FACTSHEET

Food Security, Livelihoods and Nutrition (FSLN) Assessment

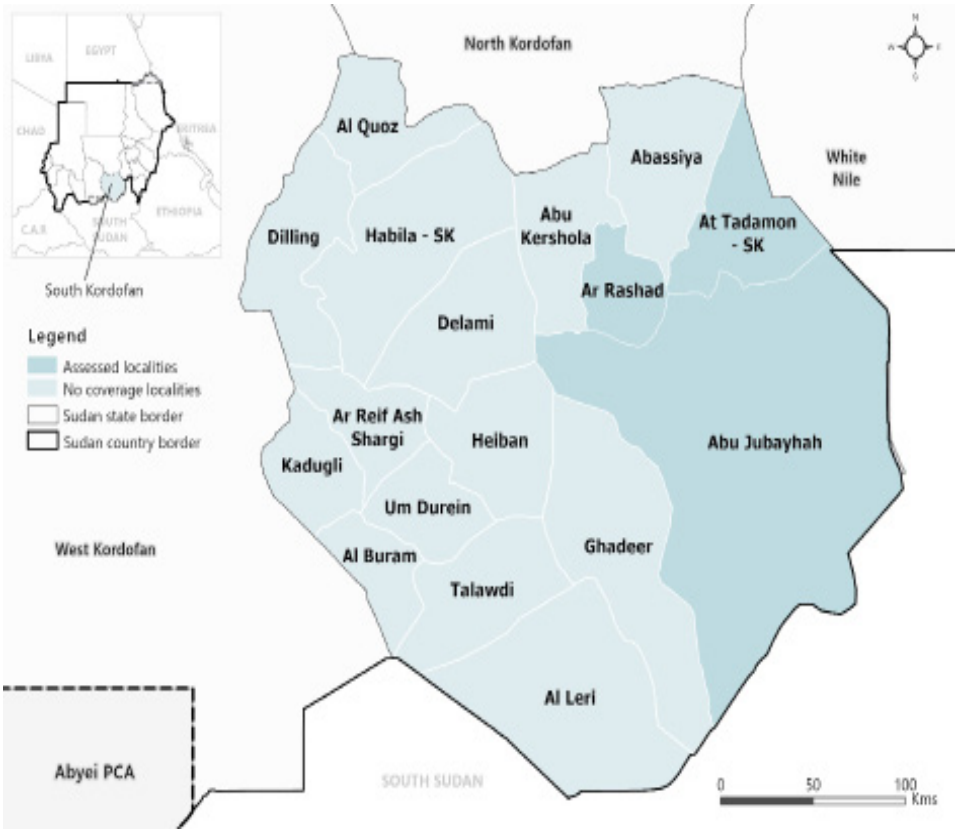
Abu Jubayhah, Ar Rashad and At Tadamon localities, South Kordofan state

June 2026 | Sudan

Key Messages

- **Food insecurity is primarily driven by affordability constraints rather than food availability**. With over four in ten households already in Phase 3 or worse and widespread reliance on asset-depleting coping strategies, **household resilience is likely to weaken further as the lean season progresses**.[4]
- **Health needs are high and healthcare services remain largely accessible**. However, **affordability and physical access barriers continue to constrain care-seeking and may contribute to rising unmet needs as seasonal disease risks increase**.
- **Sanitation and hygiene conditions represent the primary WASH concern. A substantial proportion of households rely on unimproved sanitation or open defecation, while sanitation facility sharing is widespread, increasing public health risks during the rainy season**, particularly in the context of the suspected cholera outbreak in neighbouring 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 South Kordofan, the situation remains highly fluid, triggering displacement across the state, with 72% of the displaced households reportedly not receiving any form of humanitarian assistance in the past four months.[2] As of December 2025, the situation in South Kordofan has further deteriorated amid ongoing hostilities. According to a food security analysis of South Kordofan by FEWS NET, some populations are already categorized in Catastrophe (Phase 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. The scale of hunger, acute malnutrition, and mortality is still expected to remain high in Kadugli, Dilling, and the surrounding western Nuba Mountains area, sustaining a credible risk of renewed famine.[3]

In this context, the FSLN assessment was conducted between 12 - 25 May 2026 to better understand the humanitarian needs of the affected populations in Abu Jubayhah, Ar Rashad and At Tadamon, 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.

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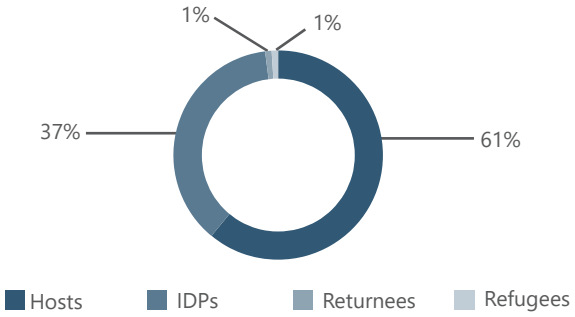
Abu Jubayhah locality findings

Demographic profiles

A total of **150** households (1,185 members) were assessed in Abu Jubayhah. Of the respondents, 57% were female and 43% male, with an overall average age of 43 years old and a median household size of 8 members. Majority of those surveyed (64%) lived in urban settings, while 36% were in rural areas, **with 79% living in inadequate (unfinished or makeshift) housing**.

Figure 1: % of assessed households by displacement status

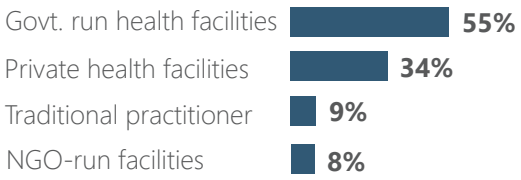


Health

In the two weeks preceding data collection, **over half of the assessed households (73%) reported at least one member in need of healthcare assistance**. Among these households, a majority were able to access the healthcare they felt needed (70%), while the remaining third reported unmet healthcare needs.

The most frequently reported symptoms were fever (79%), followed by cough (28%), malaria (21%), stomach-ache (18%) 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=77)



During the two weeks prior to data collection, **respondents reported a range of barriers to accessing healthcare services**. Overall, **65%** 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, 37% of households reported that reaching the nearest functioning health facility takes more than 30 minutes, suggesting that physical access also remains a challenge for a substantial share of the population.

Figure 3: Top 5 reported healthcare access barriers per % of assessed households (select multiple; n=150)

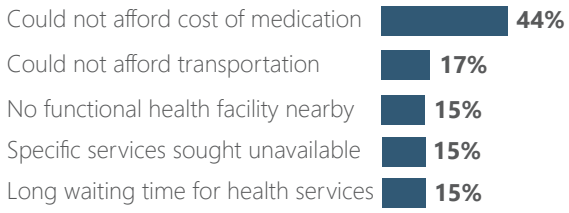
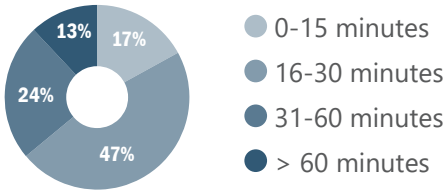


Figure 4: % of households by travel time to reach the nearest health facility by foot



Physical access challenges may be compounded for individuals with **disabilities** or **functional limitations**. Among assessed household members, 23% were reported to rely on another person to carry out day-to-day activities, indicating high dependency levels.

In addition, 5% reportedly use assistive devices in their daily lives, while 2% 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 Abu Jubayhah. **Among the 96 assessed children under five years of age, 64% were reported to have been ill** during the two weeks prior to data collection.

Fever was the most commonly reported symptom, affecting 80% of sick children, while **respiratory and gastrointestinal 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=61).

Type of illness	Frequency	Percentage
Fever	49	80%
Cough	25	41%
Diarrhoea	22	36%
Throat infection	3	20%

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Among children reported to have been ill during the two weeks prior to data collection, 57% of caregivers reported receiving counselling or support on child feeding practices. When seeking treatment, caregivers most commonly reported using government health centres (41%), followed by private clinics (26%) and traditional practitioners (15%). 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 (88%: 81% based on maternal call and 7% on vaccination card/record), followed by vitamin A supplementation (61%: 54% was based on maternal recall and 7% on vaccination card/record) and deworming (45%).

Infant and Young Child Feeding (IYCF) in Emergencies

Breastfeeding practices were generally positive among the assessed households. All four 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 16 assessed children aged 12–23 months, 75% (12 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 (15 out of 21) 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.

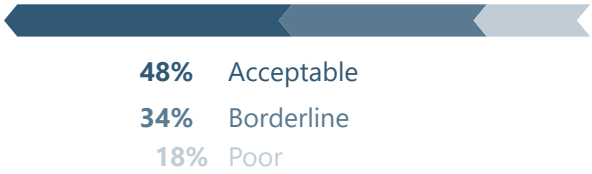
Caregivers most commonly identified economic barriers to complementary feeding, particularly a lack of financial resources to purchase food and high food prices. While 57% reported receiving counselling or support on child feeding practices since the onset of the emergency, findings suggest that affordability 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 the majority of households in Phase 2 (56%), with a further 36% in Phase 3 and 3% in Phase 4 — together meaning close to four in ten households (39%) are already experiencing crisis-or-worse levels of food consumption, while only 6% remain in Phase 1.* This points to a population where consumption has moved well beyond a stressed baseline for a substantial majority, with limited headroom before more households cross into crisis-level consumption.

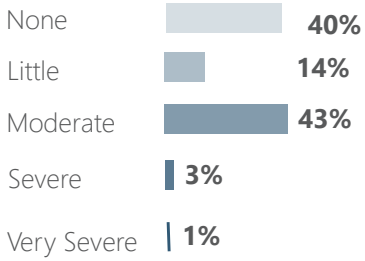
The **Food Consumption Score** (FCS) indicates that 48% of the households were classified as **acceptable**, 34% as **borderline** and 18% as **poor**. The median FCS was recorded at 41.5, which falls within the acceptable category (>35).

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



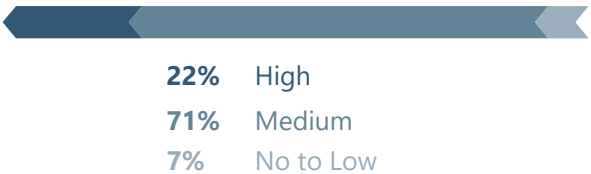
Household Hunger Scale findings indicate that 40% of assessed households reported no hunger in the 30 days preceding data collection, whereas 43% experienced moderate hunger. This distribution points to ongoing food access constraints, with **nearly half of households facing significant levels of hunger**.

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 (2.5 days/week), smaller portions (2.3) and fewer meals (2.2). More telling is that the most severe behaviour, adults restricting their own intake for children (1.1 days/week), is already present alongside borrowing (1.9) — 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)



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The **Livelihood Coping Strategies Index (LCSI)** findings over the 30 days preceding data collection, reported households employing a range of coping strategies, including stress-level measures such as selling assets (35%) and spending savings (32%). At the same time, **reliance on crisis- and emergency-level strategies was substantial**, with 41% consuming seed stocks reserved for the next planting season and 26% selling a last productive animal. Unlike short-term consumption adjustments, these strategies deplete productive assets and livelihood resources, **limiting households' capacity to recover once conditions improve and increasing the risk of prolonged food insecurity**.[7]

Rural households, whose income and food sources depend primarily on farming, livestock-rearing, and other agriculture-based livelihoods — made up over a third of the assessed population (36%, n=54). 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.**

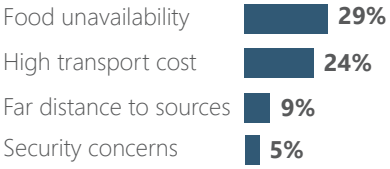
Table 2: % of households by Livelihood Coping Strategy Index (LCSI) (4 weeks prior to data collection)

LCSI	Frequency	Percentage
None	36	24%
Stress	29	19%
Crisis	57	38%
Emergency	28	19%

Own production remains the main food source for two thirds of households (61%), significantly exceeding reliance on cash purchase (49%), exchange for labour or items (33%), gifts (20%) and borrowing (18%).

Food assistance plays only a minor role (9% in-kind, 1% cash/voucher), indicating that **most households meet their food needs through their own production and other informal or market-based sources**.

Figure 8: Top 4 reported food sources access barriers per % of assessed households (select multiple; n=150)



Household income in the locality rested heavily on casual or daily labour (91%), with all other sources marginal by comparison: income from agricultural products (19%), salaried work (13%), assistance from organizations including cash-for-work (9%) and own business or commerce (7%).

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 13% of assessed households reported being registered for or receiving general food distribution, cash or voucher support, while 87% were not — consistent with the limited role of assistance among food sources noted above.

Table 3: % of top reported food assistance types received by households (select multiple; n=19)

Type of assistance	Frequency	Percentage
Food In-Kind	11	58%
Food vouchers	3	16%
Livelihoods (input) voucher	3	16%
Multi Purpose Cash Assistance	2	11%
Cash for food	1	5%

Water, Sanitation and Hygiene (WASH)

Almost all (93%) interviewed households reported use of improved water sources — mainly boreholes/tubewells (29%), piped connections (23%), delivered water via tankers, and carts & kiosks (20%). Few relied on unimproved sources (4%) or surface water (3%).

Although a majority of households relied on improved water sources, water treatment before consumption was limited to 10% only. However, limited water treatment remains a concern given the potential risk of faecal-oral 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

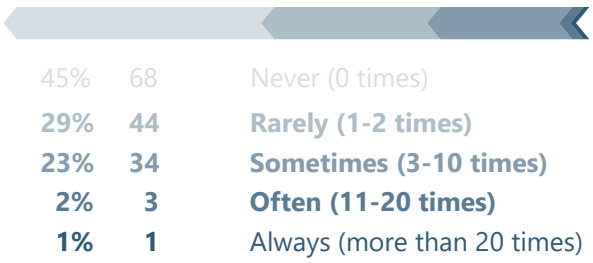


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Figure 11: % of households reporting worry about having enough water in the last 4 weeks prior to data collection

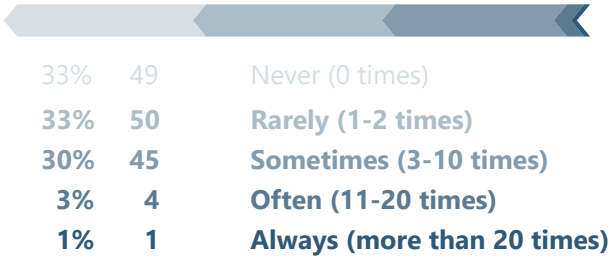


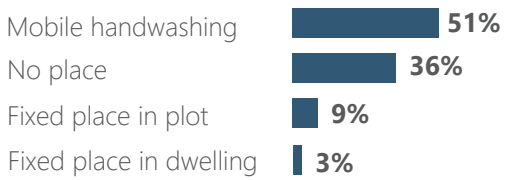
Figure 12: % of households reporting changes to daily activities due to water problems in the last 4 weeks prior to data collection

Most households used improved sanitation facilities, predominantly a flush or pour-flush to a pit latrine (67%) or a dry pit latrine with slab (12%). However, **17% 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, just over a **third** (35%) **shared their facility with other households**, with a median of around 4 households per shared facility, raising concerns around hygiene, privacy and safety.

Almost half (42%) of the households reported issues with their sanitation facilities, notably a lack of or overcrowded facilities (23%), facilities that were full or not functioning (13%), a lack of segregation between men and women (11%) and a lack of privacy (10%) — the latter two carrying particular implications for the safety and dignity of women and girls.

Handwashing practices reflected limited access to sanitation facilities. Around half of assessed households (51%) used a mobile handwashing device, while 12% had a fixed facility (in the dwelling or yard) and **over a third (36%) had no handwashing place at all**. Where a facility existed, water was usually available (80%), but soap or detergent was present in only 55% of households — meaning **nearly half lacked the means for effective handwashing**, a basic barrier to disease transmission in a context already marked by limited water treatment and widespread illness.

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. Overall, 60% of assessed households reported reduced access to at least one public service, most commonly healthcare facilities (44%), schools (36%), government facilities (21%), and therapeutic centres (21%). Fear of insecurity was the primary reason cited for avoiding these services.

Nearly half of the respondents (47%) reported experiencing protection risks in the three months preceding data collection 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.

Overall, 30% of respondents 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 (73%), routes for collecting firewood (22%), on their way to the fields (16%), on their way to school (7%), in their homes (7%) and distribution points (4%).

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

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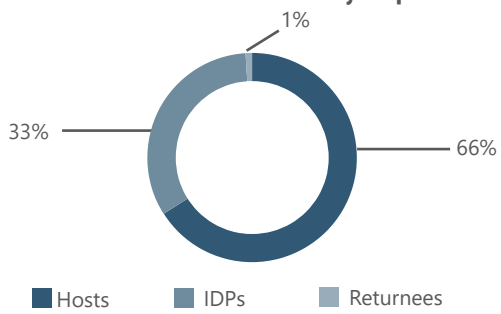
Ar Rashad locality findings

Demographic profiles

A total of **125** households (928 individuals) were assessed in Ar Rashad. Of the respondents, 74% were female and 26% male, with an overall average age of 39 years old and a median household size of 7 members. Majority of those surveyed (70%) lived in urban settings, 18% in rural and 12% in camp settings, **with 67% living in inadequate (makeshift or unfinished) housing**.

Figure 15: % of assessed households by displacement status

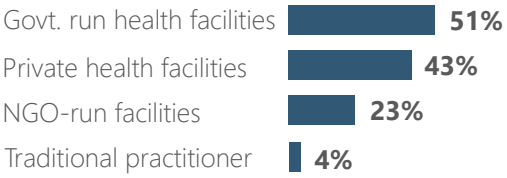


Health

In the two weeks preceding data collection, **over half the assessed households (72%) reported at least one member in need of healthcare assistance**. Among these households, a majority were able to access the healthcare they felt needed (78%), while the remaining 22% reported unmet healthcare needs.

The most frequently reported symptoms were fever (66%), followed by malaria (32%), cough (20%), diabetes (16%,) and diarrhoea (14%).

Figure 16: % of households in need of healthcare assistance, by type of consulted health facility (two weeks prior to data collection) (select multiple; n=69)



During the two weeks prior to data collection, **respondents reported a range of barriers to accessing healthcare services**. A majority of respondents (**70%**) 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, nearly half (44%) of households reported that reaching the nearest functioning health facility takes more than 30 minutes, suggesting that **physical access also remains a challenge for a substantial share of the population.**

Figure 17: Top 5 reported healthcare access barriers per % of assessed households (select multiple; n=125)

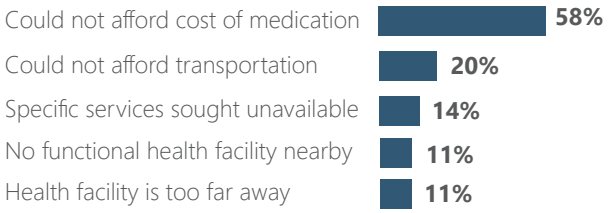
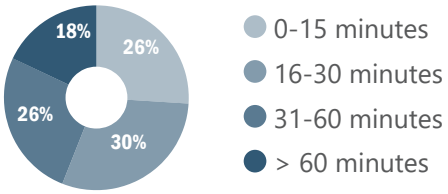


Figure 18: % of households by travel time to reach the nearest health facility by foot



Physical access challenges may be compounded for individuals with disabilities or functional limitations, though dependency levels in Ar Rashad were comparatively limited. Among assessed household members, 6% were reported to rely on another person to carry out day-to-day activities — a notably low share but still indicating that a segment of the population faces added barriers to accessing services.

A smaller proportion reported using assistive devices (3%) or requiring information in accessible formats such as sign language, easy-to-read materials, or large print (2%). While these shares are modest, findings still point to the importance of systematically considering accessibility needs when planning equitable healthcare and humanitarian assistance.

Child morbidity and vaccination

Survey findings indicate that child morbidity is a major concern in Ar Rashad. Among the 89 assessed children under five years of age, 72% were reported to have been ill during the two weeks prior to data collection.

Fever was the most commonly reported symptom, affecting 75% of sick children, followed by malaria (54%) and cough (44%).

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.

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Table 4: % of children aged 6-59 months in need of healthcare, by type of reported illness (two weeks prior to data collection) (select multiple; n=64)

Type of illness	Frequency	Percentage
Fever	48	75%
Malaria	14	54%
Cough	28	44%
Diarrhoea	22	34%
Throat infection	3	12%

Among children reported to have been ill during the two weeks prior to data collection, 48% of caregivers reported receiving counselling or support on child feeding practices. When seeking treatment, caregivers most commonly reported using government health centres (30%), followed by NGO-run health facilities (22%) and private health facilities (22%). 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 (67%: 60% based on maternal call and 7% on vaccination card/record), followed by vitamin A supplementation (49%: 46% based on maternal call and 3% on vaccination card/record) and deworming (26%).

Infant and Young Child Feeding (IYCF) in Emergencies

Breastfeeding practices were generally positive among the assessed households. A majority of the assessed children aged under six months (91%, n=10) were reportedly exclusively breastfed during the 24 hours preceding data collection, in line with recommended feeding practices for this age group. Among the 15 assessed children aged 12–23 months, 67% (10 children) were reportedly breastfed during the previous 24 hours.

Despite adequate early breastfeeding practices reported, **complementary feeding practices appeared limited** among the 33 children under five for whom dietary recall data were available. Most children (20 out of 33) consumed breast milk, while complementary foods were largely restricted to a narrow range of items, primarily grains, roots and tubers, dairy products, and vitamin A-rich fruits and vegetables. Consumption of pulses, flesh foods and eggs was rare.

This limited dietary diversity was reflected in the Minimum Dietary Diversity (MDD) outcomes, where **96% (n=24) of children failed to meet the threshold** of consuming at least five of the eight food groups in the previous 24 hour.

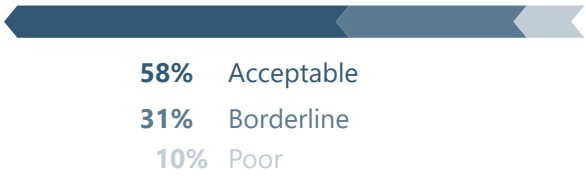
Caregivers most commonly identified economic barriers to complementary feeding, particularly a lack of financial resources to purchase food and high food prices. While 48% of caregivers reported receiving counselling or support on child feeding practices since the onset of the emergency, findings suggest 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 here are the least severe of the three localities: the majority of households (63%) fall in Phase 2, while a combined 25% are in Phase 3 or worse (Phase 4: 2%; Phase 5: 1%), and 12% remain in Phase 1.* Even so, **a quarter of households already facing crisis-or-worse consumption shows this remains a population under real strain**.

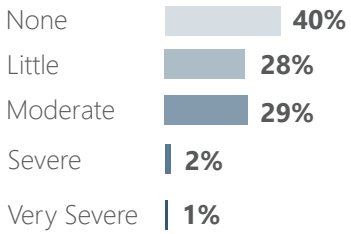
The **Food Consumption Score** (FCS) indicates that 58% of the households were classified as **acceptable**, 31% as **borderline** and 10% as **poor**. The median FCS was recorded at 44.5, which falls within the acceptable category (>35).

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



Household Hunger Scale findings indicate that 40% of assessed households reported no hunger in the 30 days preceding data collection, whereas 29% experienced moderate hunger. This distribution points to ongoing food access constraints, **with more than 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)



Over the seven days prior to data collection, households coped with food shortfalls mainly by relying on cheaper, less preferred food (2.4 days/week), limiting portion sizes (2.0) and reducing meals (1.7); borrowing food (1.6) and adults restricting their own consumption for children (0.8) were less frequent.

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

15%	High
68%	Medium
16%	No to Low

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 (41%) and borrowing (24%). At the same time, **reliance on crisis- and emergency-level strategies was widespread**: 56% reduced health expenditures, 48% consumed seed stocks intended for the next planting season, 27% cut spending on agricultural inputs, and 17% sold 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]

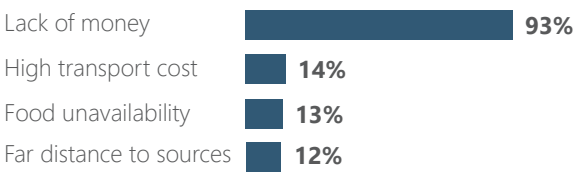
Table 5: % of households by Livelihood Coping Strategy Index (LCSI) (4 weeks prior to data collection)

LCSI	Frequency	Percentage
None	25	20%
Stress	14	11%
Crisis	66	53%
Emergency	20	16%

Purchasing food with cash was the main food source for assessed households (66%), followed by own production (55%), gathering (27%), borrowing (17%) and exchange of labour for food (6%). In-kind food assistance played only a minor role (3%), indicating that most households meet their food needs through incomes that are, as shown below, overwhelmingly casual and volatile.

Despite relying on a combination of market purchases and own production to meet their food needs, 34% of households reported facing barriers to accessing food during the seven days preceding data collection.

Figure 22: Top 4 reported food sources access barriers per % of assessed households (select multiple; n=125)



Household income in the locality rested heavily on casual or daily labour (76%), followed by income from agricultural products (48%), salaried work (21%), assistance from organizations including cash-for-work (4%) and support from family members abroad (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 24% of assessed households reported being registered for or receiving general food distribution, cash or voucher support, while 76% were not — consistent with the limited role of assistance among food sources noted above.

Table 6: % of top reported food assistance types received by households (select multiple; n=35)

Type of assistance	Frequency	Percentage
Food In-Kind	20	69%
Multi Purpose Cash Assistance	8	28%
Food vouchers	3	10%
Livelihoods (input) voucher	2	7%
Cash for food	2	7%

Water, Sanitation and Hygiene (WASH)

Most of the total households used improved water sources (80%) — mainly boreholes/tubewells (67%), protected wells (11%) and piped connections (2%), while the remaining **20% relied on unimproved sources** such as unprotected wells (8%), cart with small tank (6%), surface water (3%) and unprotected spring (2%).

Although a majority of households relied on improved water sources, water treatment before consumption was limited to 6% of the total.

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

66%	83	Never (0 times)
17%	21	Rarely (1-2 times)
14%	17	Sometimes (3-10 times)
3%	4	Often (11-20 times)

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

83%	104	Never (0 times)
8%	10	Rarely (1-2 times)
9%	11	Sometimes (3-10 times)

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

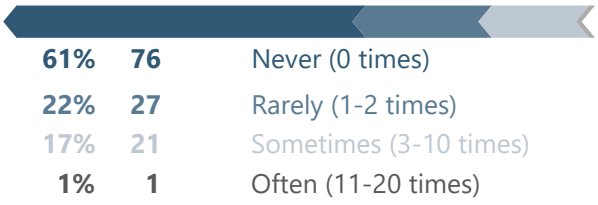
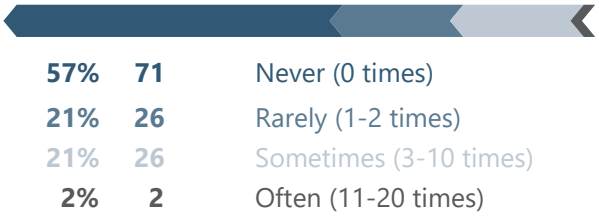


Figure 26: % of households reporting changes to daily activities due to water problems in the last 4 weeks

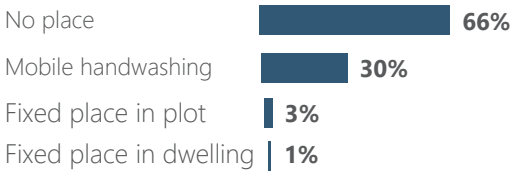


Most households used improved sanitation facilities, predominantly dry pit latrine without slab (40%), dry pit latrine with slab (28%) while only 4% used flush to pit latrine. However, **29% reported having no facility and practising open defecation** in bushes or fields — a significant share that poses clear public-health and protection risks. Among households with access to a sanitation facility, more than half (55%) shared their facility with other households, with a median of around 3 households per shared facility, raising concerns around hygiene, privacy and safety.

A majority (79%) of the households reported issues with their sanitation facilities, notably a lack of privacy (44%), which carries particular implications for the safety and dignity of women and girls, overcrowded facilities (38%), a lack of segregation between men and women (30%), while 10% reported some groups (children, women, elderly, ethnic minorities, etc.) do not have access to sanitation facilities (latrines/toilets).

Handwashing infrastructure was limited among assessed households. While 30% reported using a mobile handwashing device and 4% had a fixed facility located in the dwelling or yard, **66% reported having no designated handwashing place**. Among households with a facility, water was usually available (87%), although soap or detergent was present in only 56% of cases. Together, these findings point to **gaps in both access to and functionality of handwashing facilities, which may constrain effective hygiene practices.**

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. Overall, 42% of assessed households reported reduced access to at least one public service, most commonly schools and education facilities (40%), government facilities (14%) and therapeutic centres (14%). Fear of insecurity was the primary reason cited for avoiding these services.

Just over a quarter of respondents (27%) reported experiencing protection risks in the three months preceding data collection 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.

Overall, 22% of respondents 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 on their way to the fields or to collect firewood both at (74%), on their way to markets (37%), on their way to community centers or health centers (15%) and distribution points (11%).

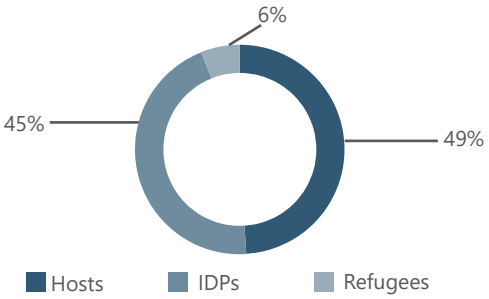
Figure 28: % of assessed households reporting women and girls feeling unsafe walking in their communities in the 3 months prior to data collection

At Tadamon locality findings

Demographic profiles

A total of **172** households (1,340 individuals) were assessed in At Tadamon. Of the respondents, 75% were female and 25% male, with an overall average age of 43 years old and a median household size of 8 members. Majority of those surveyed (76%) lived in rural settings, 18% were in formal camp and 6% were in urban, **with 82% living in inadequate (makeshift or unfinished) housing**.

Figure 29: % of assessed households by displacement status

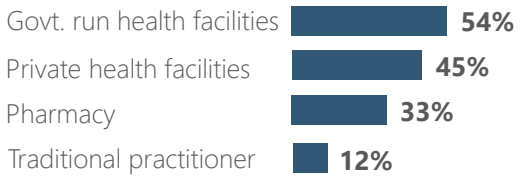


Health

In the two weeks preceding data collection, **over half the assessed households (73%) reported at least one member in need of healthcare assistance**. Among these households, a majority were able to access the healthcare they felt needed (66%), while the remaining 34% reported unmet healthcare needs.

The most frequently reported symptoms were fever (68%), followed by cough (21%), stomachache (18%), and diarrhoea (17%), and throat infection (16%).

Figure 30: % of households in need of healthcare assistance, by type of consulted health facility (two weeks prior to data collection) (select multiple; n=82)



During the two weeks prior to data collection, **respondents reported a range of barriers to accessing healthcare services**. Overall, 77% 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, 35% of households reported that reaching the nearest functioning health facility takes more than 30 minutes, suggesting that **physical access also remains a challenge for a substantial share of the population.**

Figure 31: Top 5 reported healthcare access barriers per % of assessed households (select multiple; n=172)

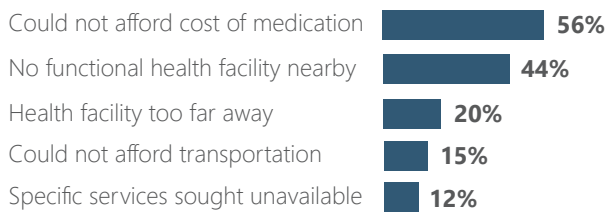
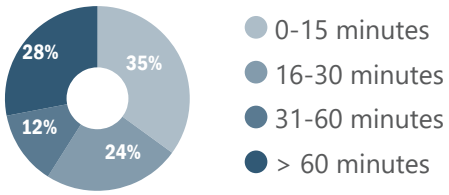


Figure 32: % of households by travel time to reach the nearest health facility by foot



Physical access challenges may be compounded for individuals with disabilities or functional limitations. Among assessed household members, 29% were reported to rely on another person to carry out day-to-day activities, indicating a high level of dependency.

In addition, 5% require information in accessible formats, such as sign language, easy-to-read materials, or large print, to access assistance and services, while 3% reportedly use assistive devices in their daily lives. These findings highlight the importance of considering accessibility needs when assessing access to equitable healthcare and humanitarian assistance.

Child morbidity and vaccination

Survey findings indicate that child morbidity is a major concern in At Tadamon. Among the 89 assessed children under five years of age, 60% were reported to have been ill during the two weeks prior to data collection.

Fever was the most commonly reported symptom, affecting **64%** of sick children, while diarrhoea, respiratory and gastrointestinal 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 7: % of children aged 6-59 months in need of healthcare, by type of reported illness (two weeks prior to data collection) (select multiple; n=99)

Type of illness	Frequency	Percentage
Fever	63	64%
Diarrhoea	34	34%
Throat infection	32	32%
Cough	19	19%
Vomiting	6	18%

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Among children reported to have been ill during the two weeks prior to data collection, 24% of caregivers reported receiving counselling or support on child feeding practices. When seeking treatment, caregivers most commonly reported using government health centres (46%), followed by private clinics (24%) and traditional practitioners (6%).

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. Measles vaccination had the highest reported coverage (74%: 54% based on maternall call and 20% on vaccination card/record), followed by vitamin A supplementation (34%: 28% based on maternall call and 6% on vaccination card/record) and deworming (15%).

Infant and Young Child Feeding (IYCF) in Emergencies

Breastfeeding practices were generally positive among the assessed households. All eleven 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 29 assessed children aged 12–23 months, 86% (25 children) were reportedly breastfed during the previous 24 hours.

Despite adequate early breastfeeding practices reported, **complementary feeding practices appeared limited** among the 45 children under five for whom dietary recall data were available. Most children (39 out of 45) 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 of the assessed children (100%) failed to meet the threshold** of consuming at least five of the eight food groups in the previous 24 hour.

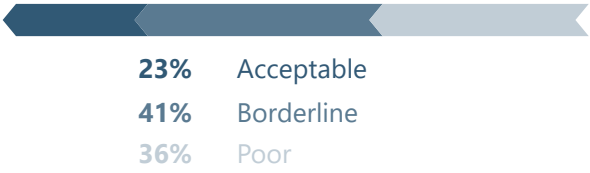
Caregivers most commonly identified economic barriers to complementary feeding, particularly a lack of financial resources to purchase food and high food prices. While 24% of caregivers reported receiving counselling or support on child feeding practices since the onset of the emergency, findings suggest 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 here are the most severe of the three localities: half of households (50%) fall into Phase 3, with a further 6% in Phase 4 or Phase 5 — together placing **56% of households at crisis-level food consumption or worse**, showing many households have limited ability to absorb further shocks and continue to face significant food security challenges.* Only 4% remain in Phase 1, **underscoring that consumption gaps here are both more widespread and more severe than in Abu Jubayhah or Ar Rashad**.

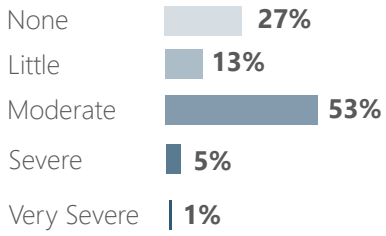
The **Food Consumption Score** (FCS) based on the seven-day recall period indicates that 41% of the households were classified as **borderline,** 36% as **poor,** while 23% were classified as **acceptable**. The median FCS was recorded at 32.5, which falls within the borderline category.

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



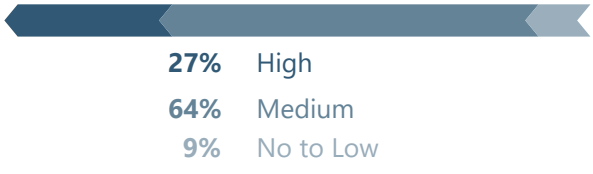
Household Hunger Scale findings indicate that 27% of assessed households reported no hunger in the 30 days preceding data collection, whereas 53% experienced moderate hunger. This distribution points to ongoing food access constraints, **with more than half of households facing significant levels of 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 (3.5 days/week), smaller portions (2.3), fewer meals (2.2) and borrowing food (2.1). More telling is that the most severe behaviour, adults restricting their own intake for children (1.1 days/week), is already present— 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)



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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 borrowing food or money (44%), spending savings (28%), and selling assets (21%). At the same time, **reliance on crisis- and emergency-level strategies was widespread**, with 24% consuming seed stocks reserved for the next agricultural season and 35% selling a last productive animal.

Unlike short-term consumption adjustments, t**hese strategies deplete productive assets and livelihood resources, limiting households' capacity to recover and increasing the risk of prolonged food insecurity**.[7]

Table 8: % of households by Livelihood Coping Strategy Index (LCSI) (4 weeks prior to data collection)

LCSI	Frequency	Percentage
None	15	13%
Stress	27	23%
Crisis	63	55%
Emergency	10	9%

Purchasing food with cash remains the main food source for a majority of HHs (78%), well ahead of own production (53%), gathering (16%), purchase with credit (15%), borrowing (15%) and in-kind assistance (12%). Food assistance plays only a minor role (12% in-kind, 2% cash/ voucher). These findings indicate that **households rely primarily on a combination of market purchases and own production to meet their food needs**, while direct food assistance reaches a relatively small share of the population.

Figure 36: Top 4 reported food sources access barrier per % of assessed households (select multiple; n=172)

Household income in the locality rested heavily on casual or daily labour (89%), followed by income from agricultural products (13%), income from own business (11%), assistance from organizations including cash-for-work (6%), selling of own assets (5%) and salaried work (4%). **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: 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 24% of assessed households reported being registered for or receiving general food distribution, cash or voucher support, while 76% were not — consistent with the limited role of assistance among food sources noted above.

Table 9: % of top reported food assistance types received by households (select multiple; n=44)

Type of assistance	Frequency	Percentage
Food vouchers	22	50%
Food in-kind	10	23%
Livelihoods (input) voucher	1	2%

Water, Sanitation and Hygiene (WASH)

Most of the total households used improved water sources (72%) — mainly piped connection (37%), boreholes/tubewells (25%), and protected wells (9%), while the remaining **28% relied on unimproved sources** such as tanker trucks (26%) and cart with small tank (2%).

Although a majority of households relied on improved water sources, water treatment before consumption was limited to only 13% of households. However, limited water treatment remains a concern given the potential risk of faecal-oral 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

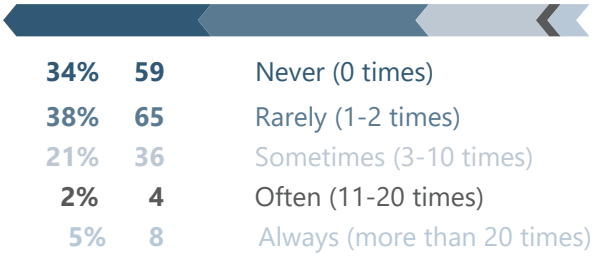

Figure 38: % of households reporting inability to wash hands due to water problems in the last 4 weeks prior to data collection

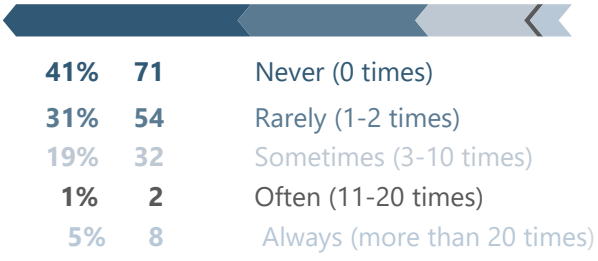

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Figure 39: % of households reporting worry about having enough water in the last 4 weeks prior to data collection

30%	52	Never (0 times)
33%	57	Rarely (1-2 times)
28%	48	Sometimes (3-10 times)
5%	8	Often (11-20 times)
2%	4	Always (more than 20 times)

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

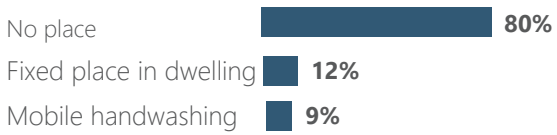
58%	99	Never (0 times)
27%	47	Rarely (1-2 times)
12%	21	Sometimes (3-10 times)
1%	1	Often (11-20 times)
1%	1	Always (more than 20 times)

Most of the households (88%) reported having no facility and practicing open defecation in bushes or fields. For the remaining 12%, used improved sanitation facilities, mainly flush to pit latrine (9%), dry pit latrine with slab (1%) and flush to septic tank (1%,). Among households with access to a sanitation facility, nearly half (47%) shared their facility with other households, with a median of around 7 households per shared facility, raising concerns around hygiene, privacy and safety.

A majority (85%) of the households reported issues with their sanitation facilities, notably lack of access to sanitation facilities (62%), facilities that were full or not functioning (9%) and sanitation facilities were too far (8%).

Access to handwashing facilities was limited among assessed households. Four out of five households (80%) reported having no designated handwashing place, while 12% had a fixed facility located in the dwelling or yard and 9% used a mobile handwashing device. Among households with a handwashing facility, only 33% reported having water available, and soap or detergent was present in just 23% of cases. These findings point to **significant gaps in both access to and functionality of handwashing facilities, which may constrain effective hygiene practices**.

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



Protection

Safety concerns and ongoing conflict continue to restrict physical access to essential public services. Overall, 60% of assessed households reported reduced access to at least one public service, most commonly schools and education facilities (60%), healthcare (48%), therapeutic centres (24%) and government facilities (20%). Fear of insecurity was the primary reason cited for avoiding these services.

More than half of the assessed households (52%) reported experiencing protection risks in the three months preceding data collection 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.

Overall, 17% of respondents 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 on their way to markets (59%), water points (55%) routes for collecting firewood (41%), latrines and bathing places (17%), on their way to the fields (14%) and distribution points (10%).

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

83%	142	Never
13%	22	Just once or twice
4%	6	Several times
1%	1	Always

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Methodology Overview

This assessment was conducted by IMPACT Initiatives in collaboration with GOAL between 12 and 25 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 South Kordofan — Abu Jubayhah, At Tadamon and Ar Rashad — where a total of 447 household surveys were completed (Abu Jubayhah: 150; At Tadamon: 172; Ar Rashad: 125). 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 GOAL 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 1.2, 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 GOAL

Founded in 1977 and headquartered in Dublin, Ireland, GOAL is an international humanitarian and development organisation working to save lives and support vulnerable communities to build resilience and achieve sustainable development. In Sudan, GOAL has been operating since 1985, delivering life-saving assistance to conflict- and crisis-affected populations. Through integrated programmes in health, nutrition, WASH, food security, livelihoods, and emergency response, GOAL works alongside communities, government, and humanitarian partners to provide timely, needs-based assistance while strengthening local systems and resilience in some of Sudan's most challenging and hard-to-reach areas.

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.

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GOAL IMPACT Shaping practices Influencing policies Impacting lives