roles, women have consistently been the forefront leaders of revolutionary change in the country, including leading the revolution that achieved the ousting of former President Omar al-Bashir and his regime in April 2019.^{cxvii} Despite leading change, women have been kept out of **leadership roles in governance** and outright prohibited or intentionally excluded from participation in conflict resolution committees/spaces.^{cxviii} This conflict has been no exception, as women and young women have been most prominent in the humanitarian response – especially in Khartoum – and led the first protest against the conflict in Khartoum on April 23 (led by the Mothers of Sudan campaign).^{cxix} Yet, they have not had an opportunity to participate in conflict negotiations to date.

“Men underestimate women and the importance of our meetings. I am part of the group, the Sudanese Organization for the Development of Women. But our beneficiaries do not have enough money to reach the meeting place.” - *Female resident of Gezira*

Despite not having the space to engage in formal decision-making bodies, local groups such as women’s and youth initiatives/networks are stepping in where possible to run **volunteer-led, community-based services** – including lifesaving health services since many international organizations have reduced their operations.^{cc} Indeed, women are more likely than men to volunteer their skills in the community to support community-led action such as information dissemination (in Khartoum and Gezira) or to lead or support in the continuity of local groups or associations (in East Darfur); such actions were reported by 10 female and 1 male survey respondents. Most of the youth networks/groups newly mobilized since the conflict. The women’s groups, on the other hand, were already in operation and many had existing partnerships with larger international actors working on issues such as GBV prevention and response.^{cci} These networks are separate from existing resistance committees in the communities, which have been playing more formal roles coordinating directly with UN agencies and INGOs in the distribution and management of humanitarian aid. Unlike the resistance committees, the women’s and youth networks are primarily mobilizing response from within the community and through remittances.



A woman leading a community-awareness raising session focused on WASH in Sudan © CARE 2023

- **Youth networks** have focused on addressing urgent humanitarian needs by voluntarily distributing assistance including food, water, medicine, and fuel. They played a role early in response by linking up people who were fleeing with those providing transportation. Youth groups also supported the transformation of public buildings such as schools and clubs into emergency care for people injured in the violence. Finally, some young people coordinated to create a website and mobile app to foster a solidarity network of people supporting each other to address urgent needs.
- **Women’s networks** have utilized their expertise on addressing sensitive issues facing women, girls, PwD, and older people such as GBV. Women’s organizations are increasingly coordinating and working together to improve their response in meeting the needs of women and girls in their communities.^{ccii} Some women are engaging very informally in humanitarian response in the ways they can, such as preparing food collectively in shelters. For the women themselves, they are also personally experiencing changes as they are learning how

to work together as a team and make critical decisions together. It has also increased their visibility and respect in the community, including amongst men.^{cciii}

- **Men's groups** (e.g., neighborhood committee, resistance committees), worked to mobilize resources from businessmen, relatives in the diaspora, and pastoralists outside of the local affected community.^{cciv}

Recommendations

Overarching Recommendations

- **Commit to closing the gender and age data gap**, as disaggregated data is needed to provide more targeted and effective programming to the most vulnerable populations.
- **Incorporate nexus-focused programming** that builds the resilience of the Sudanese community and addresses the overlapping, unfolding crises long-term and is based on increased local consultation sessions and community leadership (specifically of youth and WLO/WRO).
- **Provide more targeted food and non-food items** such as soap, menstrual products, diapers, jerry cans, fuel, and blankets in partnership with women's and youth networks.
- **Invest in strong and consistent community engagement** and feedback, monitoring and accountability system at all levels (specifically within camps/shelters and host communities with high levels of IDPs) to prevent and respond to reports of aid diversion and malfeasance (including by multilaterals/INGOs).
- **Prioritize cash-based humanitarian assistance** directly into the accounts of the recipients (e.g., Bankak mobile app), particularly for women and female-headed households, in accordance with the [Cash & Voucher Assistance and GBV Compendium](#).
- **Strengthen the existing structures** of assistance already created within the community, including traditional practices of *al-d'ara* and the large number of families hosting those who have displaced. Rather than focusing humanitarian attention exclusively on camps and shelters, expand the focus to include *'solidarity households'/host communities* to ensure the needs of non-displaced host households are also being met.
- **Use humanitarian intervention approaches that support and fund women's and young people's leadership** and decision-making power (e.g., CARE's Women Lead in Emergencies Approach⁸), and ensure that humanitarian coordination and planning processes meaningfully consult and coordinate with representative women's civil society. Accompany local groups to set up monitoring and due diligence procedures to ensure that risk is shared and mitigated throughout the system, rather than inadvertently transferred to local partners.
- **Increase behavior change programming** by engaging men and boys. Focus on their experience of evolving concepts of masculinity. Identify and engage positive male role models to co-create the programs in participatory ways.

Targeted Recommendations

Livelihoods

- Launch income generating and livelihood diversification activities and cash-for-work programs for displaced men, women, and female heads of households such as in the distribution of humanitarian aid and agricultural production for local food distribution. Programs should be developed in consultation with local women's groups to mitigate against perpetuating harmful/ limiting cultural norms.
- Identify, resource, and advocate for (if necessary with local authority) women- and locally-led initiatives such as food stalls, tea selling, barter markets, and transportation networks.
- Work with local leaders to strengthen physical, social, and financial safety networks for women workers such as re-launching village savings and loan association (VSLA) programs or female farmer collectives that can support covering (or creating) safe transportation to work sites (e.g., factories, markets) or , childcare while the school systems remain closed or pursuing education opportunities

⁸ CARE International. Women Lead in Emergencies. Available at: [link](#).

- Deliver necessary basic inputs to reignite traditional livelihoods in stable communities such as agricultural inputs, livestock vaccines, and small livestock to women to enhance their livelihood options and longer-term resilience.

Food Security

- Target the most vulnerable populations with life-saving food assistance such as pregnant women and older persons in the areas facing the most acute crisis. When necessary, deliver aid directly to the homes of those who are immobile such as PwD, older people, and the ill. Plan food delivery modalities in consultation with women that take into consideration issues of safety when leaving their residence to access aid.
- Ensure that information regarding the availability of food assistance and related reporting mechanism for mismanagement of assistance is clear and accessible, especially for women, those with limited literacy, and non-displaced residents who are hosting displaced families.
- Create kitchen gardens nearby to shelters and homes to help mitigate food insecurity from disrupted supply chains and limited imports. Strengthen the practice of *al-d'ara* by supporting pre-existing solidarity groups to prepare food for those in collective shelters and people passing by in the process of migrating.
- Scale up agricultural production and productivity by providing inputs to small-scale farmers and herding communities in stable areas to meet immediate food needs.

Nutrition

- Fund the operation of nutrition centers and community screening services for identification and treatment of severe and moderate acute malnutrition in children and pregnant and lactating women.
- Provide iron supplements to treat the growing issue of anemia.
- Provide new mothers with support in breastfeeding through awareness raising in health centers and other locations where women gather including bathing spaces and markets.

Health

- Financially support the operation of existing health facilities – including funding running costs, payment of health staff, provision of supplies and equipment, etc. – to foster their longer-term resilience and sustainability. If necessary, create mobile clinics for villages, shelters, and camps where existing facilities have shut down to reduce the distance that people travel for care.
- Prioritize delivery of the most needed medications and treatments such as malaria medication, insulin, antibiotics, and vaccinations for children. Monitor potential contagious disease outbreaks and deliver preventative and responsive medications and treatments as needed. Also, distribute critically lacking supplies such as post-exposure prophylaxis (PEP) kits, mosquito nets, and water filters.
- Expand the pool of community health workers by delivering specialized training on the most pressing health concerns to mitigate gaps in staffing of health centers (especially for women) and staff burnout. Strengthen support infrastructure to female frontline community health workers, such as traditional birthing attendants.
- Resource and train medical staff to deliver sexual and reproductive health services, including GBV responsive services and the clinical management of rape.
- Strengthen antenatal care, including screening of pregnant mothers and infants and making appropriate referrals across sectors for nutritional support.

Psychosocial support

- Establish safe and accessible mental health and psychosocial support services, especially for displaced children. Provide both in-person and phone-based services such as hotlines to mitigate access issues, whether caused by safety risks or barriers to movement for older people and persons with disabilities.
- Strengthen ongoing psychological support services for humanitarian responders experiencing trauma.
- Train health center staff in providing psychological first aid support to survivors of GBV.
- Create support groups for diverse groups in the community to meet their psychological needs, such safe spaces for women. For men, lead awareness raising efforts about drugs and alcohol and provide support structures for users—especially men—to help each other

get and stay sober. For children, create care groups with their caregivers to manage the longer-term consequences of conflict on their development.

Water

- Use water trucks to increase the water availability in camps and in communities experiencing shortages and/or dig/repair boreholes and wells in consultation with women and PwD to ensure they are in accessible, safe locations to shorten the distances that women need to travel to fetch water.
- Install solar-powered pumps that are less dependent upon the electric grid or fuel.
- Provide jerry cans for extended water storage.
- Provide filters and/or chlorination to clean water sources alongside community awareness campaigns on the importance of cleaning water and how to do it.

Hygiene

- Partner with local youth and women's groups to distribute dignity kits with clean menstrual cloths, pads, and soaps.
- Ensure that camps and collective shelters have sex-segregated latrines and bathing spaces, that are also accessible for people with disabilities or older persons. Ensure facilities have functioning lighting and locks, in consultation with community groups, especially women-led organizations.
- Provide soap to all host families with information about hygiene best practices, including hand washing and mitigating water borne disease from cross contamination.

Protection

- Train front-line humanitarian actors in the basic concepts of GBV (e.g., how to use the [GBV Pocket Guide](#)), disclosures, and safe referrals.
- Make information about GBV services accessible in communities, taking into account barriers to information faced by certain groups, including the lack of Internet access, mobile phone connections, and literacy. Provide clear messaging to the crisis-affected population on the risks of rape, abduction, and trafficking and risk mitigation strategies and reporting .
- Establish safe houses for women and children, in particular for women survivors of rape.
- Introduce child protection mechanisms across programming to mitigate against forcible recruitment of boys into armed groups and girls / young women into sex slavery.



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About CARE International

CARE works with poor communities in developing countries to end extreme poverty and injustice. Our long-term aid programs provide food, clean water, basic healthcare and education and create opportunities for people to build a better future for themselves. We also deliver emergency aid to survivors of natural disasters and conflict, and help people rebuild their lives. We have over 70 years' experience in successfully fighting poverty, and we help change lives of millions of people around the world.

CARE has been operating in Sudan since 1979 implementing humanitarian and development programs particularly focused on women's and girls' empowerment, gender justice, humanitarian action and resilience building. CARE operates in seven states in Sudan: Khartoum, Al Gezira, East Darfur, South Darfur, Kassala, Gedaref and South Kordofan. CARE Sudan is committed to working in partnerships and currently works in with 12 national NGO's, line ministries and in several alliances. The total reach of CARE's many projects for the year of 2022 sums up to a total of 1,509,747 project participants, the majority of being women and girls. Since the start of the war in April 2023, CARE has scaled up its emergency response reaching over 800,000 people with WASH, health, nutrition, cash and food security services. CARE's donors in Sudan include the EU, USAID, BHA, the Dutch Ministry of Foreign Affairs, the German Ministry of Foreign Affairs, Global Affairs Canada, the Luxembourg Ministry of Foreign Affairs, the World Food Programme and UNHCR.

More information: www.care.org

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