FROM SAFETY RISKS TO ACTION

GBV Safety Audit Report

Tawila Locality, North Darfur State, Sudan

September 2026

United Nations Population Fund

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The safety and dignity of women and girls must remain central to humanitarian action. In Tawila, North Darfur, communities continue to face displacement, insecurity, limited access to essential services, inadequate infrastructure and significant economic pressures. For women and girls, these conditions affect their ability to move safely, access assistance and services, seek support, and live with dignity.

This Safety Audit was undertaken to better understand the safety and protection concerns affecting women and girls and to identify practical measures that can be addressed through humanitarian programming and coordination. The audit brings together information from community consultations, key informant interviews, direct observations and service mapping. It gives particular attention to the conditions in which women and girls access humanitarian assistance and essential services, and to the barriers that may increase their exposure to protection risks.

The findings demonstrate that safety cannot be addressed through one intervention or by one sector alone. Lighting, shelter, WASH, health and SRH services, humanitarian distributions, referral pathways, reporting mechanisms and community protection structures are all part of the environment in which women and girls experience safety. Addressing gaps in these areas requires coordinated action, clear responsibilities and continued follow-up.

Our sincere gratitude goes to the women, girls, community representatives, service providers, and all participants who generously contributed their time, insights, and perspectives to this assessment. We also extend our appreciation to the 34 national and community-based organizations, UN agencies, field staff, and facilitators whose dedication ensured the assessment was carried out safely, adhering strictly to humanitarian and ethical standards.

The purpose of this report is to support practical action. The findings should inform programme planning, coordination and resource allocation and help partners identify measures that can make services, facilities and humanitarian assistance safer and more accessible for women and girls. UNFPA encourages humanitarian partners, local authorities, community structures and donors to use the findings of this audit to strengthen protection measures and address identified gaps.

UNFPA remains committed to working with partners and communities to strengthen GBV risk mitigation, protection mainstreaming and access to safe, confidential and dignified services for women and girls in Tawila.

Acronyms and Abbreviations

Acronym	Definition
AAP	Accountability to Affected Populations
AIDS	Acquired Immunodeficiency Syndrome
AoR	Area of Responsibility
CBPN	Community-Based Protection Networks
CCCM	Camp Coordination and Camp Management
CFM	Community Feedback Mechanism
CM	Case Management
CMR	Clinical Management of Rape
CP	Child Protection
CVA	Cash and Voucher Assistance
DHC	District Health Centre
DRR	Disaster Risk Reduction
ECDO	El-Emar Charitable Development Organization
FaSER	First and Second Line Emergency Response
FEWS NET	Famine Early Warning Systems Network
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FSL	Food Security and Livelihoods
GBV	Gender-Based Violence
HAC	Humanitarian Aid Commission
HIV	Human Immunodeficiency Virus

HOPE	Hope and Friendship for Development Organization
IDP	Internally Displaced Person
IMPACT	IMPACT Initiatives
INGO	International Non-Governmental Organization
IOM	International Organization for Migration
IPC	Integrated Food Security Phase Classification
KII	Key Informant Interview
MHM	Menstrual Hygiene Management
MHPSS	Mental Health and Psychosocial Support
MOH	Ministry of Health
MOSD	Ministry of Social Development
NFI	Non-Food Item
NGO	Non-Governmental Organization
NNGO	National Non-Governmental Organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PSEA	Protection from Sexual Exploitation and Abuse
PSS	Psychosocial Support
SAM	Severe Acute Malnutrition
SEA	Sexual Exploitation and Abuse
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection

UN	United Nations
UNDSS	United Nations Department of Safety and Security
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USA	United States of America
WASH	Water, Sanitation, and Hygiene
WFP	World Food Programme
WGSS	Women and Girls Safe Space
WHO	World Health Organization
WLO	Women-Led Organization

Executive Summary:

The September 2026 GBV Safety Audit indicates that women and girls in Tawila face interconnected safety and protection risks associated with insecurity, displacement, social and economic pressures, inadequate infrastructure, and barriers to essential services. These conditions affect mobility, privacy, dignity, access to humanitarian assistance, and access to protection and support services.

The assessment covered selected IDP camps, gathering sites and host-community locations, including Dabba Nayra, Tawila Omda, Hillat Neima, Shakshako/Salbalaba, Rwanda, Argo/Borgo, Daly, Kanjara, Kayma and Kereker. A mixed-methods approach was used, comprising **59 focus group discussions (FGDs), 186 key informant interviews (KIIs), 69 direct field observations, and 44 service points mapped and assessed**. Findings from FGDs and KIIs reflect reported perceptions and experiences within the assessed locations and should not be interpreted as population-level prevalence estimates.

Key findings at a glance

- **Darkness:** Nighttime lighting was functional in only **15%** of observed sites (failing at **85%** of locations), with just **1** out of 69 surveyed sanitation facilities (latrines/showers) having adequate lighting after dark.
- **Shelter:** across **90%** of surveyed sites, shelters lacked interior door locks, while **83%** housed unrelated families together.
- **Latrines:** **73%** of the 983 latrine and shower units counted could be seen into; working interior locks at **4%** of locations; separated by sex at **22%**.
- **Firewood:** Firewood collection was identified by **62%** of key informants as a location associated with sexual violence; additionally, **94%** reported that women and girls gather firewood to generate income.
- **Trend:** **62%** of focus groups participants reported perceptions of Increased GBV since the arrival of Newcomers; **47%** of key informants report an increase in reported sexual violence and **46%** in security concerns for women and girls.
- **Clinical care:** A significant majority of health facilities (**68%**) do not operate on a 24/7 basis, and an identical proportion (**68%**) lack fully stocked post-rape kits; additionally, **64%** are without a designated GBV focal point.
- **Exploitation:** Participants across **31%** of focus groups reported that assistance was conditional on providing favours. Furthermore, **14%** of key informants identified transactions of sex for monetary support as a livelihood source.
- **Children:** Unaccompanied children are noted by **73%** of key informants, with unaccompanied girls and boys cohabiting in shared shelter arrangements across **87%** of surveyed sites.
- **Girls' Access and Safety:** Girls face greater safety barriers than women across all nine evaluated service categories. Key informant reports indicate that **40%** view

education as unsafe for girls, while schools remain unreachable for women and girls in **39%** of assessed sites.

Physical and environmental conditions were identified as important safety concerns. Approximately **85% of assessed IDP camps** were reported to have no, non-functional or severely deficient night lighting, creating additional safety concerns for women and girls moving after dark. In 90% of assessed locations, shelters lacked doors that could be locked from the inside, while 67% had no internal partitions.

Insecurity and restrictions on movement further affect the protection environment. The assessment identified signs of armed actors on or near the site in 23% of assessed locations and armed individuals who may threaten community safety in 14%. Reported protection concerns included sexual violence, public harassment, domestic violence, psychological and emotional violence, economic coercion and restrictions on movement.

WASH conditions present significant safety, privacy and dignity concerns. While latrines and showers were accessible at most assessed locations, key safety features were largely absent: working interior locks were observed at only 4% of locations, latrines were lit at night at 1%, and separate facilities for women and men were available at only 22%. Of the 983 latrine and shower units counted, 73% were visible from outside, raising additional privacy concerns.

Key protection and accountability issues were also highlighted in relation to humanitarian aid delivery and distribution mechanisms. Distribution sites were underscored as major focal points for safety and protection risks, with safety issues during distributions being raised in 47% of focus group discussions. Specific concerns raised included insufficient crowd control measures, an absence of gender-segregated queuing systems, and minimal female staff representation.

Findings from the **59 FGDs** further identified concerns regarding the safety, fairness and accessibility of humanitarian assistance and distribution processes. These included reported safety concerns at distribution points, perceptions of unequal treatment, concerns about favour-seeking and exploitation, limited alternative collection options for at-risk groups, and insufficient assistance at distribution points. These findings reflect concerns reported by FGD participants and do not establish the prevalence or occurrence of sexual exploitation and abuse. They nevertheless highlight the importance of strengthening Protection from Sexual Exploitation and Abuse (PSEA) and Accountability to Affected People (AAP) measures within humanitarian assistance and distribution processes.

Access to health, sexual and reproductive health (SRH), and GBV-related services remains a significant concern, with gaps in both service readiness and safe access. Of the 57 health facilities observed, 89% were centrally located, yet only 32% operated 24/7 and 32% provided a confidential consultation space. Among 184 key informants, 93% identified at least one barrier to women and girls accessing services, most commonly the lack of female staff (61%), insufficient medicines (42%), inconvenient locations (39%) and unsafe travel (31%). Availability of specialised care was also limited: 84% of the 25 mapped health service points had no gynaecologist or obstetrician, and 68% lacked complete post-rape kits. These gaps may limit timely, confidential and appropriate access to essential health and GBV-related services,

particularly for women and girls facing additional barriers related to age, disability, mobility, economic circumstances, displacement status or geographical location.

The assessment also identified gaps in Women and Girls Safe Spaces (WGSS), confidential GBV referral mechanisms, and PSEA-related reporting and feedback channels. Reported barriers included limited awareness of available mechanisms, concerns about confidentiality, fear of reprisal and social stigma. These barriers may affect the ability of women and girls to safely seek information, raise concerns and access available protection and support services.

Overall, the audit indicates that safety and protection risks in Tawila are interconnected across the physical environment, movement pathways, humanitarian assistance, WASH conditions and access to essential services. Women and girls may encounter multiple barriers simultaneously, including unsafe routes, inadequate lighting, distance to services, transportation constraints, limited service availability and concerns about confidentiality. The findings highlight the importance of coordinated risk mitigation across sectors, with attention to physical safety and infrastructure, safe access to health and GBV services, protection and accountability within humanitarian assistance, confidential reporting and referral, and accessibility for groups facing additional barriers.

Addressing these priority concerns requires converting key audit observations into targeted risk-mitigation measures, each supported by designated lead actors, defined implementation schedules, measurable indicators, and robust monitoring channels. Five key focus areas have been prioritized for risk reduction:

- **Enhance physical security and environment**: upgrade WASH infrastructure, expand lighting, ensure safe transit routes, and improve shelter privacy.
- **Expand access to health, SRH, and GBV care**: streamline inter-agency referral pathways and establish reliable emergency transport systems.
- **Foster inclusive and accessible programming**: prioritize marginalized groups facing disproportionate risk, including adolescent girls, women with disabilities, female-headed households, and newly displaced communities.
- **Uphold safety, PSEA, and accountability at aid distribution sites**: ensure gender-balanced staffing, disseminate accessible information, and maintain confidential feedback and complaints channels.
- **Advance survivor-centered support and confidential reporting**: ensure clear, accessible information regarding available assistance and response services.

1. Context

Tawila locality, located in North Darfur State, is a major hub for displaced communities affected by ongoing conflict. The humanitarian landscape is characterised by recurring waves of displacement, severe damage to civilian infrastructure, widespread insecurity along transit corridors, acute deficits in basic services, worsening food insecurity, disrupted livelihoods and continuing population movements. These conditions have placed sustained pressure on humanitarian systems and created a highly dynamic operating environment in which population needs and service capacity continue to change.

According to IOM[1] reporting from **August 2026**, the displaced population in Tawila surpassed **700,000 individuals,** further arrivals continuing to be recorded. The scale and geographic spread of displacement create significant challenges for the provision of essential and reproductive health services. The August 2026 UNFPA contribution to the Geneva briefing highlighted the logistical challenges of delivering sexual and reproductive health care across Tawila. Comprehensive emergency obstetric care, including C-section services, was concentrated in a single hospital, while humanitarian actors were seeking to expand access through community-based approaches and mobile medical teams. Seasonal rains further complicate the provision of care by affecting roads and secondary routes used by patients, health workers and humanitarian supplies..

The broader availability of basic services is similarly constrained. The February 2026 Rapid Needs Assessment of Tawila locality[2], jointly produced by Save the Children and IMPACT, documents needs across health, WASH, livelihoods, food security and other sectors. The assessment provides an important baseline for understanding the conditions in which humanitarian services are being delivered, including the availability and functionality of infrastructure on which displaced communities depend.

The wider humanitarian environment is further affected by public-health and food-security concerns. Overcrowding and inadequate infrastructure place additional pressure on essential services, while a FaSER alert[3] **alert circulated in September 2026** identified a reported disease outbreak in Tawila camps as an early-warning concern.[4] At the same time, FEWS NET'[4]'s May–September 2026 analysis reported Emergency-level food-security outcomes across parts of Greater Darfur and identified a continued risk of Famine under specified scenarios in areas including the Tawila IDP settlement.[5] he analysis attributed worsening conditions to conflict, displacement, depletion of food stocks, high food prices and anticipated deterioration in commercial and humanitarian access. The IPC special snapshot likewise identified the Tawila

[1] International Organization for Migration (IOM), "DTM Sudan Displacement and Return Snapshot (8)," August 18, 2026, IOM Displacement Tracking Matrix Portal.

[2]https://reliefweb.int/report/sudan/sudan-rapid-needs-assessment-tawila-locality-north-darfur-state-february-2026

[3]https://reliefweb.int/report/sudan/sudan-faser-alert-summary-report-disease-outbreak-tawila-camps-north-darfur

[4] Sudan Key Message Update: Emergency and risk of Famine persist in North Darfur and South Kordofan, May - September 2026 FEWS NET'

IDP settlement among areas at risk of Famine under a reasonable worst-case scenario involving intensified conflict and further restrictions on humanitarian access.

These conditions have implications for protection and assistance programming. Economic hardship, dependence on humanitarian assistance and constrained mobility can affect how households access food, cash, markets, livelihoods and essential services. For women and girls, these pressures may interact with existing social and mobility constraints and may influence when, where and under what conditions assistance can be accessed. The relevance to GBV risk mitigation is therefore not limited to the availability of services, but also extends to the circumstances in which people access them.

Humanitarian operations are additionally affected by physical and security constraints on movement. The August 2026 UN briefing described many routes in and around Tawila as difficult tracks rather than established roads and noted that seasonal rains can make some routes impassable, including for four-wheel-drive vehicles and humanitarian supply trucks. Combined with insecurity and the distances between communities and service points, these conditions can disrupt referrals, health care, GBV services, psychosocial support, case management and other time-sensitive assistance. .

Against this broader humanitarian context, the June 2026 Tawila GBV Safety Audit provides a programme-specific baseline for the September assessment. The June audit was developed through the GBV AoR and partners, including UNFPA, ECDO, HOPE, the National Association for Children Protection and Patients Helping Fund, with the stated purpose of strengthening GBV quality programming, protection mainstreaming and risk mitigation in North Darfur. It provides a reference against which changes in the operating environment and previously identified risks can be assessed.

The need for a follow-up assessment reflects both the changing context in Tawila since June and the broader scope of the September exercise. Since the June audit, the context has continued to evolve through new displacement, expansion of displacement sites, changes in service availability, seasonal flooding, disease concerns, worsening food-security conditions and changing humanitarian access. The September assessment also covers a larger number of sites, enabling a more comprehensive assessment of safety and protection conditions and how risks vary across locations. This broader coverage provides an opportunity to identify risks that may not have been captured in June and to assess which previously identified risks remain relevant, which have changed, what new risks have emerged, and whether existing mitigation measures remain appropriate and effective.

The September 2026 GBV Safety Audit is consequently a protection-risk-management assessment rather than a prevalence study. It examines the physical environment, service accessibility, referral pathways, community structures, humanitarian assistance arrangements and relevant programme practices to identify conditions that may increase exposure to GBV and other protection risks or impede safe, confidential and survivor-centred assistance. It does not seek to measure GBV prevalence or collect survivor-identifying information; rather, it assesses the safety conditions and access barriers relevant to the locations and populations covered by the assessment, with the findings intended to inform practical risk-reduction measures.

2. OBJECTIVES, SCOPE AND METHODOLOGY

2.1 Overall Objective:

The overall objective of the September 2026 GBV Safety Audit is to identify environmental, structural, social, economic and service-related factors that affect the safety and dignity of women and girls in Tawila and to generate practical recommendations for strengthening GBV risk mitigation, protection mainstreaming and safe access to services. The audit is not a prevalence survey and does not document individual GBV cases. It focuses on observed environmental conditions, community perspectives, service-access barriers, institutional gaps and protection concerns that may affect the safety of women and girls.

2.2 Specific Objectives:

The specific objectives of the Safety Audit are as follows:

1. Identify existing and potential protection and protection/ GBV-related risks affecting women and girls, including physical hazards, inadequate lighting, unsafe communal areas and other high-risk locations.
2. Assess the adequacy and functionality of existing safety, protection and community-based mechanisms, including measures intended to prevent or mitigate identified risks.
3. Assess barriers to safe, confidential and dignified access to GBV, and other essential services, including reporting, referral and support mechanisms.
4. Prioritise practical risk-mitigation actions and recommendations based on identified risks, community perspectives and available evidence, to support multi-sectoral humanitarian response and advocacy.

2.3. Geographic and Population Coverage :

The September 2026 GBV Safety Audit covered Tawila locality, including selected IDP camps, gathering sites and host-community locations. Assessment locations were prioritised based on population concentration, displacement patterns, humanitarian service availability, accessibility and identified protection concerns.

The assessment engaged women and girls, community-based protection networks (CBPNs), women leaders, persons with disabilities, WGSS staff, women-led organisations and NGOs, service providers, humanitarian actors and other relevant community representatives. Particular attention was given to the experiences and safety concerns of women and girls and to barriers affecting access to protection and essential services.

The audit examined safety and protection conditions across shelter and gathering sites, health, WASH, security, humanitarian assistance and distribution points, and community-based

services. The assessment also considered the availability and accessibility of specialised GBV services, referral pathways and relevant community protection mechanisms.

2.4 Assessment Approach and Methodology :

The Safety Audit applied a mixed-methods, participatory and protection-focused approach combining desk review, community consultations, key informant interviews, focus group discussions, direct field observations and service mapping. The approach was designed to triangulate information from different sources and to distinguish observed conditions from reported perceptions and service-level findings.

The assessment focused on identifying environmental, structural, service-related and community-level factors that may increase exposure to GBV and other protection risks or create barriers to safe and dignified access to services. Findings were considered in relation to the operating environment and the practical availability and functionality of existing mitigation measures.

2 4.1 Preparation and Planning

Before field implementation, GBV and protection actors participated in a practical refresher session conducted on the GBV AoR Safety Audit How-To Guide, Safety Audit Checklist, GBV Risk Analysis Guidance and relevant consultation/FGD tools. The preparation covered the purpose of the audit, appropriate use of tools, safe data collection, distinction between observation and consultation, documentation of risks and translation of findings into mitigation actions.

To ensure comprehensive field coverage, assessment teams were structured into four distinct operational units **(Teams A, B, C, and D)** dedicated to conducting direct visual observations, focus group discussions, key informant interviews, and service mapping assessments.

A desk review of available secondary information on Tawila locality was also undertaken to provide contextual information on population movements, site characteristics, humanitarian conditions and service availability.

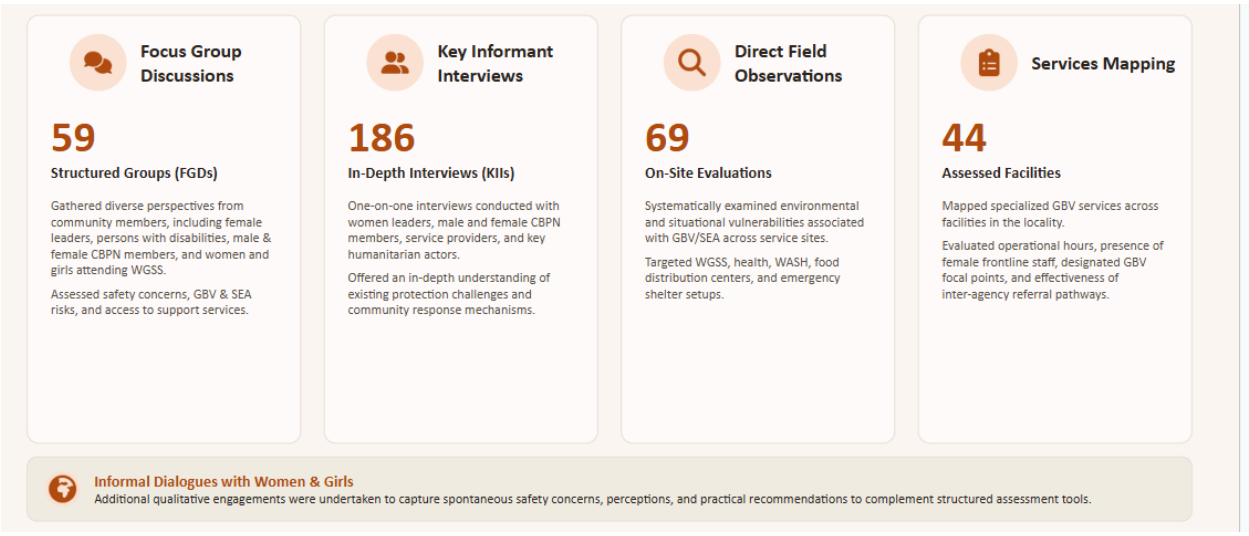
2.4.2 Community Consultations

Safe consultations were conducted with women and girls, CBPN members, women leaders, persons with disabilities, WGSS staff, WLOs/NNGOs and relevant community representatives.

Consultations explored safety concerns, barriers to accessing services, priority risks, existing protection mechanisms and community perspectives on practical risk-mitigation measures. Particular attention was given to issues affecting women's and girls' mobility, privacy, dignity and ability to access assistance and specialised services safely.

2.4.3: Data collection

Data were collected using structured Kobo-based tools ,Each tool covers a different angle: what teams observed, what informants and communities reported, and what services were available. Together they allow findings to be triangulated. The used tools were:



2.4.4 GBV and PSEA Awareness Campaign:

GBV and PSEA awareness activities were implemented alongside the assessment as a complementary community-engagement component. This initiative functions as a primary engagement gateway to foster open community dialogue surrounding protection rights, risk reduction, and available support services.

Utilising dynamic modalities—including theatre performances, interactive discussion forums, and mobile field outreach—the campaign ensures inclusive access and robust information sharing. Integrating these awareness sessions within the broader assessment framework establishes a unified approach to evaluating localised vulnerabilities, strengthening community-based protective networks, and expanding local participation.

2.4.5 Referral Pathways:

Updated inter-agency referral information was made available to assessment teams to support timely, confidential and survivor-centred referrals where participants requested or required information or support.

2.4.6 Ethical Considerations and Do No Harm:

The assessment followed humanitarian ethical principles, confidentiality and a survivor-centred approach. No individual GBV cases were documented, and participants were not required to disclose personal experiences of violence. Data were collected and analysed at aggregate level, focusing on risks, barriers, service conditions, community perspectives and protection concerns.

Field teams were expected to apply do-no-harm principles and avoid questions or approaches that could expose participants to additional risk, stigma, retaliation or distress. Where participants requested information or support, assessment teams used the available referral pathways to facilitate safe and confidential access to appropriate services.

3. SAFETY RISK ANALYSIS FRAMEWORK

For the purposes of this audit, safety risks are interpreted through a protection-focused framework that considers conditions which may increase women's and girls' exposure to GBV and other protection risks, restrict safe movement and access to essential services, or limit the availability and functionality of protective mechanisms.

The framework recognises that safety in Tawila is multidimensional and dynamic. Risks may arise from the physical environment, insecurity, displacement and overcrowding, inadequate infrastructure, barriers to services, economic pressures, social norms, gaps in reporting and referral mechanisms, and limitations in institutional or community-based protection mechanisms. These factors may interact and reinforce one another.

3.1 Risk Classification and Prioritisation

The audit considers identified risks across the following dimensions:

Priority is given to risks where significant exposure or potential consequences are combined with inadequate or insufficient mitigation measures. Particular attention is given to risks affecting essential services, restricting movement or help-seeking, creating repeated exposure to harm, or disproportionately affecting people experiencing multiple vulnerabilities.

3.2 Interpretation of Findings

The findings are interpreted using three complementary sources of evidence:

1. Direct observation: conditions physically observed by assessment teams, including lighting, WASH facilities, shelter conditions, access routes, communal areas and service points.

2. Community and key-informant perspectives: safety concerns, experiences and perceptions reported through FGDs, KIIs and consultations with women, girls, community protection structures, service providers and other relevant actors.
3. Service and operational assessment: information concerning the availability, accessibility and functionality of services, referral mechanisms, staffing, operating hours and other relevant arrangements.

These sources are complementary and are not treated as interchangeable measures of GBV prevalence. Community reports may identify protection concerns that are not captured through formal reporting systems, while direct observation and service mapping identify environmental and institutional conditions that may increase exposure to harm or create barriers to seeking assistance.

4. DETAILS SAFETY AUDITS FINDINGS:

The Safety Audit covered established IDP camp locations and selected local communities, including Tawila Al-Omda, Daba Naira, Dali, Borgo, Rowanda and Argo. The findings show variation across locations in the safety concerns reported by women and girls, physical and environmental conditions, barriers to accessing services, and the groups perceived to face greater exposure to risk.

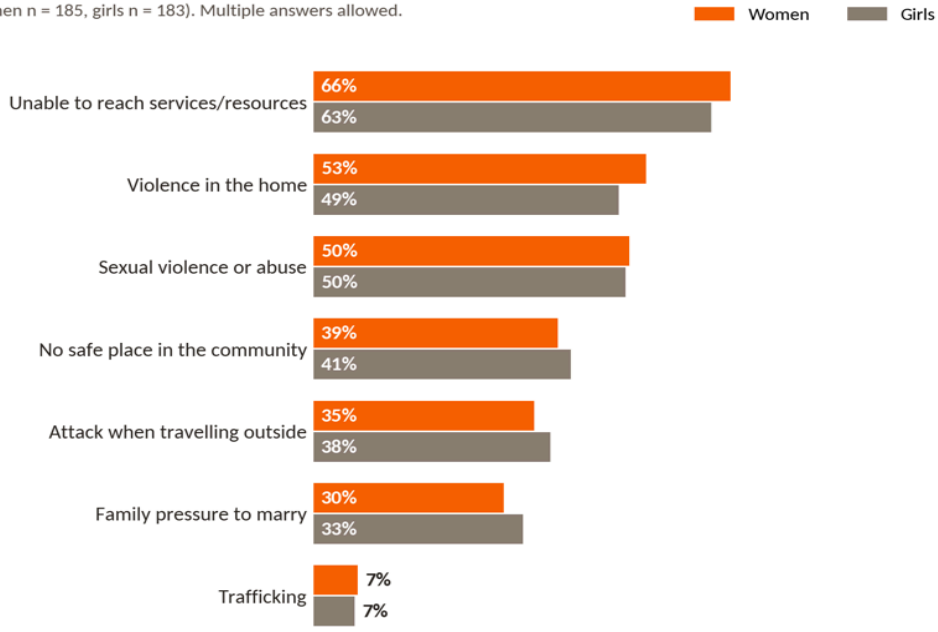
4.1 Protection & Perception of Safety,and Insecurity:

Women and girls consulted during the assessment described safety as an everyday experience shaped by their ability to move freely, access essential services, maintain privacy, protect their children, and seek assistance without fear, intimidation, or humiliation. Safety was therefore understood in broader terms than protection from physical violence. Dignity, respectful treatment, and a sense of personal reassurance were also important. Several participants, particularly adolescent girls, described safety as “a feeling” rather than something that could be guaranteed through formal security measures alone.

What the data show. Key informants most frequently identified difficulty accessing services or resources as a safety concern for both women (66%) and girls (63%), followed by violence in the home (53% and 49%, respectively) and sexual violence or abuse (50% for both women and girls) (Figure 1). In addition, 47% of key informants reported an increase in reported sexual violence, while 46% reported an increase in security concerns affecting women and girls. Among focus groups, 62% reported that GBV had worsened since the arrival of newcomers (Figure 3), indicating heightened protection concerns in the context of continued population movement and pressure on services and resources.

Figure 1. Main safety concerns for women and girls

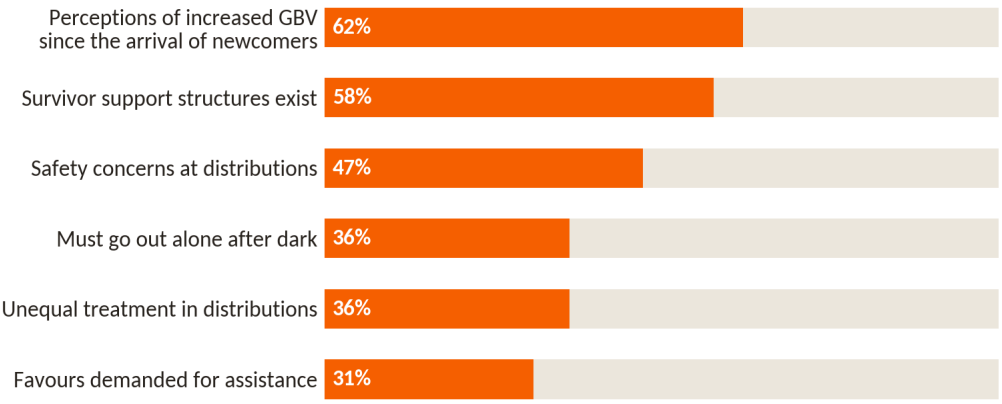
Key informants (women n = 185, girls n = 183). Multiple answers allowed.



Source: GBV Safety Audit, Tawila, North Darfur, September 2026.

Figure 3. Focus group findings

Focus groups answering each question (n = 42-58 of 59).



Source: GBV Safety Audit, Tawila, North Darfur, September 2026.

Participants reported that prolonged displacement, insecurity, economic hardship, and disruptions to essential services have affected their perceptions of safety and changed how they manage daily activities. Women described restricting their movements, avoiding certain locations, and reducing activities after dark. These restrictions were reported to affect access to livelihoods, agricultural activities, education, healthcare, and other essential services. Movement

after dark was identified as a particular concern, including in situations where urgent access to healthcare is required.

Economic hardship was frequently described as an additional source of household stress. Participants referred to loss of livelihoods, financial insecurity, displacement, and increased household responsibilities as factors contributing to tension within families. Some women reported increased hostility and domestic violence affecting women and children in this context..

Women and girls with disabilities face additional protection concerns linked to physical accessibility barriers, reliance on others for mobility or assistance, and difficulties accessing services independently. These factors increase dependence on caregivers or other household members and may limit women's and girls' ability to move safely or seek support on their own.

Concerns around water access and disruptions to essential services were also reported as contributing to insecurity and increasing the burden of daily activities. Participants described adapting their behaviour to reduce perceived risks, including spending more time indoors. However, remaining at home was not necessarily perceived as providing protection, particularly where household tensions or domestic violence were present.

Overall, Taken together, the findings indicate that perceptions of safety are closely connected to autonomy, mobility, access to essential services and the ability to seek support. Risk was described as cumulative, with insecurity, displacement, economic pressure, service disruption and household-level tensions interacting to shape daily decisions and coping strategies. These conditions may have greater consequences for women and girls who have fewer resources, limited mobility or reduced ability to make independent decisions. Safety measures therefore need to address not only physical security but also the practical conditions that enable women and girls to move, access services and seek assistance safely.

The findings presented in this section reflect reported perceptions and experiences from assessment participants. They should not be interpreted as a measure of the prevalence or incidence of GBV. Rather, they provide an indication of the protection concerns and contextual factors that women and girls identified as affecting their sense of safety and ability to navigate their daily environment.

4.1.1 Proximity to Security Installations:

The location of some displacement sites in relation to security infrastructure creates an additional dimension of insecurity. Observers recorded signs of armed actors on site or nearby at 23% of locations, and armed people who may threaten community safety at 14%. Where armed people were seen (11 locations), it was most often at the settlement entrance (6) or inside the settlement (5). Participants associated proximity to these locations with

- ➔ Persistent feelings of fear;
- ➔ Heightened surveillance and monitoring;
- ➔ Restrictions on mobility and movement;

- ➔ Ambiguity regarding safe travel routes;
- ➔ Hesitancy in reaching out for support or assistance.

These concerns may affect when and where women and girls feel able to move and whether they feel comfortable approaching services or protection mechanisms.

Key informants named attacks when travelling outside the camp as a safety concern for women (35%) and girls (38%), and 31% said travel to services is unsafe. As a result, 93% reported that women and girls usually travel outside in groups rather than alone. Participants in focus group discussions also reported a lack of female personnel within local police and community security structures

This is relevant to women's access to protection because participants indicated that the availability of female personnel can influence whether women and girls feel able to raise sensitive concerns or seek assistance. Where female personnel are absent, women may face an additional barrier to engaging with formal security or reporting structures.

4.1.2 Forms of Gender-Based Violence and Harmful Practices:

The assessment identified multiple forms of GBV and related protection concerns affecting women and girls, including sexual violence, public harassment, violence within the home, psychological and emotional violence, economic coercion and restrictions on movement. Key informants identified several settings in which women and girls may face increased exposure to GBV, particularly while undertaking activities outside the immediate settlement environment.

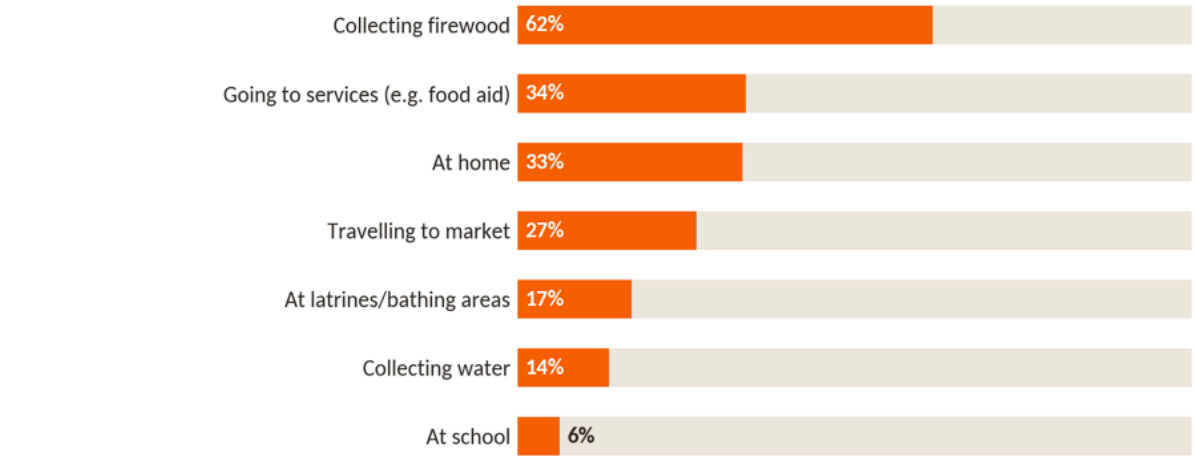
These concerns were not described as isolated forms of harm. Participants connected them to the wider conditions in which women and girls live, including insecurity, economic dependence, household stress, displacement and restricted access to services. In particular, movement restrictions were identified as both a protection concern in themselves and a factor that can prevent women and girls from reaching health services, humanitarian assistance, livelihoods and GBV support.

According to key informants, firewood collection (62%) was most commonly cited as a setting where sexual violence takes place. Other frequently reported locations included food assistance service points (34%), domestic environments (33%), routes to markets (27%), and latrines or bathing facilities (17%) (Figure 2; n = 177, multiple responses allowed). Livelihood endeavors outside camp boundaries likewise entail grave protection risks. Of the key informants reporting that women and girls travel outside the camp to earn income, 94% specified collecting firewood and 92% collecting straw as income-generating pursuits, whereas 14% noted transactional sex for financial support (Figure 12).

These data demonstrate how basic survival tasks and income generation heighten exposure to GBV. Reflecting these hazards, reports of GBV along water and firewood collection routes were noted in 50% of assessed locations, highlighting the acute vulnerability associated with travel beyond the immediate camp boundary.

Figure 2. Where sexual violence occurs

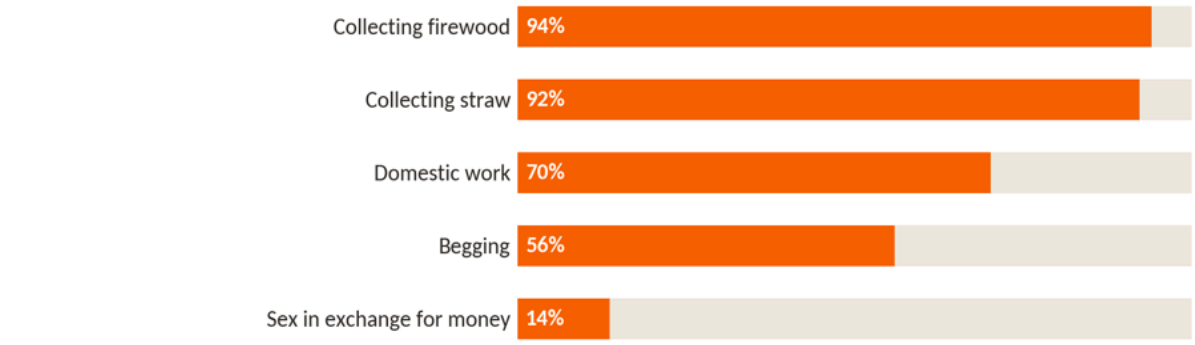
Key informants who answered (n = 177). Multiple answers allowed, so shares do not add to 100%.



Source: GBV Safety Audit, Tawila, North Darfur, September 2026.

Figure 12. Income activities outside the camp

Key informants who said women/girls leave the camp to earn income (n = 168). Multiple answers allowed.



Source: GBV Safety Audit, Tawila, North Darfur, September 2026.

The assessment also identified protection concerns affecting children and adolescents. 73% of key informants reported unaccompanied children in their communities, while unaccompanied girls and boys were reported to be sharing shelters at 87% of observed locations. Family pressure to marry was identified as a safety concern for girls by 33% of key informants, while 7% identified trafficking. These findings identify specific child protection concerns requiring further consideration in relevant sectoral and inclusion responses.

4.2 Shelter, Physical and Environmental Safety:

The physical environment was consistently identified as a major source of safety concern across assessed locations. Night lighting was not functional at 85% of the 68 locations where it was

evaluated, walkways were unlit at 81%, dark or dangerous areas were present at 59%, and latrines and showers were lit at night at only one of 69 locations.

The lack of lighting affects more than visibility.Women and girls reported that moving after dark becomes uncertain and unsafe, particularly when accessing latrines, collecting water, seeking health care or moving between shelters and communal facilities. Key activities affected by the absence of lighting include:

- ➔ Mobility and movement after dark;
- ➔ Safe access to latrines and sanitation facilities;
- ➔ Water collection activities;
- ➔ Access to emergency health care services; and
- ➔ Overall visibility surrounding shelters.

Where lighting is absent or unreliable, women and girls have to choose between delaying essential activities until daylight and moving through environments they perceive as unsafe. This makes lighting both a physical-environment issue and a relevant GBV risk-mitigation concern.

Shelter design, layout and household arrangements also presented safety and privacy concerns. In 68% of assessed locations, shelters were insufficiently spaced, while 46% lacked designated safe cooking areas. These conditions may increase the risk of accidents and make it more difficult to maintain safe separation between cooking activities and living areas, particularly in densely occupied settings. While the audit did not establish a formal rate of fire incidence, the combination of severe shelter density, open-flame cooking in high-traffic family quarters, and heavy reliance on highly flammable local materials creates critical safety risks. The findings therefore support the need to integrate shelter layout, cooking arrangements and household safety into site-level risk mitigation.

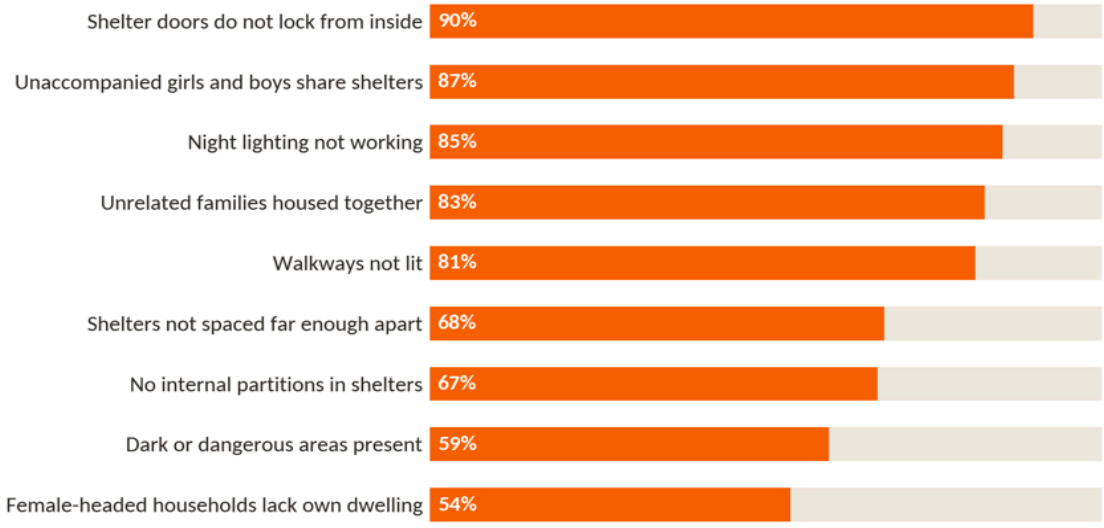
4.2.1 Shelter Dynamics, Privacy, and household safety:

Shelter conditions have a direct bearing on privacy, dignity and personal safety. The level of congestion limits physical separation between households and reduces the availability of private space. Participants described how crowded living conditions contribute to household stress, reduced privacy and difficulties maintaining personal boundaries.

Community consultations further highlighted that residing within a shelter structure fails to guarantee a sense of personal security for women and girls. Key issues raised encompassed household friction, interpersonal abuse, and severe constraints on dignity resulting from overcrowded domestic environments. Shelter doors lacked functional interior locks across 90% of surveyed sites, while 83% housed unrelated families together, 87% contained shared living arrangements for unaccompanied boys and girls, and 67% of assessed locations lacked internal privacy partitions. (Figure 4). For those confronting domestic violence or related protection hazards, such absence of private living quarters severely impairs their capacity to safely report incidents or seek confidential assistance.

Figure 4. Shelter and site safety gaps

Observation, share of the 69 locations where the gap was found (lighting and spacing n = 68).



Source: GBV Safety Audit, Tawila, North Darfur, September 2026.

Overall, the findings show that shelter safety is not determined by the availability of a physical structure alone. The internal conditions of the living environment including congestion, privacy, household composition and the ability to maintain personal space also influence how safe and secure women and girls are able to feel in their daily lives.

4.2.2 Mobility Dynamics and Movement Constraints:

Mobility is affected by a combination of physical and environmental conditions, including poor lighting, unsafe routes, distance to services and limited transportation options. These

constraints are particularly significant after dark, when women and girls may have fewer safe options for reaching communal facilities or services outside the immediate settlement.

The practical consequence is that access to essential services may depend on whether women and girls can safely navigate the environment at the time they need them. This is particularly relevant for emergency healthcare, GBV referrals, water collection and humanitarian assistance. Where safe movement depends on travelling in groups, waiting until daylight or relying on available transport, women and girls may have fewer options to respond quickly to urgent needs.

4.3 WASH Infrastructure, Water Access and Safety

Water, sanitation and hygiene (WASH) conditions form an important part of the daily safety environment for women and girls. In displacement settings, access to water and sanitation is not limited to the availability of infrastructure. Women and girls must also be able to reach facilities, use them with adequate privacy and dignity, and do so under conditions that are physically accessible and reasonably safe.

The assessment identified significant gaps in both sanitation infrastructure and water access. These gaps have practical implications because water collection and sanitation use are routine activities that may require women and girls to leave their shelters, travel through communal areas, wait in public spaces and use facilities during both daylight and night-time hours.

4.3.1 Sanitation Infrastructure and Safety

The evaluation of sanitation infrastructure across the surveyed areas revealed critical structural and operational shortcomings:

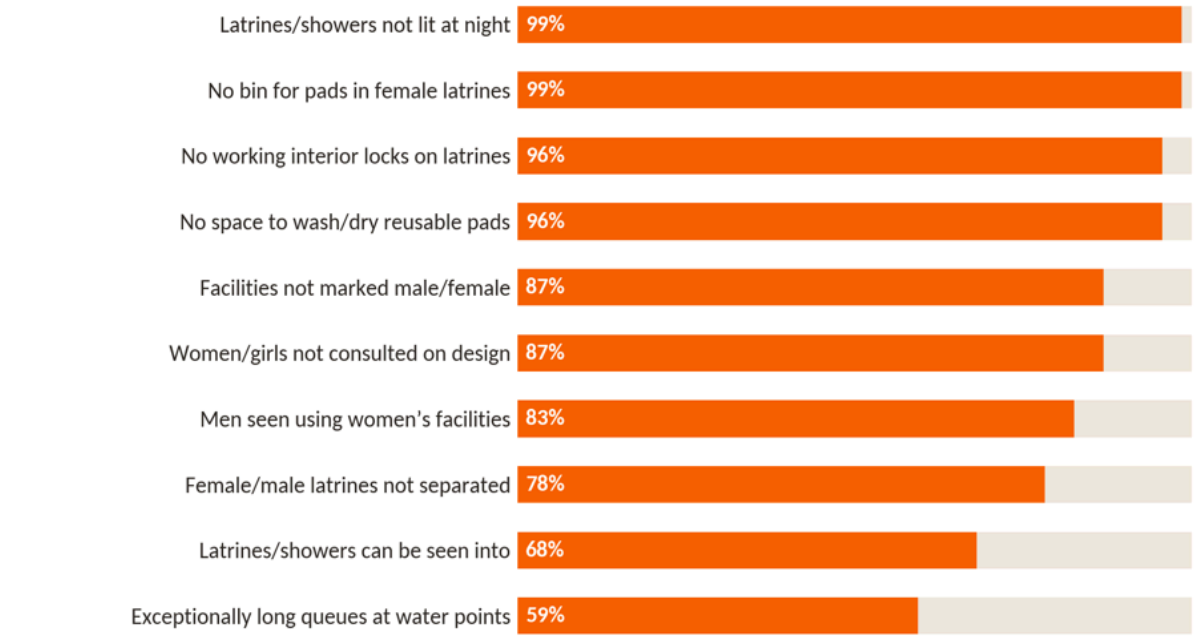
- Sanitation provision was deficient across most assessed camps.
- Working interior locks were observed at only 4% of assessed locations, while latrines were lit at night at just 1% of locations and facilities were separated for women and men at only 22% of locations.
- 73% of all evaluated latrine and shower units offered clear sightlines from the outside.
- Men were observed utilizing facilities designated for women across 83% of the sites.

These findings demonstrate that sanitation access cannot be assessed solely by the presence or number of facilities. Facility layout, privacy, lighting and basic safety features directly influence whether women and girls can use sanitation facilities safely and with dignity. Limited internal locking, inadequate nighttime lighting and insufficient gender separation may compromise privacy and safe use, particularly after dark. The visibility of many latrine and shower units from outside further raises concerns regarding privacy, while the observed use of women-designated facilities by men may further affect women's and girls' sense of safety and comfort.

Consequently, there is an important distinction between physical availability and safe, functional access. Even where latrines and showers are present, deficiencies in privacy, security, lighting and facility management may limit their safe use. These conditions may be particularly significant for women and girls who require access to sanitation facilities at night or who face additional mobility or accessibility constraints.

Figure 5. Latrine, shower and water point gaps

Observation, share of the 69 locations where the gap was found.



Source: GBV Safety Audit, Tawila, North Darfur, September 2026.

4.3.2 Water Access and Safety

Water access presents both service-access and protection concerns for women and girls. The assessment identified physical and economic barriers to accessing clean water, particularly the distance to water points and commercial tariffs. For women and girls responsible for household water collection, these barriers may increase the time spent travelling, waiting and carrying water, potentially increasing exposure to safety risks during movement and while using communal water points. Where water points are distant or unaffordable, households may also face difficult choices about when, where and how to obtain

water, with potentially greater impacts on women and girls where they are primarily responsible for household water collection.

Participants identified several factors affecting the safety and accessibility of water points:

- ➔ Distance and safety of access routes;
- ➔ Lighting and visibility around water points;
- ➔ Waiting time and crowding;
- ➔ Privacy and dignity;
- ➔ Affordability and commercial pricing;
- ➔ Representation of women in water-management structures; and
- ➔ Accessibility for women and girls with disabilities.

These factors are interconnected. A water point may be physically available but remain difficult to use safely if the route is distant or poorly lit, waiting areas are overcrowded, costs are unaffordable, or the facility is inaccessible to women and girls with disabilities. Similarly, long waiting times can increase the amount of time women and girls spend in public or communal spaces while seeking an essential service.

The assessment therefore highlights that the availability of water alone does not demonstrate safe access. Safe access requires that women and girls can reach, wait for and collect water without avoidable barriers to mobility, privacy, dignity or accessibility. Particular attention is warranted where multiple barriers occur together, as these conditions may increase exposure to protection risks and constrain women's and girls' ability to safely access an essential service.

4.3.3 Overall WASH Safety Implications

Overall, the audit highlights how structural deficiencies in WASH infrastructure transcend basic service gaps to directly shape the safety environment for women and girls. Given their routine use, the strategic location, physical accessibility, adequate lighting, privacy features, and operational state of water points and sanitation facilities are fundamental to ensuring community safety. Although the findings do not draw a direct causal link between WASH deficits and GBV or protection incidents, these unsafe conditions heighten vulnerability and severely restrict the ability of women and girls to fulfill essential needs with dignity and privacy.

To address these challenges, WASH humanitarian programming must look beyond technical metrics and service coverage to prioritize safe access and usability. Routine assessment and ongoing monitoring of WASH facilities must evaluate whether women and girls—including those with disabilities or those accessing facilities at night—can reach and use water points and sanitation services safely, privately, and with dignity.

4.4 Humanitarian Assistance, Prevention of Sexual Exploitation and Abuse (SEA), and Accountability to Affected People (AAP)

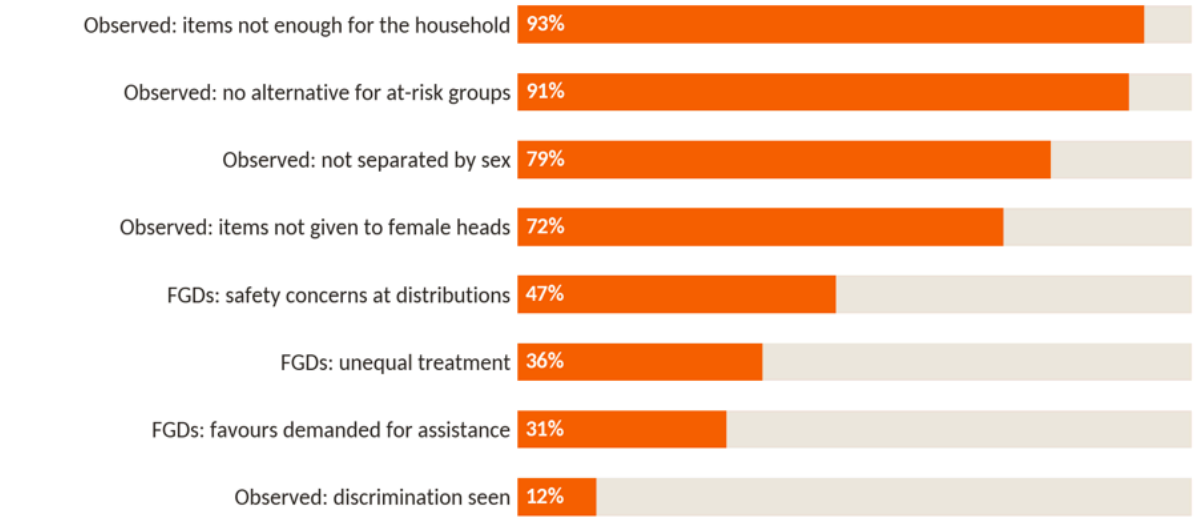
The assessment identified significant concerns regarding the safety, equity, accessibility and accountability of humanitarian assistance, with important implications for PSEA and AAP. Findings from 59 focus groups indicate that barriers within distribution processes may create conditions in which people with limited alternatives to assistance are more vulnerable to pressure, favour-seeking or exploitation. 47% of FGDs reported safety concerns at distribution points, 36% reported perceptions of unequal treatment, and 31% reported that assistance was linked to favour-seeking and exploitation. In addition, 91% reported limited alternative collection options for at-risk groups, while 93% reported that assistance was insufficient. These findings are particularly relevant to PSEA because dependence on humanitarian assistance, combined with limited choice and unequal access, can increase power imbalances between affected people and those involved in assistance processes.

Observed distribution practices further highlight gaps in safe and equitable access. Only 21% of the 43 distributions observed were separated by sex, while items were provided directly to female heads of household in only 28%. Although female staff oversaw 84% of distributions, discrimination was directly observed at 12% of distributions (Figure 10). The presence of female staff is a positive operational feature, but it does not by itself address concerns related to unequal treatment, exploitation, confidentiality, complaints handling or the ability of affected people to safely refuse inappropriate requests or report misconduct.

These findings emphasize the urgent need for humanitarian assistance frameworks that actively reduce power asymmetries, coercion, bias, and abuse, ensuring vulnerable populations can access support safely and equitably. Vulnerable groups with few alternatives face heightened risks due to widespread unmet needs, limited distribution channels, and frequent reports of requested favors. To address these challenges, humanitarian actors must implement confidential and accessible feedback channels, maintain clear communication regarding entitlements and code of conduct standards, establish safe reporting systems, configure distribution sites with protection in mind, and consistently monitor PSEA risks to ensure access to aid is never tied to favors or personal leverage.

Figure 10. Safety and fairness of aid distributions

Observation of 43 distributions; focus groups answering each question (n = 42-55).



Source: GBV Safety Audit, Tawila, North Darfur, September 2026.

4.5 General Health, SRH, and GBV Service Provision

Access to healthcare remains constrained across the assessed locations, with gaps affecting general healthcare, maternal and newborn health, sexual and reproductive health, adolescent services, HIV and STI services, and emergency referral. The assessment indicates that the challenge is not limited to whether a facility exists. The location of services, operating hours, transportation, privacy, availability of essential supplies and referral arrangements all influence whether women and girls can obtain appropriate care safely and in a timely manner.

4.5.1 General Healthcare Access

A health facility was available in 83% of observed locations, but these facilities primarily provided primary care, while specialised treatment remained outside the displacement settlements. The presence of a facility therefore did not necessarily mean that appropriate care was readily accessible. Only 32% of observed facilities were open 24/7, and only 32% had a confidential consultation space. For women and girls requiring care outside regular operating hours, specialised treatment, or confidential consultations, these gaps may create additional barriers.

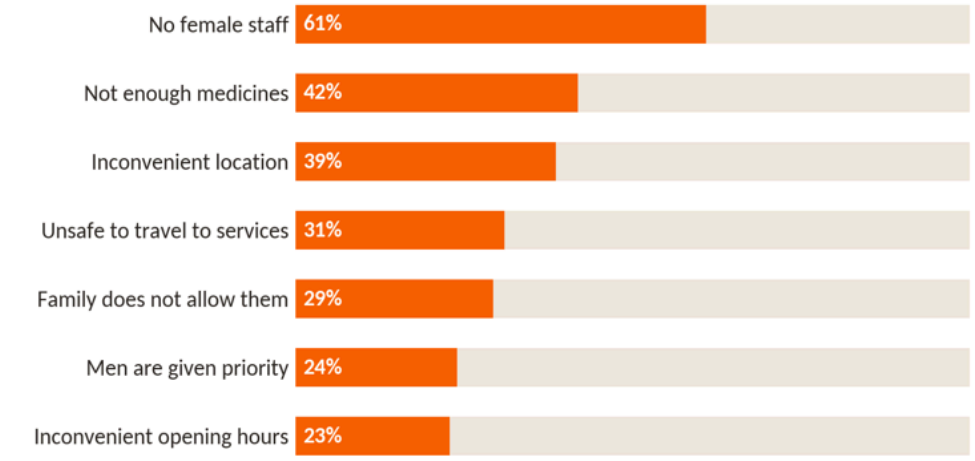
Access barriers were widespread. 93% of key informants identified at least one barrier to women and girls reaching health services. The most frequently reported were lack of female staff (61%), insufficient medicines (42%), inconvenient location (39%) and unsafe travel (31%) (Figure 7). Limited private consultation space also affects access to sensitive health, SRH and GBV-related services, where confidentiality is important for disclosure and care-seeking.

Capacity constraints were also reported at service level. 21% of service providers reported turning women and girls away because of insufficient resources. This indicates that physical

availability of a health service does not always translate into access to the care required. The practical gap is therefore broader than facility coverage. Continuity, staffing, medicines, privacy, safety and referral capacity all affect whether women and girls can obtain appropriate care. These constraints may be particularly significant for those requiring time-sensitive or specialised services, including women and girls seeking GBV services.

Figure 7. Barriers to reaching services

Key informants (n = 184). Multiple answers allowed.



Source: GBV Safety Audit, Tawila, North Darfur, September 2026.

4.5.2 Maternal and Newborn Health

Maternal and newborn care presents specific gaps in service readiness and emergency response capacity. During informal fieldwork dialogues, participants reported that many gathering sites lacked maternal, antenatal and emergency obstetric services, with shortages of delivery infrastructure, clean drinking water and essential medical supplies. The audit data reinforce these concerns: of the 25 health service points mapped, 84% had no gynaecologist or obstetrician and 28% had no midwife. In addition, 68% of the 57 health facilities observed were not open 24/7, limiting the availability of care outside regular operating hours and potentially creating gaps for women requiring urgent obstetric attention. These findings point to weaknesses in the availability of specialised personnel, essential supplies and continuous emergency care.

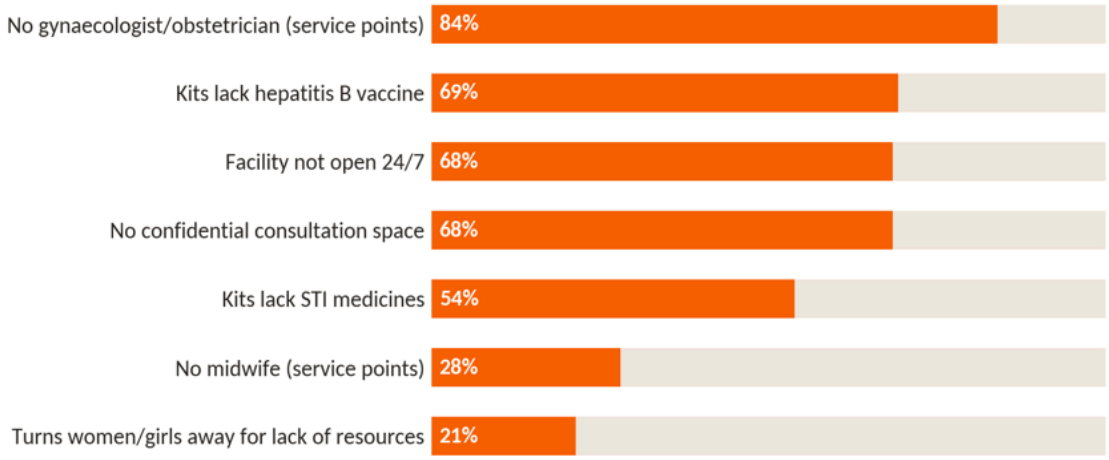
Food and nutritional constraints further affect the environment in which pregnant and breastfeeding women manage their health. Informal dialogues indicated difficulties meeting basic nutritional needs and accessing specialised prenatal dietary support. In parallel, 93% of the 43 distributions observed provided items that were reported as insufficient for the household. While this finding is not specific to pregnant or breastfeeding women, it indicates a broader level of household resource constraint that may compound existing challenges to maternal wellbeing and care-seeking.

4.5.3. Sexual and Reproductive Health and Family Planning

Access to comprehensive SRH and GBV-related services remains substantially constrained across the assessed areas. Family planning options, including long-acting reversible contraceptives and other modern methods, were reported to be largely unavailable, limiting the range of choices available to women and girls. Service mapping of 25 health service points identified significant gaps in GBV service readiness: only 32% had complete post-rape kits, 36% had a designated GBV focal point, 36% had staff trained to care for child survivors, 61% had staff trained in clinical care for survivors, and 46% had a safe and confidential space.

Figure 8. Health and SRH service gaps

Observation of 57 health facilities; service mapping of 25 health service points (kit items: 13 providers with kits).

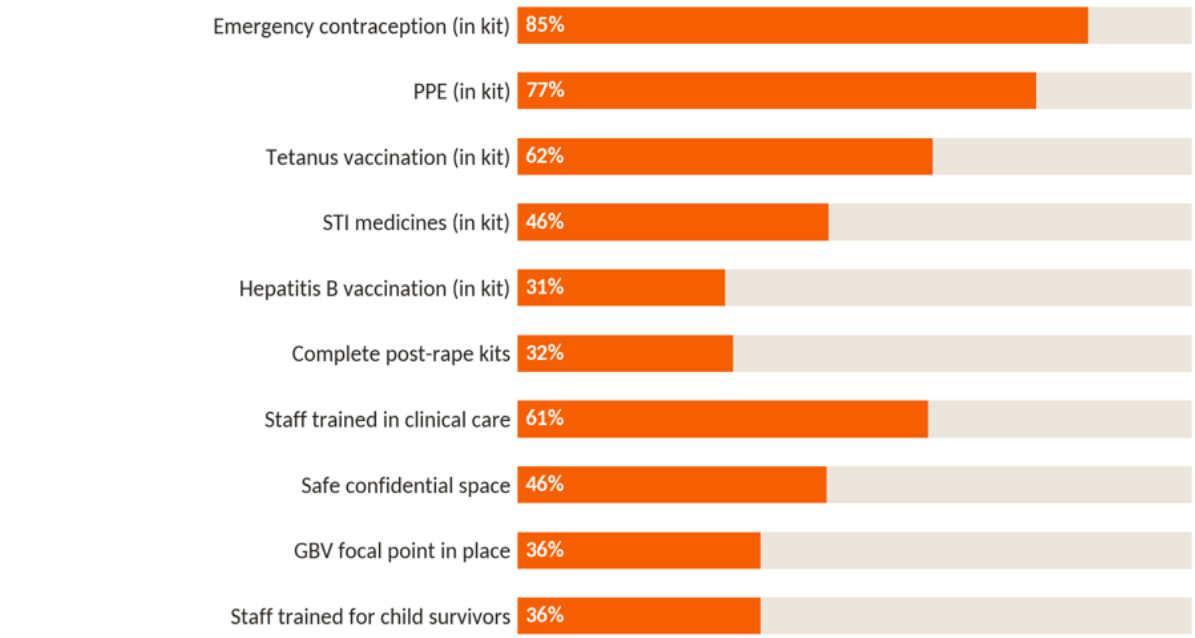


Source: GBV Safety Audit, Tawila, North Darfur, September 2026.

Among the 13 providers with post-rape kits, emergency contraception was available in 85%, while STI medicines were available in only 46% and hepatitis B vaccine in 31% (Figure 9). These gaps indicate that the presence of a service point does not necessarily translate into comprehensive, timely or confidential SRH and GBV care. Limited availability of essential commodities, trained personnel and confidential spaces may constrain the quality and completeness of care available to women, girls and GBV survivors, including child survivors.

Figure 9. Readiness for clinical management of rape

Service mapping, health providers (kit items n = 13; readiness n = 23-25). Share that HAVE each item.



Source: GBV Safety Audit, Tawila, North Darfur, September 2026.

4.5.4 Emergency Referral

Emergency referral presents a significant gap in timely access to care. During informal fieldwork dialogues, participants reported limited medical transportation and emergency referral arrangements at night in many camps and gathering locations, as well as considerable distance between some sites and the referral hospital in Tawila. The audit findings indicate additional barriers to reaching care after dark: 68% of the 57 health facilities observed were not open 24/7, while key informants identified inconvenient location (39%) and unsafe travel (31%) as barriers to health services for women and girls.

The physical environment further compounds these constraints. Night lighting was not functioning at 85% of observed locations, and 59% had dark or dangerous areas. In addition, 36% of focus groups reported that women and girls sometimes have to go out alone after dark. Taken together, these findings indicate that the availability of a referral facility does not by itself ensure timely emergency care. Limited operating hours, unsafe or poorly lit routes, lack of reliable night-time transport and the need for women and girls to travel after dark may create additional barriers to reaching care when urgent treatment is required.

4.5.5 Harmful Practices and Adolescent Health and Protection Concerns

Adolescents have specific health and protection needs that are not fully addressed through general health-service provision. Community consultations identified FGM as an ongoing harmful practice affecting girls, highlighting the continued influence of social norms on girls' bodily autonomy, wellbeing and access to appropriate support. The assessment also identified

concerns related to tobacco use and substance dependency among young people. For adolescents, access to appropriate support depends not only on whether services are present, but also on whether they are confidential, age-appropriate, acceptable and trusted. Adolescents may be reluctant to seek support where privacy cannot be assured or where they lack reliable information about available services. These considerations are particularly important for girls, who may face additional restrictions on mobility and decision-making.

The findings therefore point to the need for adolescent-sensitive health and protection responses, including confidential and age-appropriate information, trusted service entry points, appropriate referral mechanisms and engagement with caregivers and community structures. Prevention efforts should also address harmful social norms and emerging concerns around substance use while ensuring that adolescents can access support without stigma or unnecessary barriers.

4.6 WGSS and Confidential Reporting Systems

Women and Girls Safe Spaces (WGSS) serve as critical entry points within the protective environment, facilitating discreet access to specialized case management, psychosocial support (PSS), and multi-sectoral referral pathways. However, the protective efficacy of a WGSS cannot be measured by infrastructure alone; it is entirely contingent upon safe physical access, community-wide service awareness, strict adherence to data protection and confidentiality protocols, and survivor trust in institutional response mechanisms.

The assessment reveals significant fractures between the existence of safe spaces and their actual operational functionality. While physical WGSS infrastructure was observed in 62% of assessed locations, key informants noted that genuinely safe, girl-friendly environments were accessible in only 68% of sites (compared to 75% for adult women).

Furthermore, only 58% of focus group participants confirmed the operational presence of survivor support mechanisms, and a matching 58% of locations demonstrated localized awareness of post-GBV clinical care pathways. These statistical trends underscore a critical protection gap: the presence of an asset or referral pathway does not automatically translate into safety, access, or utilization by at-risk

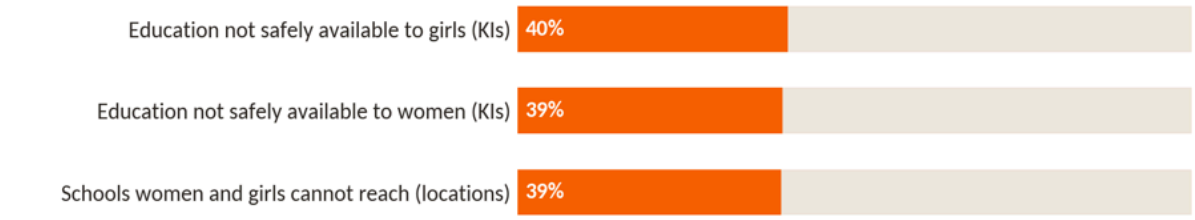
4.7 Education:

The audit findings indicate significant barriers to safe and sustained access to education, with girls facing particular protection concerns. 40% of key informants reported that education was not safely available to girls, compared with 39% for women, while schools were not reachable for women and girls in 39% of observed locations (Figure 11). Family pressure to marry was identified as a safety concern for girls by 33% of key informants, while child labour was raised in

eight key informant interviews. These findings highlight how restricted access to education intersects with wider risks affecting girls, including pressure toward early marriage and reduced opportunities to remain in protective learning environments.

Figure 11. Access to education for women and girls

Observation, 69 locations; key informants (girls n = 182, women n = 183).



Source: GBV Safety Audit, Tawila, North Darfur, September 2026.

Informal fieldwork dialogues indicated that, where formal educational infrastructure is unavailable, children rely on makeshift learning spaces with limited basic resources. Participants reported shortages of seating, desks, writing boards and instructional materials, while many learning spaces lacked functional latrines, safe drinking water and adequate furniture. Irregular attendance was also reported, with male students reportedly representing the majority of enrolled learners.

Education disruption affects girls and boys through different pathways. For adolescent girls aged 13 and above, participants identified economic pressure and the absence of school feeding initiatives as factors affecting continued participation in education and increasing pressure toward early marriage. For boys, informal consultations indicated that many adolescent boys aged 10 and above leave education to seek informal work in local commercial markets in Tawila. Food shortages, malnutrition and illness were also reported as contributing to absenteeism.

Taken together, the findings indicate that education functions not only as a learning opportunity but also as an important protective environment. Weak infrastructure, inadequate learning conditions, economic pressure and barriers to regular attendance may reduce children's access to the structure, supervision, information and peer support provided through education, while increasing exposure to other protection risks.

4.8 Food Insecurity and assistance adequacy

Acute food insecurity continues to place substantial strain on displaced households, with particularly significant implications for women and children. Community consultations indicated extended gaps in humanitarian food assistance, with reductions in the quantity of assistance reportedly prioritising newly arrived populations facing critical emergency needs. These reductions occur alongside depleted household food stocks, severe financial constraints and high market prices that exceed the purchasing capacity of existing cash-based assistance. Together, these pressures may limit households' ability to consistently meet basic food needs and increase reliance on coping strategies.

The audit findings highlight a clear gap between the availability and adequacy of assistance. In 79% of focus groups, participants reported that their communities received distributions or other forms of assistance. However, among the 43 distributions observed, 95% were food distributions, and the items provided were considered sufficient for the household in only 7% of cases. This indicates that although humanitarian assistance reaches many communities, the quantity provided may be insufficient to meet household needs. Persistent shortfalls in food assistance, combined with limited purchasing power and reduced household resources, may place additional pressure on families to adopt negative coping strategies, with potentially greater consequences for women, children and other household members with limited control over resources.

5. Vulnerability and Inclusion

The assessment identified distinct and overlapping barriers affecting different groups of women and girls, shaped by age, disability, displacement status, household responsibilities, economic resources, mobility and access to information and services. Vulnerability is therefore not experienced uniformly. The same service or assistance may be available within a location but remain less accessible, less safe or less appropriate for particular groups. This is particularly relevant where women and girls depend on others for movement, information, household resources or access to services.

Across all nine service categories assessed, key informants rated services as less safely available to girls than to women (Figure 6). The largest differences were reported for food assistance (71% for girls compared with 58% for women), clean water (82% compared with 71%) and non-food items (33% compared with 24%). Fewer than one-third of key informants considered dignity kits, shelter or non-food items safely available to girls. These differences indicate that girls face additional barriers beyond those affecting women generally, particularly in relation to essential services that require movement, interaction with service providers or reliance on adults.

5.1 Adolescent Girls

For adolescent girls, age and dependence on adults can compound barriers to mobility, information, and confidential access to services. Their ability to seek assistance may be affected where services are distant, information is not age-appropriate, or privacy cannot be assured. Service design should therefore consider girls' specific needs for confidentiality, accessible communication, trusted support, and safe, age-appropriate referral pathways.

5.2 Women and Girls with Disabilities

Women and girls with disabilities may experience physical, communication and social barriers that limit their ability to access services independently and confidentially. The assessment identified concerns related to inaccessible facilities, reliance on others for movement, communication barriers and social isolation. These constraints may be compounded where services are distant, routes are unsafe or information is provided in formats that are not accessible.

Inclusion therefore needs to be considered as part of safe service delivery, rather than as a separate requirement. The ability to reach a service, understand available information, communicate a need, maintain privacy and receive assistance without unnecessary dependence on others are all relevant to safety and dignity.

5.3 Female-Headed Households

Female-headed households face additional pressures related to caregiving responsibilities, limited resources, access to income and control over household assets. These pressures can affect women's ability to travel for assistance, pursue livelihoods or access services where distance, transportation costs or competing household responsibilities create additional

constraints. The audit found that female-headed households had their own dwelling in only 46% of observed locations, while items were provided directly to female heads of household in only 28% of the 43 distributions observed. These findings highlight the importance of considering household structure, control over assistance and caregiving responsibilities when assessing whether support can be accessed and used equitably.

5.4 Newly Displaced Women and Girls

Newly displaced women and girls may face disrupted social support networks, limited knowledge of available services and unfamiliarity with referral and assistance mechanisms. Displacement may also increase reliance on humanitarian assistance at a time when household resources, documentation, livelihoods and social connections may have been disrupted.

These conditions can make it more difficult to identify available support and navigate services, particularly where information is inconsistent or services are located outside newly established areas. Clear information, accessible referral pathways and safe entry points to assistance are therefore particularly important for newly displaced populations.

5.5 Intersectional Vulnerability and Inclusion

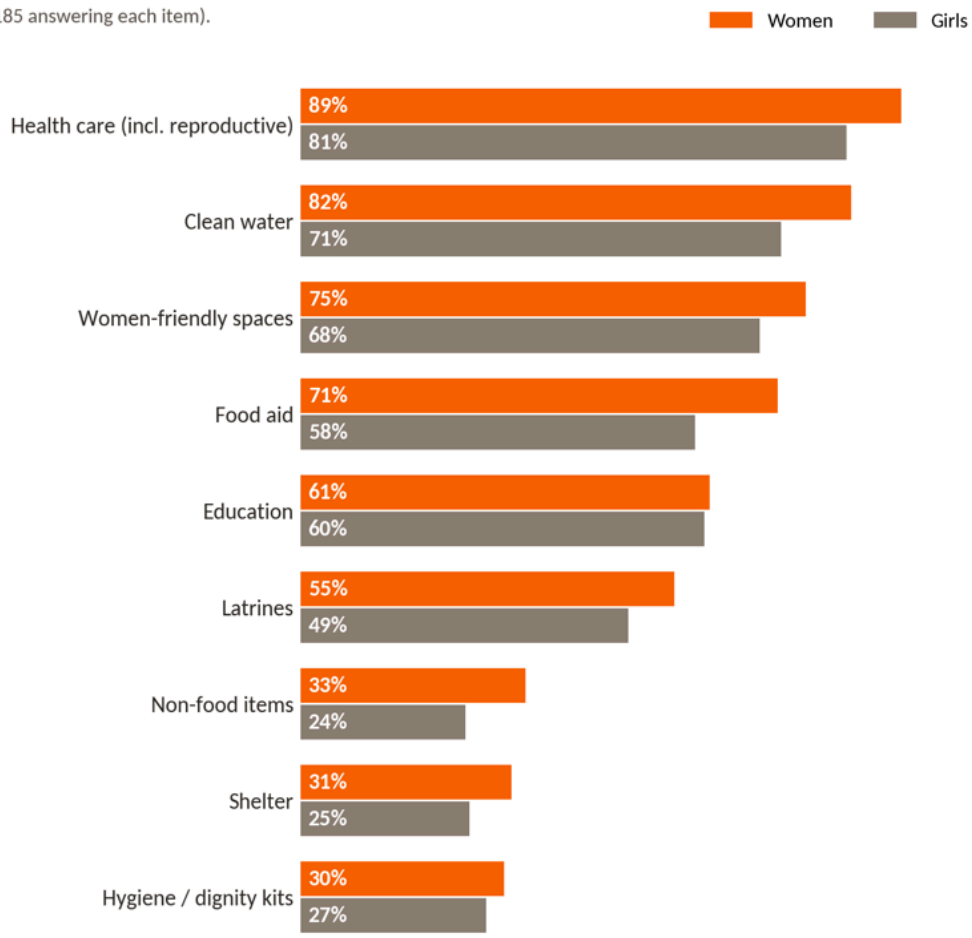
The assessment demonstrates that vulnerability may result from intersecting barriers rather than a single characteristic. For example, an adolescent girl with a disability who is newly displaced may face substantially different constraints from an adult woman who has established social networks and greater control over household resources. Similarly, a female-headed household with limited income may experience distance, transportation and caregiving barriers at the same time.

This has important implications for how safety risks and programme access are assessed. The presence of a service or formal eligibility does not necessarily mean that it can be used safely in practice. Programme teams should consider who can realistically reach and use services, whether privacy can be maintained, whether information is accessible, and whether particular groups require adapted communication, physical access, additional support, or alternative arrangements.

The findings therefore support an approach that looks beyond broad categories of “women” and “girls” and considers the barriers faced by different groups within the affected population. This is particularly important where several constraints occur together and may require targeted measures rather than a standard service response.

Figure 6. Services safely available to women and girls

Key informants (n = 179-185 answering each item).



Source: GBV Safety Audit, Tawila, North Darfur, September 2026.

6. Priority Action Areas and Operational Recommendations

The Safety Audit findings identify a set of interconnected operational priorities affecting the safety, dignity and access of women and girls across Tawila. These include unsafe physical environments, gaps in WASH and health services, barriers to safe humanitarian assistance, limited referral and support mechanisms, disrupted education, household resource constraints, and additional barriers affecting adolescent girls, women and girls with disabilities, female-headed households and newly displaced populations. Addressing these issues requires coordinated action across sectors rather than reliance on standalone GBV interventions.

Translating the findings into practice requires clear prioritization, assigned responsibilities, measurable actions and routine monitoring. Priority should be given to measures that can reduce immediate exposure to safety risks while strengthening the functionality and accessibility of essential services. Community feedback, referral monitoring and regular review of safety conditions should be incorporated into implementation so that interventions can be adjusted as needs and operating conditions change.

The Safety Audit should therefore serve as a shared evidence base for inter-sectoral planning, resource mobilization and operational prioritization in Tawila. Implementation should focus on the assessed IDP locations—Tawila Al-Omda, Daba Naira, Dali, Borgo, Rowanda and Argo—with prioritization based on identified safety gaps, population needs and service coverage. A coordinated action framework should define priority interventions by location, identify lead actors, specify resource requirements and establish a mechanism for tracking implementation and outstanding gaps.

6.1 Immediate Priorities: 0–3 Months

6.1.1 Lighting and safe movement

Restore or install lighting around latrines, water points, health facilities, WGSS, distribution areas and priority pedestrian routes. Site teams should identify poorly lit areas with women and girls and maintain a simple system for reporting and repairing non-functional lights.

6.1.2 Distribution safety and accountability

Improve safety at distribution points through appropriate queue management, separate arrangements where needed, adequate staffing and the presence of female staff where feasible. Distribution sites should also have clear, confidential and accessible channels for complaints and feedback, including options for people who cannot safely report concerns in public.

6.1.3 WASH safety

Building on the safety audits findings, address the most immediate safety gaps. Priority measures should include functional doors and locks, adequate lighting, privacy, appropriate separation of facilities, safe access routes and accessibility for women and girls with disabilities.

6.1.4 PSEA and safe reporting

Ensure women, girls and other affected community members know what conduct to expect from humanitarian personnel, where to report concerns and what support is available. Reporting channels should be confidential, accessible and linked to appropriate referral and follow-up arrangements.

6.1.5 Disability inclusion

Identify and remove immediate barriers affecting women and girls with disabilities, including inaccessible facilities, difficult access routes, communication barriers and unnecessary reliance on others to obtain services. Where standard arrangements cannot provide safe access, reasonable accommodation should be provided.

6.1.6 Physical safety and site-level risk reduction

Prioritize site-level infrastructure improvements in locations with the most significant environmental safety gaps identified through the audit. Immediate priorities should include lighting, safer routes to essential services and practical mobility arrangements for persons with disabilities.

6.1.7 Frontline personnel safety

Review safety arrangements for humanitarian staff and service providers working in higher-risk locations, with particular attention to services that need to remain available during periods of insecurity or restricted movement. Continuity measures should protect both personnel and access to essential, survivor-centred services.

6.1.8 Cash and protection linkages

Strengthen basic protection risk mitigation and referral information into cash and voucher assistance where households face significant resource constraints or difficulty reaching services. Information on available support should be provided without requiring disclosure of GBV or other protection concerns as a condition of receiving assistance.

6.1.9 Accountability to affected populations

Make community feedback part of routine programme management. Feedback should be collected through accessible channels, reviewed regularly, referred to the responsible actor and tracked through to action or response. Communities should also be informed when feedback results in changes to services or programme arrangements.

6.2 Cluster-Specific Recommendations

The September 2026 GBV Safety Audit indicates that the safety concerns identified in Tawila extend beyond the scope of specialized GBV services. Unsafe movement, inadequate lighting and sanitation, limited health-service readiness, food insecurity, constrained livelihoods, disrupted education and barriers to confidential support interact to shape the daily safety environment for women and girls.

The findings therefore support integrated humanitarian and protection programming in Tawila, using the Safety Audit as a shared evidence base for operational planning, resource mobilization and coordination. Sector-specific interventions should be implemented alongside cross-sectoral measures that address common barriers such as safe movement, accessibility, privacy, information, referral and accountability.

Sector		Recommendation / Priority Mitigation Action	Responsible Actors
Protection	GBV	• Prioritize locations where women and girls face barriers to GBV support or where WGSS coverage is absent or difficult to access. • Strengthen confidential referral pathways between WGSS, health facilities and specialized GBV services, including clear information on where survivors can obtain post-GBV care. • Ensure GBV services are accessible to adolescent girls, women with disabilities and newly displaced populations through appropriate communication, physical access and referral arrangements. • Integrate GBV risk analysis into site-level planning, particularly around unsafe routes, sanitation facilities, water points and distribution locations.	GBV coordination; GBV partners; UNFPA; Protection; WLOs;
	Protection	• Establish routine monitoring of identified protection risks, including documentation, unsafe movement, armed presence, domestic violence concerns, family separation and risks affecting unaccompanied children. • Strengthen safe and confidential mechanisms for reporting protection concerns, with clear referral and follow-up responsibilities. • Prioritize protection outreach in locations where women and girls have limited access to formal support or female personnel. • Ensure protection concerns identified through site, WASH, health and assistance monitoring are referred through appropriate mechanisms. • Strengthen community-based protection mechanisms, including safe reporting, early warning and protection monitoring, with meaningful participation of women, girls and persons with disabilities.	Protection Cluster; Protection partners; CCCM; GBV AoR; Child Protection; WLOs; local authorities

	CP	• Expanding Child-Friendly Spaces and Youth Protection Interventions, CP entities have to scale safe, localized environments and community-led protection mechanisms across densely populated displacement locations. • Strengthen identification, family tracing, alternative care and referral mechanisms for unaccompanied and separated children. • Review shelter arrangements where unaccompanied girls and boys are sharing living spaces and ensure appropriate safeguarding measures. • Strengthen prevention and response to family pressure for marriage, trafficking and other identified risks affecting girls. • Ensure child-protection referral information is available through health, education, WGSS and community structures.	Child Protection AoR/UNICEF, CP partners, Education partners, GBV AoR, MHPSS actors, CCCM and community-based organizations.
CCCM		• Map and regularly update site-level safety risks, including dark areas, unsafe routes, poorly located communal facilities and barriers affecting persons with disabilities. • Develop location-specific mitigation plans for priority sites rather than applying uniform measures across all settlements. • Ensure women, adolescent girls and persons with disabilities participate in identifying and reviewing site safety concerns. • Track unresolved environmental safety risks through routine site coordination and monitoring. • Install and maintain lighting along priority pathways, around the camp and identified high-risk locations.	Shelter/NFI, CCCM; Protection; Child Protection; GBV coordination, WLOs.
Shelter / NFI		• Provide or repair appropriate locks and privacy measures, particularly for households facing protection concerns and female-headed households. • Review shelter arrangements where unrelated families or unaccompanied children are sharing living spaces, with appropriate protection and child-protection follow-up. • Integrate safe cooking arrangements and separation of cooking areas from living spaces into shelter and site improvements.	Shelter/NFI; CCCM; Protection and AoR; WLOs; ABC coordination

		• Provide solar lighting and essential NFIs such as locks, sleeping materials, kitchen sets, jerry cans and mosquito nets, prioritizing high-risk locations and households. • Prioritize shelter and NFI assistance toward female-headed households, households with persons with disabilities, and women and girls living in unsafe, overcrowded shelters to enhance physical safety and privacy.	
WASH	Water Sanitation Hygiene	• Prioritize the upgrade sanitation facilities with functional internal locks, adequate lighting, privacy measures and gender separation, prioritizing locations with the greatest gaps. • Address the visibility of latrines and showers from outside through appropriate screening and facility-layout improvements. • Review sanitation where men are using women-designated facilities and address underlying capacity, layout or management constraints. • Prioritize water points where distance, unsafe routes, crowding, waiting times or affordability create barriers for women and girls. • Incorporate disability-accessible design and meaningful participation of women and girls into WASH rehabilitation and monitoring. • Install and maintain lighting along priority pathways, around water points, distribution areas, and other identified high-risk locations. • Address barriers to water affordability and access for vulnerable households through appropriate assistance and monitoring.	WASH Cluster; WASH partners; CCCM; local authorities, ABC coordination
Health	PHC	• Prioritize non-24/7 facilities caring for high volumes of displaced women and girls, for setting up on-call systems or extended operating hours for critical needs. • Strengthen emergency referral package: designate referral facilities, emergency contact points, transport options and night-time referral procedures, and disseminate this information to health workers, WGSS, community focal points and women's groups. • Deploy mobile health teams to underserved and newly displaced locations where distance, unsafe travel or limited facility coverage is	DHC/MOH; WHO, Health partners; UNFPA,

		restricting access, with scheduled outreach linked to fixed-site referral services. ● Pre-position essential medicines and emergency supplies at designated health hubs before seasonal access constraints, with minimum stock levels and replenishment responsibilities agreed with health partners. ● Prioritize facilities with the largest identified readiness gaps for essential medicines, confidential consultation space and female health personnel, based on the audit findings and routine service monitoring.	
	SRH / CMR	● Bring priority health facilities to minimum CMR readiness: ensure complete post-rape kits, emergency contraception, STI treatment and hepatitis B vaccination are available, with stock monitoring and replenishment responsibilities assigned. ● Assign trained CMR providers and GBV focal points to facilities currently lacking them, prioritizing locations serving large or underserved displaced populations. ● Strengthen confidential survivor referral pathway linking community entry points, health facilities, GBV case management and referral hospitals, including a clear procedure for referrals outside facility operating hours. ● Provide confidential consultation space at facilities where none currently exists, using appropriate room reconfiguration or other privacy measures where construction is not immediately feasible.	DHC/MOH; WHO UNFPA; health partners; GBV actors
	MHPSS	● Integrate psychological first-line support and safe referral into frontline services at health facilities, WGSS and child-protection entry points, rather than creating parallel access points wherever this is operationally feasible. ● Deploy mobile/community-based MHPSS support to underserved and newly displaced locations where fixed services are unavailable or difficult to reach.	MHPSS actors; GBV AoR; Health actors, WHO, UNFPA

		• Train designated frontline personnel on psychological first-line support, safe identification and referral, with clear boundaries to prevent non-specialized staff from providing specialized mental-health interventions beyond their competence.	
FOOD SECURITY, LIVELIHOOD		• Reconfigure distribution sites where safety concerns were identified, including separate or managed queues where appropriate, safer entry/exit arrangements, accessible collection points and clear crowd-management procedures. • Ensure women can safely access and control assistance, including appropriate arrangements for female-headed households and accessible collection mechanisms for persons with disabilities. • Expand safer livelihood options for women and girls where reported income-generating activities involve exposure to unsafe routes or GBV risks. • Integrate protection risk screening and referral information into CVA delivery without making assistance conditional on disclosure of GBV or other protection concerns.	FSL Cluster; WFP; livelihood/CVA actors; Protection; WLOs; donors, ABC coordination
EDUCATION	Education / Safeguarding Security / Community Safety	• Establish/strengthen Safe Learning Spaces and accelerated/catch-up learning opportunities, particularly for displaced children and adolescents. • Integrate safeguarding, GBV/CP referral information, MHPSS, confidential feedback mechanisms and MHM/private WASH facilities within education services. • Strengthen community-based safety monitoring, including identification and mitigation of unsafe areas and routes, without transferring security responsibilities to affected communities. • Develop targeted retention measures for adolescent girls, addressing identified economic barriers and gaps affecting continued participation, including engagement with caregivers and community structures.	

HUMANITARIAN ACCESS		• Develop service-continuity plans for health, WASH, food and protection services in locations vulnerable to insecurity, flooding or other access disruptions. • Pre-identify alternative access routes, referral arrangements and service delivery options for locations likely to become inaccessible during seasonal flooding or insecurity. • Pre-position priority supplies before predictable seasonal access constraints, using agreed storage locations and replenishment plans. • Review security arrangements to ensure that access controls do not unnecessarily prevent women and girls from reaching essential services or confidential support. • Maintain safe, non-discriminatory humanitarian access and establish contingency arrangements for disrupted access.	Agency security focal points; UNDSS; implementing partners Local authorities; OCHA; humanitarian partners
	Flooding / DRR	• Map flood-prone areas, pre-position essential supplies and establish contingency plans and alternative access routes for rainy-season disruptions.	CCCM; OCHA; local authorities; and relevance clusters
PSEA / AAP		• Strengthen PSEA measures, confidential reporting channels, staff awareness and survivor-centred referral arrangements. • Provide standardized community information on entitlements, expected staff conduct, prohibited behaviour and reporting mechanisms before and during distributions and service delivery. • Track allegations and concerns relating to favour-seeking, exploitation or unequal treatment through established PSEA and safeguarding mechanisms, with appropriate referral and follow-up. • Systematically document operational adjustments driven by community feedback and actively communicate these changes to demonstrate how complaints directly inform corrective measures.	PSEA network; agencies/partners; AAP actors and all relevant clusters
INTER-SECTORAL COORDINATION		• Develop funded site-specific action plans for the highest-risk locations, assigning a lead sector, supporting actors, required resources and monitoring indicator to each priority action.	OCHA; relevant Clusters/AoRs; local authorities; humanitarian partners; donors

		• Establish a consolidated Safety Audit action tracker showing identified gap, responsible actor, agreed mitigation, status and outstanding resource requirement. • Use the audit evidence to target resource mobilization toward priority gaps in lighting, WASH safety, health/CMR readiness, shelter privacy, emergency referral and GBV services. • Review implementation progress through existing coordination structures and revise priorities when displacement patterns, service coverage, insecurity or seasonal access conditions change.	

***Note:** Recommendations will be reviewed and refined with each relevant Cluster/AoR to agree on **feasible, actionable actions, responsibilities and timelines** before implementation.

7. Conclusion:

The September 2026 GBV Safety Audit should now move from assessment to action. The report provides humanitarian actors in Tawila with a common evidence base for identifying where existing services, infrastructure and response arrangements are not sufficiently safe, accessible or accountable for women and girls. Its value will ultimately be measured by whether that evidence changes operational decisions and improves conditions on the ground.

The next step is to translate the findings into a joint, funded and site-specific action plan through existing coordination structures. Each priority action should have a clear lead actor, supporting actors, resource requirements and an agreed means of tracking progress. Actions that can be implemented quickly—such as addressing critical lighting and privacy gaps, improving referral arrangements, strengthening safe access to services and establishing accessible feedback mechanisms should not wait for longer-term programming cycles. More substantial infrastructure, staffing and service-readiness gaps should be incorporated into sector plans and resource mobilization efforts.

Implementation will require shared responsibility across sectors. Several of the risks identified through the audit sit at the intersection of different mandates and cannot be resolved through a single-sector response. Clusters and AoRs should therefore incorporate relevant findings into their existing plans and partner workplans, while inter-sectoral coordination should track actions that require joint delivery. Where responsibility is unclear, the issue should be assigned rather than left unresolved between sectors.

The audit should also inform funding and prioritization decisions. Humanitarian leadership and donors should use the evidence to direct resources towards the most significant safety gaps and locations, particularly where basic mitigation measures are currently absent or where service limitations create barriers to timely assistance. Funding decisions should recognize that some safety improvements require modest targeted investment, while others require sustained support to health services, WASH infrastructure, shelter, protection and community-based systems.

Accountability to affected populations must remain central to implementation. Women, adolescent girls, persons with disabilities and other groups facing additional barriers should have meaningful opportunities to shape the measures intended to improve their safety. Communities should be able to understand what actions are being taken, access information about available services, raise concerns safely and see those concerns reflected in programme adjustments.

The audit should not be treated as a one-off exercise. Progress should be reviewed through existing coordination and monitoring mechanisms, with priority actions updated as displacement patterns, insecurity, access constraints and service availability change. Follow-up should assess not only whether an activity was completed, but whether the identified safety barrier has actually been reduced.

The central task now is straightforward: turn evidence into decisions, decisions into funded actions, and actions into measurable improvements in safety and access. The September Safety

Audit provides the basis for that process. Sustained commitment from humanitarian actors, local authorities, communities and donors will determine whether its findings result in practical improvements in the daily lives of women, girls, children and other affected populations in Tawila.

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