FACTSHEET

Food Security, Livelihoods and Nutrition (FSLN) Assessment

Abu Zabad, Al Meiram and An Nuhud localities, West Kordofan state

June 2026 | Sudan

Key Messages

- **Food security remains precarious and is primarily driven by affordability constraints.** Nearly half of households reported poor or borderline food consumption, while reliance on asset-depleting coping strategies was widespread. As the lean season approaches, continued use of these strategies is **likely to further undermine household resilience and increase the risk of deterioration.**[4]
- **Healthcare access remains fragile**. While most households requiring care were able to obtain it, affordability, particularly the cost of medication, and physical access barriers continue to constrain utilization. **These constraints are of particular concern as seasonal disease risks increase during the rainy season.**
- **WASH conditions continue to pose important public health risks.** Limited water treatment practices, combined with insecurity-related constraints affecting access to water sources in some areas, may increase vulnerability to waterborne diseases during the rainy season, particularly in the context of the reported cholera outbreak in West Kordofan.[4]

Map 1: Assessment Coverage

Context & Rationale

Since April 2023, armed clashes broke out across multiple cities in Sudan. The conflict triggered mass displacement, insecurity, and the destruction of critical infrastructures, significantly worsening an already severe humanitarian crisis, leaving more than 33.7 million people, including 17.3 million children in need of humanitarian assistance nationwide.[1]

In West Kordofan, the humanitarian situation is heavily impacted by the ongoing conflict between the warring parties, triggering displacement, disrupted livelihoods, and impeded commercial and humanitarian access across the state.[2] As of December 2025, the situation in West Kordofan has further deteriorated amid ongoing hostilities. According to a food security analysis of West Kordofan by FEWS NET, some populations are already categorized in Catastrophe (Phase 4 and 5)*, with hotspot areas reporting higher emergency-level outcomes. The cumulative effects of conflict, movement restrictions, and market disruptions have significantly heightened vulnerabilities among both displaced and non-displaced populations. Recent SMART surveys from West Kordofan conducted in December 2025 found global acute malnutrition (GAM) prevalence above the Critical threshold (15 percent).[3]

In this context, the FSLN assessment was conducted between 12 - 22 May 2026 to better understand the humanitarian needs of the affected populations in Abu Zabad, Al Meiram and An Nuhud, with a focus on Food Security and Livelihoods (FSL), Water, Sanitation and Hygiene (WASH), Health, Nutrition and Protection, to support coordinated response planning. Findings are representative at the locality level for the general population.

ALIGHT

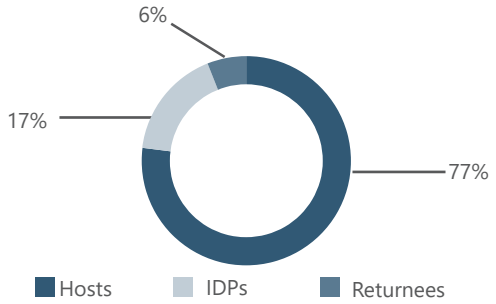
IMPACT Shaping practices Influencing policies Impacting lives

Abu Zabad locality findings

Demographic profiles

A total of **122** households (709 members) were assessed in Abu Zabad. Of the respondents, 44% were female and 56% male, with an overall average age of 45 years old and a median household size of 7 members. Almost all of those surveyed (98%) lived in urban settings, while 2% were in rural areas, **with 53% living in inadequate (unfinished or makeshift) housing**, **resulting in the majority being exposed to weather-related hazards as the lean season advances.**

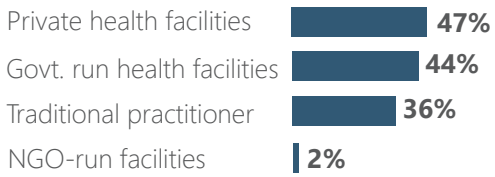
Figure 1: % of assessed households by displacement status



Health

The locality is facing deteriorating health conditions due to the combined impacts of ongoing conflict and disease outbreaks. Nearly two-thirds of households (65%) had a member needing care in the two weeks before data collection, and while most who sought it were able to access it (74%), the remaining 26% with unmet needs represents a real risk, particularly given the suspected cholera outbreak in the area, suggesting that any further shrinkage in access would translate directly into higher morbidity and mortality. Fever (78%) was by far the most common symptom, followed by malaria (48%), cough (27%), eye infection (21%), and diarrhoea (16%).

Figure 2: % of households in need of healthcare assistance, by type of consulted health facility (two weeks prior to data collection) (select multiple; n=59)



During the two weeks prior to data collection, **respondents reported a range of barriers to accessing healthcare services**. Overall, 72% of households experienced at least one key constraint when seeking healthcare. The cost of medication was the most commonly reported barrier, highlighting affordability challenges in accessing care. In addition, 43% of households reported that reaching the nearest functioning health facility takes more than 30 minutes, **highlighting persistent physical access barriers that may negatively affect timely access to healthcare and health outcomes.**

Figure 3: Top 5 reported healthcare access barriers per % of assessed households (select multiple; n=122)

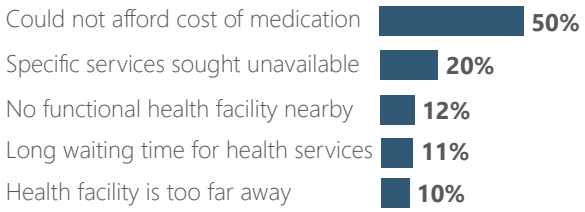
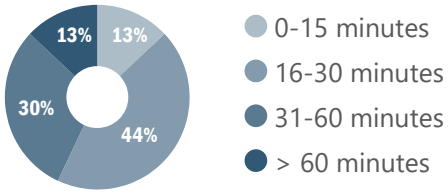


Figure 4: % of households by travel time to reach the nearest health facility by foot



These barriers compound further for individuals with disabilities or functional limitations. Around three in ten household members (31%) rely on another person to carry out day-to-day activities, indicating high dependency levels, with a further 5% using assistive devices daily and 4% requiring accessible information formats. These findings highlight the importance of considering accessibility needs when assessing equitable access to healthcare and humanitarian assistance.

Child morbidity and vaccination

Survey findings indicate that child morbidity is a major concern in Abu Zabad. **52% of the 77 assessed children under five were reported ill in the two weeks before data collection**. Fever was the most commonly reported symptom, affecting 70% of ill children, cough (43%), while **respiratory and diarrhoea symptoms** were also frequently reported.

These findings point to a substantial burden of illness among young children, particularly given that these types of conditions are among the most common contributors to poor child health outcomes worldwide,[5] and highlight the importance of continued monitoring of public health risks.

Table 1: % of children aged 6-59 months in need of healthcare, by type of reported illness (two weeks prior to data collection) (select multiple; n=40).

Type of illness	Frequency	Percentage
Fever	28	70%
Cough	17	43%
Diarrhoea	13	33%

Among children reported to have been ill during the two weeks prior to data collection, 56% of caregivers reported receiving counselling or support on child feeding practices. When seeking treatment, caregivers relied mostly on formal health facilities (66%), with a notable proportion relying on alternative providers, predominately traditional practitioners (20%). These findings suggest that formal health facilities remain the primary source of care for sick children, although a notable proportion of caregivers continue to rely on alternative providers.

Coverage of key preventive child health interventions remained below the 90% target, potentially increasing children's vulnerability to infectious diseases and nutrition-related health risks.[6] Measles vaccination had the highest reported coverage (56%: 52% based on maternal call and 4% on vaccination card/record), followed by vitamin A supplementation (44%: 42% based on maternal call and 2% on vaccination card/record) and deworming (38%).

Infant and Young Child Feeding (IYCF) in Emergencies

Breastfeeding practices were limited among the assessed households. Only 9 out of 20 assessed children aged under six months were reportedly exclusively breastfed during the 24 hours preceding data collection, in line with recommended feeding practices for this age group. Among the 12 assessed children aged 12–23 months, 92% (11 children) were reportedly breastfed during the previous 24 hours.

Alongside low prevalence of breastfeeding, **complementary feeding practices also appeared to be limited** among the 34 children under five for whom dietary recall data were available. Most children (26 out of 34) consumed breast milk, while complementary foods were largely restricted to a narrow range of items, primarily pulses, grains, roots, tubers, and dairy products. Consumption of animal-source foods and micronutrient-rich foods was rare or absent.

This limited dietary diversity was reflected in the Minimum Dietary Diversity (MDD) outcomes, where **all 18 children (100%) failed to meet the threshold** of consuming at least five of the eight food groups in the previous 24 hour.

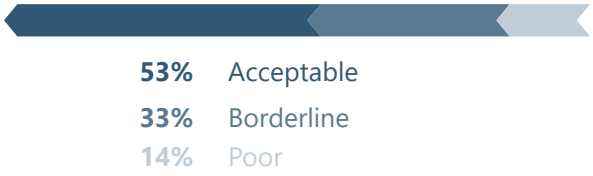
Caregivers most commonly identified economic barriers to complementary feeding, particularly a lack of financial resources to purchase food and high food prices, suggesting that affordability constraints continue to limit dietary diversity among young children. Given the small sample size, these results should be interpreted with caution.

Food Security and Livelihoods (FSL)

Food consumption outcomes place 21% of households in Phase 3 (Crisis) or worse, alongside 55% in Phase 2 and 24% in Phase 1, meaning roughly a fifth of households are already at crisis-or-worse levels with limited buffer against further shocks.

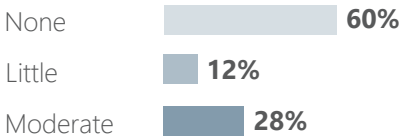
The **Food Consumption Score** (FCS) places the majority in acceptable category (53%), with a further 33% in **borderline** and 14% in **poor**. The median FCS was recorded at 44.5, which falls within the acceptable category (>35).

Figure 5: % of households by Food Consumption Score (FCS) (7 days prior to data collection)



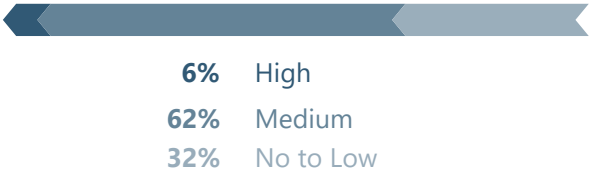
Household Hunger Scale findings indicate that 60% of assessed households reported no hunger in the 30 days preceding data collection, whereas 28% experienced moderate hunger. This distribution points to ongoing food access constraints, with **over a quarter of households facing significant levels of hunger**.

Figure 6: % of households by Household Hunger Scale (HHS) score (4 weeks prior to data collection)



Households cope with food shortfalls mainly through low-cost adjustments: cheaper food (1.9 days/week), smaller portions (1.5) and fewer meals (1.2). More telling is that the most severe behaviour, adults restricting their own intake for children (0.5 day/week), is already present alongside borrowing (0.5), an early sign some households have exhausted milder options.

Figure 7: % of households by reduced Coping Strategy Index (rCSI) score (7 days prior to data collection)



The **Livelihood Coping Strategies Index (LCSI)** findings over the 30 days preceding data collection, reported households adopting a range of coping strategies, including stress-level measures such as selling assets (24%) and spending savings (22%).

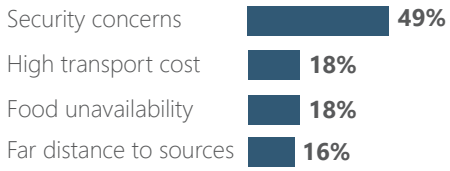
At the same time, **reliance on crisis- and emergency-level strategies was substantial**, with half consuming seed stocks reserved for the next planting season, 35% reduced health expenditures and 50% selling a last productive animal. This pattern reflects significant pressure on household livelihoods, with **many households resorting to strategies that compromise future wellbeing, productive capacity, and recovery prospects**.[7]

Table 2: % of households by Livelihood Coping Strategy Index (LCSI) (4 weeks prior to data collection)

LCSI	Frequency	Percentage
None	46	38%
Stress	20	17%
Crisis	38	31%
Emergency	17	14%

Purchase with cash remains the main food source for nearly three quarters of households (70%), followed by own production (59%) and exchange for labour or items (14%). No in-kind food, cash, or voucher assistance was reported, indicating that **most households meet their food needs through their informal or market-based sources and other sources such as own production**.

Figure 8: Top 4 reported food sources access barriers per % of assessed households (select multiple; n=122)



Household income in the locality rested heavily on casual or daily labour (84%), with all other sources marginal by comparison: income from own business (18%) and income from agricultural products (16%). **This near-total dependence on casual labour leaves household income highly volatile and exposed to shocks.**

At the same time, registration for and receipt of food assistance was limited: only 11% of assessed households reported being registered for or receiving general food distribution, cash or voucher support, while 89% were not consistent with the limited role of assistance among food sources noted above.

Water, Sanitation and Hygiene (WASH)

Almost all (96%) interviewed households reported use of improved water sources, mainly protected well (32%), boreholes/tubewells (29%) and other fewer reports on delivered water and piped connections. Few relied on unimproved sources (3%) or surface water (1%).

Although the majority of households relied on improved water sources, water treatment before consumption was limited to only 41% of households. However, limited water treatment remains a concern given the potential risk of waterborne disease transmission resulting from contamination during water collection, transport, storage or handling.

Figure 9: % of households reporting insufficient drinking water in the 4 weeks prior to data collection

Figure 10: % of households reporting inability to wash hands due to water problems in the last 4 weeks prior to data collection

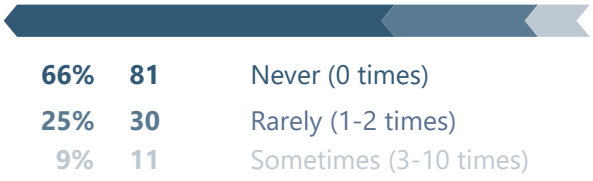


Figure 11: % of households reporting worry about having enough water in the last 4 weeks prior to data collection

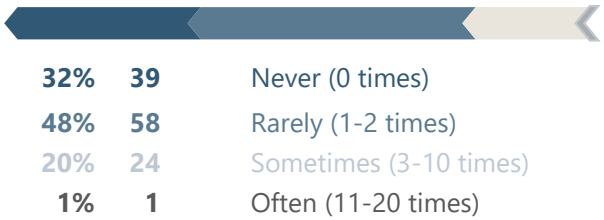


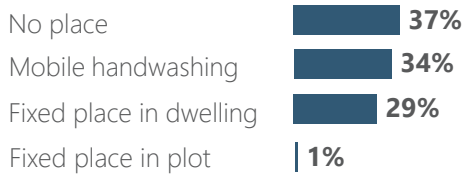
Figure 12: % of households reporting changes to daily activities due to water problems in the last 4 weeks

Most households used improved sanitation facilities, predominantly flushing-based facilities (94%), with only 2% used unimproved ones, mainly dry pit latrine without slab. However, **3% reported having no facility and practising open defecation** in bushes or fields. Among households with access to a sanitation facility, **8% shared their facility with other households**, with an average of 3 households per shared facility, raising concerns around hygiene, privacy and safety.

Over a third (34%) of the households reported issues with their sanitation facilities, notably a lack of privacy (14%), a lack of segregation between men and women (11%), facilities that were full or not functioning (11%) and overcrowded facilities (6%).

Handwashing practices reflected limited access to sanitation facilities. While 34% reported using a mobile handwashing device and 30% had a fixed facility located in the dwelling or yard**, 37% reported having no designated handwashing place.** Among households with a facility, water was usually available (95%), although soap or detergent was present in lower rates (80%). Together, meaning that the core issue being access to a facility in the first place, not its condition once available.

Figure 13: % of households by type of handwashing facility most commonly used



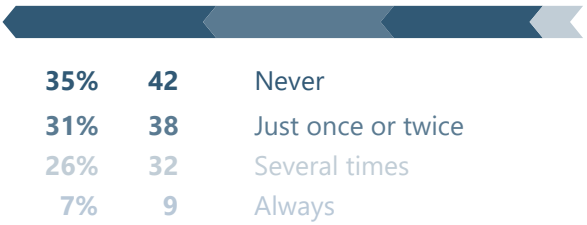
Protection

Safety concerns and ongoing conflict continue to restrict physical access to essential public services. The majority of households (61%) reported reduced access to at least one public service, mainly access to health-related services (healthcare facilities (61%) and therapeutic centres (52%). Schools (50%), government facilities (22%), and education facilities (15%) also noted limited access. Fear of insecurity was the primary reason cited for avoiding public services.

In the three months preceding data collection, two-thirds of respondents (66%) reported experiencing protection risks that limited household members' ability to access resources, carry out activities, or make decisions to meet their basic needs, including working, farming, or fetching water.

Majority of respondents (65%) reported that **women and girls experienced situations where they felt unsafe moving within the community**. The locations most commonly avoided due to safety concerns were markets (90%), water points (27%), on their way to the school (16%), on their way to health centers (16%), in their homes (5%) and public transportation (4%).

Figure 14: % of assessed households reporting women and girls feeling unsafe walking in their communities in the 3 months prior to data collection

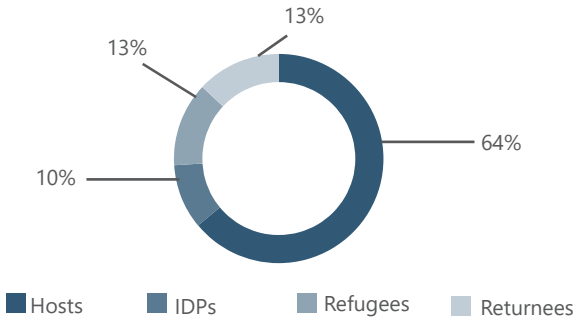


Al Meiram locality findings

Demographic profiles

The **208** households (1,280 members) assessed in Al Meiram form the largest sample in this factsheet and are, like Abu Zabad, a predominantly urban population in weak housing: 88% live in urban settings, and an even larger share, **91%, live in inadequate housing, leaving most of the assessed population exposed to weather-related hazards as the lean season advances**. Respondents were 53% male and 47% female, with an average age of 42 and a median household size of 7.

Figure 15: % of assessed households by displacement status

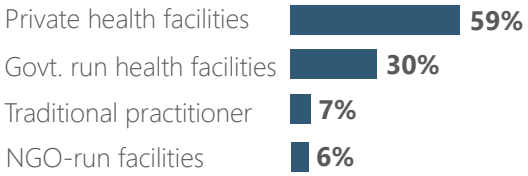


Health

Al Meiram shows the most fragile healthcare access of the three West Kordofan localities. 67% of households had a member needing care in the two weeks before data collection, but barely half of those who sought it (51%), were able to access the care they needed, leaving 49% with unmet needs. This level of unmet need raises the risk of morbidity and mortality given the wider disease outbreak context.

Fever (53%) was the most common symptom, followed by cough (30%), diarrhoea (17%), and eye infections (12%).

Figure 16: % of households in need of healthcare assistance, by type of consulted health facility (two weeks prior to data collection) (select multiple; n=71)



During the two weeks prior to data collection, **respondents reported a range of barriers to accessing healthcare services**. Overall, **76%** of households experienced at least one key constraint when seeking healthcare. The cost of medication was the most commonly reported barrier, highlighting affordability challenges in accessing care. In addition, 34% of households reported that reaching the nearest functioning health facility takes more than 30 minutes, **highlighting persistent physical access barriers that may negatively affect timely access to healthcare and health outcomes.**

Figure 17: Top 5 reported healthcare access barriers per % of assessed households (select multiple; n=208)

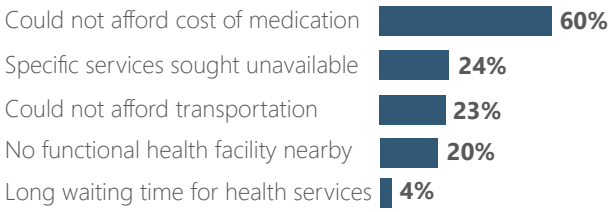
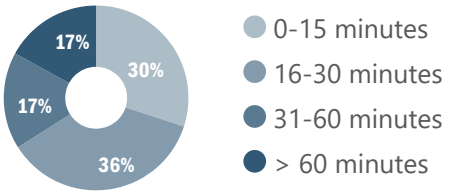


Figure 18: % of households by travel time to reach the nearest health facility by foot



Physical access challenges may be compounded for individuals with disabilities or functional limitations. This is the case for almost third of household members in Al Meiram, who reported relying on another person to carry out day-to-day activities (29%) indicating high dependency levels. While another 2% reported using assistive devices on the daily and 1% require information in accessible formats, such as sign language, easy-to-read materials, or large print, to access assistance and services. These findings highlight the importance of considering accessibility needs when assessing equitable access to healthcare and humanitarian assistance.

Child morbidity and vaccination

Survey findings indicate that child morbidity is a major concern in Al Meiram. **Among the 194 assessed children under five years of age, 66% were reported to have been ill** during the two weeks prior to data collection. Fever was the most commonly reported symptom, affecting 69% of ill children, while **diarrhoea** and **respiratory symptoms** were also frequently reported.

These findings point to a substantial burden of illness among young children, particularly given that these types of conditions are among the most common contributors to poor child health outcomes worldwide,[5] and highlight the importance of continued monitoring of public health risks.

Table 3: % of children aged 6-59 months in need of healthcare, by type of reported illness (two weeks prior to data collection) (select multiple; n=129).

Type of illness	Frequency	Percentage
Fever	89	69%
Diarrhoea	55	43%
Cough	48	37%

Counselling reach was notably weak in the locality, as only 10% of caregivers of sick children reported receiving feeding support. When seeking treatment, caregivers relied mostly on formal health facilities (64%), with a notable proportion relying on alternative providers, predominately traditional practitioners (5%).. These findings suggest that formal health facilities remain the primary source of care for sick children, although a notable proportion of caregivers continue to rely on alternative providers.

Coverage of key preventive child health interventions remained below the 90% target, potentially increasing children's vulnerability to infectious diseases and nutrition-related health risks.[6] Measles vaccination had the highest reported coverage (56%: 55% based on maternal call and 1% on vaccination card/record), followed by vitamin A supplementation (26% entirely based on maternal call) and deworming (15%).

Infant and Young Child Feeding (IYCF) in Emergencies

Breastfeeding practices were generally positive among the assessed households. 17 out of 25 assessed children aged under six months were reportedly exclusively breastfed during the 24 hours preceding data collection, in line with recommended feeding practices for this age group. Among the 30 assessed children aged 12–23 months, 77% (23 children) were reportedly breastfed during the previous 24 hours.

Despite adequate early breastfeeding practices reported, **complementary feeding practices appeared limited** among the 21 children under five for whom dietary recall data were available. Most children (56 out of 73) consumed breast milk, while complementary foods were largely restricted to a narrow range of items, primarily dairy products, grains, roots, tubers and pulses. Consumption of animal-source foods and micronutrient-rich foods was rare or absent.

This limited dietary diversity was reflected in the Minimum Dietary Diversity (MDD) outcomes, **where 50 out of 51 assessed children (98%) failed to meet the threshold** of consuming at least five of the eight food groups in the previous 24 hour.

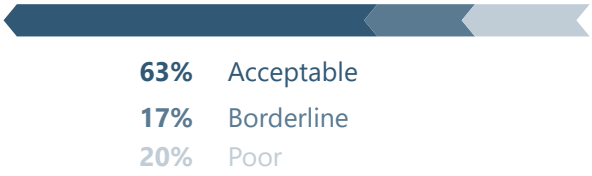
Caregivers most commonly identified economic barriers to complementary feeding, particularly high food prices and a lack of financial resources to purchase food, suggesting that affordability constraints continue to limit dietary diversity among young children. Given the small sample size, these results should be interpreted with caution.

Food Security and Livelihoods (FSL)

Food security remains precarious, with food consumption outcomes place nearly half of households in Phase 2 (42%), with a further 19% in Phase 3, 4% in Phase 4 and 4% in Phase 5*, meaning over a quarter of the households are already experiencing crisis-or-worse levels of food consumption and **Al Meiram is the only locality out of the three with households already in the most severe phase**. With limited resilience against economic shocks, the continued deterioration in food security could drive more households into vulnerability crisis and increase the risk of severe acute food insecurity.

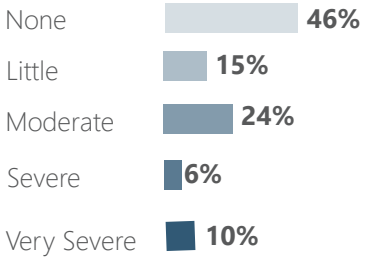
The **Food Consumption Score** (FCS) places the majority in acceptable category (63%), with a further 17% in **borderline** and 20% in **poor**. The median FCS was recorded at 52, which falls within the acceptable category (>35).

Figure 19: % of households by Food Consumption Score (FCS) (7 days prior to data collection)



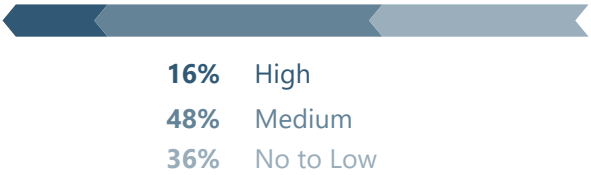
Household Hunger Scale findings indicate that 46% of assessed households reported no hunger in the 30 days preceding data collection, whereas 24% experienced moderate hunger. This distribution points to ongoing food access constraints, with **nearly a quarter of households facing significant levels of hunger**.

Figure 20: % of households by Household Hunger Scale (HHS) score (4 weeks prior to data collection)



Households cope with food shortfalls mainly through low-cost adjustments: cheaper food (2.6 days/week), smaller portions (1.4) and fewer meals (1.3). More telling is that the most severe behaviour, adults restricting their own intake for children (0.7), is already present alongside borrowing (1.1 days/week), an early sign some households have exhausted milder options.

Figure 21: % of households by reduced Coping Strategy Index (rCSI) score (7 days prior to data collection)



The **Livelihood Coping Strategies Index (LCSI)** findings over the 30 days preceding data collection, confirms **Al Meiram as the most stressed of the three localities on this measure**. Households reported adopting a range of coping strategies, including stress-level measures such as selling assets (61%), selling non-food items (61%) and spending savings (52%). At the same time, **reliance on crisis- and emergency-level strategies was substantial**,

with 77% reported that at least one household member had migrated in search of employment opportunities, selling of productive assets (59%), More than half reduced health expenditures, 53% consuming seed stocks reserved for the next planting season, 84% selling of house, and 84% gathering of wild foods. This pattern reflects significant pressure on household livelihoods, with **many households resorting to strategies that compromise future wellbeing, productive capacity, and recovery prospects**.[7]

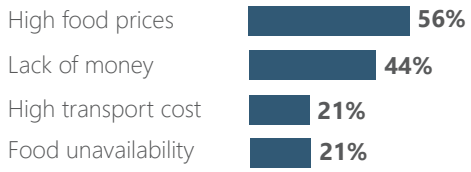
Table 4: % of households by Livelihood Coping Strategy Index (LCSI) (4 weeks prior to data collection)

LCSI	Frequency	Percentage
None	44	23%
Stress	33	18%
Crisis	87	46%
Emergency	24	13%

Purchase with cash remains the main food source for nearly three quarters of households (73%), followed by own production (43%), gathering (13%), exchange for labour or items (12%) and borrowing (9%).

Food assistance plays only a minor role (2% in-kind), indicating that **most households meet their food needs through their informal or market-based sources and other sources such as own production**.

Figure 22: Top 4 reported food sources access barriers per % of assessed households (select multiple; n=208)



Household income in the locality rested heavily on casual or daily labour (86%), with all other sources marginal by comparison: Income from agricultural products (23%), income from business (8%), support from family members abroad (6%) and salaried work (3%). **This near-total dependence on casual labour leaves household income highly volatile and exposed to shocks.**

At the same time, registration for and receipt of food assistance was limited: only 3% of assessed households reported being registered for or receiving general food distribution, cash or voucher support, while 97% were not consistent with the limited role of assistance among food sources noted above.

Table 5: % of top reported food assistance types received by households (select multiple; n=6)

Type of assistance	Frequency	Percentage
Food vouchers	3	50%
Food In-Kind	1	17%
Multi Purpose Cash Assistance	1	17%

Water, Sanitation and Hygiene (WASH)

Almost all (99%) interviewed households reported use of improved water sources — mainly boreholes/ tubewells (39%) and other fewer reports on delivered water, piped connections and protected well. Few (1%) relied on unimproved sources and surface water.

Although a majority of households relied on improved water sources, water treatment before consumption was limited to only 2% of households. However, limited water treatment remains a concern given the potential risk of waterborne disease transmission resulting from contamination during water collection, transport, storage or handling.

Figure 23: % of households reporting insufficient drinking water in the 4 weeks prior to data collection

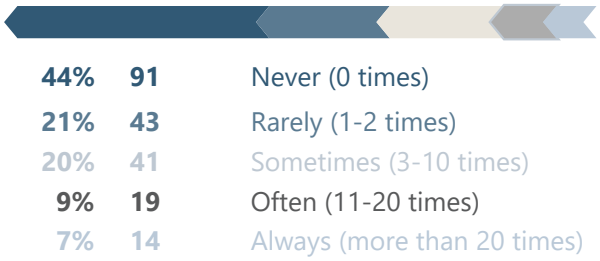


Figure 24: % of households reporting inability to wash hands due to water problems in the last 4 weeks prior to data collection

Figure 25: % of households reporting worry about having enough water in the last 4 weeks prior to data collection

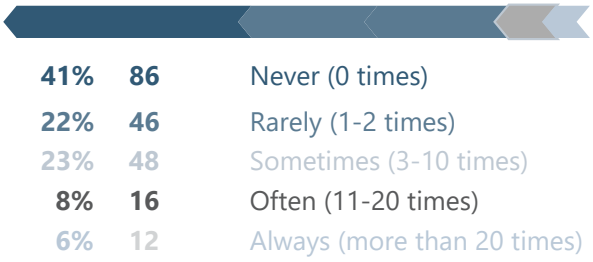


Figure 26: % of households reporting changes to daily activities due to water problems in the last 4 weeks

42%	87	Never (0 times)
23%	47	Rarely (1-2 times)
24%	49	Sometimes (3-10 times)
10%	21	Often (11-20 times)
1%	3	Always (more than 20 times)

Most households used improved sanitation facilities, predominantly flushing-based facilities (79%). However, **20% reported having no facility and practising open defecation** in bushes or fields — a significant share that poses clear public-health and protection risks. Among households with access to a sanitation facility, nearly a **third (36%) shared their facility with other households**, with an average of 3 households per shared facility, raising concerns around hygiene, privacy and safety.

More than half (52%) of the households reported issues with their sanitation facilities, notably a lack of or overcrowded facilities (34%), a lack of segregation between men and women (19%), facilities that were full or not functioning (17%), unhygienic latrines (17%) and a lack of privacy (13%) — the latter carrying particular implication for the safety and dignity of women and girls.

Handwashing practices reflected limited access to sanitation facilities. While 10% reported using a mobile handwashing device, **90% reported having no designated handwashing place.** Among households with a facility, water was usually available (73%), although soap or detergent was present in lower rates (30%). Together, these findings point to **gaps in both access to and functionality of handwashing facilities, which may constrain effective hygiene practices for the majority of the households.**

Figure 27: % of households by type of handwashing facility most commonly used

Protection

Safety concerns and ongoing conflict continue to restrict physical access to essential public services. Fear of insecurity was the primary reason cited for avoiding public services. Nearly half of households (45%) reported reduced access to at least one public service, mainly access to health-related services (healthcare facilities 45%) and schools (31%). Government facilities (27%), therapeutic centres (16%), and education facilities (13%) also noted limited access.

In the three months preceding data collection, more than a third of respondents (39%) reported experiencing protection risks that limited household members' ability to access resources, carry out activities, or make decisions to meet their basic needs, including working, farming, or fetching water.

Over a third of the respondents (32%) reported that **women and girls experienced situations where they felt unsafe moving within the community**. The locations most commonly avoided due to safety concerns were markets (79%), water points (66%), on their way to school (42%), routes for collecting firewood (21%), on their way to health centers (13%) and on their way to the fields (12%).

Figure 28: % of assessed households reporting women and girls feeling unsafe walking in their communities in the 3 months prior to data collection

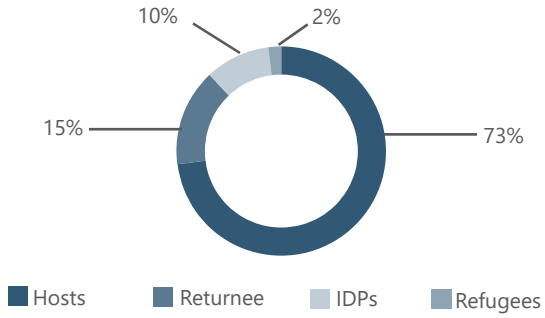
66%	137	Never
9%	19	Just once or twice
20%	41	Several times
3%	7	Always

An Nuhud locality findings

Demographic profiles

A total of **136** households (774 members) were assessed in An Nuhud. Of the respondents, 39% were female and 61% male, with an overall average age of 48 years old and a median household size of 7 members. Almost all of those surveyed (85%) lived in urban settings, while 15% were in rural areas, **with 30% living in inadequate (unfinished or makeshift) housing, resulting in the majority being exposed to weather-related hazards as the lean season advances.**

Figure 29: % of assessed households by displacement status

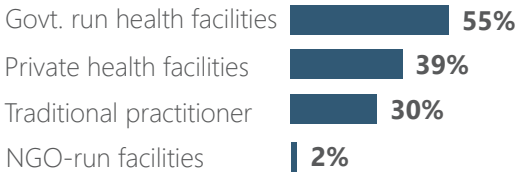


Health

An Nuhud is facing deteriorating health conditions. In the two weeks preceding data collection, **over half the assessed households (57%) reported at least one member in need of healthcare assistance**. Among these households, a majority were able to access the healthcare they felt needed (56%), while the remaining 44% reported unmet healthcare needs.

The most frequently reported symptoms were fever (64%), followed by cough (32%), diarrhoea (25%) and breathing difficulties (21%).

Figure 30: % of households in need of healthcare assistance, by type of consulted health facility (two weeks prior to data collection) (select multiple; n=44)



During the two weeks prior to data collection, **respondents reported a range of barriers to accessing healthcare services**. Overall, **79%** of households experienced at least one key constraint when seeking healthcare. The cost of medication was the most commonly reported barrier, highlighting affordability challenges in accessing care.

In addition, 48% of households reported that reaching the nearest functioning health facility takes more than 30 minutes, **highlighting persistent physical access barriers that may negatively affect timely access to healthcare and health outcomes.**

Figure 31: Top 5 reported healthcare access barriers per % of assessed households (select multiple; n=136)

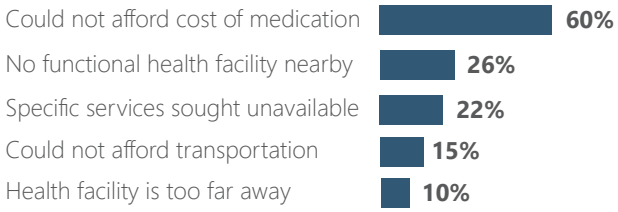
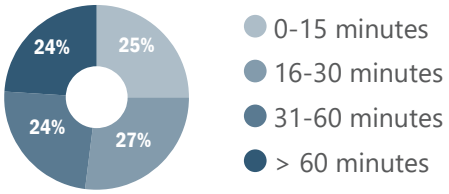


Figure 32: % of households by travel time to reach the nearest health facility by foot



Physical access challenges may be compounded for individuals with disabilities or functional limitations. This is the case for over a quarter of household members in An Nuhud, who reported relying on another person to carry out day-to-day activities (26%) indicating high dependency levels. While another 5% reported using assistive devices on the daily and 4% require information in accessible formats, such as sign language, easy-to-read materials, or large print, to access assistance and services. These findings highlight the importance of considering accessibility needs when assessing equitable access to healthcare and humanitarian assistance.

Child morbidity and vaccination

Survey findings indicate that child morbidity is a major concern in An Nuhud. **Among the 75 assessed children under five years of age, 61% were reported to have been ill** during the two weeks prior to data collection.

Fever was the most commonly reported symptom, affecting 65% of ill children, while **respiratory and diarrhoea symptoms** were also frequently reported.

These findings point to a substantial burden of illness among young children, particularly given that these types of conditions are among the most common contributors to poor child health outcomes worldwide,[5] and highlight the importance of continued monitoring of public health risks.

Table 6: % of children aged 6-59 months in need of healthcare, by type of reported illness (two weeks prior to data collection) (select multiple; n=46).

Type of illness	Frequency	Percentage
Fever	30	65%
Cough	22	48%
Diarrhoea	18	39%

Among children reported to have been ill during the two weeks prior to data collection, 66% of caregivers reported receiving counselling or support on child feeding practices. When seeking treatment, caregivers relied mostly on formal health facilities (60%), with a notable proportion relying on alternative providers, predominately traditional practitioners (24%). These findings suggest that formal health facilities remain the primary source of care for sick children, although a notable proportion of caregivers continue to rely on alternative providers.

Coverage of key preventive child health interventions remained below the 90% target, potentially increasing children's vulnerability to infectious diseases and nutrition-related health risks.6 Measles vaccination had the highest reported coverage (62%: 51% based on maternal call and 11% on vaccination card/record), followed by vitamin A supplementation (46%: 43% based on maternal call and 3% on vaccination card) and deworming (31%).

Infant and Young Child Feeding (IYCF) in Emergencies

Breastfeeding practices were generally positive among the assessed households. 6 out of 10 assessed children aged under six months were reportedly exclusively breastfed during the 24 hours preceding data collection, in line with recommended feeding practices for this age group. Among the 13 assessed children aged 12–23 months, 62% (8 children) were reportedly breastfed during the previous 24 hours. Despite adequate early breastfeeding practices reported, **complementary feeding practices appeared limited** among the 21 children under five for whom dietary recall data were available. Most children (21 out of 29) consumed breast milk, while complementary foods were largely restricted to a narrow range of items, primarily grains, roots, tubers, pulses, and dairy products. Consumption of animal-source foods and micronutrient-rich foods was rare or absent.

This limited dietary diversity was reflected in the Minimum Dietary Diversity (MDD) outcomes, where **all 21 children (100%) failed to meet the threshold** of consuming at least five of the eight food groups in the previous 24 hour.

Caregivers most commonly identified economic barriers to complementary feeding, particularly a lack of financial resources to purchase food and high food prices, suggesting that affordability constraints continue to limit dietary diversity among young children. Given the small sample size, these results should be interpreted with caution.

Food Security and Livelihoods (FSL)

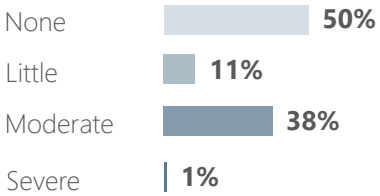
An Nuhud shows the most severe food consumption picture of the three localities: food consumption outcomes place 47% of households in Phase 2, with a further 37% in Phase 3 and 2% in Phase 4*, meaning over a third of households are already at crisis-or-worse levels. With limited resilience against economic shocks, the continued deterioration in food security could drive more households into vulnerability crisis and increase the risk of severe acute food insecurity.

The **Food Consumption Score** (FCS) places the majority in acceptable category (37%), with a further 29% in **borderline** and 34% in **poor**. The median FCS was recorded at 35, which falls within the borderline category (21.5 - 35).

Figure 33: % of households by Food Consumption Score (FCS) (7 days prior to data collection)

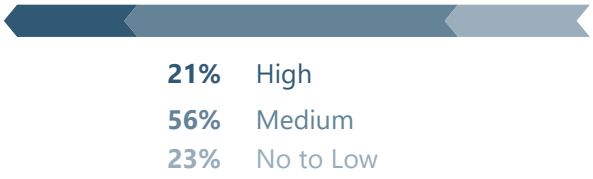
Household Hunger Scale findings indicate that 61% of assessed households reported little-to-no hunger in the 30 days preceding data collection, whereas 38% experienced moderate hunger. This distribution points to ongoing food access constraints, with **over a third of households facing significant levels of hunger**.

Figure 34: % of households by Household Hunger Scale (HHS) score (4 weeks prior to data collection)



Households cope with food shortfalls mainly through low-cost adjustments: cheaper food (3 days/week), smaller portions (2.4) and fewer meals (1.9). More telling is that the most severe behaviour, adults restricting their own intake for children (0.8), is already present alongside borrowing (1), an early sign some households have exhausted milder options.

Figure 35: % of households by reduced Coping Strategy Index (rCSI) score (7 days prior to data collection)



The **Livelihood Coping Strategies Index (LCSI)** findings over the 30 days preceding data collection, reported households adopting a range of coping strategies, including stress-level measures such as spending savings (43%), selling assets (41%) and borrowing (26%). At the same time, **reliance on crisis- and emergency-level strategies were substantial**, with 74% consuming seed stocks reserved for the next planting season, 57% reduced health expenditures and 53% selling a last productive animal. This pattern reflects significant pressure on household livelihoods, with **many households resorting to strategies that compromise future wellbeing, productive capacity, and recovery prospects**.[7]

Rural households, whose income and food sources depend primarily on farming, livestock-rearing, and other agriculture-based livelihoods, made up 15% (n=21). Among these rural households, 11% reported having exhausted these coping options.

Although affecting a limited share of households, the depletion of livelihood coping strategies is a concerning indicator of vulnerability, as it reflects a loss of buffers that households can draw upon in times of crisis. **This points to particularly acute coping pressures among rural households.**

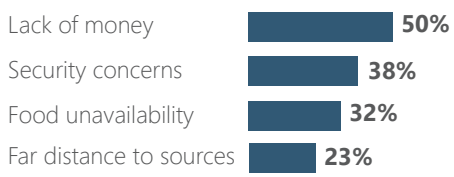
Table 7: % of households by Livelihood Coping Strategy Index (LCSI) (4 weeks prior to data collection)

LCSI	Frequency	Percentage
None	11	9%
Stress	20	16%
Crisis	65	52%
Emergency	29	23%

Food sources remain market-based: purchase with cash remains the main food source for two thirds of households (63%), followed by own production (57%), exchange for labour or items (18%) and borrowing (10%).

Food assistance plays only a minor role (8% in-kind, 1% cash/voucher), indicating that **most households meet their food needs through informal or market-based sources and other sources such as own production**.

Figure 36: Top 4 reported food sources access barriers per % of assessed households (select multiple; n=136)



Household income in the locality rested heavily on casual or daily labour (68%), with all other sources marginal by comparison: income from agricultural products (13%) and own business or commerce (11%). **This near-total dependence on casual labour leaves household income highly volatile and exposed to shocks.**

At the same time, registration for and receipt of food assistance was limited: only 19% of assessed households reported being registered for or receiving general food distribution, cash or voucher support, while 79% were not consistent with the limited role of assistance among food sources noted above.

Table 8: % of top reported food assistance types received by households (select multiple; n=26)

Type of assistance	Frequency	Percentage
Food In-Kind	16	62%
Food vouchers	1	4%

Water, Sanitation and Hygiene (WASH)

The majority of interviewed households (80%) reported use of improved water sources, mainly protected wells (42%), and other fewer reports on borehole/tubewells, delivered water and piped connections. The remaining 20% relied on unimproved sources (19%) or surface water (1%).

Although a majority of households relied on improved water sources, water treatment before consumption was limited to only 30% of households. However, limited water treatment remains a concern given the potential risk of waterborne disease transmission resulting from contamination during water collection, transport, storage or handling.

Figure 37: % of households reporting insufficient drinking water in the 4 weeks prior to data collection

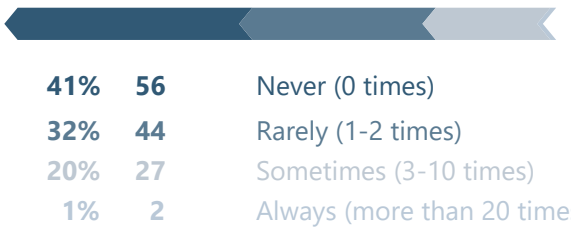


Figure 38: % of households reporting inability to wash hands due to water problems in the last 4 weeks prior to data collection

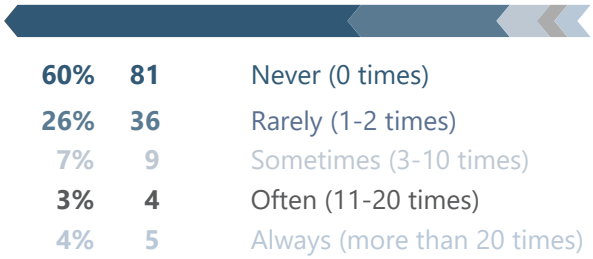


Figure 39: % of households reporting worry about having enough water in the last 4 weeks prior to data collection

37%	50	Never (0 times)
40%	55	Rarely (1-2 times)
13%	17	Sometimes (3-10 times)
6%	8	Often (11-20 times)
4%	6	Always (more than 20 times)

Figure 40: % of households reporting changes to daily activities due to water problems in the last 4 weeks

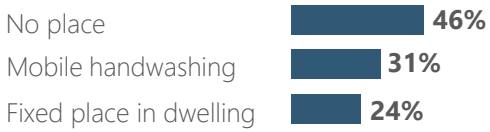
52%	71	Never (0 times)
30%	41	Rarely (1-2 times)
14%	19	Sometimes (3-10 times)
1%	1	Often (11-20 times)
3%	4	Always (more than 20 times)

Most households used improved sanitation facilities, predominantly flushing-based facilities (90%) and dry pit latrine with slap (9%), with only **1% reported having no facility and practising open defecation** in bushes or fields. Among households with access to a sanitation facility, **10% shared their facility with other households**, with an average of 2 households per shared facility, raising concerns around hygiene, privacy and safety.

Nearly a quarter (21%) of the households reported issues with their sanitation facilities, notably facilities that were full or not functioning (10%), a lack of sanitation facilities or overcrowded (7%), a lack of privacy (6%) and a lack of segregation between men and women (5%) — the latter two carrying particular implications for the safety and dignity of women and girls.

Handwashing practices reflected limited access to sanitation facilities. While 31% reported using a mobile handwashing device and 24% had a fixed facility located in the dwelling or yard, **46% reported having no designated handwashing place.** Among households with a facility, water was usually available (92%), although soap or detergent was present in lower rates (61%). Together, these findings point to **gaps in both access to and functionality of handwashing facilities, which may constrain effective hygiene practices for nearly half of the households.**

Figure 41: % of households by type of handwashing facility most commonly used



Protection

Safety concerns and ongoing conflict continue to restrict physical access to essential public services. Fear of insecurity was the primary reason cited for avoiding public services. The majority of households (65%) reported reduced access to at least one public service, mainly access to health-related services (healthcare facilities (65%) and therapeutic centres (47%). Schools (45%) and government facilities (29%) also noted limited access.

In the three months preceding data collection, two-thirds of respondents (60%) reported experiencing protection risks that limited household members' ability to access resources, carry out activities, or make decisions to meet their basic needs, including working, farming, or fetching water.

Protection risks are the highest of the three West Kordofan localities on the women's and girls' safety measure. The majority of respondents (81%) reported that **women and girls experienced situations where they felt unsafe moving within the community**. The locations most commonly avoided due to safety concerns were markets (78%), water points (33%), on their way to the fields (24%), on their way to health centers (22%), on their way to school (11%), in their homes (10%) and distribution points (7%).

Figure 42: % of assessed households reporting women and girls feeling unsafe walking in their communities in the 3 months prior to data collection

19%	25	Never
30%	39	Just once or twice
30%	39	Several times
21%	28	Always

Methodology Overview

This assessment was conducted by IMPACT Initiatives in collaboration with ALIGHT between 12 and 22 May 2026, as part of the broader Food Security, Livelihoods and Nutrition (FSLN) assessment targeting hotspot localities across the Kordofan region.

This factsheet presents findings from the three assessed localities in West Kordofan — Abu Zabad, Al Meiram and An Nuhud— where a total of 466 household surveys were completed (Abu Zabad: 122; Al Meiram: 208; An Nuhud: 136). Of these, the assessed population comprised host community, internally displaced, refugee and returnee households.

IMPACT provided technical support across sampling design, data collection tool design and coding, field team training, and data cleaning and analysis, while ALIGHT led implementation, including field monitoring and data collection.

The sample was designed to achieve representation at the locality level for the general population, assuming a 95% confidence level, a ±10% margin of error, a design effect of 1.5, and a 5% buffer, with a minimum of five interviews per cluster, following a two-stage cluster sampling design. In the first stage, 1km^2 grid cells (hexagons) were selected using probability proportional to size (PPS) from a sampling frame based on WorldPop (2025) and IOM Displacement Tracking Matrix (DTM) population estimates. Grid cells between bordering localities and those containing fewer than five households were removed from the sampling frame prior to selection.

Findings are representative at the locality level for the general population, in each of the three assessed localities. Comparison between localities are valid at the design level of precision and any further breakdown within a locality (e.g., by displacement status) is indicative only. Results may not capture the full diversity of conditions, particularly among harder-to-reach populations.

Endnotes

[1] United Nations Office for the Coordination of Humanitarian Affairs (OCHA) summary, Sudan Humanitarian Needs and Response Plan, March 2026

[2] DTM Sudan Focused Flash Alert: Kordofan Region (Update 05) | Publication Date: 11 March 2026

[3] Famine Early Warning Systems Network (FEWSNET), Sudan Food Security Outlook (February - September 2026)

[4] FEWSNET: Sudan Key Message Update: Emergency and risk of Famine persist in North Darfur and South Kordofan, May - September 2026 | Publication Date: 8 June 2026

[5] World Health Organization, Child mortality and causes of death

[6] World Health Organization, Global Nutrition Targets 2030 to improve maternal, infant, and young child nutrition.

[7] World Food Program, Livelihood Coping Strategies for Food Security Guidance Note, March 2023

*Phases refer to the classification of Acute Food Insecurity:

- Phase 1: Minimal/None: Households can meet their basic food and non-food needs without relying on negative coping strategies.

- Phase 2: Stressed: Households have minimal adequate food consumption but cannot afford basic non-food needs without resorting to stressful coping strategies.

- Phase 3: Crisis: Households have significant food gaps with high or above-usual acute malnutrition, or they can only mitigate these food gaps by selling off essential livelihood assets.

- Phase 4: Emergency: Households face large food gaps that result in very high acute malnutrition and excess mortality. At this stage, immediate action is required to save lives.

- Phase 5: Catastrophe/Famine: Households have an extreme lack of food and face starvation and destitution.

ABOUT ALIGHT

Alight has worked alongside communities in Sudan for more than two decades, building long-term partnerships grounded in trust, local leadership, and a deep understanding of the contexts where it operates. Since the outbreak of conflict, Alight has sustained and expanded its humanitarian presence across the country, delivering health, nutrition, WASH, protection, and food security and livelihoods programming even amid extraordinary access and security constraints.

Alight works hand in hand with national staff and local partners to ensure assistance is timely, relevant, and delivered with dignity. Guided by the people it serves, Alight remains committed to standing alongside Sudanese communities for as long as the crisis demands.

ABOUT IMPACT

Founded in 2010 and headquartered in Geneva, IMPACT Initiatives is a leading applied research organization and the largest independent provider of data in crisis-affected contexts.

Through our initiatives we enable humanitarian and other aid actors to make better, evidence-based decisions by delivering timely, relevant, and methodologically rigorous data and analysis. Our extensive presence across crisis-contexts allows us to collect data directly from crisis-affected people wherever needed, including among the most vulnerable and hard-to-reach.

ALIGHT

IMPACT Shaping practices Influencing policies Impacting lives