FACTSHEET

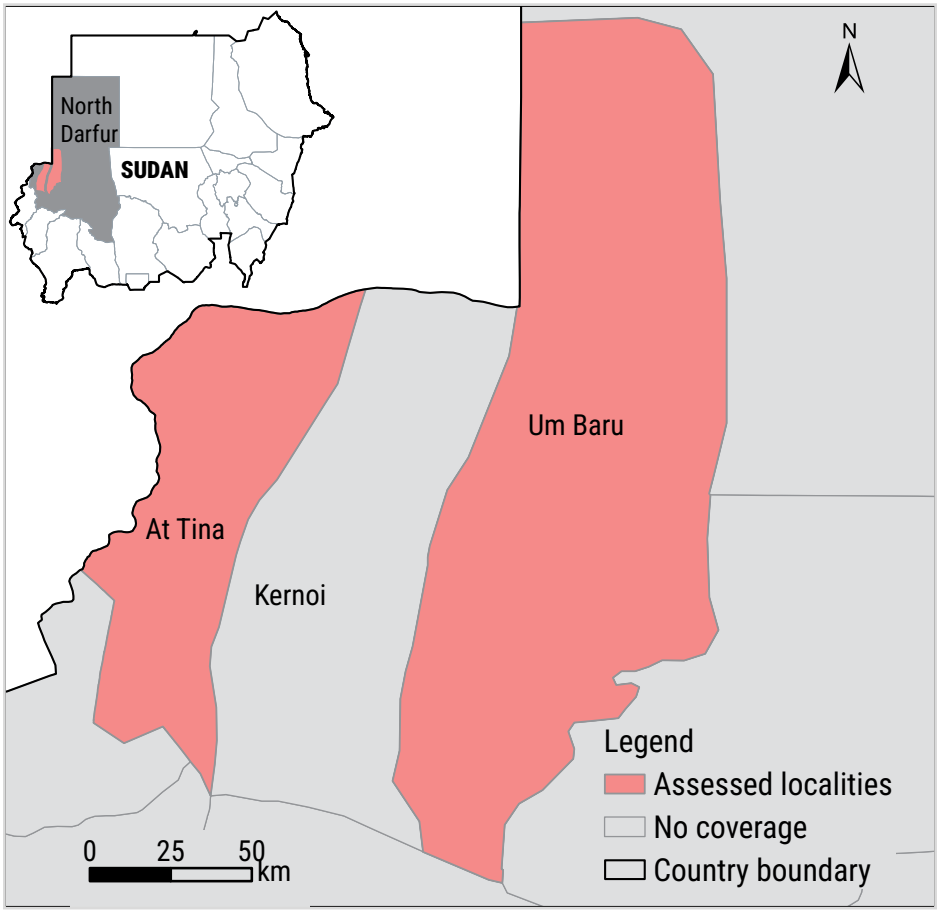
Food Security, Livelihoods and Nutrition Assessment: IDP sites in Um Baru and At Tina Localities, North Darfur state

January 2026 | Sudan

Key Messages

- More than half of the assessed households reported at least one member was feeling sick in the 2 weeks prior data collection (53%) in Um Baru and 62% in At Tina. Additionally, 30% in Um Baru and 55% in At Tina had unmet healthcare needs, reflecting the public health situation in both localities
- WASH conditions remain poor and heighten both health and protection risks. In Um Baru and At Tina, 32% and 26% of households relied on unprotected water sources, respectively, while 65% and 97% did not treat drinking water, and 60% and 70% practiced open defecation.
- Food security is fragile, affected by frequent food access gaps, poor dietary diversity, and reliance on negative coping strategies, with 47% of households in Um Baru and 49% in At Tina reported having no food at least once in the month prior data collection.

Map 1: Assessment Coverage



Context & Rationale

Since April 2023, the conflict in Sudan has continued to escalate across large parts of the country, with devastating consequences for civilians and the widespread disruption of essential services. Repeated displacement, insecurity, and the destruction of infrastructure have deepened an already severe humanitarian crisis, leaving more than 30 million people in need of humanitarian assistance nationwide.[1]

In December 2025, a Standardized Monitoring Assessment for Relief and Transitions (SMART) survey conducted in At Tina locality identified a serious public health concern related to malnutrition. Global Acute Malnutrition (GAM) was estimated at 19.7%, exceeding the WHO emergency threshold of 15%, while Severe Acute Malnutrition (SAM) reached 4.5%.[2] [3] The SMART survey conducted in Um Baru locality in December 2025 reported GAM at 52.9% and SAM at 19%.[4] An internal data gap analysis conducted by IMPACT indicates that IDP sites in both localities remain insufficiently covered by systematic public health and multi-sectoral needs assessments.

In this context, the assessment was conducted between 7-29 of December 2025 to better understand the humanitarian needs of IDPs in both localities, with a focus on Food Security and Livelihoods (FSL), Water, Sanitation and Hygiene (WASH), Health, and Nutrition, to support targeted and coordinated response planning. Overall, the findings are representative only of the overall IDP population across the assessed sites.

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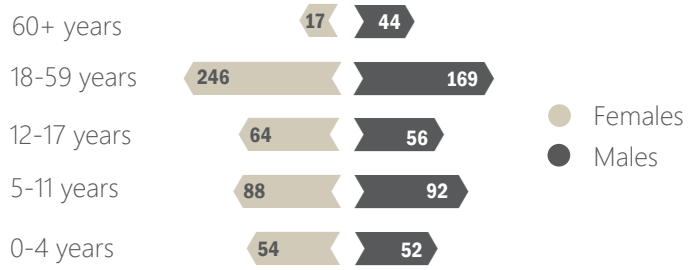
Um Baru locality findings

Demographics

A total of 151 households were assessed, of which 70% were male respondents and 30% were female respondents. The median household (HH) size was 6 members.

Figure 1: Composition of the 151 assessed HHs by age group and sex

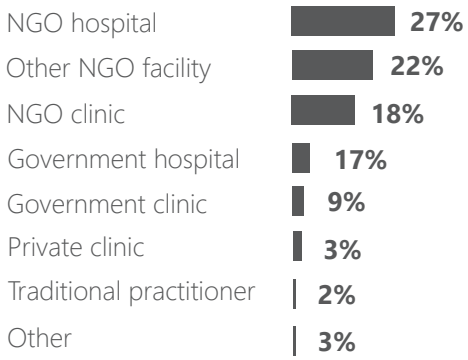


Health

In the two weeks preceding data collection, over half the HHs (53%) reported at least one member in need of healthcare assistance. Among HHs who reported illness, 69% were able to access the healthcare they felt needed, while a third (31%) reported unmet healthcare needs.

The most frequently reported symptoms were fever (53%), followed by diarrhoea (33%), eye infection or red eyes (23%), and cough (21%).

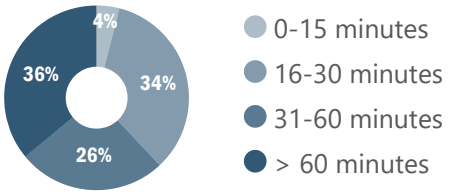
Figure 2: % of households in need of healthcare assistance, by type of consulted health facility (two weeks before data collection) (select multiple; n=55)



When extending the recall period to the last 2 weeks, multiple barriers to accessing healthcare services were reported. A majority (62%) of respondents indicated at least one key constraint when seeking care, while over a third (38%) reported no barriers.

The most commonly reported barriers were insufficient staff at health facilities (16%), lack of information on how to access care (15%), and absence of a functional health facility nearby (15%). Additional barriers included unavailability of specific services (13%), inability to afford the cost of medication (10%), long distance to health facilities (9%), and lack of appropriately trained staff (7%).

Figure 3: % of households by travel time to reach the nearest health facility by foot (n=151)



A third of HHs (36%) reported that the nearest health facility being more than 60 minutes away, indicating a substantial physical barrier to accessing basic healthcare services. Overall, 26% of HHs reported walking times exceeding 30 minutes. This is particularly relevant given that over half of HHs (53%) reported at least one member in need of healthcare in the two weeks preceding data collection.

Child morbidity and vaccination

Survey findings indicate that child morbidity is a critical public health concern in the assessed IDP sites. Of the 95 children under five years of age, 45% were reportedly ill in the two weeks preceding data collection.

Fever, diarrhoea, cough, and other conditions such as skin and eye infections were the most commonly reported illnesses among children during the two weeks before data collection. These illnesses are among the leading global causes of childhood morbidity and mortality, collectively accounting for over 50% of child deaths worldwide.[5]

Table 1: % of children aged 6-59 months in need of healthcare, by type of reported illness (two weeks before data collection) (select multiple; n=43).

Type of illness	Frequency	Percentage
Fever	34	79%
Diarrhoea	25	58%
Cough	17	40%
Fast breathing	1	2%
Other	1	2%

Among the 43 children reported to have been ill in the two weeks preceding data collection, 98% of caregivers reported seeking healthcare.

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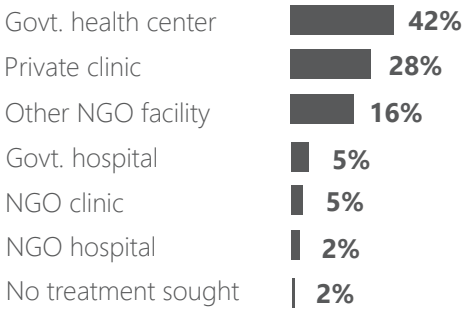
Figure 4: % of children under 5 years old in need of healthcare, by type of consulted health facility (two weeks before data collection) (n=43).



Coverage of measles vaccination, vitamin A supplementation, and deworming remained below the 90% target, thereby increasing the risk of infectious diseases, malnutrition, impaired child growth, and mortality.[6]

Table 2: % of children aged 9-59 months who received measles vaccination in the six months prior to data collection (n=85)

Measles vaccination	Frequency	Percentage
No	58	68%
Vaccination card	18	21%
Maternal recall	9	11%

Table 3: % of children aged 6-59 months who received vitamin A in the six months prior to data collection (n=87)

Vitamin A	Frequency	Percentage
No	62	71%
Maternal recall	16	18%
Vaccination card	6	7%
Don't know	3	3%

Table 4: % of children aged 12-59 months who received deworming treatment in the six months prior to data collection

Deworming	Frequency	Percentage
No	79	95%
Yes	4	5%

Nutrition

54% of caregivers reported that children under five years of age had undergone growth monitoring and malnutrition screening. This coverage is below the national target of ≥90%, leaving many children at elevated risk of malnutrition, which can further lead to sever or complicated malnutrition conditions and related deaths.[7]

Of the 46 households with under-five children who attended screening, 26 reported that their children are malnourished, indicating that malnutrition is a widespread public health problem in the assessed IDP sites. Among the 26 HHs, 23 were able to access feeding services, primarily through therapeutic feeding centers.

Respondents further indicated that access to nutrition services is constrained by recurrent stock-outs, long travel distances, shortages of qualified health staff, and weak referral systems. These barriers contribute to increased severity of malnutrition, reduced recovery rates, higher defaulting from treatment, and mortality levels exceeding minimum Sphere standards.[8]

Infant and Young Child Feeding in Emergencies

Among children under six months of age (n=8), all were reportedly exclusively breastfed in the 24 hours prior to data collection, indicating full adherence to recommended exclusive breastfeeding practices for this age group. Continued breastfeeding among older children was also very high, as 94% (n=15) of children aged 12–23 months were still being breastfed, while only 6% (n=1) had stopped breastfeeding earlier than recommended.

Despite high breastfeeding prevalence, complementary feeding practices were extremely limited. Based on 24-hour dietary recall, 90% of children consumed breast milk, while only 10% consumed foods from the grains, roots, tubers, or plantains group. No children were reported to have consumed pulses, dairy products, flesh foods, eggs, or fruits and vegetables. Overall, all assessed children aged 6–59 months failed to meet the Minimum Dietary Diversity (MDD) threshold, with a median MDD score of 1, indicating universally inadequate dietary diversity.

Caretakers identified high food prices (70%) and lack of financial resources to purchase food (41%) as the main barriers to adequate complementary feeding, followed by lack of information on the importance of complementary feeding (19%), poor hygiene conditions or lack of water and competing workloads limiting time for child care both at 7%, and lack of time for food preparation (4%). Although 67% of caregivers reported receiving counselling or support on child feeding practices since the emergency began, overall feeding practices remain critically inadequate.

Food Security and Livelihoods (FSL)

The Food Consumption Score across the assessed IDP sites indicates that 40% of HHs were classified as acceptable, 36% as borderline, and 24% as poor.

The median Food Consumption Score was 32, which falls within the borderline category (21.5–35). This median is close to the threshold for acceptable consumption (≥36), indicating that a substantial proportion of HHs remain at risk of inadequate food consumption.

The Household Hunger Scale score analysis reveals that, in the 30 days prior data collection, 72% of households experienced little to no hunger and 28% moderate hunger. The proportion of households experiencing moderate hunger highlights persistent food access challenges among a segment of the population.

Figure 5: % of households by Household Hunger Scale (HHS) score (4 weeks before data collection)

Households commonly relied on consumption-based coping strategies, such as reducing portion sizes and meals (median 1 day a week), alongside widespread use of crisis and emergency strategies, particularly reducing health expenditures (36%) and withdrawing children from school (21%), highlighting reliance on coping strategies that have longer-term negative impacts on human capital, dignity and wellbeing.[9]

Table 6: % of households by Livelihood Coping Strategy Index (LCSI) (4 weeks before data collection)

LCSI	Frequency	Percentage
None	55	36%
Stress	12	8%
Crisis	52	34%
Emergency	32	21%

Water, Sanitation and Hygiene (WASH)

90 minutes was the median time required for HHs to fetch water. A third of HHs (32%) relied on unprotected wells as their primary water source, representing a concerning practice in terms of water safety. Even among HHs using protected sources, such as boreholes or tubewells (56%), water treatment practices remained limited.

Overall, 65% of HHs reported that they do not treat drinking water prior to consumption. Only 35% of HHs reported using at least one water treatment method, most commonly boiling or straining water through cloth (both at 58%), while other methods such as settling (8%) and solar disinfection (4%) were rarely reported.

Figure 6: % of HHs reporting insufficient drinking water in the last 4 weeks prior to data collection

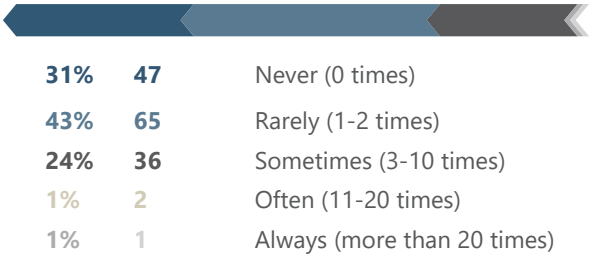


Figure 7: % of HHs reporting inability to wash hands due to water problems in the last 4 weeks prior to data collection

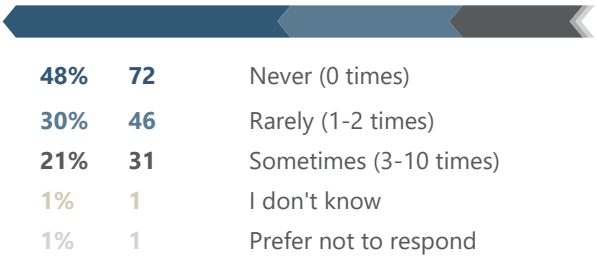


Figure 8: % of HHs reporting worry about having enough water in the last 4 weeks prior to data collection

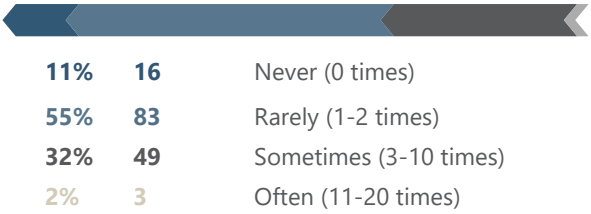
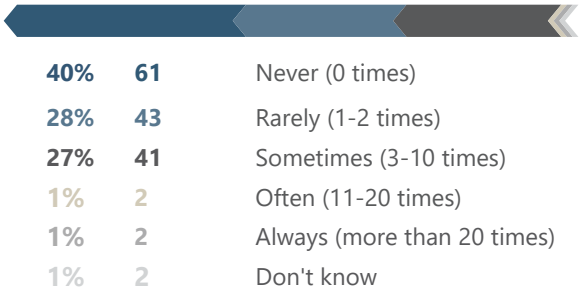


Figure 9: % of HHs reporting changes to daily activities due to water problems in the last 4 weeks



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A majority of HHs reported no sanitation facility, practicing open defecation (60%). Among HHs with access to sanitation facilities, 23% reported using a flush toilet connected to a pit latrine, while 12% reported using a flush toilet discharging to an unknown location. Among HHs reporting access to a sanitation facility, 25% indicated that the facility was shared, while 75% reported using a private facility. The median number of HHs sharing a sanitation facility was 3 HHs.

Almost half (47%) of households reported no concerns regarding exisiting sanitation facilities or were unable to assess conditions (28% responded with "don't know"). However, 9% reported a lack of sanitation facilities or overcrowding, 7% reported that facilities were not segregated by sex, particularly among shared facilities, and 6% reported that accessing sanitation facilities was perceived as dangerous. Smaller proportions reported problems with privacy (3%), unclean facilities (2%), or non-functional latrines (1%), while access barriers for vulnerable groups were reported by a limited number of households (1%).

Figure 10: % of HHs by type of handwashing facility most commonly used (n=43).

Figure 11: % of HHs with water available at the handwashing facility (n=151)

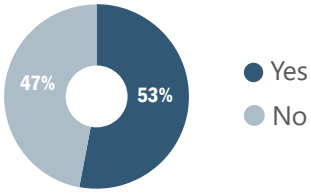
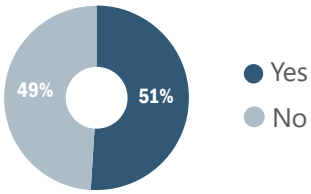


Figure 12: % of HHs with soap or detergent available for handwashing (n=151)



Protection

Safety concerns specifically among women and girls were reported across households. Although a third (36%) reported no immediate concerns, 23% reported avoiding areas in their village/neighbourhood/vicinity several times over the 3 months prior data collection. The areas mostly avoided were markets (63%, n=61), Social/community areas (34%, n=33), water points (29%, n=28), distribution areas (24%, n=23), and on the way to collect firewood (18%, n=17).

Figure 13: % of women and girls reported feeling unsafe walking in their communities in the last 3 months prior data collection (n=151)

36%	54	Never
40%	60	Just once or twice
20%	30	Several times
4%	6	Always
1%	1	Prefer not to respond

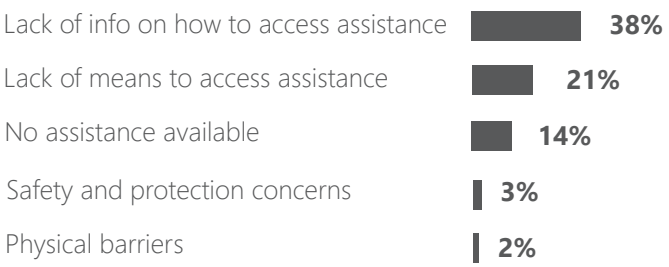
In terms of shocks affecting households in the 3 months before data collection, displacement or forced movement registered the highest with (72%), followed by armed conflict (48%), looting or destruction of property (33%), and price increase/market disruption (17%).

Accountability to Affected Population

Half of the respondents (50%) in Um Baru reported receiving aid in the 12 months prior data collection. Food assistance (in kind) was the highest reported form of assistance (95%), followed by healthcare (45%) and cash assistance (5%). Other reported forms were less common -fewer than 5% each- and included sanitation services, hygiene and personal items, drinking water and education.

Most households reported being satisfied with the aid received (92%), where 7% (n=5) reported that the assistance was insufficient and 1% (n=1) noting difficulties related to accessibility, such as distance or hard-to-reach service points.

Figure 14: % of barriers faced by households in accessing humanitarian aid in the 12 months prior data collection (select multiple; n=199)



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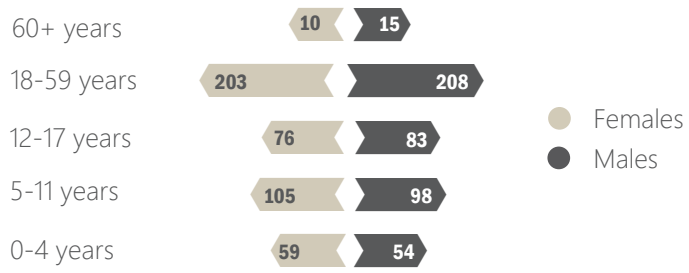
At Tina locality findings

Demographics

Data collection in At Tina locality covered 150 HHs, with a near-even distribution of respondents by sex. Just over half were male at 54%, while females accounted for 46%. Household size was relatively large, with a median of six members per HH.

Figure 1: Composition of the assessed 150 HHs by age group and

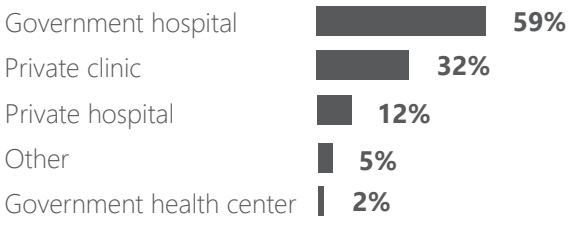


Health

In the two weeks preceding data collection, 62% of HHs reported that at least one member required healthcare assistance. Among HHs that reported illness during this period, 44% indicated that they were able to access the healthcare they felt was needed, while the remainder did not access care.

Fever was the most frequently reported symptom (51%). Other commonly reported symptoms included diarrhoea (26%), eye infection or red eyes (13%), and cough (8%), with a substantial proportion of respondents also reporting other, unspecified symptoms (40%).

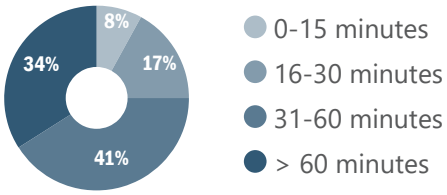
Figure 2: % of households in need of healthcare assistance, by type of consulted health facility (two weeks before data collection) (select multiple; n=41)



When extending the recall period to the past 2 weeks, most respondents reported encountering at least one barrier when attempting to access healthcare services, whereas only 16% reported no barriers. The absence of a functional health facility nearby was the most commonly cited constraint (49%), followed by the inability to afford the cost of medication (43%).

Additional barriers included the inability to afford transportation to a health facility (13%), the unavailability of the specific service sought at the facility visited (11%), and concerns related to safety or insecurity while travelling to a health facility (10%).

Figure 3: % of households by travel time to reach the nearest health facility by foot (n=150)



One third of HHs (34%) reported that the closest healthcare facility being more than 60 minutes away. In total, 75% of HHs indicated walking times of over 30 minutes to reach the nearest facility. These distances were reported in a context where 62% of HHs stated that at least one member required healthcare during the two weeks prior to data collection.

Child morbidity and vaccination

Child morbidity levels in At Tina indicate a critical public health concern. Of the 108 under five children assessed, 46% were reported ill during the two weeks prior to data collection.

Fever, diarrhoea, cough, and other conditions such as skin and eye infections were the most commonly reported illnesses among children during the two weeks before data collection. These illnesses are among the leading global causes of childhood morbidity and mortality, collectively accounting for over 50% of child deaths worldwide.[5]

Table 1: % of children aged 6-59 months in need of healthcare, by type of reported illness (two weeks before data collection) (n=86).

Type of illness	Frequency	Percentage
Fever	33	66%
Diarrhoea	23	46%
Cough	8	16%
Fast breathing	4	8%
Other	18	36%

Among the 50 children who were reported ill in the two weeks preceding data collection, 74% were taken to seek healthcare services. However, 26% did not receive any treatment, indicating ongoing gaps in access to child health services.

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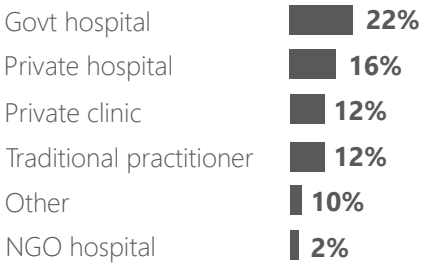
Figure 4: % of children under 5 years old in need of healthcare, by type of consulted health facility (two weeks before data collection) (n=50).



Coverage of measles vaccination, vitamin A supplementation, and deworming remains below the 90% target, thereby increasing the risk of infectious diseases, malnutrition, impaired child growth, and mortality.[6]

Table 2: % of children aged 9-59 months who received measles vaccination in the six months prior to data collection (n=98)

Measles vaccination	Frequency	Percentage
No	63	64%
Don't know	2	2%
Maternal recall	33	34%

Table 3: Table 3: % of children aged 6-59 months who received vitamin A in the six months prior to data collection (n=102)

Vitamin A	Frequency	Percentage
No	82	80%
Maternal recall	17	17%
Vaccination card	1	1%
Don't know	2	2%

Table 4: of children aged 12-59 months who received deworming treatment in the six months prior to data collection (n=97)

Deworming	Frequency	Percentage
No	85	88%
Yes	12	12%

Nutrition

Preventive nutrition services in At Tina remain limited, where only 24% of households with under five children (n=108) reported that children had undergone growth monitoring and malnutrition screening. This coverage is below the national target of ≥90%, leaving many children at elevated risk of malnutrition.[7]

Among the 6 households with malnourished children, 5 were able to access feeding services, mainly through nutrition programs or health facility/ clinic. Despite this, the gaps persist in referral pathways, availability of therapeutic foods, and awareness of malnutrition and treatment availability.

Respondents further indicated that access to nutrition services is constrained by insecurity or conflict, damaged facilities, long travel distances, shortages of qualified health staff, and weak referral systems. These barriers contribute to increased severity of malnutrition, reduced recovery rates, higher defaulting from treatment, and mortality levels exceeding minimum Sphere standards.[8]

Infant and Young Child Feeding in Emergencies

Among children under six months of age (n=6), all were reportedly exclusively breastfed in the 24 hours prior to data collection, indicating adherence to recommended exclusive breastfeeding practices in early infancy. However, breastfeeding practices among older children were less consistent. Among children aged 12–23 months, only 63% (n=12) were still being breastfed, while 37% (n=7) had discontinued breastfeeding earlier than recommended.

Complementary feeding practices showed limited dietary diversity. Based on 24-hour dietary recall, 77% of children consumed breast milk, while 23% consumed grains, roots, tubers, or plantains and 23% consumed pulses, nuts, or seeds. Smaller proportions consumed flesh foods (17%) and dairy products (13%), while only 3% consumed vitamin A-rich fruits or vegetables and 3% consumed other fruits or vegetables. No children were reported to have consumed eggs. Overall, all assessed children aged 6–59 months failed to meet the Minimum Dietary Diversity (MDD) threshold, with a median MDD score of 2, indicating universally inadequate dietary diversity.

Caretakers identified high food prices (73%) and lack of financial resources to purchase food (50%) as the primary barriers to adequate complementary feeding, followed by child illness or low appetite (20%), lack of adequate Infant and Young Child Feeding (IYCF) information (17%), and lack of information on the importance of complementary feeding (7%). Access to IYCF counselling was limited, as only 23% of caregivers reported receiving feeding counselling since the emergency began. Poor complementary feeding and early stopping of breastfeeding among many older infants increase the risk of malnutrition, illness, and poor child growth in At Tina IDP sites.

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Food Security and Livelihoods (FSL)

Food consumption levels among households in At Tina indicate widespread food insecurity. Only 33% of HHs were classified as having acceptable food consumption score, 39% as borderline, and 27% as poor.

The median Food Consumption Score was 29, which falls within the borderline category (21.5–35) and remains close to the threshold for acceptable consumption (≥36). This suggests that many households are at high risk of food insecurity if conditions worsen.

The Household Hunger Scale score analysis reveals that, in the 30 days prior data collection, 60% of households experienced little to no hunger, 38% moderate hunger and 2% severe hunger. The proportion of households experiencing moderate hunger highlights persistent food access challenges among more than third of the population.

Figure 5: % of households by Household Hunger Scale (HHS) score (4 weeks before data collection) (n=150)

To cope with shortages, households relied heavily on both food and livelihood related strategies. Common practices included reducing meal size and frequency (median 2 days per week), alongside crisis and emergency coping strategies such as reducing health expenditures (65%), withdrawing children from school (55%), and sending household members to eat elsewhere (35%), indicating severe stress on household resilience.

Table 6: % of households by Livelihood Coping Strategy Index (LCSI) (4 weeks before data collection) (n=150)

LCSI	Frequency	Percentage
None	20	13%
Stress	13	9%
Crisis	96	64%
Emergency	21	14%

Water, Sanitation and Hygiene (WASH)

Water access in At Tina IDP sites remains extremely constrained. Households spent a median of 83 minutes collecting water. More than one-quarter of households (26%) relied on unprotected wells as their primary source of drinking water, posing concerning safety concerns.

Overall, 97% of HHs reported that they do not treat drinking water prior to consumption. Only 3% of HHs reported using at least one water treatment method, exclusively boiling (100%).

Figure 6: % of HHs reporting insufficient drinking water in the last 4 weeks prior to data collection (n=150)

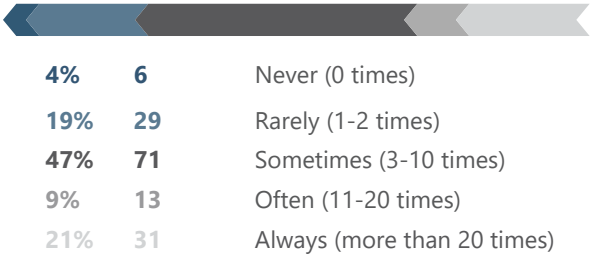


Figure 7: % of HHs reporting inability to wash hands due to water problems in the last 4 weeks prior to data collection (n=150)

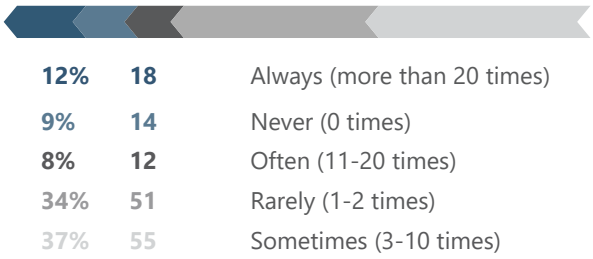


Figure 8: % of HHs reporting worry about having enough water in the last 4 weeks prior to data collection (n=150)

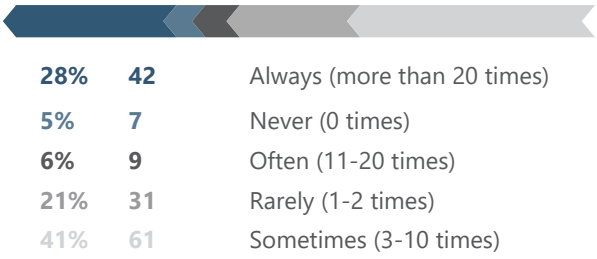
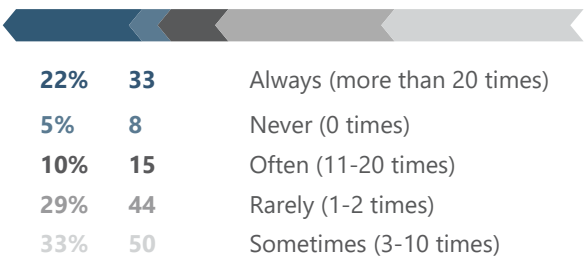


Figure 9: % of HHs reporting changes to daily activities due to water problems in the last 4 weeks (n=150)



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Sanitation coverage was critically low, with 70% of households practicing open defecation. Among those with access to sanitation facilities, 15% used flush toilets connected to pit latrines, 13% used dry pit latrines with slabs, and only 1% used dry pit latrines without slabs. Of households with sanitation facilities, 64% reported that the facility was shared, with a median of three households sharing a single latrine.

Sanitation challenges were widespread, as only 5% of households reported no problems. Nearly all households facing difficulties cited lack of facilities or overcrowding (99%), while others reported absence of private facilities (18%), lack of sex-segregated facilities (17%), and non-functional or full latrines (10%).

Handwashing conditions were also inadequate, where only 18% of households had water available at handwashing points, and just 20% had soap or detergent present, significantly increasing the risk of disease transmission.

Figure 10: % of HHs by type of handwashing facility most commonly used (n=150).

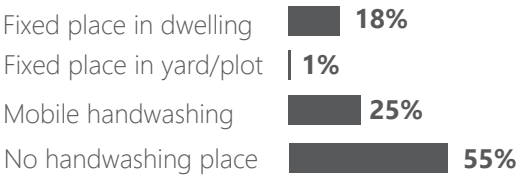


Figure 11: % of HHs with water available at the handwashing facility (n=150)

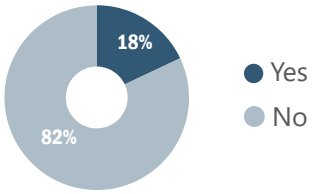
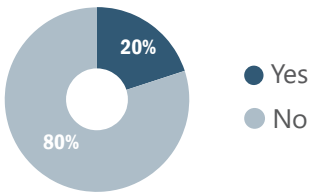


Figure 12: % of HHs with soap or detergent available for handwashing (n=150)



Protection

More than two-thirds of women and girls 72% had to avoid areas of the village/neighbourhood/vicinity several times because of security concerns over the 3 months prior data collection The areas mostly avoided were markets (88%), water points and social/community areas (both at 38%), on the way to collect firewood (31%) and latrines & bathing facilities (14%).

Figure 13: % of women and girls reported feeling unsafe walking in their communities in the last 3 months prior data collection (n=150)

6%	9	Always
1%	1	Don't know
16%	24	Just once or twice
5%	8	Never
72%	108	Several times

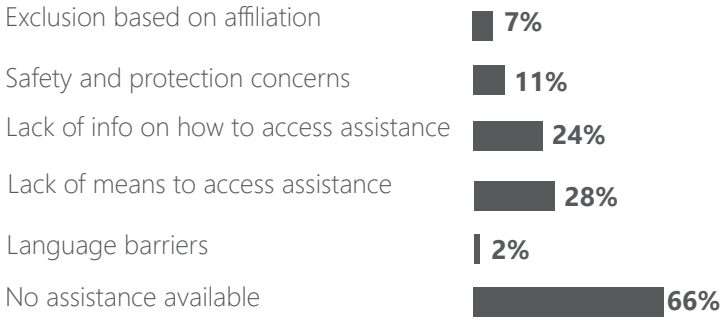
Households also reported frequent exposure to shocks in the 3 months before data collection, with armed conflict or violence affecting 73% of households, followed by displacement or forced movement (71%), looting or destruction of property (45%), and price increases or market disruptions (15%).

Accountability to Affected Population

Humanitarian assistance coverage in At Tina remains limited, where only 26% of households reported receiving aid in the 12 months prior data collection. Food assistance (in kind) was the highest reported form of assistance (97%), followed by protection services (13%). Drinking water, hygiene and personal items, and livelihood support were each reported by only 3% of households.

Among households that received assistance, 69% reported being satisfied with the aid provided, while 23% reported that the assistance was insufficient and 3% reporting either the aid being of poor quality or it did not address their most urgent needs.

Figure 14: % of barriers faced by households in accessing humanitarian aid in the 12 months prior data collection (select multiple; n=224)



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Methodology Overview

The assessment was conducted in collaboration with GOAL Global in both localities. In Um Baru locality, data collection tool place between 7-12 of December 2025, with a total of 151 household interviews across 3 IDP sites: 107 in Shegeg Karo, 35 in Um Baru town and 9 in Lil. As for At Tina locality, data collection took place between 25-29 of December 2025, with a total of 150 household interviews across 2 IDP sites: 115 Alhilla Aljadeeda and 35 in At Tina town.

The findings aim to determine the humanitarian needs of IDPs in At Tina and Um Baru localities, in North Darfur state, with a focus on Food Security and Livelihoods (FSL), Water, Sanitation, and Hygiene (WASH), Health, Nutrition, Protection, Disability and Accountability to Affected Population (AAP) . Additionally, to assess the severity of life saving basic needs, availability of essential services, barriers of accessing those services and identify initial public health priorities.

The sample size was estimated using the known population size per stratum and assumptions of 95% confidence level, 50% estimated proportion for household indicators, 10% margin of error, and a 10% buffer. The sites were purposively selected based on their geographical proximity, relative homogeneity in population characteristics, and accessibility for data collection.

In Um Baru locality, IDPs were treated as a single stratum, and the sample of 151 households was proportionally allocated across sites using PPS sampling. Within each site, households were selected using systematic random sampling with a random start and fixed interval, following a geographic ordering of shelters with support from community leaders.

In At Tina locality, the assessment covered IDPs living both inside camps (Alhilla Aljadeeda) and in host-community settings (At Tina town), which were treated as a single stratum, with households proportionally allocated between in-camp and out-of-camp sites using Probability Proportional to Size (PPS) sampling.

Overall, findings are representative only of the overall IDP population across the assessed sites and should be interpreted as indicative of severity and priority needs rather than causal relationships. Given the purposive selection of sites based on accessibility and the relatively small sample size, results are not generalizable beyond the assessed locations and may not capture the full diversity of conditions or perspectives, particularly among harder-to-reach populations. In addition, qualitative components were intended for light triangulation and may not have reached full saturation.

Endnotes

[1] International Organization for Migration (IOM), Dec 17 2025. DTM Sudan Displacement and Return Overview . IOM, Sudan.

[2] Sudan, Welt Hunger Hilfe, Action Against Hunger Canada, At Tina Locality, SMART Survey final report, North darfur, Sudan, December 2025.

[3] World Health Organization, Malnutrition in children, cut-off values for public health significance.

[4] Sudan, Um Baru Locality, SMART Survey final report, North darfur, Sudan, December 2025.

[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] Republic of Sudan National Nutrition Policy, 2009

[8] SPHERE Hand BOOK:- Management of malnutrition standard 2.2: Severe acute malnutrition

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

ABOUT IMPACT

IMPACT Initiatives is a Geneva based think-and-do-tank, created in 2010. IMPACT is a member of the ACTED Group.

IMPACT's teams implement assessment, monitoring & evaluation and organisational capacity-building programmes in direct partnership with aid actors. Headquartered in Geneva, IMPACT has an established field presence in over 15 countries. IMPACT's team is composed of over 300 staff, including 60 full-time international experts, as well as a roster of consultants, who are currently implementing over 50 programmes across Africa, Middle East and North Africa, Central and South-East Asia, and Eastern Europe

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