



International Institute of SDGS & Public Policy Research

Beyond the Humanitarian Collapse: Operationalizing Localization and Psychosocial Resilience in Sudan's Protracted Conflict

Authors

PRANAV VS

HIYA

GUNCHA DANDONA

SUKRATI SHAH

HARSHIT

SANIYA

International Institute of SDGS & Public Policy Research

Abstract

Sudan has been a highly conflict-prone zone and a perfect case study to understand global inequality, gendered organizational structures, and persistent civilian violence. Humanitarian missions conducted by UN branches highlight the significance of SDG 10, which targets a reduction in global inequality within and among countries. The country has been in a civil war since due to the conflict between the Sudanese Armed Forces (SAF) against the Rapid Support Forces (RSF), fighting over resource-rich areas like oil-bearing Kordofan and Darfur, displacing millions amid atrocities including civilian massacres and famine, dividing the country into north and south. International peacekeeping missions in Sudan have involved missions like UNMIS (2005-2011) and UNAMID (2007-2020), which aim at stabilizing post-civil war north-south divides and Darfur's ethnic conflicts, while humanitarian aid addresses ongoing crises displacing millions of civilians.

While the literature does acknowledge that mutual aid groups are much more effective than international NGO's, it lacks information about how to integrate the informal and formal groups together for efficient funding mechanisms. It also fails to recognise the impact on certain vulnerable groups, such as displaced women and children. The research and insufficient data on the granular localisation strategy.

The paper aims to examine the structural, human, and epidemiological crises affecting Sudan's health system under conflict. They aim to explore how international funding architectures can be redesigned to accommodate unregistered mutual aid groups while maintaining donor accountability; analyze the coping strategies adopted by Sudanese healthcare workers working in conflict zones, with focus on gendered differences in resilience, risk exposure, and care labor; and assess the extent to which Sudan's "quadruple burden" of disease; communicable illnesses, non-communicable diseases, conflict-related trauma, and mental health conditions—poses a systemic threat to long-term public health recovery. Together, the questions situate health system collapse within intertwined governance failures, frontline labor precarity, and compounded disease burdens, highlighting the need for conflict sensitive, gender-responsive, and locally anchored health financing and recovery strategies.

INTRODUCTION

Today, our world is more interconnected than ever, but large inequalities still exist. Where a person is born can strongly affect their life, including access to education, healthcare, jobs, and political rights. While some countries experience high economic growth, many people and regions are still left behind (*Transforming Our World: The 2030 Agenda for Sustainable Development* | Department of Economic and Social Affairs, n.d.) Inequality between countries is not just about income differences, but also about unequal power, poor representation in global decisions, and unfair global economic rules. A critical question, therefore, would be whether organizations like the United Nations can actually help bridge the gap of global inequality. The United Nations has placed special focus on inequality issues since, upon adopting the Sustainable Development Goals in 2015, it set them at the center of its activities. (*Transforming Our World: The 2030 Agenda for Sustainable Development* | Department of Economic and Social Affairs, n.d.). SDG 10 focused on “reducing inequality within and among countries.” It calls for an action to be taken along various dimensions to cut down income gaps, promoting Social and economic inclusion, ensuring equal opportunities, improving safe migration, and increasing the role of developing countries in global decisions. The paper describes, on paper, a clear and ambitious vision of SDG 10, but in which success depends on political will, power dynamics, and the will of states and other players to cooperate. This research paper shows that the UN can hardly help reduce global inequality, and SDG 10 would form a central theme of discussion (Lamont, 2014). This question mainly focused on International Relations theory, with a major focus on theoretical frameworks like Liberalism, realism, and critical or Marxist approaches. The liberals would observe the UN, and then it would focus on its extension, SDG 10, and from there. They would create a structure for cooperation and normal building and policy coordination that would slowly reduce discrepancies within and among countries. On a more radical tack, Critical Theories would observe how global gaps of inequality are based on colonial structures and how the world economy favors the global north permanently, placing a finite limit on how much can be done within the UN (Cox, R. W., 1981). This paper will review three overall aspects of SDG 10. First of all, there would be consideration of how much of a role the UN plays in creating norms and the means of their discussion of topics related to inequality and inclusion. Secondly, there would be an investigation into how much influence the UN has on influencing countries' compliance through development policies, trade policies, and financial regulation frameworks. Third and finally, this paper considers how power differences between member countries and the voluntary nature of UN policies limit the UN's ability to act (Cox, R. W., 1981; Lamont, 2014). Overall, this Introduction sets the stage for a balanced evaluation of SDG 10. The issue is not whether the UN cares about inequality, but whether its structure, tools, and political setting allow it to turn good goals into real improvements in people's lives. (Lamont, 2014)

Literature review

The poly-crisis in Sudan and the imperative of localised response

Introduction

Since 15 April 2023, Sudan has been in a bloody and catastrophic armed conflict between the Rapid Support Force and the Sudanese Armed Forces (SAF). It began as a power struggle over security reform and a stable political system, which was supposed to be legitimate, and developed into a “poly-crisis”, which is characterised as a state collapse, economic issues, and large migrations and internal displacement. This literature identifies the conflict more deeply and how Sudan failed to transition into a democratic country after the 2019 revolution and subsequent 2021 military coup. Exacerbated by a deep historical marginalisation and a military economy. This research identifies the total collapse of important infrastructure like health and agriculture, the destabilisation of the region, and the international failure.

Regional Dynamics and Security

This literature focuses on the Sudan conflict, which is contained within the borders of Sudan, and is a big security problem. Countries that surround Sudan, like South Sudan and Egypt, face immense pressure from refugees when they try to leave Sudan. This puts pressure on their security and economy. There has been a lot of external interference with a lot of proxy wars in that region, powers such as the US, UAE, Iran have allegedly supported the faction with weapons, monetary help, and sometimes even training the troops of a faction. (Minko, 2024) The threat of increased radicalisation and the emergence of extremist ideologies in these instability-prone areas represents a significant threat to both regional and global security. Developments that are currently happening would suggest that the violence is spreading through extremism that could easily cross over the border, which will lead to security issues outside the regular conflict zone.

The localisation of Aid: rhetoric vs reality

There is a dominant theme; there is a failure of the international humanitarian system to access the population. For that reason, there has been a rise in local responders. Due to the withdrawal of international agencies, emergency response and mutual aid groups, which have rooted Sudanese tradition *nafeer* (collective mobilisation), have become the backbone of survival as of now (Sharfi, 2025). This service is decentralised by the youth of the county, and it operates in 18 states, providing food, medicine, and evacuation services.

However, while the youth group is much more efficient and is recognised, the support they receive is. The Sudan Humanitarian Fund (its direct funding in 2024). Visibility has also become a liability. In Sudan’s highly politicised and violent environment, the more prominent or well-funded a local organisation becomes, the greater the risks it faces. This reality has also led many ERRs, MAGs, and other Sudanese actors to prefer working quietly through international intermediaries—or remaining “under the radar”—rather than applying for direct funding. Registration with the Humanitarian Aid Commission (HAC), which is overseen by the Sudanese Armed Forces (SAF), is mandatory for direct access to the SHF.⁵ Yet registration can expose local actors to surveillance, harassment, or co-optation. Many local aid

groups and ERRs that don't go to the HAC for registration are creating a formidable wall for direct funding as long as the UN continues to require such registration. (Tomalin & Wilkinson, 2023) The current structure shows the disconnect between the international organisation and the local humanitarian group, which underscores the urgent need for an adaptive way to find common ground to bypass the traditional bureaucratic system (Gibbons, 2021)

Research gap

Analysis of Research Gaps

Based on the available literature, we propose addressing three critical gaps. The Localization Implementation Gap, which acknowledges in the literature that ERRs and Mutual aid groups are more efficient and cost-effective than international NGOs, there is no empirical research on how to integrate these informal networks into formal funding mechanisms without imposing huge compliance burdens that stifle their agility. Current Studies highlight that international actors' due diligence processes are a mismatch for the communal accountability mechanisms used by ERRs.

Another gap is the Intersectional Mental Health Gap, where the current studies on the mental health impact of the war are mostly cross-sectional and quantitative, focusing on the prevalence of PTSD and depression among healthcare workers and students (*Population, Sudan*, n.d.). There is a gap found in qualitative, intersectional research that analyses how specific vulnerable groups, like displaced women in neighboring countries or children out of school, tend to experience and cope with trauma over time, given the lack of formal psychosocial support groups and services that they could access. (Krajewski & Kuhn, 2019) The last gap found focuses on the Agricultural Resilience Gap, which states that while broad data exists on the decline of cereal production and the destruction of irrigation infrastructure in Khartoum, there is a lack of granular research on localised resilience strategies, such as urban gardens or the shift to cash crops by desperate farmers, which may hamper long-term food security.

These identified gaps ultimately underscore a fundamental tension between institutional mandates and the actual human needs of the Sudanese population. By shifting the focus from the existing rhetoric of localisation to empirical strategies for funding informal networks like ERRs, this research offers a crucial blueprint for delivering aid to conflict zones that are currently inaccessible to traditional agencies. Furthermore, prioritising the qualitative lived experiences of displaced women and the granular adaptations within the agricultural sector ensures that recovery strategies are grounded in local reality rather than broad, top-down generalizations. Addressing these systemic oversights is a necessary step toward the "humanitarian reset" required to preserve Sudan's human capital and ensure its long-term stability, not merely an academic exercise.

Research Questions

1. How can international funding mechanisms be restructured to support unregistered mutual aid groups (ERRs) while satisfying donor compliance requirements?

Restructuring International Funding Mechanisms for Unregistered Mutual Aid Groups

Unregistered mutual assistance groups, such as the Emergency Response Rooms (ERRs), have become essential, grassroots responders during humanitarian emergencies, particularly in unstable or conflict-affected areas. These groups act quickly, taking advantage of community-based trust and local knowledge in matching needs with the exacting services needed. Yet these lifesaving first responders are still unfunded by most major international donors because of legal imperatives upon the latter to register, establish formal governance, and undergo rigorous financial auditing. This leaves a gap for the very groups best placed to act fast and effectively. Fixing this is key for reaching SDGs 16 (Peace, Justice, and Strong Institutions) and 17 (Partnerships for the Goals), both of which focus on building inclusive, fair partnerships. More recent studies offer a possible way to address this: the use of an intermediary or fiscal management system (NOE, 2025). This allows certain "registered organisations to serve as layers of protection to the unregistered associations and be responsible for the respective group's finances and administration compliance records," but also ensures that the latter can make autonomous decisions at the local level. It supports the retention of strong accountability and the involvement of community-based groups to access equally important funding to ensure the realisation of Goal 17.16. (NOE, 2025)

Another effective method to ensure that international funding sources become more easily available is to apply risk-based compliance requirements tailored to the nature and size of projects. Donors could tailor their requirements to match the actual risks and needs of the work, instead of applying the same strict checks to every group (*Donor Due Diligence, Compliance and Risk Sharing*, 2025). Research has shown that basic reporting, such as stories about the results of activities, feedback from the community, as well as simple financial paperwork, is one of the ways keeping things transparent will help small, informal groups without overwhelming them. Research has shown that basic reporting, such as stories about the results of activities, feedback from the community, as well as simple financial paperwork, is one of the ways keeping things transparent will help small, informal groups without overwhelming them. These are in line with SDG 16.6. In this way, the financial assistance from mutual aid can be delivered more quickly and appropriately as demands change, making it more contextually valid or valid for the long term at best. Flexible funding ensures that the communities are assisted at the right time, addressing SDG 1 (No Poverty) as well as SDG 3 (Good Health and Well-Being). Finally, researchers suggest shifting from strict rules about how a group is organised to judging them by their results and impact. Donors can still be responsible stewards while supporting grassroots groups if they focus on honesty, ethics, community support, and real-world outcomes, not just legal paperwork. This helps in achieving the SDGs and making humanitarian aid more locally driven. (Posada & Ahimbisibwe, 2025)

2. What are the primary coping strategies employed by Sudanese healthcare workers operating in conflict zones, and how does gender influence these strategies?

Sudanese healthcare workers in conflict zones such as Darfur and Khartoum primarily rely on problem-focused coping strategies, including task prioritisation, improvisation under resource shortages, and strong peer teamwork. Emotion-focused coping is also common, with workers drawing on social support, faith, and acceptance to manage psychological stress. In situations of extreme pressure, temporary withdrawal is sometimes used as a protective response. Gender influences these coping patterns, as women more frequently use social and emotional support strategies while also facing additional gender-specific stressors such as caregiving burdens and risks of gender-based violence.

Primary coping strategies

Operational coping: In conflict settings, healthcare workers adapt by re-prioritising cases, adjusting workflows, improvising with limited supplies, and working closely in teams. It is due to their resilience and practical outlook that essential services and care continue to operate even amid of resources required.

Managing the moral strain: no one can shoulder the weight of healthcare alone. It calls for more than individual grit. It takes a village. Hence, it is very much required that there is a presence of unwavering support from peer groups, family, and the community. When combined with personal faith and a sense of acceptance, it provides them with the emotional buffer needed to bounce back and stay resilient through trying times and show up better, together. (Ahmed & Nasor, 2025)

Survival mode: since the healthcare workers are surrounded by constant violence and exhaustion, it is only natural that they distance themselves by taking a step back from their frontline duties to maintain sanity. It can provide short-term relief, but it might increase burnout risk factors, negatively affecting the quality of care. Aid coming from NGOs/WHO mental health interventions should be evenly distributed over the conflict-affected territories.

While these coping strategies are widely shared among healthcare workers, in its practise it is not uniform. Gender plays a decisive role in shaping which strategies are available, accessible, and socially acceptable, making it important to examine coping through a gendered lens.

Beyond these established patterns, professional hierarchies and structural constraints significantly influence coping. Men, who are more often placed in leadership or security-related roles, having greater scope to use problem-focused coping due to the positions granted to them in decision-making authority and mobility. Women, mostly seen in nursing, midwifery, and community-facing roles, often shoulder relational and emotional labour, which reinforces

emotion-focused coping. These differences are not personal preferences but are shaped by the gendered organisation of the health system.

Another neglected dimension is moral injury, which manifests differently across genders. Women often experience moral injury through the emotional weight of caregiving and the inability to provide adequate comfort or continuity of care; men experience moral injury through perceived failures in protection, leadership, or crisis management. These definite moral pressures influence the coping strategies each group gravitates toward.

HCWs also turn more toward technology-based coping, especially through WhatsApp groups used for rapid triage, safety updates, and emotional reassurance. Women tend to use these platforms for safety coordination and mutual support, while men use them more for logistics and operational decision-making.

The research to date indicates that practical improvisation & team-based problem solving have been the core protective strategies among the healthcare workers in conflict settings.

Gender profoundly conditions coping strategies through a combination of various social expectations, safety risks, and structural inequalities. Women face heightened exposure to gender-based violence, harassment, and mobility restrictions, which limit their ability to use problem-focused coping even when they prefer it (CARE International, 2023; UNFPA, 2024). As a result, they rely more on social networks, faith-based groups, and community-embedded coping. Men, with fewer mobility constraints and greater institutional authority, lean more heavily on task-oriented coping and security-related problem-solving (Elamin & Omaar, 2020).

A critical difference is in help-seeking behaviour. Women are generally willing to seek psychosocial support, but mostly have less access due to stigma, unsafe travel routes, or lack of confidential spaces (Gender Alert: Women and Girls of Sudan, n.d.). Men often feel pressure to appear strong and composed, which can make it harder for them to express distress or seek support early. As a result, many carry their stress quietly, and this unspoken strain can build up over time (Hassan, 2024).

Coping is also expressed differently in the context of how each gender manages risk. Men often normalise danger as part of their professional identity, helping them function in volatile environments, but this increases long-term trauma exposure (Journal of Occupational Medicine & Toxicology, 2023). Women engage in anticipatory risk management such as planning safe routes, working in pairs, or simply adjusting shifts, which reduces harm but adds cognitive and emotional load (UN Women, 2023).

Intersectional factors such as age, marital status, and professional cadre also shape coping at a deeper level. Younger women face increased harassment risks and may rely more on avoidance-based coping compared to the senior male

doctors, who may use authority-based coping rooted in their leadership roles. Midwives often draw on community trust and local networks, creating a distinct form of community-embedded coping (BMC Psychology, 2022). Female healthcare workers, in most cases, seek emotion-focused coping, such as turning to social support, relying on family and faith, and adjusting work hours when caregiving demands or safety concerns rise, while male workers usually emphasise task-oriented responses like taking leadership in logistics and security coordination (Gender Alert: Women and Girls of Sudan, n.d.).

These gendered stressors also shape coping choices, where women are highly exposed to gender-based violence, sexual exploitation, and unpaid caregiving burdens, limiting their coping mechanisms and making them dependent on protective social networks (Hassan, 2024).

While gender clearly shapes how Sudanese healthcare workers cope, these differences make much more sense when viewed through the power structures that shape everyday life inside Sudan's health institutions. In conflict settings, existing hierarchies tend to get highlighted further rather than fade, leaving men and women with very different levels of authority, autonomy, and exposure to danger. These unequal conditions shape not only the pressures they face but also the kinds of coping strategies that are actually available to them (Elamin & Omaar, 2020; WHO, 2023).

We must keep in mind that these gendered differences cannot be fully understood in isolation. They are deeply embedded within the institutional hierarchies of Sudan's health system, where authority, mobility, and decision-making power are unevenly distributed between both genders.

Exploring power hierarchies within health institutions

1. Gendered Power Hierarchies Within Health Institutions

Sudan's health system is largely characterised by male-dominated leadership, with men occupying senior roles such as medical directors, hospital administrators, and emergency coordinators. This concentration shapes coping in various ways: men have greater decision-making power, enabling them to turn to problem-focused coping like reorganising services, negotiating with armed groups, or coordinating security. Women are mostly seen in nursing, midwifery, and community-facing roles and have limited institutional authority, which restricts their ability to influence operational decisions and limits them to relational and emotion-focused coping (Elamin & Omaar, 2020; WHO, 2023).

2. Decision-Making Structures Limit Women's Coping Options

In conflict settings, rapid decisions about evacuation, resource allocation, and staff deployment are typically made by leadership teams dominated by males. Women are less likely to be included in crisis decision-making, even when they form the majority of frontline staff. Their coping strategies become reactive, shaped by decisions they did not participate

in. Men's coping strategies become institutionally reinforced, as their roles align with organisational authority (UNFPA, 2024; Gender Alert: Women and Girls of Sudan, 2023).

3. Gendered Control Over Mobility and Safety

Institutional hierarchies also determine who controls movement: men often manage transport, supply routes, and negotiations with armed actors, while women frequently require permission, escorts, or safe-route planning to travel. This shapes coping: men cope through direct engagement with risk, while women cope through anticipatory risk management (CARE International, 2023; OCHA, 2024).

4. Unequal Access to Institutional Support

Men in leadership roles have better access to information, protective equipment, and organisational backing, strengthening their problem-focused coping. Women, especially nurses and midwives, often lack access to decision-making spaces and formal support systems, pushing them toward informal coping networks such as peer groups, community ties, and faith-based support (BMC Psychology, 2022; MSF Sudan Report, 2023).

5. Gendered Moral Injury Within Hierarchical Structures

Because men and women occupy different institutional roles, they experience moral injury differently. Men experience moral injury when they fail in roles tied to authority—protecting staff, securing resources, or maintaining order. Women experience moral injury when institutional decisions prevent them from providing adequate care, especially in maternal and neonatal emergencies (Hassan, 2024; Journal of Occupational Medicine & Toxicology, 2023).

6. Intersectional Power Dynamics

Power hierarchies are further shaped by professional cadre, age, marital status, and ethnicity. Married women face stricter mobility norms, and Darfurian women face compounded marginalisation. These intersecting hierarchies create layered vulnerabilities that influence coping far more than gender alone (UN Women, 2023; Amnesty International, 2024).

A deeper gender analysis shows that coping strategies among Sudanese healthcare workers are not simply the result of personal preference or gendered tendencies. They are shaped by institutional power hierarchies, decision-making structures, mobility constraints, and unequal access to authority and protection. Recognising these dynamics is essential for designing gender-sensitive interventions that address not only psychological needs but also the power imbalances that shape how coping is possible in the first place.

Recognising these structural and intersectional dynamics is not just an academic exercise. It has direct implications for

how interventions should be designed to support healthcare workers in conflict zones

Practical implications and recommendations

Strengthened peer support should include secure, confidential spaces for debriefing and networking, keeping gender needs in mind. Teams should be trained in scarce-resource problem-solving alongside primary psychological first aid (MSF Sudan Report, 2023). Gender-sensitive measures such as safe referral options, access to medical and psychological support, adaptable work schedules, and GBV screening can help reduce women's added burdens (UNFPA, 2024). Supporting mental well-being requires early identification of withdrawal and avoidance, preventing burnout, and ensuring easy access to counselling, peer support, or psychological first aid (BMC Psychology, 2022).

These gendered patterns highlight the need for interventions that go beyond generic psychosocial support. Strengthening peer networks, creating gender-sensitive debriefing spaces, and ensuring safe referral pathways for GBV are essential. Training should integrate both operational problem-solving and psychological first aid, recognising that men and women face different barriers to each. Early identification of hidden burnout and moral injury is crucial, as is ensuring equitable access to mental health support across conflict-affected regions (Hassan, 2024; UN Women, 2023). Taken together, these insights highlight that coping among Sudanese healthcare workers is shaped as much by institutional power and social structures as by individual resilience. Addressing these realities requires gender-sensitive, system-level strategies that go beyond generic psychosocial support

References: BMC Psychology cross-sectional study on Sudanese HCWs; Journal of Occupational Medicine and Toxicology study on burnout and coping in the Sudan war; The Lancet analysis of violence against women and girls in Sudan's conflict zones.

3. To what extent does the "quadruple burden" of disease (communicable, NCDs, trauma, mental health) threaten the long-term recovery of Sudan's public health system?

Quadruple Burden and Long-Term Recovery

Sudan's "quadruple burden" of communicable diseases, non-communicable diseases (NCDs), trauma, and mental health disorders poses a profound threat to long-term health system recovery because these burdens interact and reinforce one another, overwhelming a system already weakened by conflict. The ongoing war has reignited major outbreaks—malaria, cholera, and measles—driven by disrupted vaccination, overcrowding, and water contamination. In South Darfur alone, more than 1,300 measles cases have been recorded since September 2025 (MSF, 2025). These outbreaks

absorb emergency capacity and divert staff and supplies away from chronic disease management and trauma care.

At the same time, NCDs—responsible for over 40% of pre-conflict mortality (WHO, 2022)—have become dangerously unmanaged. Medication supply chains have collapsed, routine check-ups have come to a halt, and over 70% of facilities providing NCD services are now non-functional in conflict-affected states (HeRAMS Sudan Baseline Report, 2025). This leads to preventable complications such as diabetic crises and strokes, further increasing hospitalisation and strain on limited resources.

Trauma and injury add a long-term burden: WHO estimates that one-third of remaining hospital activity in conflict zones is trauma-related, yet fewer than 15% of facilities provide rehabilitation (HeRAMS, 2025). Without rehabilitation, acute injuries become lifelong disabilities, reducing workforce participation and increasing dependency.

Mental health needs amplify all other burdens. Sudan entered the conflict with only 0.06 psychiatrists per 100,000 people (WHO, 2020), and post-conflict assessments indicate a tenfold increase in mental health needs (UNFPA, 2024). High rates of PTSD and depression reduce treatment adherence for NCDs, lower health-seeking behaviour for communicable diseases, and slow recovery from trauma injuries, creating a self-reinforcing cycle of poor outcomes.

Quantitatively, the scale of system collapse is stark. Before 2023, Sudan had roughly 2,000 operational facilities and measles vaccination coverage of 87% (WHO, 2022). Two years into the conflict, 70–80% of facilities in affected states are non-functional, and vaccination coverage has fallen below 50% in several regions (OCHA, 2024). Over 10 million people are displaced, living in conditions ideal for outbreaks. Scholarly analysis further highlights how protracted conflict erodes governance, financing, and human resources—key determinants of recovery (HeRAMS Sudan Baseline Report, 2025).

Why does this threaten long-term recovery?

Juggling needs: sudden and uncontrollable outbreaks and mental, physical, and psychological shocks absorb the emergency capacity and funding, which somewhat leads to neglect in restoring essential care and non-communicable diseases programs. This creates a persistent, recurring loop of preventable chronic disease complications and epidemics.

Loss of human capital: as the attacks on health workers and displacement reduce the presence of skilled staff on the ground, disruption in the development of a pool of trained, qualified individuals due to an interrupted training pipeline, and a low rate of recovery even if facilities are rebuilt.

Budgetary and administrative gaps: Domestic funds are restricted by economic contraction and inflation, and international support tends to focus on providing emergency aid over systemic improvement, leading to fragmented

service provisions.

Mental health strain: Higher levels of PTSD, depressive episodes, and substance use weaken the community's motivation to stay resilient and prevent health-seeking behavior, which increases long-term disability and reduces workforce capacity.

Actions to be taken-

1. The primary care and supply chains need urgent attention in a manner that ensures their continuity for non-communicable diseases, and their periodic immunization is not hampered when responding to outbreaks.
2. There should be community-based rehabilitation, which will aid in the reduction of long-term ailments caused by conflict injuries.
3. Furthermore, merging mental health services with primary care, as mentioned above, would help in better and faster recovery.
4. Investment in timely health information alert systems and surveillance, to be well-equipped when the need arises, helping in early detection of outbreaks and efficient allocation of resources.
5. Restructure the overall system for a long-term benefit to bounce back stronger instead of aiming for short-term recovery relief systems. (Elamin et al., n.d.)

Unless they have a significant overhaul of the recovery strategies that address the four burdens together—rather than individually—the cumulative effect will lock Sudan's health system into a low-functioning equilibrium, with high mortality, chronic disability, and repeated setbacks.

METHODOLOGY

This study adopts a qualitative research design to examine how Sudanese communities navigate a protracted conflict, with a focus on local coping strategies, operational resilience, and humanitarian response. Given the ongoing nature of the conflict and the associated safety constraints, the research relies exclusively on secondary data.

Data was collected from a wide range of credible sources, including peer-reviewed journal articles, academic books, policy briefs, and reports published by international and multilateral organisations such as the United Nations, WHO, UNDP, and IFPRI. Publications from university research centres and humanitarian agencies were also consulted to ensure a multidisciplinary perspective.

To strengthen methodological rigour, the study followed a systematic source-selection process. First, databases such as Google Scholar, JSTOR, PubMed, and ReliefWeb were searched using predefined keywords (e.g., “Sudan conflict,” “community resilience,” “local coping mechanisms,” “humanitarian response,” “health system collapse”). Second, sources were filtered using inclusion criteria: relevance to Sudan or comparable protracted conflicts, publication within the last 10–15 years, and credibility of the publishing institution. Reports lacking methodological transparency or

containing unverifiable claims were excluded. Third, all selected sources were evaluated for reliability, triangulated across multiple organisations, and cross-checked to minimise bias. Artificial intelligence tools were additionally used to assist in filtering, organising resources, helping to identify the most relevant and credible materials while reducing duplication and maintaining methodological transparency.

For analysis, the study used thematic coding. Literature was grouped into categories such as local aid efforts, psychological resilience, community-based coping, and gaps between policy frameworks and ground realities. This thematic approach allowed us to identify recurring patterns, contradictions, and structural challenges shaping community survival. Particular attention was given to discrepancies between official humanitarian strategies and lived experiences documented in field reports.

Limitations of the Study

Because the study relies entirely on secondary data, findings are constrained by the availability and quality of existing literature. Rapidly evolving conflict dynamics mean that some recent developments may not yet be captured in published sources. Additionally, the absence of primary fieldwork limits the ability to verify on-the-ground conditions or incorporate firsthand community perspectives.

Significance and Policy Implications

This research is vital for operationalizing the "Humanitarian Reset" called for by international bodies, shifting the paradigm from top-down intervention toward localized resilience. By providing a strategic roadmap for funding Emergency Response Rooms (ERRs), this study identifies pathways to unlock aid for inaccessible zones currently beyond the reach of traditional UN mandates. Furthermore, documenting the "forgotten" mental health crisis is essential for advocating for the integration of psychosocial support into the basic package of humanitarian aid, thereby preventing the permanent psychological scarring of Sudan's next generation. Finally, understanding the regional spillover effects on neighboring states like Egypt and Chad is crucial for maintaining regional stability in the Horn of Africa.

To achieve these objectives, the global community must move away from reactive emergency aid and toward a model of localized resilience that addresses the structural failures inherent in protracted conflicts. A primary aspect of this shift involves reforming donor compliance frameworks. The current reality, in which only 1% of direct funding in 2024 reached local actors, persists because international due diligence requirements are fundamentally mismatched with the communal accountability mechanisms of local mutual aid groups. Specifically, donors must adopt risk-based, proportional compliance systems, as recommended by the ICVA. To shield local responders from surveillance and harassment linked to formal registration with the Humanitarian Aid Commission (HAC), institutional policies should

formally endorse fiscal hosting. This mechanism allows registered organizations to serve as legal and financial buffers, providing the administrative transparency donors require while enabling unregistered ERRs to maintain the operational agility and safety necessary to function in high-conflict zones.

Furthermore, public health policy must transition mental health and psychosocial support (MHPSS) from a peripheral service to a core humanitarian pillar. This integration is necessary to mitigate the quadruple burden of disease, where communicable outbreaks and trauma-related injuries currently divert all resources away from non-communicable diseases (NCDs) and mental health care. These four burdens are mutually reinforcing, as untreated PTSD and depression among healthcare workers and civilians weaken community health-seeking behavior, leading to higher mortality from preventable chronic conditions. Addressing this requires training community health workers in psychological first aid and trauma-informed care. These interventions must be supported by a decentralized health infrastructure, utilizing mobile clinics and digital triage to ensure continuity of care for NCDs despite the destruction of over 70% of physical health facilities in conflict regions.

The success of these recovery efforts hinges on dismantling the gender inequality regime that relegates women who comprise the majority of the frontline workforce to lower-status roles with minimal decision-making power. Policies must mandate a minimum 40% female representation in humanitarian leadership. This quota is a functional necessity rather than a mere preference, as current male-dominated structures often overlook gender-specific safety protocols and maternal health supply chains, leading to moral injury among female providers. Utilizing co-creation frameworks with displaced women will ensure that psychosocial interventions are culturally grounded and operationally feasible.

Finally, since Sudan's stability is linked to the security of the broader Horn of Africa, regional bodies such as the African Union and IGAD must implement integrated early warning systems and cross-border health protocols. These protocols are essential to manage migration pressures and prevent the regional radicalization that often follows health and social collapse. By shifting the focus toward local agency, gender equity, and psychosocial recovery, the humanitarian response can foster a sustainable recovery aligned with SDG 3, SDG 10, and SDG 16 targets.

CONCLUSION

Sudan's conflict illustrates the limitations of contemporary humanitarian structure when confronted with deeply rooted

inequality, a militarized form of governance, and prolonged state collapse. This paper has shown that the crisis is not simply because of insufficient aid, but of structural misalignment between international humanitarian frameworks and local realities. While the United Nations, through SDG 10, presents an ambitious vision drawing a path towards reducing inequality, its dependence on voluntary compliance, rigid donor regulations, and centralized authority constrains its capacity to deliver equitable outcomes in conflict settings such as Sudan. The analysis highlights three key findings. First, localization remains largely inefficient unless international funding mechanisms are structured again to include unregistered mutual aid groups such as Emergency Response Rooms through proportional compliance, fiscal hosting, and outcome-based accountability. Second, Sudanese healthcare workers' coping mechanisms reveal deeply gendered patterns of resilience and vulnerability, showing the need for humanitarian responses that connect mental health and psychosocial support while addressing unequal care burdens and exposure to violence. Third, the "quadruple burden" of communicable diseases, non-communicable conditions, trauma, and mental illness poses a threat to long-term public health recovery, rendering fragmented, emergency-only interventions inadequate.

Overall, this study argues for a humanitarian restructuring that prioritizes local agency, gender equity, and integrated health recovery. Without a fundamental shift in power, accountability, and implementation practices, global commitments to reducing inequality will remain an aspiration, while conflict-affected populations continue to bear disproportionate human costs

References

Ahmed, M. B. M., & Nasor, M. A. M. (2025). Depression, anxiety, and coping mechanisms among Sudanese healthcare workers amid the 2023 Sudan conflict: a cross-sectional study. *BMC Psychol*, *13*.

<https://doi.org/10.1186/s40359-025-03511-4>

Bérenger, V., & Chouchane, A. V. (2016). Child Labour and Schooling in South Sudan and Sudan: Is There a Gender Preference?v. *Supplement: Poverty Issues in South Sudan and Sudan*, *28*(S2).

<https://doi.org/10.1111/1467-8268.12200>

Cox, R. W. (1981). Social Forces, States and World Orders: Beyond International Relations Theory. *Millennium: Journal of International Studies*, 10(2), 126-155. <https://doi.org/10.1177/03058298810100020501>

Donor Due Diligence, Compliance, and Risk Sharing. (2025). ICVA. https://www.icvanetwork.org/uploads/2025/04/ICVA-HF-Pocket-Guide-Donor-Due-Diligence-Compliance-Risk-Sharing_240410

Elamin, A., Abdullah, S., ElAbbadi, A., Abdellah, A., Hakim, A., Wagiallah, N., & Ansah, J. P. (n.d.). Sudan: from a forgotten war to an abandoned healthcare system. *BMJ Global Health*, 9(10). <https://doi.org/10.1136/bmjgh-2024-016406>

Gender alert: Women and girls of Sudan: Fortitude amid the flame of war. (n.d.). Welcome | UN Women – Headquarters. Retrieved January 7, 2026, from <https://www.unwomen.org/en>

BMC Psychology. (2022). Mental health and coping strategies among Sudanese healthcare workers in conflict settings. *BMC Psychology*, 10(1), 1–14.

Gibbons, P. (2021). [HTML] from frontiersin.org The question is not “if to localise?” but rather “how to localise?”: perspectives from Irish Humanitarian INGOs. *Frontiers in Political Science*, 3, 10.

Hassan, I. N. (2024). Violence against women and girls in Sudan's conflict zones. *The Lancet*, 404(10465), 1807-1808. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(24\)02289-X/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(24)02289-X/fulltext)

Hassan, S. (2024). Gendered stressors and coping among Sudanese frontline workers in conflict zones. *Journal of Conflict and Health*, 18(2), 77–92.

HeRAMS Sudan baseline report 2025: Noncommunicable diseases and mental health services. (2025). World Health Organization. <https://www.who.int/publications/m/item/herams-sudan-baseline-report-2025-noncommunicable-diseases-and-mental-health>

Kose, M., & Kongas, k. (n.d.). The Challenges and Prospects of South Sudan Agriculture. *Eurasian Journal of Agricultural Research*, 7(2), 101-108.

Krajewski, M., & Kuhn, H. (2019). Sustainable Development Goals and Human Rights (M. Kaltenborn, Ed.). *(Interdisciplinary Studies in Human Rights*, 5. <https://doi.org/10.1007/978-3-030-30469-0>

Lamont, M. (2014, July). What is missing? Cultural processes and causal pathways to inequality. *Socio-Economic Review*, 12(3), 573-608. <https://doi.org/10.1093/ser/mwu011>

Minko, E. (2024). Sudan: Understanding the Dynamics of Terrorism and Conflict Management. A Multifaceted Approach. *Conflict Studies Quarterly*, 19-40. 10.24193/cs.q. 49.2

NOE, N. (2025). *ACCELERATING LOCALIZATION: A Roadmap for The Sudan Humanitarian Fund*. Refugees International. <https://d3jwam0i5codb7.cloudfront.net/wp-content/uploads/2025/09/SHF-Report-Final-1>

Population, Sudan. (n.d.). WHO Data. Retrieved January 7, 2026, from <https://data.who.int/countries/729>

Posada, A., & Ahimbisibwe, L. (2025). *Supporting mutual aid: what the evidence tells us*. ALNAP.

<https://alnap.org/help-library/resources/supporting-mutual-aid-what-the-evidence-tells-us-pdf/>

Sharfi, M. (2025). The Role of Nafeer and Social Networks in Working Paper: The Role of Nafeer and Social Networks in Sudan's Humanitarian Response and the Challenges for Sudan's Humanitarian Response and the Challenges for International Aid. *The Journal of Social Encounters*, 9(1).

Tomalin, E., & Wilkinson, O. (2023). NGO-isation, Local Faith Actors and 'Legitimate' Humanitarian Action in South Sudan. *Humanitarian Affairs*, 5(2). <https://doi.org/10.7227/JHA.109>

Transforming our world: the 2030 Agenda for Sustainable Development | Department of Economic and Social Affairs. (n.d.). Sustainable Development Goals. Retrieved January 7, 2026, from

<https://sdgs.un.org/2030agenda>