



Background

Conflicts have a differential gendered impact on communities, increasing the vulnerabilities of women and girls even if they are not directly part of the armed parties. Sudan's complex crisis has been marked by protracted conflicts, drought, and an economic downturn. The clashes between the Sudanese Armed Forces (SAF) and the Rapid Support Forces (RSF) have a disproportionate impact on women and girls who have limited access to services, especially sexual and reproductive health care, while facing increased protection risks, especially gender-based violence. The aim of the first Rapid Gender Analysis (RGA) Brief is to explore existing information and data regarding gender, age, and disability to inform humanitarians of pre-existing vulnerabilities and capacities of crisis affected populations, and of the best suited programmatic approach to people with varying needs.

OVERVIEW

On April 15, 2023, the Sudanese Armed Forces (SAF) and Rapid Support Forces (RSF) erupted into heavy clashes in Khartoum. The armed fighting is concentrated in urban centres, mostly affecting Khartoum and areas along the east-west corridor of Kassala to West Darfur.¹ Violence continues to escalate despite the ceasefire that was announced on April 24, 2023. According to the Federal Ministry of Health (FMoH), between April 15 and 27, 589 people have been killed and 4,599 have been injured due to the violence.²

As of 6 May, 334,000 civilians are estimated have been displaced internally (a majority of whom are women and children), fleeing to safer areas within Sudan while 120,000 have left Sudan with the majority seeking refuge in Central African Republic, Chad, Ethiopia, Egypt, the Kingdom of Saudi Arabia, and South Sudan.³ Vulnerable populations such as female-headed households, persons with disabilities, urban poor, pregnant and lactating women, children, and internally displaced persons (IDPs) before this conflict are at a heightened risk.

Frontline organizations have begun providing initial reports that residential buildings, water, and energy infrastructure are damaged, some banks have closed while communications and internet connectivity have also

been breached. Basic services are down, and civilians risk their lives to travel to more secure areas. Families are prioritising women and children for evacuations to safer places, leading to family separations, and exposing them to higher risks of gender-based violence and trafficking en -route to safety⁴ For persons with physical disability, this is particularly difficult as there is limited support to help their mobility. Public and private facilities have been looted including health centres and aid organizations as the situation gets dire.

Demographic Breakdown

Sudan has a total population of 49.7M with an annual growth of 2.75%⁵. Prior to the recent upsurge of violence, Sudan tallies 15.8 M people in need (including 8.7M children) of humanitarian assistance due to the 2021 coup and subsequent intercommunal violence, flooding, drought, and economic deterioration.⁶ Of those in need, 57% were female and 43% were male.⁷ Population data for Sudan is difficult to glean from secondary data as the last official census was in 2008 and current sources only focus on the persons in need. The below chart reflects the population breakdown of people in need sourced from the 2023 Sudan Humanitarian Needs Overview (HNO)⁸. There is a continued need to collect updated sex, age, and disability data on the whole population.

Table 1: Population data on people in need

Population	Total	Male	%	Female	%
Vulnerable Residents	11.4M	5.82M	51%	5.59M	49%
Internally Displaced Persons	2.5M	1.23M	49%	1.28M	51%
Refugees	.93M	.44M	48%	.48M	52%
Returnees	.92M	.44M	48%	.48M	52%
Total	15.8M	7.93m	43%	7.87	57%

From the available data, women and girls are the most affected by previous and current conflicts. Most of the population is comprised of a significant number of young people with children aged 0-14 making up 41% of the population.⁹ The young population is attributed to Sudan’s high fertility rate with 4.54 children per woman in 2020¹⁰, low use of contraception at 8.3%¹¹, and low life expectancy (68 years for females and 63 years for males).¹² The adolescent fertility rate (births per 1,000 women ages 15-19) is 82 which results in health complications for many women and delivery complications for subsequent births¹³. Polygamy is a common practice in Sudan with 22% of married women (24% in rural areas versus 17% in urban centres) being in polygynous unions.¹⁴ Data from 2018 shows small gender disparities with 50.4% of girls and 51.2% of boys in completed lower secondary school.¹⁵ Yet, the gender gap in adult literacy (above 15 years old) is wider with 56.1% of women and 65.4% of men are literate.

As of September 2022, Sudan hosts the second largest population of refugees in Africa with approximately 1.14 million refugees (43% are children, 52% are adults and 5% are elders). The majority of refugees are from South Sudan (an estimated 811,000 South Sudanese refugees of whom 52% are female¹⁶) but there are other African refugees from Eritrea, Ethiopia, the Central African Republic (CAR) and Chad. There are also Syrian and Yemeni refugees, however, because they are Arab, they are considered “brothers and sisters” under Arab/Islamic notions of asylum. The Government of Sudan does not require them to register with UNHCR and the Commissioner for Refugees. Except for political rights, they are privy to the same treatment and rights as Sudanese citizens¹⁷. However, now with the conflict and likely political changes, their legal status in Sudan may be threatened, particularly for women and girls who are not as protected as their male counterparts.

Key Findings

FOOD SECURITY & NUTRITION

Among the clusters, Food Security and Livelihoods Cluster had the highest population of people in need - 11.7 million before the conflict. Kassala, Blue Nile, Central, West, and North Darfur states had the highest prevalence of food insecurity.¹⁸ Compared to households headed by men, households headed by women were more food insecure with 42% of female-headed households being food insecure, compared with 31% of male-headed households.¹⁹ Food intake was also 10% lower in female-headed households than in male-headed households.²⁰ Disparities between women and men in terms of food intake exists within the same household with 79% of women not meeting the minimum acceptable diet requirements.²¹ As a result of the conflict, the price of basic commodities, including water, food, and fuel, have risen by 40-60% in some areas and far exceeding the household incomes²² This is particularly concerning for female-headed households as they tend to rely more on remittances from their spouses and family members who are working abroad. As the conflict progresses, it will be difficult for them to access money while simultaneously being on the move. Poor women are also affected by price fluctuation as they are usually dependent on petty trade such as tea selling have lost their daily income, heightening their food insecurity and increasing their vulnerability to protection risks as they seek alternative modalities of coping. Persons with disabilities and the elderly will also be at a heightened risk as they have even less mobility during the clashes and have to rely on others to access food. Although over 65% of the population is engaged in agriculture, the long series of dry spells, flooding, and crop failure due to inadequate rain has had the cumulative impact of putting the nation's food security in jeopardy.²³

Sudan has one of the highest rate of child malnutrition in the world with three million children under five who are malnourished and more than 610,000 children who suffer from severe acute malnutrition.²⁴ **Malnutrition has been on the rise in Sudan with the highest affected region being Darfur and the eastern parts of the country, which have also been affected by political violence.**²⁵ In South Kordofan, there are continued barriers to adequate access to nutrition services for children under five, combined with limited community outreach system for identification (screening) of malnourished cases and referral to nutrition treatment centres/services.²⁶ As displacement rates are anticipated to increase, nutrition services will continue to be stretched which may also cause growing tensions with the host communities. There are 905,000 pregnant and lactating mothers who are acutely malnourished²⁷ which contributes to the undernutrition of children. 35% of children aged 6-18 are not in school, which removes them from the social safety net of school feeding programmes and increases the household stressors.²⁸

HEALTH

Access to health facilities has been fraught with challenges due to ongoing conflicts as armed groups have been attacking and invading facilities since the 2021 coup and rapidly depleting medical supplies.²⁹ Persons with chronic illnesses or discreet conditions, like the elderly, are particularly affected as there isn't specialized care or a consistent supply of medication to sustain their needs. Additionally, according to the data submitted by UNFPA, an estimated 210 000 pregnant women are likely to be affected by these severe disruptions in health services³⁰. Before the conflict broke out in 2023, 70% of the population reported that they had access to a health facility within 30 minutes travel from their home and 80% has access to health facilities within one-hour's travel; however, these facilities were poorly equipped (including limited electricity) and had minimal staff with the appropriate range of skills to meet the needs of the community.³¹ As a result of the clashes between SAF and RSF, 61% of health facilities have closed in Khartoum which leaves the majority of the population without adequate access to health services.³² Within the existing facilities, 70% lack essential lifesaving medicines³³ including those needed to fight malaria, dengue and chikungunya that would be most needed during the rainy season of March to October.³⁴ Additionally, the country is still dealing with the effects of the high rates of malaria³⁵ and the 2022 outbreaks of measles and polio.³⁶ In South Kordofan State, all health facilities are working with very limited hours, capacity, and staff and are at risk of closing³⁷ due to inadequate financial resources³⁸.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR): Attacks on health facilities put additional strain on a sector that was already struggling to put together a comprehensive package on reproductive healthcare.³⁹ Sudan already experiences one of the highest maternal mortality rates in the world (295 out of 100,000 live births)

and healthcare providers have been sounding the alarm about the deteriorating situation, especially in North Darfur.⁴⁰ Healthcare providers are struggling to provide the SRH Minimum Initial Service Package (MISP) as facilities close while other areas are inaccessible. The number of facilities providing Basic Emergency Obstetric, and New-born Care (BEmONC) and Comprehensive emergency obstetric and new-born care (CEmONC) were already not commensurate to the population needs, with some pregnant women having had to walk three kilometres to give birth in a facility.⁴¹ Because of this, most women give birth at home with without professional birth attendants, and now even more women are at further risk of delivering without medical supervision or support.⁴² Pre-clashes, women and girls living in rebel-held areas had limited to no access to contraception, antenatal care, or emergency contraception so they use traditional methods with unpredictable outcomes.⁴³ With even less access amidst the current unrest, women are less able to control the number and spacing of their children leading to a heighten the risk of pregnancy and birth complications for women and their children.

WATER, SANITATION & HYGIENE (WASH)

Nationwide, the crumbling WASH infrastructure has left 17.3 million people lacking access to basic level drinking water supply, and approximately 24 million lacking access to proper sanitation facilities with more than 10.5 million people practicing open defecation.⁴⁴ A needs assessment in South Kordofan State conducted by CARE in March 2023 found that a majority of water facilities were poorly managed and not well maintained due to looting, disrepair, unavailable supplies and lack of expertise around maintenance.⁴⁵ As the clashes continue, reports indicate a destruction of public infrastructures⁴⁶ that further challenges the already limited water and sanitation infrastructure. Given that women are the primary managers of water within the household, they face increased safety and protection risk as they must travel long distances to access water sources. (26% people required more than 50 minutes to fetch water).⁴⁷ There is concern people may drink from the Nile or use the same troughs as animals as there is a lack of potable water, which may increase diarrheal disease and other water-borne illnesses.⁴⁸ Moreover, 46% of schools do not have access to sufficient drinking water services and 71% of schools reported not having any handwashing facilities.⁴⁹ Lack of access to clean water disproportionately affects women and children as they are more vulnerable to the safety and protection risks associated with adaptations (such as open defecation and fetching water) and exposed to greater health risks as women may be more likely to reduce water use for personal hygiene to provide for the household.⁵⁰ For example, as prices of basic commodities increase, many women and girls sacrifice using clean and sanitary menstrual hygiene products to conserve resources including water.

PROTECTION ISSUES

GENDER-BASED VIOLENCE: The prevalence of gender-based violence rises during times of conflict as safety nets for women and girls, including the rule of law are severely compromised and even severed. Gender based violence is widespread; however, it is often shrouded by a culture of shame and impunity and thus remains underreported.⁵¹ The main barriers to reporting are the fear of perpetrator, the possibility of repeated violence, and the reaction of male family members who can enforce expulsion from the community, tribe, divorce and social exclusion.⁵² Intimate partner violence, particularly in the form of physical violence, is normalized as part of the patriarchal marital setup.⁵³ Women and girls – but also boys - with mental and/or physical disabilities are at a heighten risk of exploitation and sexual abuse.⁵⁴

As domestic violence survivors are in confined to their homes with perpetrators as they take cover from the active conflict, they are at an increased risk of violence as resources run low and tensions run high within the household. Furthermore, judicial authorities do not recognize marital rape⁵⁵. Survivors will not be able to report to formal or informal authorities as it is viewed as part of the marriage. As healthcare facilities and organizations are attacked, gender based violence (GBV) services will be further disrupted which is an additional hurdle for GBV survivors to access lifesaving services. Additionally, there have been previous reports of conflict-related sexual violence over the years but the punishment that survivors face vis-a-vis the lack of arrests and convictions of perpetrators had led to despondency.⁵⁶ Persons on the move, particularly women and girls, are at a heightened risk as they may have to travel through insecure areas controlled by armed actors to get to their final destination. There have been reports of abuses with people escaping from the conflict being stopped by armed forces.

As the different factions take over sections of the country, RSF has been reported to move into people's homes to take refuge as well as confiscate any food they may need for their missions. There have also been reports of sexual violence perpetrated by armed actors against women and girls when they take over the household⁵⁷.

CHILD PROTECTION: Humanitarian crises cause levels of life-altering traumatic injuries and stress in the lives of children, and they are often the most vulnerable. As the violence escalates and people are displaced, the number of IDP, returnee and nomadic children separated or unaccompanied will rise as families take flight and children are separated in the processes or children are sent to safer areas.⁵⁸ Putting children at risk of recruitment into armed militias, trafficking and/or gender-based violence. In the past, physical abuse, trafficking, killing, and maiming have also been reported to be key child protection concerns.⁵⁹ Sudan has a high prevalence (88%) of Female Genital Mutilation (FGM), with a significant number performed by healthcare professionals (41%).⁶⁰ There is an increased risk of FGM as girls are married off to unburden families and/or in exchange for needed resources. Sudan has had an anti-FGM campaign that started five decades ago and though change has been slow, the nation has seen a decline in the number of cases.⁶¹ Child marriage is prevalent in Sudan with 26.6% of girls aged 20-24 years were first married before 15 years of age while 60.2% of girls aged 20-24 years were first married or in union before 18 years of age.⁶² Before these clashes, adolescent boys aged 12-14 and 15-17 years of age were most at risk for high child labour that put them at risk to safety risks and recruitment by armed actors, while also preventing school attendance.⁶³ 1 in 3 girls and 1 in 4 boys have been affected by school closures,⁶⁴ leaving adolescent girls especially vulnerable to child marriage and other human rights violations. Additionally, armed actors have been known to keep schools closed in the past⁶⁵ in addition to parents also choosing to keep their children home for fear of their safety.

SAFEGUARDING / PSEA: The risks of sexual exploitation, abuse and sexual harassment are heightened during an emergency as actors providing aid exert power, and new actors enter the environment, which presents an opportunity for exploitation, abuse, and harassment. Sudanese culture is patriarchal, and its hierarchical nature can reinforce inequalities and expose crisis affected populations to further risk of PSEA. As the situation remains fluid and families prioritize evacuating women and girls, they will be at a higher risk for abuse while seeking out safety and security. With services being down, such as power and phone lines, hotlines may be unreachable to survivors and families wishing to report abuses and violations. Additionally, as the flow of aid continues to increase, new humanitarian actors and staff may not be fully oriented in PSEA and thus underprepared to prevent, mitigate, and even respond to reports. Finally, as there is a breakdown in the rule of law, formal government reporting channels are affected which will likely impact survivor's willingness to seek redress and support. As of 2021, PSEA has been included in the Humanitarian Response Plan and the PSEA Action Plan has been costed and resourced. According to IASC- PSEA Network, it is estimated that between 26% to 50% of the affected population can safely access complaint channels.⁶⁶ This percentage will likely decrease with the disruption caused by the fighting.

WOMEN'S PARTICIPATION

Women have been forming groups to fight for freedom and human rights since Sudan sought independence. In 2019, women were at the forefront of the revolution as protestors and were reported to make up 70% of the protestors.⁶⁷ Sudanese Women coalitions have issued a statement calling for an end to war⁶⁸. Women have also been at the forefront of raising awareness and sensitizing community on gender-based violence. Women led organizations (WLOs) and Women's Rights Organizations (WROs) have been critical to the establishment of GBV services and serve as a bridge to survivors when reporting. However, due to the patriarchal nature of society, women and women's groups have been side-lined from formal political participation and conflict resolution processes. During the transitional government, only two women were appointed to the eleven-person Sovereign Council.⁶⁹ The commitment to have 40% women's participation and representation fell short even before the clashes occurred.⁷⁰ Women's political participation in public action such as in protests and campaigns is deterred by a range of threats on her or acts of physical abuse.⁷¹

There is a growing feminist solidarity movement with women in Sudan to keep humanitarian and parties to the conflict accountable for the situation and the consequences of their actions/inaction.⁷² In rural areas such as Kassala, women are working to meaningfully participate in the humanitarian response via formal structures, networks and associations. This is particularly important as communities in Sudan prefer to settle issues on the community level instead of relying on government intervention.

Recommendations to Humanitarian Actors, INGOs and Government

- Consistently collect sex, age, and disability disaggregated data in coordination with local actors and national and international stakeholders; prioritize funding for progressive data collection exercises such as RGA to ensure programming meets the evolving needs of crisis affected populations
- Establish feedback loops to actively share back research findings and program initiatives to community members for mutual accountability
- Prioritize flexible funding modalities to ensure humanitarian responses can be adapted appropriately to respond to the dynamic and rapidly changing context of the crisis

Food Security & Nutrition

- In the short term, ensure targeted nutritious food sources are provided via direct assistance to the affected population, with specific attention to the unique needs of pregnant and lactating women, children under five, the elderly and persons with disabilities.
- Support open schools by initiating and strengthening school feeding programs, while working to safely increase enrolment rates.
- Provide additional training, supplies and resources to community health workers conducting mobile screenings for malnutrition and providing frontline care.
- Provide flexible funding to strengthen existing malnutrition treatment facilities that provide outpatient therapy, targeted supplementary feeding, and stabilization, especially targeting pregnant and lactating women and children under 5 years old.
- As the situation stabilizes, provide multi-purpose cash assistance to the most vulnerable groups such as displaced female headed households and women small scale traders to support local market recovery. Also provide cash for agricultural work targeting small-scale and subsistence farmers (who are typically women) and pastoralists to encourage farming and spur local economies.

Health

- Recruit and train male and female skilled medical personnel to provide more specialized care for targeted diseases, especially related to water-borne illnesses, pregnancy, and chronic disease
- Improve coordination and accountability for the safe delivery of supplies to health facilities (including but not limited to vaccinations) to sustain the gains made on polio, measles, and malaria treatments
- Adopt mobile health facilities to provide safe and accessible treatment to displaced communities

Sexual And Reproductive Health and Rights (SRHR)

- Ensure the continuity of services to provide the full package of lifesaving SRH services and supplies guided by the MISP to women and girls in the acute phases of the emergency.
- Provide training to frontline community health workers as professional birth attendants and increase supplies, transport, and resources for skilled midwives.
- Expand programming that engage men and boys around the importance of breastfeeding, nutrition for girls of reproductive age and modern contraception methods.

Water, Sanitation & Hygiene (WASH)

- In the short term, provide direct water assistance through water trucking and provision of water treatment solutions and safe storage equipment.
- In more stable areas, conduct participatory consultations with community members and newly displaced populations (especially women and vulnerable groups), on how to rehabilitate water facilities to be most accessible and construct gender segregated latrines (considering the needs persons with disabilities and the elderly). Ensure local teams are well trained on regular maintenance using locally available supplies.
- Provide hygiene kits and waste disposal and management tools while raising awareness on safe water and hygiene practices to mitigate the spread of disease.

Protection Issues

Gender Based Violence

- Consider GBV as a priority cross-cutting issue in the initial emergency response package and all sectors should identify culturally appropriate GBV prevention and risk mitigate strategies.
- Work with existing local GBV service providers to update, maintain and create referral pathways; expand mobile GBV and Health services to ensure that survivors can access timely, safe, and accessible services.
- Provide required training to non-specialist frontline workers on psychological first aid and the skilful use of referrals pathways and protocols for safe and ethical documentation, response, and advocacy.

Child Protection

- Strengthen and make more accessible existing child protection referral pathways and establish new ones where none exist, with special attention to create accessibility for those living with disabilities
- Provide specialized and culturally appropriate psychosocial support for children to cope with the conflict and related trauma
- Identify and coordinate closely with local experts, child advocates and community leaders to support community led campaigns around anti-FGM, reduced child marriage and trafficking

Safeguarding/SEAH

- Create and reinforce existing systems to identify, report, and respond to emergency response risks of SEAH, including worker-to-worker and worker-to-community impacts.
- Train staff on SEA and establish zero-tolerance policies on SEAH with gender-responsive grievance redress mechanisms.
- Organize culturally appropriate community awareness raising and sensitization on PSEA and ensure the accessibility of safe reporting mechanisms.

Women's Participation

- Coordinate actively to create participatory feedback sessions with affected communities, especially targeting the inclusion of women networks, groups, and movements in the design and implementation of humanitarian response programming
- Ensure the meaningful representation of affected women in negotiations held around the de-escalation of crisis and the pathway to long-term recovery
- Provide resources for women to engage in self-directed learning and skill building through CARE programs such as Women Lead in Emergencies

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⁴ [Sudan Complex Emergency Appeal](#)

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⁷ HNO 2023 (issued in November 2022)

⁸ HNO 2023 (issued in November 2022)

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¹¹ <https://fp2030.org/sudan>

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¹³ <https://data.worldbank.org/indicator/SP.ADO.TFRT?locations=SD>

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¹⁵ [Gender Data Portal. Sudan. World Bank](#)

¹⁶ HNO 2023 (issued in November 2022)

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- ⁷¹ <https://ishr.ch/wp-content/uploads/2023/03/HRC52-Sudan-joint-oral-statement-final.docx.pdf>
- ⁷² *Women on the Frontlines: A Feminist Perspective on the Ongoing Crisis in Sudan*. WILPF. May 2022