THE REPUBLIC OF SOUTH SUDAN

MINISTRY OF HEALTH

HEALTH SECTOR STRATEGIC PLAN 2023 - 2027

FOREWORD

The Government of the Republic of South Sudan is committed to the optimal health and wellbeing of all people living in South Sudan. This is expressed in a bold constitutional provision to provide free primary health care and emergency services for all citizens. Although, the more than two decades of liberation war weakened the health system in South Sudan and negatively impacted on the health status of the people, the government remains committed to delivering health care services to the population to attain the highest standards of health and wellbeing. To do so, the Ministry of Health embarked on development of the second health sector strategic plan (HSSP) 2023-2027 to implement the second phase of its National Health Policy 2016-2026.

The HSSP 2023-2027 articulates strategic approaches and interventions for health service delivery, health financing, health information systems, leadership and governance, human resources for health, and access to essential medicines to ensure improved health services. It draws its mandate, guiding principles and policy frameworks from the Constitution of the Republic of South Sudan (2011), South Sudan Vision 2040, Revised National Development Strategy 2021-2024, and the National Health Policy 2016-2026. It is cognizant of global health agenda, frameworks, and efforts such as Universal Health Coverage and health related Sustainable Development Goals, the Agenda for Sustainable Development, and Family Planning 2030, among others.

The development of this strategic plan was led by the Ministry of Health with inputs from all levels as well as from partners and key health sector stakeholders. The government envisages that implementation of the strategic plan shall strengthen South Sudan's health system to improve health outcomes and contribute to attainment of Universal Health Coverage. The successful implementation of this strategic plan and its monitoring and evaluation framework is contingent upon commitment of sufficient resources and inclusive engagement of all stakeholders at all levels of service delivery.

Finally, I urge all stakeholders to align their programs and financing with the strategic directions and priority health needs and interventions defined herein for efficient and effective use of resources. I am confident that the health sector and partners will do their best to realize the strategies, interventions and health outcomes spelled out in this strategic plan to contribute towards Universal Health Coverage, leaving no one behind for better health and wellbeing of the people of the Republic of South Sudan.

MINISTRY OF HEALTH
21 JUL 2023
MINISTER'S OFFICE
REPUBLIC OF SOUTH SUDAN

Hon. Yolanda Awel Deng Juach

Minister of Health
The Republic of South Sudan

ACKNOWLEDGEMENTS

The development of the South Sudan Health Sector Strategic Plan 2023-2027 has been a participatory process that was led by the Ministry of Health and involved the collective engagement of various stakeholders within the health sector. The engagement focused on policy dialogue on the current state of the health system, technical and operational issues affecting the sector, and the strategic approaches to improving performance. Strategic objectives and priorities were identified, and appropriate interventions were discussed and agreed upon, including the monitoring and evaluation framework and the resource requirements of the plan. The Ministry of Health would like to gratefully acknowledge the contribution and commitment of all the stakeholders who participated in this process.

The Directorate of Policy, Planning, Budgeting and Research at the Ministry of Health coordinated the development of this strategic plan, with the support of key health sector partners. We would like to recognize and applaud the excellent coordination and leadership provided by the Directorate, as well as the collaborative efforts by all other Ministry of Health technical officers in their respective Directorates for their active engagement and inputs throughout the HSSP 2023-2027 development. Special thanks also go to the State Ministries of Health, Members of the Parliamentary Committee on Health and Population, and the County Health Departments for their enriching contributions and perspectives during the consultative processes.

The Ministry of Health would like to acknowledge the technical and operational support from the World Health Organization, and the financial support from Global Affairs Canada and the European Union – WHO partnership for Universal Health Coverage whose contributions made development of the HSSP 2023-2027 possible.

We duly acknowledge all relevant government line ministries and institutions, United Nation's agencies, Non-Government Organizations – National and International, Civil Society Organizations, and the private sector for their valuable contributions at national and subnational levels towards the successful development of this HSSP 2023-2027.

21-07-23

MINISTRY OF HEALTH
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OFFICE OF THE UNDERSECRETARY
REPUBLIC OF SOUTH SUDAN

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AMR	Antimicrobial Resistance
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
BEmONC	Basic Emergency Obstetric and Newborn Care
BHI	Boma Health Initiative
BHT	Boma Health Teams
BHW	Boma Health Workers
BPHNS	Basic Package of Health and Nutrition Services
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHD	County Health Department
CHE	Current Health Expenditure
CMS	Central Medical Stores
CMSA	Central Medical Supplies Agency
CRVS	Civil Registration and Vital Statistics
COVID-19	Corona Virus Disease 2019
DFCA	Drug and Food Control Authority
DHIS2	District Health Information Software 2
DQA	Data Quality Assessment
EWARS	Early Warning, Alert and Response System
EOC	Emergency Operations Center
FSNMS	Food Security and Nutrition Monitoring System
FY	Financial/Fiscal Year
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPF	Health Pooled Fund
HPV	Human Papilloma Virus
HRH	Human Resources for Health
HRHIS	Human Resources for Health Information System
HSSC	Health Sector Steering Committee
HSPR	Health Sector Performance Review
HSSP	Health Sector Strategic Plan
HSTI	Health Science Training Institute
ICT	Information and Communications Technology
IDSR	Integrated Diseases Surveillance and Response
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IPC	Integrated food security Phase Classification
IPTp	Intermittent Preventive Treatment of malaria during pregnancy
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MDR/RR-TB	Multi-Drug Resistant/Rifampicin Resistant Tuberculosis
MIS	Malaria Indicator Survey
MoFP	Ministry of Finance and Planning
MPDSR	Maternal and Perinatal Death Surveillance and Response
NBTS	National Blood Transfusion Services
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organizations
NHP	National Health Policy
NTDs	Neglected Tropical Diseases
OPD	Outpatient Department
ORS	Oral Rehydration Solution
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PHCC	Primary Health Care Center
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public Private Partnership
PPPs	Purchasing Power Parities
R-ARCSS	Revitalized Agreement for the Resolution of the Conflict in the Republic of South Sudan
RMNCAHN	Reproductive, Maternal, New-born, Child, Adolescent Health & Nutrition
R-TGoNU	Revitalized Transitional Government of National Unity
SARA	Service Availability and Readiness Assessment
SBA	Skilled Birth Attendance
SBCC	Social and Behavior Change Communication
SDG	Sustainable Development Goals
SMoH	State Ministry of Health
SOPs	Standard Operating Procedures
TB	Tuberculosis
TGoNU	Transitional Government of National Unity
TTI	Transfusion Transmitted Infections
TWG	Technical Working Group
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

South Sudan's Constitution provides for the right to health care mandating all levels of government to "promote public health, establish, rehabilitate and develop basic medical and diagnostic institutions and provide free primary health care and emergency services for all citizens". This is the overarching framework upon which health care delivery hinges in South Sudan as elaborated in the country's National Health Policy 2016-2026 which envisions a healthy and productive population in South Sudan living a dignified life, with the mission to improve the health status of the people by effective delivery of the Basic Package of Health and Nutrition Services (BPHNS). The tenets of Universal Health Coverage (UHC) are central to the goal of the National Health Policy which is "A strengthened national health system and partnerships that overcome barriers to effective delivery of the BPHNS; and efficiently responds to quality and safety concerns of communities while protecting the people from impoverishment and social risk."

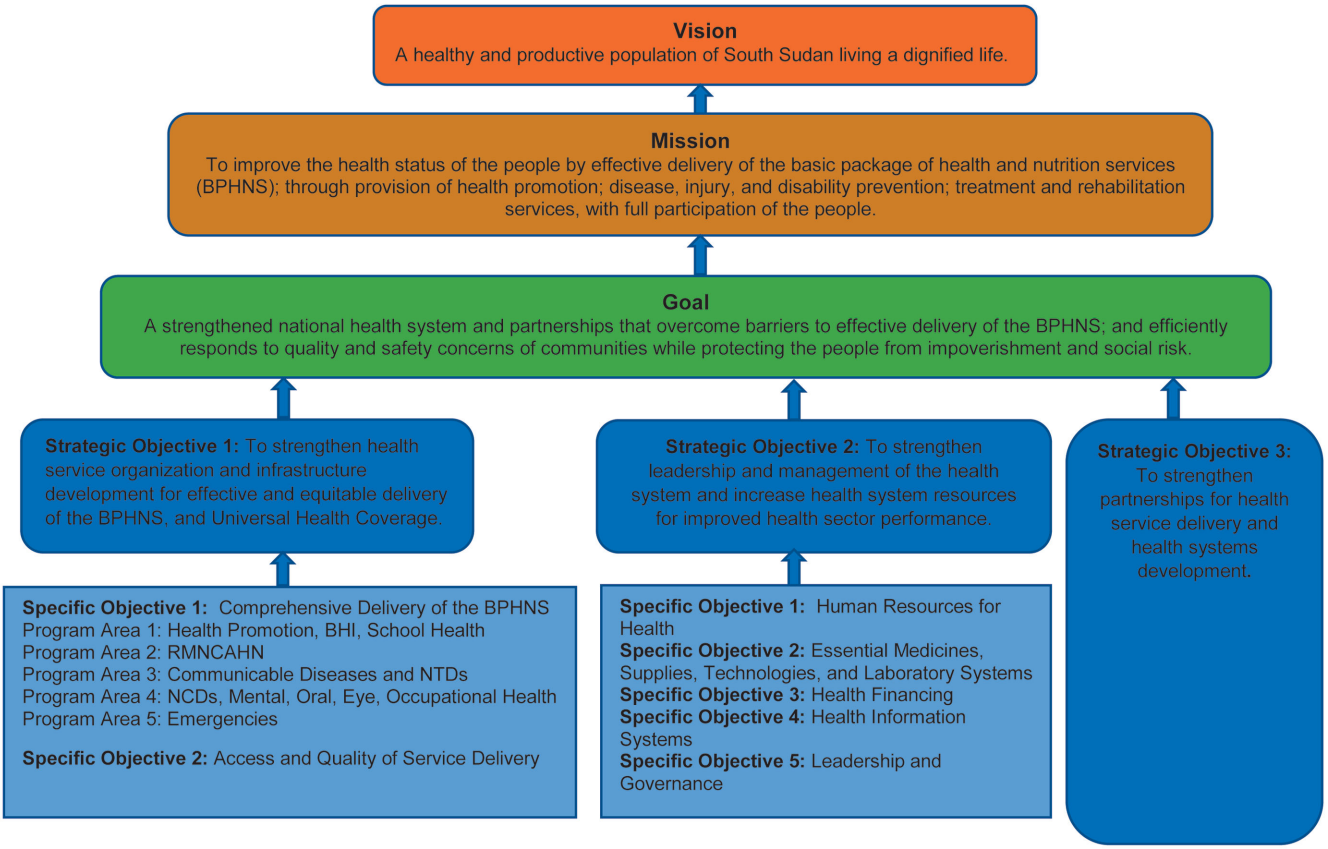
The National Health Policy provides for its implementation through two Health Sector Strategic Plans (HSSP); the first HSSP 2017-2022, and this second HSSP 2023-2027 which defines the strategic approaches, key interventions, monitoring and evaluation framework, resource requirements, and the implementation arrangements needed to guide the Ministry of Health and partners in strengthening the health system and delivering the BPHNS over the duration of the strategic plan. The HSSP 2023-2027 builds on the lessons learnt from implementation of the HSSP 2017-2022. The 2021 health sector performance review assessed performance of the HSSP 2017-2022 against a selected set of core indicators. The review showed that whilst there was some notable progress in 13 of the 52 (25%) key indicators assessed which achieved their HSSP targets; majority of indicators (39/52) did not achieve their targets. The review proposed key recommendations to address the challenges identified in the implementation of the HSSP 2023-2027 in order to improve the performance of the health sector. Those recommendations have contributed to shaping the priorities of this strategic plan, HSSP 2023-2027.

Additionally, the consultative process of developing this strategic plan which included national consultations with a wide range of stakeholders and sub-national consultations in all States and Administrative Areas including with County and Community teams, contextualized the situation analysis, and provided vital inputs in shaping the objectives, strategies, priority interventions, indicators, resource requirements, and implementation framework of this plan.

The Strategic Framework:

The HSSP 2023-2027 is organized into three Strategic Objectives (aligned to the National Health Policy 2016-2026 objectives): (i) To strengthen health service organization and infrastructure development for effective and equitable delivery of the Basic Package of Health and Nutrition Services; (ii) To strengthen leadership and

management of the health system and increase health system resources for improved health sector performance; and (iii) To strengthen partnerships for healthcare delivery and health systems development. There are seven specific objectives across Strategic Objectives one and two, and 32 objectives in total. For each objective, the strategies, key interventions, indicators, and targets are outlined in the plan.



Strategic Objective 1	**Comprehensive Delivery of the BPHNS**	*Program Area 1: Health Promotion, Boma Health Initiative (BHI) and School Health* 1. Address health inequities and social cultural barriers to healthcare access through health promotion 2. Strengthen and scale up implementation of the Boma Health Initiative 3. Ensure provision and utilization of school health services *Program Area 2: Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAHN)* 1. Enhance access to and utilization of sexual and reproductive health services, including adolescent health services 2. Ensure reduction in Maternal Mortality and Morbidity through provision of and utilization of comprehensive maternal health services 3. Ensure reduction in neonatal and childhood mortality through provision and utilization of high impact quality newborn and child health and nutrition services 4. Improve the nutritional status and reduce morbidity and mortality associated with malnutrition among the most vulnerable population *Program Area 3: Communicable Diseases and Neglected Tropical Diseases* 1. Ensure reduction in morbidity and mortality due to malaria towards pre-elimination levels 2. Ensure reduction in the incidence and prevalence of Tuberculosis 3. Ensure reduction in the incidence and prevalence of HIV/AIDS 4. Ensure reduction in the incidence, morbidity, and mortality due to Viral Hepatitis 5. Ensure reduction in the incidence, morbidity, and mortality due to Sexually Transmitted Infections 6. Ensure reduction in morbidity, disability, and mortality due to Neglected Tropical Diseases (NTDs) *Program Area 4: Non-Communicable Diseases, Mental, Oral, Eye, and Occupational Health* 1. Ensure reduction in morbidity and mortality due to Non-Communicable Diseases (NCDs) 2. Ensure reduction in the incidence and prevalence of mental health illness and substance abuse 3. Ensure provision and utilization of oral health care services 4. Ensure provision and utilization of eye care health services to reduce the burden of avoidable blindness 5. Ensure provision and utilization of occupational health services *Program Area 5: Emergencies*

		1. Ensure reduction in the incidence and mitigate the impact of public health emergencies
	Access and Quality of Service Delivery	1. Enhance equitable access to the BPHNS at all levels 2. Improve quality and safety for delivery of the BPHNS at all levels 3. Improve diagnostic capacity and referral services 4. Improve availability and functionality of health infrastructure for BPHNS delivery
Strategic Objective 2	**Human Resources for Health**	Scale up the production, strengthen management and development of the human resources for health required for effective delivery of the basic package of health and nutrition services
	Essential Medicines	1. Promote sustainable and equitable access to pharmaceuticals and related health technologies 2. Strengthen the national quality laboratory system that is safe and reliable for effective diagnostic services 3. Strengthen the national blood transfusion services to ensure access to safe and adequate blood supplies
	Health Financing	Ensure adequate and sustainable health financing for equitable access of essential health services by all South Sudanese without financial hardship
	Health Information Systems	1. Strengthen the generation, analysis and use of health data and information for evidence-based decision making at all levels 2. Strengthen monitoring and evaluation systems at all levels
	Leadership and Governance	Strengthen the leadership and governance role of the health sector at all levels for effective health system performance and development
S3	**Partnerships**	Strengthen partnership for health service delivery and health systems development

Monitoring and Evaluation:

Core indicators for measuring the performance of the selected interventions are defined, including their baseline data, and targets across the five years of the strategic plan, to move the country towards achievement of Universal Health Coverage. The Ministry of Health directorates and sub-national units will develop annual operational plans to implement the HSSP 2023-2027; and at each level, regular performance monitoring and review of the progress being made during the implementation of the plan will be conducted at different intervals – quarterly performance reviews, joint annual reviews, midterm reviews, and end-term evaluation of the HSSP 2023-2027.

Implementation Arrangements:

The implementation arrangements shall ensure that effective governance structures are established at each level, under the leadership of the Ministry of Health. At the national level, the Health Sector Steering Committee (HSSC), chaired by the Minister of Health, will meet on a quarterly basis, and will be responsible for high level tracking of implementation of the HSSP 2023-2027, advocacy, resource mobilization, awareness creation, and engagement with key stakeholders. Program technical working groups under the leadership of the respective Directors General will provide the technical oversight on joint planning, implementation, monitoring and evaluation of the HSSP 2023-2027 for each program area, and will provide relevant updates to the HSSC quarterly meetings. Sub-national level coordination forums shall be led by the State Ministry of Health and County Health Department as relevant. The sub-national levels shall extract priority strategic activities from the HSSP 2023-2027 to develop annual operational plans, whose implementation shall be monitored on a quarterly and annual basis.

Donors and partner agencies shall ensure they align to the HSSP 2023-2027 priorities and ensure that data and information generated at sub-national level for monitoring the implementation of the strategic plan, are reported in the national Health Management Information System (HMIS), and parallel reporting systems are

subsequently integrated into the HMIS. Other key stakeholders including private sector, civil society, academia, parliamentary health committee, and other government line Ministries, shall be engaged in the relevant coordination forums and their support enlisted in implementation of activities linked to their areas of expertise and mandate such as public-private-partnerships, research through academia, addressing socioeconomic determinants of health, climate change impact on health, as well as for advocacy e.g., for increased budgetary allocation to the health sector through the parliamentary health committee and Ministry of Finance.

The Ministry of Health will sign Compacts/Co-operation Agreements with partner agencies to ensure their alignment with and support towards the implementation of the HSSP at all levels of the health system; establish and strengthen the functionality of inter-sectoral/ministerial forums; and ensure public/community participation.

Financial Implications:

The OneHealth Tool was used for costing the HSSP 2023-2027. The tool costs interventions by health services/programs and by health system inputs. It also includes an impact module that reflects the impact/expected benefits of the intervention in terms of reduction in maternal mortality, neonatal mortality, child mortality and stunting rates and the estimated number of cases averted. Three scenario assumptions are defined: Scenario 1 (business as usual) assumes the country continues with the current coverage with minimal increment over the next five years; Scenario 2 (alternative) assumes scale up of interventions coverage up to 65%; while Scenario 3 (ambitious) assumes scale up of interventions coverage up to 90%.

	Cost by Year (USD)					Total Cost Year 1 - 5 (USD)	Average cost per Year (USD)	Cots per capita (USD)
	Year 1	Year 2	Year 3	Year 4	Year 5			
Scenario 1 (Business as Usual)	203,952,853	266,109,832	215,050,711	234,130,475	220,278,814	1,139,522,685	227,904,537	14
Scenario 2 (Alternative)	324,470,448	423,356,552	342,126,131	372,480,301	350,443,568	1,812,876,999	362,575,400	23
Scenario 3 (Ambitious)	449,266,775	586,185,995	473,713,104	515,741,955	485,229,556	2,510,137,384	502,027,477	31

Scenario 1, 2 and 3 have estimated total budgets of US$1.1 billion, US$1.8 billion, and US$2.5 billion, respectively. The average cost per year for scenario 1, 2 and 3 will be US$227 million, US$362 million, and US$502 million respectively which corresponds to a distribution of US$14, US$23, and US$31 per capita over the strategic plan period respectively. The most ambitious scenario saves a total of 67,396 lives over the duration of the HSSP, followed by the alternative scenario with 48,675 lives saved and finally the ‘business as usual’ scenario with 30,596 lives saved. An analysis of the proportion of total costs by program area had the highest proportions of the budget allocated to Infrastructure (17.94%), Essential medicines, supplies and technologies (15.08%), Reproductive, maternal, newborn and adolescent health (14.08%), Malaria (13.44%) and Nutrition (11.24%). In terms of

cost per life saved, the ambitious scenario appears to be the most advantageous, followed by the alternative scenario, with the ‘business as usual’ scenario being the least cost effective. The ambitious scenario reflects the reality of the needs, taking into consideration the current level of inflation, the average population growth rate, the level of resource mobilization, as well as the level of needs for rehabilitation and construction of health infrastructure.

The mapping of the available resources shows the potential availability of resources close to US$1.66 billion (for the five years) or an annual amount of US$332 million. This presents a funding gap of about US$847 million over 5 years, or about US$169 million per year against the ambitious scenario. Potential interventions to expand the fiscal space include favourable macroeconomic conditions with increased government budget allocation to health; innovative financing to increase the health sector's resources; improved efficiency in management of existing resources; and creation of a system for harmonizing and capturing the country’s own revenues at national and sub-national levels. These remain viable options to be explored over the strategic plan period to reduce the funding gap and ensure adequate resources are available for the effective implementation of the HSSP 2023-2027.

CHAPTER 1: BACKGROUND AND INTRODUCTION

1.1 Demographic, Socio-Economic and Political Context

The Republic of South Sudan is the world's youngest nation and became Africa's 55th country on July 9, 2011. Located in Eastern Africa, South Sudan is bordered by Sudan, Ethiopia, Kenya, Uganda, Democratic Republic of Congo, and Central African Republic. The country expands on an area of 644,329 square kilometres and has an estimated population of 14.2 million (51.1% male, 48.9% female), an annual population growth rate of 3.57%,[1] and total fertility rate of 4.5 (2020).[2] It has one of the youngest populations in the world with about 73.7% of the population below the age of 30 years.

The Country administratively comprises of 10 States namely, Northern Bahr el Ghazal, Western Bahr el Ghazal, Warrap, Lakes, Upper Nile, Unity, Jonglei, Central Equatoria, Eastern Equatoria, and Western Equatoria, and three Administrative Areas namely, Greater Pibor, Ruweng and Abyei. These are further subdivided into Counties and Payams, with the lowest administrative level being the Boma.

Most of the population lives in the rural areas, with only 17% living in urban areas.[3] Access to safe water and improved sanitation is estimated at 40% and 10%[4] respectively, whereas only 7.2% of the population has access to electricity.[5] Public infrastructure, such as roads and bridges are lacking in most parts of the country, compromising access to over 60% of the population during rainy seasons.[6] Many communities continue to remain at risk of disease outbreaks including waterborne diseases, given the poor access to safe water and improved sanitation, and the perennial flooding the country experiences.

Literacy rates are among the lowest in the world, estimated at 34.5% for those 15 years and older with higher literacy rates among males (40.3%) than females (28.9%).[7] From 2010 to 2020, the total net enrolment rate in primary, lower secondary, and upper secondary education were as low as 38%, 44% and 36% respectively. The country's human development index of 0.385 (2021), is the lowest in the world with a life expectancy of 55.0 years at birth, 5.5 expected years of schooling, 5.7 mean years of schooling, and gross national income per capita of 768 (2017 Purchasing Power Parity [PPP$]).[8]

Economy

South Sudan's economy relies heavily on exploiting natural resources particularly oil, which accounts for an estimated 90% of the total government revenue, 95% of total exports and more than half of the country's gross domestic product (GDP).[9] The

[1] South Sudan Population Projections, 2020-2040 https://nbs.gov.ss/wp-content/uploads/2022/05/Population-projections-for-South-Sudan-2020-2040.pdf
[2] World Bank https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=SS
[3] Southern Sudan Counts: Tables from the 5th Sudan Population and Housing Census, 2008. November 19, 2010
[4] Water, Sanitation and Hygiene (WASH) in South Sudan Briefing note. UNICEF (2021)
[5] World Bank. https://data.worldbank.org/indicator/EG.ELC.ACCS.ZS?locations=SS
[6] Government of the Republic of South Sudan. South Sudan Development Plan 2011–2013
[7] United Nations Educational, Scientific and Cultural Organization. South Sudan. Education and Literacy.
[8] United Nations Development Programme. Human Development Report 2021/2022
[9] African Development Bank Group, The Political Economy of South Sudan, 2018

GDP per capita in 2015 was US$ 1,071.78 and has been declining since 2013 when it was at its highest (US$ 1659.14).[10] The economy has been affected by the fluctuating oil prices, high inflation rates, conflict, the COVID-19 pandemic, and crises such as flooding, that have eroded the country's productive capacity; consequently, the economy is estimated to have contracted by an estimated 5.4% in the 2020/2021 financial year (FY). It is however, projected to grow in the subsequent financial years due to improving macroeconomic conditions and relative peace, although this outlook could be affected by various factors including bottlenecks in oil production, natural disasters like floods, and potential conflict.

The country has also battled with high inflation rates as well as a widening gap between the official and parallel currency exchange rates. The Bank of South Sudan is implementing an exchange rate policy reform as part of a wider reform process to facilitate macroeconomic stabilization, which has resulted in a reduction of the gap between the official and parallel currency exchange rates.[11]

With no formalized welfare system in the country, and most of the population living in rural areas and depending on land for their livelihoods, given the main source of livelihood for at least 85% of the population is crop, livestock, and fisheries production, most South Sudanese are economically vulnerable.[12,13] Poverty is overwhelming, estimated at 76.4% nationally (at the international poverty line of $1.90 per person per day in 2011 PPP), and large disparities in living standards exist across the country, with inherent income inequalities, given the country's Gini coefficient of 44.1.[14,15]

Nevertheless, it is hoped that the implementation of the 2018 Revitalized Agreement for Resolution of Conflict in South Sudan will be a key driver for the economy, with reduction of conflict in the county, allowing other non-oil sectors to register some growth. It remains critical that the country diversifies into non-oil revenue for a more stable economy.

Political Context

The civil conflict in December 2013 and July 2016, pushed back and slowed down the realization of peace and development that was hoped for after independence, following more than two decades of civil war. Negotiations between the dissenting parties after the 2013 conflict led to the signing of a peace agreement in August 2015, with the formation of a Transitional Government of National Unity (TGoNU). The 2016 conflict, however, undermined the peace agreement. In September 2018, the warring parties signed the Revitalized Agreement on the Resolution of the Conflict in the Republic of South Sudan (R-ARCSS) and on 22nd February 2020, the Revitalized Transitional Government of National Unity (R-TGoNU) was formed whose task was to implement the R-ARCSS within a transitional period of 36 months, leading up to a general election. On 4th August 2022, the parties to the peace agreement agreed to extend the transitional period for an additional 24 months.

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[10] World Bank Data. GDP. South Sudan https://data.worldbank.org/indicator/NY.GDP.PCAP.KD?locations=SS

[11] World Bank. South Sudan Economic Monitor - Towards a Jobs Agenda (English). Washington, D.C. : World Bank Group. http://documents.worldbank.org/curated/en/099650002152233681/P1737580e2efa4025093600b8be2b53aa10

[12] Food and Agriculture Organization of the United Nations. South Sudan Emergency Livelihood Response Programme. 2018. http://www.fao.org/3/i9646en/I9646EN.pdf

[13] Bertelsmann Stiftung, BTI 2022 Country Report — South Sudan. Gütersloh: Bertelsmann Stiftung, 2022

[14] World Bank. https://data.worldbank.org/indicator/SI.POV.GINI?locations=ZF-SS

[15] World Bank. https://databankfiles.worldbank.org/public/ddpext_download/poverty/987B9C90-CB9F-4D93-AE8C-50588BF00QA/AM2020/Global_POVEQ_SSD.pdf

The structure of the Executive of the R-TGoNU includes the President, First Vice-President, four Vice Presidents, the Council of Ministers and Deputy Ministers. The First Vice-President oversees the governance cluster, while the other four Vice-Presidents each oversee one of the following clusters: Economy; Services; Gender and Youth; and Infrastructure. The Legislature is constituted by the Transitional National Legislative Assembly and the Council of States. The Judiciary is independent and subscribes to the principle of separation of powers and the supremacy of the rule of law.[16]

The mandate of the R-TGoNU includes restoring permanent and sustainable peace, reforming the civil service, and rebuilding the country's infrastructures. Although civic participation in governance is still low, this is being strengthened through partner support.[17] The decentralized nature of governance also facilitates more public participation at subnational level.

The R-TGoNU at the national and subnational level grapples with institutionalization of accountable governance and improvement of service delivery due to the inadequate human resource and management capacities as well as weak accountability systems. This is compounded by the poor macro-economic situation and high poverty rates. However, it is envisaged that the restoration of peace and the decentralized system of governance, will provide an opportunity for revenue generation, strengthening public financial management, and accountability. Peace and security are "prerequisites" for sustainable development.

1.2 Policy Context

Health is an outcome of sustainable development, as outlined in the sustainable development goal (SDG) 3 which is to 'Ensure healthy lives and promote well-being for all at all ages'. The 2019 SDG summit called on countries to mainstream the 2030 SDG Agenda into national planning instruments, policies, strategies, and financial frameworks.[18,19] As such, the republic of South Sudan has developed several national policies and strategies that mainstream the SDGs including other relevant global and regional frameworks and commitments.

The Health Sector Strategic Plan (HSSP) 2023-2027, was developed cognizant of existing global, regional, and national frameworks and commitments, which have helped to shape the priorities of the plan. It implements the second phase of the National Health Policy (NHP) 2016-2026, and defines the strategic approaches, key interventions, monitoring and evaluation framework, resource requirements, and the implementation arrangements to guide the Ministry of Health and partners in strengthening the health system and delivering quality, people-centered, and integrated health services to the people of South Sudan for the next five years (2023-2027). Some of the global, regional, and national frameworks and commitments to which the HSSP 2023-2027 aligns to are outlined below.

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[16] The Transitional Government of National Unity. The Revitalized Agreement on the Resolution of the Conflict in the Republic of South Sudan (Revitalized ARCSS). 12 September 2018.

[17] https://www.ss.undp.org/content/south_sudan/en/home/projects/support-to-democracy-and-participation.html

[18] UN General Assembly. A/RES/74/4 Political declaration of the high-level political forum on sustainable development convened under the auspices of the General Assembly

[19] https://sdgs.un.org/topics/national-sustainable-development-strategies

1.2.1 Global

South Sudan is a signatory to the following global commitments that inform and contribute to shaping the priorities of the country's national polices and strategies including this Health Sector Strategic Plan 2023-2027.

1. **The 2030 Agenda for Sustainable Development** – Adopted in 2015 with its 17 goals and 169 targets, SDG goal 3 specifically address good health and wellbeing, and targets by 2030 to: reduce maternal, neonatal and child mortality; end epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases, and combat other communicable diseases; reduce premature mortality from non-communicable diseases, and promote mental health and well-being; strengthen the prevention and treatment of substance abuse; reduce global deaths and injuries from road traffic accidents; ensure universal access to sexual and reproductive health-care services; achieve universal health coverage; and, reduce the number of deaths and illnesses due to environmental contaminants.
2. **International Health Regulations (2005)** – Provides the legal framework for coordinated and collective action for global public health security and requires the country to implement key actions 'to prevent, protect against, control, and provide a public health response to the international spread of disease and this includes strengthening core surveillance and response capacities.
3. **Paris Declaration on Aid Effectiveness (2005)** – Provides a roadmap for the country to implement specific measures to improve the quality of aid and its impact on development focusing on country ownership, donor alignment, harmonization, measurable results, and mutual accountability.
4. **Innocenti Declaration (2005)** – Calls on governments, manufacturers, Non-Governmental Organizations (NGOs), multilateral and bilateral organizations and financial institutions to adhere to their responsibilities to promote healthy infant and young child feeding practices including the promotion of breastfeeding.
5. **The Accra Agenda for Action (2008)** – Calls for improved country ownership in development processes through wider participation in policy formulation, stronger leadership on aid co-ordination and more use of country systems for aid delivery; inclusive partnerships with civil society participation; delivering results that have real and measurable impact; as well as building country management capacity.
6. **Busan Partnership for Effective Development Cooperation (2011) –** Highlights a set of common principles for all development actors that are key to making development cooperation effective; these include ownership of development priorities by developing counties, a focus on results, partnerships for development, and transparency and shared responsibility. It encourages the use of country public financial management systems for development financing; emphasizes on the role of aid as a complement to other sources of development financing and proposes domestic resources be mobilized to increase government resources, national institutions to be strengthened, and stronger relationships established between development co-operation and the private sector.
7. **The New Deal for Engagement in Fragile States (2011) –** Proposes key peacebuilding and state building goals, focuses on new ways of engaging to support inclusive country-led and country-owned transitions out of fragility, and identifies commitments to build mutual trust and achieve better results in fragile states.
8. **Global Nutrition Targets (2025) –** In May 2012, the 65th World Health Assembly (WHA) endorsed a Comprehensive Implementation Plan on Maternal, Infant and

Young Child Nutrition that included six global targets: reducing stunting and wasting in children under five years, halting the epidemic of obesity, reducing anaemia in women of reproductive age, reducing low birth weight, and increasing the rate of exclusive breastfeeding. Global targets were established to identify priority areas, inspire ambition at country level and develop accountability frameworks.

9. **Addis Ababa Action Agenda (2015) –** Adopted and endorsed in 2015, it provides a global framework through a comprehensive set of policy actions, to finance sustainable development by aligning all financing flows and policies with economic, social, and environmental priorities, establishing a strong foundation to support the implementation of the 2030 Agenda for Sustainable Development.
10. **Kigali Declaration on Neglected Tropical Diseases (2022)** – Commits to the achievement of the SDG 3 target on NTDs and to the delivery of the WHO 2030 NTD road map by adopting people-centred approaches and working across sectors, to eradicate two diseases (dracunculiasis and yaws), eliminate at least one disease in 100 countries, and decrease the number of people requiring interventions for Neglected Tropical Diseases by 90%.
11. **Nutrition for Growth (N4G)** is a global pledging moment to drive greater action toward ending malnutrition and helping ensure everyone, everywhere can reach their full potential. N4G delivers much-needed action on policy and financing commitments to SDG 2 – Ending Hunger in All its Forms – which is an underlying driver of 12 of the 17 SDGs.

1.2.2 Regional

In addition to the global commitments, South Sudan aligns to the following regional commitments, which guide its health sector priorities:

1. **Abuja Declaration on HIV/AIDS, Tuberculosis, and other related infections diseases (2001)** – Committed African Union member States to strengthen the response to AIDS, Tuberculosis (TB) and Malaria, and to allocate at least 15% of their annual national budgets to health. In the **Abuja+12 Declaration (2013),** further commitments were made to effectively tackle the HIV epidemic on the continent, focusing on ownership, accountability, and sustainability.
2. **Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (2008)** – Calls on Member States to update their national health policies and plans according to the Primary Health Care approach, with a view to strengthening health systems.
3. **Common African Position on the Post 2015 Agenda (2014)** – Focuses on achieving universal and equitable access to quality health care and comprehensive sexual reproductive health rights for vulnerable populations, by addressing communicable and non-communicable diseases, reducing malnutrition, improving hygiene and sanitation, and strengthening health systems.
4. **Addis Declaration on Immunization (2016)** – Committed to continued investment in immunization programs for universal access to immunization as a cornerstone for health in Africa.

5. **Abidjan Declaration (2022)** – Committed to strengthening resilience in nutrition and food security on the African continent, to end malnutrition in all its forms, build strong partnerships to accelerate progress on nutrition and food security, including strengthening legislative, regulatory and normative frameworks for nutrition.
6. **Treaty for the Establishment of East African Community (2007)** – Article 118 of the treaty mandates partner States to cooperate around health issues, and to develop policies for the region, taking joint action towards the prevention and control of communicable and non-communicable diseases, promoting the management of health delivery systems, developing a common drug policy and drug registration procedures, harmonising national health policies and regulations to achieve quality health, co-operating in promoting research and in the development of specialised health training, promoting the development of good nutritional standards, and developing a common approach on the control and eradication of illicit or banned drugs.

1.2.3 National

South Sudan's Constitution of 2011 provides for the right to health care mandating all levels of government to "promote public health, establish, rehabilitate and develop basic medical and diagnostic institutions and provide free primary health care and emergency services for all citizens". This is the overarching framework upon which health care delivery hinges in South Sudan, guiding development of relevant country policies, plans, and strategies that address the health sector. Currently, the Revised National Development Strategy 2021-2024, and the National Health Policy 2016-2026 are the key national documents guiding the priorities of the HSSP 2023-2027.

1. **Revised National Development Strategy 2021-2024** – The South Sudan National Development Strategy 2018-2021 was revised by the transitional government as required to align to the peace agreement. It outlines the goal of the social sector as, to 'Increase support for human capital development and protect the vulnerable population, to leave no one behind' through providing affordable health care by establishing health provision hierarchy from primary health to critical care, investing in infrastructure, and developing the health workforce; expanding on the provision of social safety nets; and strengthening human and institutional capacity for efficient and effective social services.
2. **National Health Policy (NHP) 2016-2026 –** Defines the Government of South Sudan's vision and policy directions for the health of its citizens and provides the foundation and guidance for the strategic approaches to implement these policies. Its three main policy objectives are: (i) To strengthen health service organization and infrastructure development for effective and equitable delivery of the Basic Package of Health and Nutrition Services and Universal Health Coverage; (ii) To strengthen leadership and management of the health system and increase health system resources for improved health sector performance; and (iii) To strengthen partnerships for healthcare delivery and health systems development. The NHP 2016-2026 is being implemented through two five-year strategic plans: the first five-year HSSP 2017-2022, and this second HSSP 2023-2027.

1.3 HSSP 2023-2027 Development Process

In addition to the above frameworks and commitments that guided the prioritization process for the HSSP 2023-2027, extensive, inclusive and participatory consultations at national and sub-national levels were conducted as part of the HSSP 2023-2027 development process, involving a wide range of stakeholders including Government, Donors, United Nations agencies, Non-Governmental Organizations, Professional Associations, Academia, Private Sector, Civil Society Organizations and Community representatives. These consultations contributed to the situation analysis process, identification of the strategies and key interventions, which were further concretized during a national stakeholder workshop where the monitoring and evaluation framework and the costing of the proposed interventions were also agreed upon. The process of developing and drafting the HSSP 2023-2027 was led by the Directorate of Policy, Planning, Budgeting and Research at the Ministry of Health (MoH) with inputs from other MoH directorates and technical support from the World Health Organization. The draft HSSP 2023-2027 was then reviewed by relevant stakeholders and inputs incorporated to produce the final HSSP 2023-2027 document.

CHAPTER 2: SITUATION ANALYSIS

2.1 Introduction

The review of the performance of the last strategic plan (HSSP 2017-2022) which was conducted in 2021 (covering the period from 2017 to June 2021), provided an analysis of the health sector performance by policy objective and strategic area. Findings from the review, in addition to the consultative processes that were conducted at the subnational and national levels during the development of this strategic plan, provide the basis for the situation analysis and the evidence informing the strategic approaches and interventions prioritized in this strategic plan.

The 2021 health sector performance review showed that whilst there was some notable progress in 13 of the 52 (25%) key indicators assessed which achieved their HSSP targets; majority of indicators (39/52) did not achieve their targets. The review proposed key recommendations to address the challenges identified in the implementation of the HSSP 2017-2022 in order to improve the performance of the health sector. Those recommendations have contributed to shaping the priorities of this strategic plan, HSSP 2023-2027.

At the impact level, South Sudan's life expectancy at birth (55 years) is among the lowest globally, as mortality rates remain among the highest with neonatal, infant, under-five mortality rates estimated at 39.63, 63.76 and 98.69 deaths per 1000 live births respectively, and a maternal mortality ratio of 1,223 deaths per 100,000 live births. Although some disease specific mortality rates such as TB and AIDS-related mortality have declined, mortality due to malaria and non-communicable diseases have increased over the past five years.

The main causes of morbidity remain communicable diseases; malaria, is the top cause of morbidity (64%) and mortality (45%) among outpatients, followed by pneumonia and diarrhea.[20] Several Counties report malaria cases above the threshold perennially especially during the rainy seasons, affecting mainly children under five years. The last malaria indicator survey (2017) estimated malaria prevalence of 32%, 34% and 18% among children under-five, protection of civilian's sites, and internally displaced persons, respectively.[21]

Non-communicable diseases are on the rise particularly hypertension and diabetes, which account for 44% and 24% of the five tracer indicators seen in out-patient departments (OPDs) across the country.[22]

Malnutrition remains a persistent problem in the country, adversely affecting the well-being of women and children. Today, one in every five children in South Sudan suffers from wasting and requires lifesaving nutrition interventions.[23] While the exclusive breastfeeding rate has improved from 45% in 2010 to 62% in 2022, only

[20] MoH and WHO, South Sudan Integrated Disease Surveillance and Response (IDSR) Epidemiological Bulletin Week 35 of 2020 (August 24 – August 30)
[21] South Sudan Malaria Information Survey, Presentation of Draft Results, January 2019
[22] Health Sector Performance Review Report, 2021
[23] FSNMS Round 27

9% of the children have access to the minimum acceptable diet for optimal growth and development.[24]

Determinants of health such as income, education level, access to safe water and sanitation, cultural beliefs, housing conditions, and political instability/conflict in some locations, affect health seeking behaviors, access to quality health services, and therefore the health status of the population.

The decades of conflict the country experienced prior to its independence, undermined the health system capacity to deliver essential health services and eroded the health security capabilities, resulting in a weak health system prone to acute events and shocks. The health system is characterized by inadequate health sector financing, sub-optimal coordination, low health workforce density, weak supply chain management with frequent stockout of supplies, and a weak health information system. Recurrent humanitarian crises such as conflict, seasonal flooding and health emergencies including disease outbreaks and the COVID-19 pandemic in 2020, further strained the already weak health system, exacerbating inequities and access to quality essential health services. These findings, reflect the weak state of the health system in the country, and the need for a more strategic and focused approach to improve health sector performance within the stipulated period of the HSSP 2023-2027.

2.2 Health Impact Trends

The dismal performance of health service delivery in the past five years, has affected the overall health status of the population over time resulting in relatively low achievement at the impact level. As no population-wide surveys have been conducted since the Sudan household health survey of 2010, trends in performance against most of the impact indicators are based on global estimates and projections.

Mortality by age and sex:

- *Life expectancy at birth* is among the lowest in the world, estimated at 55.48 years (2020) a decline from 55.95 years in 2018, with females having higher life expectancy (57 years) than males (54 years).[25]
- *Adult mortality rate between 15 and 60 years of age* for South Sudan has gradually declined since its independence in 2011 from an estimated 348.5 deaths per 1000 population to an estimated 321.4 deaths per 1000 population in 2016, with males having a higher mortality rate (335.2) than females (307.8).[26]
- *Neonatal mortality rate,* which is the highest globally, estimated at 39.63 deaths per 1000 live births in 2021, showed minimal gradual decline from 39.88 in 2017.[27]
- *Infant mortality rate* estimate, which is among the highest in the world, remained at 63.76 deaths per 1000 live births from 2017 to 2021.

[24] FSNMS Round 27
[25] World Bank. https://data.worldbank.org/indicator/SP.DYN.LE00.MA.IN?locations=SS
[26] World Health Organization Global Health Observatory Data
[27] UN Inter-agency Group for Child Mortality Estimation. https://childmortality.org/data/South%20Sudan

- *Under-five mortality rate* also among the highest globally, remained at 98.69 deaths per 1000 live births from 2017 to 2021.

Mortality by cause:

- *Maternal mortality ratio* has significantly reduced since the 2006 Sudan household health survey when it was estimated at 2,054 deaths per 100,000 live births.[28] It is currently estimated to stand at 1,223 deaths per 100,000 live births (2020), which is the highest maternal mortality ratio globally.[29]
- *TB mortality rate (among HIV-negative people)* has declined from 53 to 28 deaths per 100,000 population between 2017 and 2021, similarly estimated *AIDS-related deaths* declined from 8900 (2017) to 7553 (2022);[30] both improvements as a result of expanded access to TB treatment and antiretroviral therapy (ART) and a declining incidence of TB and HIV infections.
- *Malaria mortality rate* is estimated to have increased to 66.39 deaths per 100,000 population in 2020, from 65.59 in 2017.
- *Non-communicable diseases (NCDs) age-standardized mortality rate* similarly increased from an estimated 467.1 to 481.1 per 100,000 population, between 2017 and 2019.[31]

Morbidity:

- *HIV prevalence rate* among adults aged 15 to 49 years is estimated to have decreased from 2.2% in 2017 to 1.94% in 2022 with the prevalence estimated to be higher in women (2.47%) than men (1.41%); whereas the *HIV incidence* per 1000 population (adults 15 to 49 years) is estimated at 1.3 (2022), a reduction from 1.5 in 2017.[32]
- *Incidence of tuberculosis* has been estimated at 227 per 100,000 population per year over the last five years.[33]
- *Malaria incidence* estimated at 286.9 new cases per 1000 population at risk each year (2020), has been gradually increasing since 2017 when it was 277.8.

Malnutrition

- *Wasting* levels remain high at 16.1%, which is above the WHO emergency threshold of 15%.[34] Whereas S*tunting* levels have reduced from 31% in 2010 to 16.3% in 2020.

[28] Sudan Household Health Survey (SHHS) 2006
[29] Trends in maternal mortality 2000 to 2020: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA. 2023
[30] WHO Global Health Observatory
[31] WHO Global Health Observatory
[32] South Sudan 2022 HIV Estimates
[33] WHO Global Health Observatory
[34] FNMS Round 27

Fertility:

- *Total fertility rate* has been declining from an estimated 5.3 births per woman (2011) to 4.5 births per woman in 2020.[35]
- *Adolescent fertility rate (births per 1000 women ages 15-19 years)* has also declined from an estimated 82 births per 1000 women (2011) to 54 births per 1000 women in 2020.[36]

2.3 Health Outcomes: The State of Universal Health Coverage Services

Universal health coverage (UHC) means that all people have access to the full range of quality health services they need (health promotion, prevention, treatment, rehabilitation, and palliative care), when and where they need them, without suffering financial hardship. South Sudan's UHC service coverage index (SDG 3.8.1) of 32 (2019 estimate) is the second lowest globally (after Somalia's of 27) far below the global average of 67, and its catastrophic health expenditure as measured by the proportion of the population with household spending on health greater than 10% of total household budget stands at 13.4% (2017 estimate).[37] This highlights the current state of inadequate access to quality health services, inherent inequities, low coverage of essential health services in the country, and financial hardship in accessing care.

2.3.1 State of health along the age cohorts

The Ministry of Health promotes a life course approach to health service delivery for all age cohorts, towards achieving UHC, through the directorates of reproductive health, primary health care, and medical services, although elderly/geriatric medicine is not yet well established in the country.

Reproductive, maternal, and newborn health services

These are provided as a component of the basic package of health and nutrition services. Assessment on the progress made in the delivery of reproductive, maternal, and newborn health services, are based on the following key performance indicators:

Family planning services: Contraceptive prevalence rate (any method) among all women aged 15-49 years is estimated at 6%, slightly higher (8%) in married/in-union women, whereas the unmet need for family planning stands at 20% among all women (28% in married/in-union women) and the proportion of demand for family planning satisfied with modern methods is only 21%.[38]

[35] World Bank. https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=SS
[36] World Bank https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=SS
[37] Data Source: WHO Health Financing Progress Matrix: Background Indicators: https://www.who.int/teams/health-systems-governance-and-financing/health-financing/hfpm-background-indicators
[38] United Nations Population Fund, Data 2022: South Sudan https://www.unfpa.org/data/world-population/SS

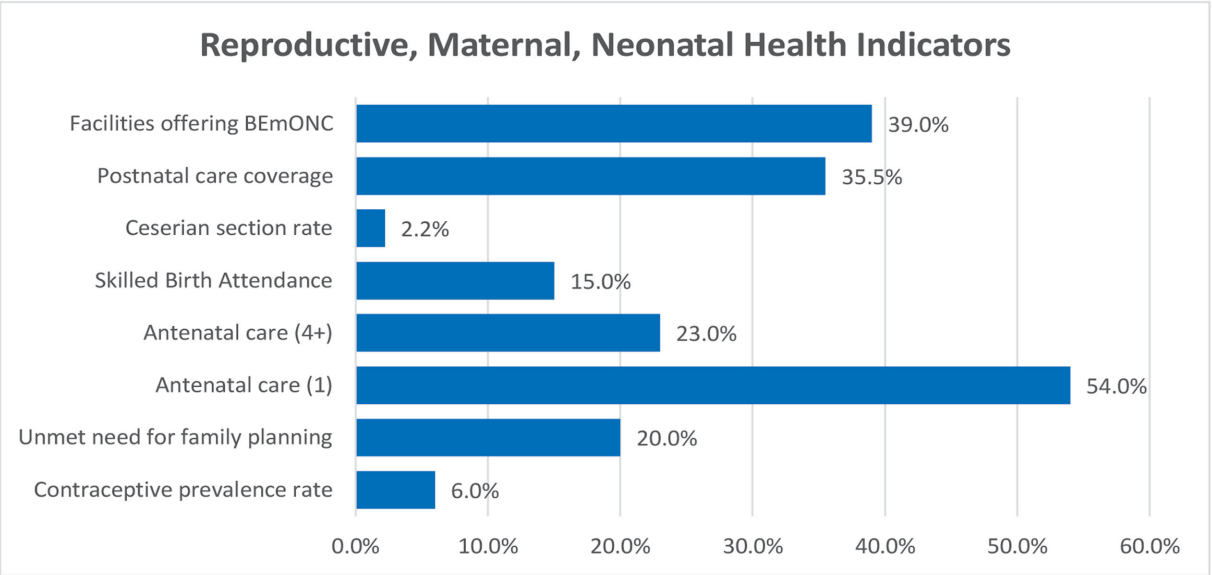


Figure 1: Summary of selected reproductive, maternal, and newborn health indicators

Antenatal care (ANC4+) coverage has declined from an estimated 25% in 2017 (HSPR 2021 report) to 23% by the end of 2021 (47% reporting rate, DHIS2), whereas ANC1+ coverage stands at 54% (2021), a significant drop-out rate from ANC1+ to ANC4+, indicating poor utilization of the service, which also makes timely detection and management of pregnancy related complications challenging.

Skilled Birth Attendance (SBA) coverage has remained below 20% (18% in 2019, 13% in 2020, and 15% by the end of 2021) with marked disparities noted between States.

Postnatal care coverage data based on the DHIS2 records low coverage of 31.7% in 2020, and 35.5% in 2021.

Caesarean section rate is estimated at 2.2%[39] much lower than the globally acceptable rate of 10-15%. The *proportion of health facilities providing Comprehensive Emergency Obstetric and Newborn Care (CEmONC)* is estimated at only 3% (5% of facilities offer caesarian section and 4% blood transfusion services), whereas *Basic Emergency Obstetric and Newborn Care (BEmONC)* is only offered in 39% of health facilities,[40] indicating the dire situation of access to life-saving interventions to treat major obstetric and newborn causes of morbidity and mortality.

Child Health and Nutrition

Child mortality and morbidity remains high in South Sudan, with pneumonia, diarrhea, malaria, and measles being the major causes of morbidity in children under five years.[41] Malnutrition continues to be a key contributor to the poor health status of children under five years. A summary of the key indicators for both child health and nutrition are summarized in **table 1**.

[39] Health Sector Performance Review Report, 2021, Republic of South Sudan
[40] Service Availability and Readiness Assessment (SARA), 2018, Republic of South Sudan
[41] Basic Package of Health and Nutrition Services, 2019, South Sudan

Indicator	Value	Source
Children Under 5 years who are wasted	16.1%	Food Security and Nutrition Monitoring System (FSNMS) Round 27
Children Under 5 years who are stunted	16.3%	FSNMS Round 26
Exclusive breastfeeding <6months	62%	FSNMS Round 27
Initiation of breastfeeding within the first hour	77.2%	FSNMS Round 26
Minimum acceptable diet for children 6-23 months	9%	FSNMS Round 27
Deworming 12-59 months	63%	FSNMS Round 26
Vitamin A supplementation 6-59 months	84%	FSNMS Round 27
Coverage of diarrhea treatment	79%	SARA 2018
Children aged < 5 years with pneumonia symptoms taken to a health facility	47%	Sudan Household Health Survey 2010
Fully immunized child	18.9%	EPI coverage survey 2017
Measles vaccination coverage	83%	Official coverage estimates 2021
Pentavalent 3	83%	Official coverage estimates 2021

Table 1: Summary of selected child health and nutrition indicators

Immunization coverage with Pentavalent 3 has been improving based on the official coverage data from 49% in 2018 to 83% in 2021;[42] however, WHO/UNICEF estimates put the current coverage at only 49% (**figure 2**). Data quality is a key contributor to the marked differences seen between the different data sources, particularly the administrative coverage estimates. Similarly, Measles vaccination coverage with at least one dose was estimated at 83% in 2021 (official coverage estimates). Fully immunized child coverage is estimated as 18.9% from the 2017 EPI coverage survey.[43]

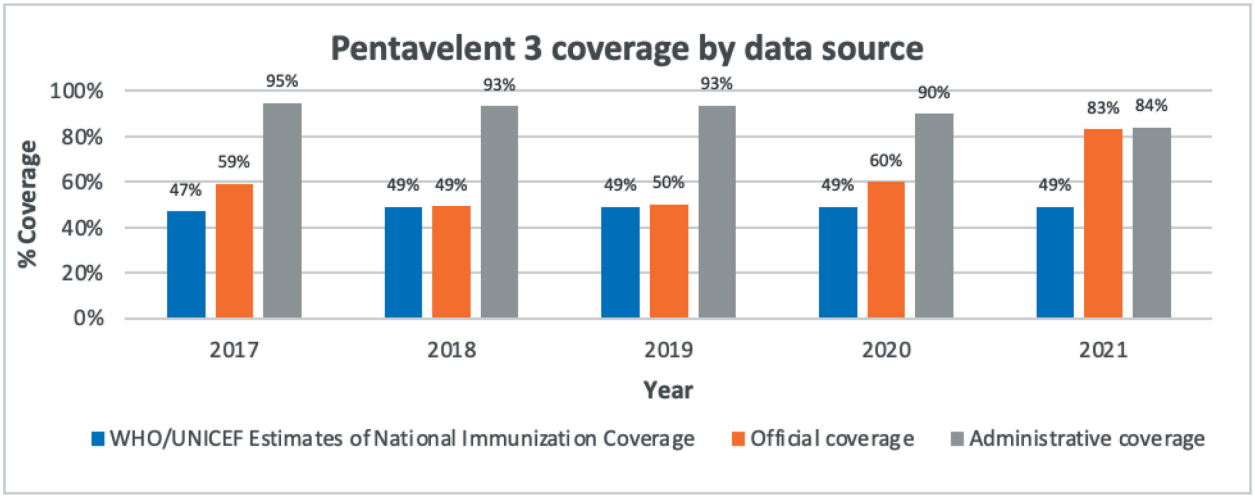


Figure 2: Pentavalent 3 coverage - WHO-UNICEF estimates, official coverage, and administrative coverage

[42] http://immunizationdata.who.int/pages/coverage/dtp.html?CODE=AFR&ANTIGEN=DTPCV3&YEAR=&ADVANCED_GROUPINGS=Least%20developed

[43] South Sudan National Immunization Coverage Survey Final Report 2017

Care seeking for symptoms of pneumonia data dates to the last household survey in 2010, where it was estimated at 47%, whereas the proportion of children with diarrhea receiving oral rehydration solution (coverage of diarrhea treatment) improved significantly from 38.6% in 2010 to 79% in 2018 (SARA).

Vitamin A supplementation coverage is estimated at 84% percent for children 6-59 months, whereas deworming is estimated at 63% for children 12-59 months which is below the recommended threshold of >80% for adequate impact of public health importance.[44]

Nutrition Status: Exclusive breastfeeding rate for infants 0-5 months of age is estimated at 62%, whilst early initiation of breastfeeding (within the first hour) is estimated at 77.2%. The global acute malnutrition (GAM) rate (children under 5 years who are wasted) estimated at 16.1% is above the WHO emergency threshold of 15%, although it has been declining from 18.1% in 2016.[45] The prevalence of stunting is estimated at 16.3%, and severe stunting at 3.9 percent. Stunting rates between 10 to <20% are considered of medium public health significance based on WHO classification for stunting.[46]

Adolescents

Adolescent and youth friendly services are being established in health facilities across the country, as young people are empowered to have access to sexual and reproductive health and rights in all contexts. However, there is still resistance among some communities regarding access to contraceptives by adolescents particularly girls who are not yet married. Adolescent fertility rate (births per 1000 women ages 15-19 years) is estimated at 54 births per 1000 women (2020).[47] Girl child marriages are still a problem in South Sudan; the proportion of women aged 20-24 years who were married or in union by age 15 years is estimated to be 9%.[48] The probability of dying among adolescents aged 10-14 years and those 15-24 years (per 1000 population) is estimated at 8.3 and 15.3 respectively, which are among the highest in the world.[49] To be able to grow, thrive and survive, adolescents need age-appropriate comprehensive education; opportunities to develop life skills; health services that are acceptable, equitable, appropriate, and effective; and safe and supportive environments.

While adolescence is a critical period of physical growth and for improving nutrition status of adolescent children, there is lack of information about the nutritional status of this group in the country. There is need for deliberate efforts to assess the nutrition situation among adolescent and invest in health and nutrition interventions targeting adolescents' children.

[44] Food Security and Nutrition Monitoring System, South Sudan, round 26 Report
[45] Food Security and Nutrition Monitoring System, South Sudan, round 26 Report
[46] Food Security and Nutrition Monitoring System, South Sudan, round 25 Report
[47] World Bank https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=SS
[48] WHO Global Health Observatory
[49] World Bank, 2020 data

Adults and Elderly

Adult health indicators are covered in subsequent sections under communicable and non-communicable diseases. Data is currently not disaggregated to monitor health indicators for the elderly; furthermore, health services targeted towards addressing the needs of the elderly are not yet established in the country.

2.3.2 State of prevention and control of communicable diseases

Communicable diseases remain a major public health problem in South Sudan, with malaria, pneumonia, and diarrhea accounting for about 77% of outpatient cases in under five years children. Other infections including measles, cholera and meningitis are common causes of outbreaks in the country. HIV and TB prevalence and incidence remain high, and South Sudan is still home to most neglected tropical diseases.

Malaria remains the leading cause of morbidity and mortality with a gradually increasing incidence in the country from 277.8 cases per 1000 population at risk in 2017 to an estimated 286.9 cases per 1000 population at risk in 2020. Mortality from malaria has also increased from 65.59 deaths per 100,000 population in 2017 to an estimated 66.39 deaths per 100,000 population in 2020.

The last malaria indicator survey was conducted in 2017 and gave an Insecticide Treated Net (ITN) coverage of 39%. However, the 2022 world malaria report estimates the current proportion of population with access to an ITN as 59.3%, an improvement over the years, but still low coverage of this important preventive intervention. Additionally, the number of people protected by Indoor Residual Spraying (IRS) is estimated at only 263,856. The number of malaria cases treated with Artemisinin-based combination therapies (ACT) increased from previous years to an estimated 1,618,709 (**table 2**).[50]

Although data on malaria is being captured in the DHIS2, data quality is poor and incomplete, limiting effective monitoring of progress made on malaria control. The 2018 SARA survey indicated high availability of malaria services (95%) in the country, however, only 6% of facilities assessed had all malaria service tracer items. Facilities assessed had on average 49% of malaria service tracer items. Malaria diagnosis by microscopy was the least commonly offered service, with only 18% of facilities offering it. Thus, significant gaps still exist in malaria service delivery and effective implementation of preventive interventions to address this leading cause of morbidity and mortality in the country.

	2019	2020	2021
Number of LLINs distributed	713,717	4,273,6441	1,685,771
Modelled % of population with access to an ITN	33.6	52.5	59.3
Number of people protected by IRS	344,242	-	263,856
Number of Rapid Diagnostic Tests distributed	-	280,150	-
Any first line treatment courses distributed (including ACT)	4,308,214	220,548	1,618,709*
Number of malaria cases treated with any first-line treatment courses (including ACT)	122,665	822,563	1,618,709
ACT treatment courses delivered	4,308,214	195,878	1,618,709*
Number of malaria cases treated with ACT	122,665	822,563	1,618,709

Table 2: Commodities and distribution coverage 2019-2021 (World Malaria Report, 2022)

[50] World malaria report 2022. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO

HIV prevalence rate among adults aged 15 to 49 years is estimated at 1.94%, higher in females (2.47%) than males (1.41%), and the HIV incidence is estimated at 1.3 per 1000 uninfected population among the age group 15-49 years (and 0.79 per 1000 uninfected population among all ages).[51] According to the 2022 Antenatal Care (ANC) Sentinel Surveillance Survey, HIV prevalence amongst women attending ANC was highest in Western Equatoria and Unity States, at 6.0% and 5.9% respectively, and lowest in Northern Bahr el Ghazel and Warrap states.[52] HIV prevalence is reportedly higher in key populations, such as among sex-workers where a survey conducted in 2019 among 605 sex workers in Yambio, found a 13.6% prevalence rate. Other sources (UNAIDS) estimate the prevalence among sex-workers at 16%, with some key statistics in this group being, 76.3% HIV testing and status awareness, 75.3% ART coverage, and 43.7% condom use.

In 2022, it was estimated that there are 164,450 people living with HIV (PLHIV), 13,978 (8.5%) of whom are children (0-14 years), and approximately 61% of all adult PLHIV were female. About 63,777 (39%) PLHIV, know their status. The number of adults and children newly infected with HIV was estimated at 10,933 and adults and child deaths due to AIDs estimated at 7,553 (**table 3**). As of 2022, the percentage of people living with HIV who are on anti-retroviral treatment (ART) was 32%, whereas coverage of pregnant women who receive antiretroviral drugs (ARV) for prevention of mother-to-child transmission (PMTCT) is estimated at 53% (3884/7321), early infant diagnosis was estimated at 20.8% and final vertical transmission rate including during breastfeeding at 26.3%. With regard to the global 95-95-95 targets, South Sudan's progress (by December 2022) shows an estimated 39% of PLHIV know their HIV status, 32% of all PLHIV are on ART, and 27% of all PLHIV are virally suppressed. Out of the total number of PLHIV on ART, only 55% access viral load testing, of which 84% is virally suppressed.

The following were identified as key drivers of the HIV epidemic in South Sudan during the 2022 program review: lack of knowledge and awareness about HIV, very low uptake and use of condoms, extremely high rates of sexual and gender-based violence, elevated rates of transactional sex and sex work, high levels of HIV-related stigma and discrimination, poverty and food insecurity, high levels of illiteracy and low educational attainment, and weak health systems, among others. Among the challenges noted, were equity gaps with children having the lowest ART coverage (17%) as well as viral load suppression; loss of patients to care with as many as 50% of PLHIV no longer in the HIV care 6 months after initiation of ART; limited investments in other important components of HIV response such as primary prevention; and limited integration of HIV services with other services.

[51] South Sudan 2022 HIV draft estimates
[52] 2022 Comprehensive Joint Review of the national HIV and TB programmes: Findings for the HIV component
* The country reports the number of patients treated rather than the number of treatment courses delivered

Indicator	Estimate (2022)
Adult aged 15 to 49 years HIV prevalence rate (%) Women aged 15 to 49 years HIV prevalence rate Men aged 15 to 49 years HIV prevalence rate	1.94 2.47 1.41
Number of Adults and children newly infected with HIV	10,933
HIV incidence per 1000 population (adults 15-49 years)	1.3
HIV incidence per 1000 population (all ages)	0.79
Number of Adult and child deaths due to AIDS	7,553
Number of People living with HIV	164,450
Number of People living with HIV who know their status	63,777
Percentage of people living with HIV who know their status	39
Number of adults and children receiving ART	52,592
Percentage of people living with HIV who are on ART	32
Coverage of pregnant women who receive ARV for PMTCT (%)	53
Number of pregnant women who received ARV for PMTCT	3,884
Number of pregnant women needing ARV for PMTCT	7,321
Early infant diagnosis (%)	20.8%
Final vertical transmission rate including during breastfeeding	26.3
New HIV infections averted due to PMTCT	<1,000
Number of HIV-exposed children who are uninfected	79,078

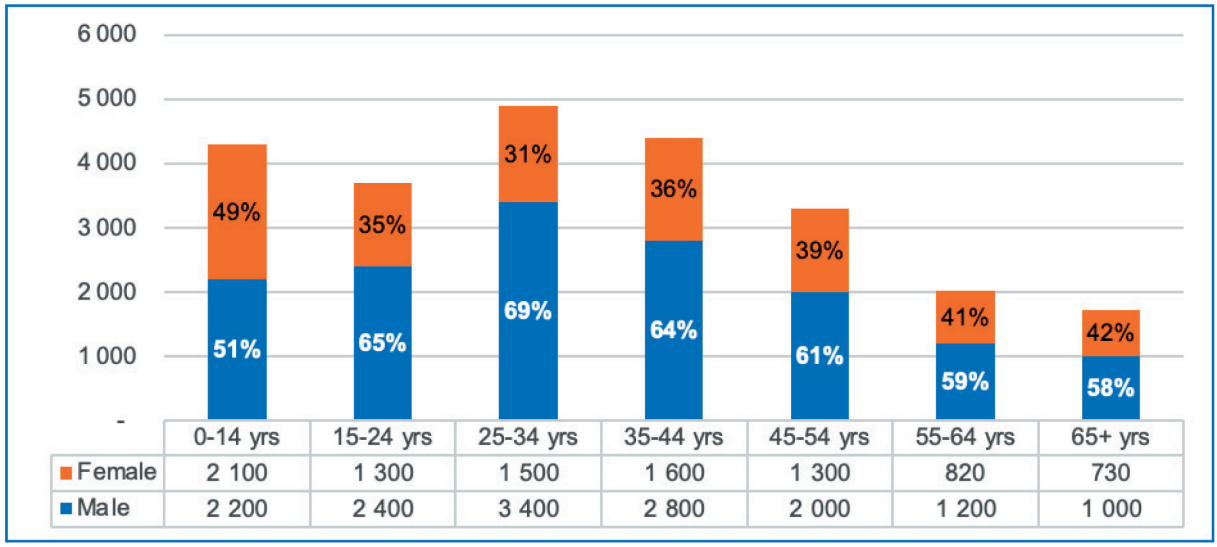
Table 3: HIV and AIDS estimates for South Sudan (UNAIDS, 2022)

Sexually Transmitted Infections (STIs) and Viral Hepatitis data in South Sudan is not readily available; ANC sentinel surveillance surveys however, collect in addition to HIV data, syphilis, and Hepatitis B virus (HBV) data. The 2020 and 2021 ANC surveys found a syphilis prevalence of 2.4%, and 1.6%, respectively, prevalence above the global elimination targets of <1%. The 2017 ANC survey estimated the HBV prevalence among pregnant women at 4.2%; prevalence of hepatitis B infection among children younger than five years in South Sudan is estimated to be the highest in Africa at 13% (far above the African mean of 2.53% and the global elimination target of <1%) pointing to rising infections acquired due to mother-to-child transmission and during the early infancy.[53]

Tuberculosis incidence is estimated at 227 per 100,000 population (24,000 cases in 2021) with the incidence of drug-resistant TB (DR-TB) at 5.1 per 100,000 population (550 cases), estimates that have been relatively constant since 2011, as no recent TB prevalence survey has been conducted therefore the true TB burden is not accurately known. The estimated TB incidence by age and sex are as shown in

[53] 2022 Comprehensive Joint Review of the national HIV and TB programmes: Findings for the HIV component

figure 3 below; approximately 61% of the total estimated TB cases in 2021 were among males.[54]



	0-14 yrs	15-24 yrs	25-34 yrs	35-44 yrs	45-54 yrs	55-64 yrs	65+ yrs
Female	2 100	1 300	1 500	1 600	1 300	820	730
Male	2 200	2 400	3 400	2 800	2 000	1 200	1 000

Figure 3: Estimated TB incidence by age and sex (2021)

TB treatment coverage was estimated at 65% (2020) with a progressive increase in the number of TB cases with rifampicin-resistant and/or multidrug-resistant TB (MDR-TB) notified and put on treatment. In 2021, 92% (15,786/17,075) of all registered new and relapse TB patients were screened for HIV of which 13% (2,027) were found to be HIV-positive. Of these 96% (1,943) were subsequently initiated on ART. The HIV-related mortality for TB was estimated at 910 for 2021 (or 8.5 per 100,000 population).[55]

Findings from the 2022 TB program review highlighted the following key challenges: limited integration of TB services in the broader health system resulting in missed opportunities and efficiencies for expanding TB service provision; limited resources for the national TB program with critical gaps including for preventive therapy; gaps and risks to quality provision of TB services for components such as drug susceptibility testing for newly diagnosed MDR-TB patients; absence of preventive therapy; inconsistent stock levels for some essential TB commodities, and outdated guidelines; as well as inequities in access to TB services.

Neglected Tropical Diseases

Most neglected tropical diseases (NTDs) are endemic in South Sudan, about 19 in total including elephantiasis, bilharzia, intestinal worms, river blindness, blinding trachoma, human African trypanosomiasis (sleeping sickness), visceral leishmaniasis (Kala-Azar), Buruli ulcer, rabies, mycetomas, and guinea worm, among others, most of which are readily preventable and/or treatable.[56] Some of

[54] Data from World TB Report 2022. Available: https://www.who.int/teams/global-tuberculosis-programme/data#csv_files
[55] 2022 Comprehensive Joint Review of the national HIV and TB programmes: Findings for the TB component

[56] South Sudan Country NTD Master Plan 2022-2026

these have been mapped, and interventions commenced while a number, particularly case management NTDs are yet to be mapped.

The goal of the NTD programme is to reduce illnesses, disability and deaths via the control, elimination, and eradication of targeted NTDs to contribute to poverty alleviation, increased productivity, and better quality of life for the affected people. The country has been able to detect and reach more people in hard-to-reach areas through active screening and treatment against human african trypanosomiasis and visceral leishmaniasis (kala azar). The total number of visceral leishmaniasis admissions have progressively declined since 2017 (4,092 cases) to about 1,102 cases by 2022; with the highest admissions across the years seen in Jonglei (75%), followed by Eastern Equatoria (13.0%), Upper Nile (10.5%), Unity (1.3%) and the least in Central Equatoria (0.1%), highlighting the geographical variations in the distribution of NTDs. One key challenge noted in the 2021 health sector performance review was the lack of NTD data in the DHIS2, due to parallel reporting, a key issue that will need to be addressed through integration of parallel reporting systems into the DHIS2.

Geographical and treatment coverage has been scaled up in the population requiring preventive chemotherapy (PC) for five PC NTDs (trachoma, onchocerciasis, soil transmitted helminths, lymphatic filariasis and schistosomiasis) with over 7.5 million people (78%) receiving treatment coverage for onchocerciasis and lymphatic filariasis.

Guinea worm disease was thought to be eliminated in 2017, however, new cases were reported between 2018 and 2021 with the highest number (10) reported in 2018, subsequently reducing to 5 cases and one dog infection in 2022. Guinea Worm Disease cases have reduced in the risk level 1 villages under active surveillance, with 99% of village volunteers and 94% health education sessions provided; there has been active cross-border surveillance in collaboration with Sudan and Ethiopia.

Mapping of NTDs continues in the country with around 50 counties now mapped for trachoma and 58 for leprosy disease. Current data shows the disease burden of trachoma and leprosy is in at least 41% (33/80) and 66% (53/80) of counties respectively. The Ministry of Health and partners will continue to scale up prevention and treatment of NTDs including those targeted for elimination in line with the WHO Global NTD roadmap 2021-2030.[57]

2.3.3 State of prevention and control of non-communicable diseases

Non-communicable diseases (NCDs), including heart disease, stroke, cancer, diabetes, and chronic lung disease are collectively responsible for almost 70% of all deaths worldwide, and almost three quarters of all NCD deaths, occur in low and middle-income countries. In South Sudan, WHO estimates that NCDs accounted for

[57] WHO South Sudan Annual Report, 2022

27% of all deaths in the country (2016), of which 10% were due to cardiovascular diseases, 7% cancers, 2% chronic respiratory diseases, 1% diabetes and 7% other NCDs including injuries. The country has not yet conducted a population-based survey (STEPS Survey) to measure the magnitude of NCDs and NCD risk factors that would be useful to guide planning. However, attempts have been made to address some of the risk factors of NCDs including through health promotion on healthy lifestyles and raising of excise taxes on tobacco and alcohol products, although regulation of these products remains weak. The country also lacks a national multi-sectorial NCD strategy and Action Plan, required to guide and strengthen response to NCDs.

Findings form the SARA survey (2018) showed very low coverage of services for NCDs in health facilities. Services for diabetes management were present in 9% of facilities, for cardiovascular diseases in 11%, for chronic respiratory diseases in 12%, and cervical cancer screening services in only 3% of facilities. The country has subsequently adapted the WHO Package for management of Essential NCDs and Mental Health Disorders (PEN-M) in Primary Health Care (PHC) and piloting of implementation of this package has started in Juba, aimed at reduction of mortality due to common NCDs (hypertension, diabetes, asthma, etc.), although this needs to be scaled up to the rest of the country.

Although NCDs and mental health disorders data were not routinely being tracked, these have now been integrated into DHIS2. Findings from the 2021 HSPR report analyzed the disease burden of tracer NCDs (chronic obstructive pulmonary disease, diabetes mellitus, hypertension, cancer of the breast, cancer of the cervix) and mental health conditions (moderate-severe depressive disorder, psychosis, epilepsy, and substance abuse). Of the five tracer NCDs, hypertension accounted for the highest proportion (44%), and cancer of the cervix for the least proportion (1%); whereas, for the mental health conditions, epilepsy accounted for the highest proportion (53.3%), and psychosis for the least proportion (3.0%). The country however needs to conduct a comprehensive population-based survey (STEPS Survey) to measure the magnitude of NCDs in the population. It is generally estimated that one in five (22.1%) people in conflict settings experienced a mental disorder, higher than the global mean prevalence of about 7%. South Sudan lacks a mental health act, has limited mental health services (with no specialized mental health hospital), and severe shortage of mental health workforce; this underscores the need to strategically address the mental health service gaps in the country.

Apart from NCDs and Mental Health services gaps in the country, other key areas that still have limited support in terms of funding, workforce and reach of services includes provision of oral/dental health services, and eye care services to reduce the burden of avoidable blindness. These remain a priority for this strategic plan.

2.3.4 State of cross-cutting health interventions

Occupational Health: Although occupational health was prioritized in the last Strategic Plan (2017-2022), not much was done to implement the proposed interventions therein due to funding constraints and prioritization of other interventions with significant contribution to reducing morbidity and mortality in the country. The weak intersectoral collaborations also limited the extent to which the health sector could influence interventions that were not predominantly in the sector's control. However, occupational health remains a priority for the safety, well-being, and motivation of the already limited health sector workforce.

School Health: The high rates of malnutrition and acute food insecurity in the country, high teenage pregnancies, rising incidence of HIV, STIs and mental health conditions, and still nascent adolescent health programs, calls for concerted efforts to implement school health interventions that will provide an integrated effective package of prioritized health services to school children. The last strategic plan targeted to establish school health programs in at least 50% of schools, however this was not implemented as there were no funds allocated towards school health, and no school health policy or strategy developed. Implementation of school health remains a priority in collaboration with other relevant line Ministries such as the Ministry of Education.

2.4 Health Security and Humanitarian Situation

The South Sudan National Action Plan for Health Security (2020-2024) was developed 'to guide the process of building national capacities to prepare for, prevent, detect, and respond to any public health events of international concern'. The Joint External Evaluation of the International Health Regulations (IHR) implementation capacities for South Sudan, conducted in October 2017 highlighted the country's capacities and gaps in relation to health security, which the National Action Plan for Health Security endeavors to address. Some of the key findings from the evaluation included: inadequate legal frameworks for implementation of IHR regulations; lack of formal inter-ministerial/sectoral coordination structures; lack of an antimicrobial resistance (AMR) national action plan; lack of a one-health policy/plan; under-developed regulatory system for food safety; limited capacities to respond to chemical threats and radiation emergencies; low immunization coverage; and low health workforce capacities. Of the 48 indicators assessed, only one (syndromic surveillance system) scored 4 (demonstrated capacity), with five indicators, mostly surveillance and national vaccine access and delivery, scoring 3 (developing capacity). Thirty (30) of the 48 indicators scored 1 (no capacity) while 12 scored 2 (limited capacity). The country has however, made some progress on these low-capacity areas, with the development and launching of the One Health Plan, and development of a draft AMR action plan; an inter-ministerial/sectoral coordination platform has also been established, and immunization coverage has been improving, whilst continuous capacity building initiatives for the health workforce have been established.

The evaluation also established the existence of surveillance systems such as the Integrated Disease Surveillance and Response (IDSR); availability of comprehensive outbreak guidelines and reporting forms; existence of a main reference laboratory, the National Public Health Laboratory; existence of disease specific response plans e.g., for Viral Hemorrhagic Fever, measles, polio, cholera, malaria, meningitis, and Hepatitis E; multi-sectoral rapid response teams; an Emergency Operations Centre (EOC) at the national level; and established risk communication structures.

The IDSR system is well established with good reporting rates and the MoH is promoting the transitioning of IDSR reporting through DHIS2. By week 50 of 2022, IDSR reporting timeliness was at 85% and timeliness for the Early Warning, Alert, and Response System (EWARS) sites at 75%.[58] Analysis of the proportion of alerts investigated within 48 hours showed a progressive improvement from 50% in 2017 to 81% in 2020, and the proportions of outbreaks investigated, confirmed, and reported also improved to a high of 88% in 2020.[59]

Due to the poor coverage of vaccination in the past years and the weak health systems, the country has experienced several outbreaks of vaccine preventable diseases, particularly measles. In 2022, at least 58 counties across all ten States reported at least one suspected case of measles, totaling to 4,137 suspected cases of measles reported in 2022 (**figure 4**), increasing to 5,283 by 2023 with 53 deaths reported since January 2022, giving a case fatality rate of one percent. Reactive vaccination campaigns have been conducted in 19 counties reaching 858,274 children. Cholera and Hepatitis E outbreaks have also occurred given the poor access to safe water and sanitation. The country continues to respond to the COVID-19 pandemic although the incidence of cases has substantially reduced. Through a nation-wide vaccination campaign, uptake of COVID-19 vaccines has been scaled up reaching close to 1 million people by the end of 2022.[60]

In 2022, South Sudan also faced and continues to face the risk of importation of diseases such as Ebola, following outbreaks in neighboring Congo and Uganda, especially given the inadequate capacities already existing in the health system, underscoring the need to strengthen the surveillance capacities at ports of entry given the porous borders.

The country also continues to face humanitarian crisis due to conflict, food insecurity, flooding, disease outbreaks, poor socio-economic status (including high poverty and high inflation rates), poor infrastructural development, and inherently weak health systems. In 2022, the country faced its fourth consecutive year of incessant floods that affected 37 Counties, destroying 45 health facilities, and causing massive population displacement. The South Sudan Humanitarian Response Plan (2022) estimates about 8.9 million people (including 4.6 million children) in need of some form of humanitarian assistance (6 million in the host community, 1.4 million internally displaced, 1.2 million returnees, and 350,000 refugees).

[58] South Sudan Weekly IDSR Bulletin, Week 50, 2022
[59] Health Sector Performance Review Report, 2021
[60] South Sudan COVID-19 dashboard

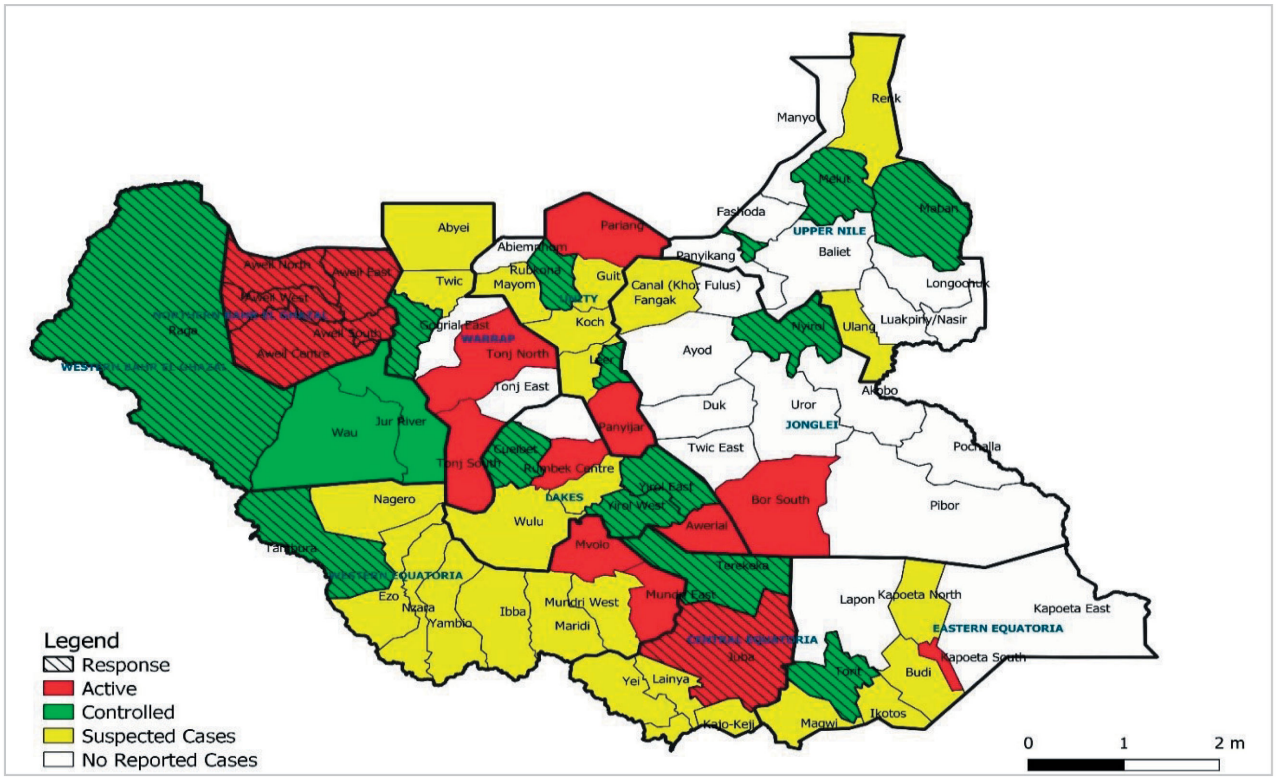


Figure 4: Counties affected with Measles outbreaks in South Sudan - 2022

South Sudan is also facing acute food insecurity; the Integrated Food Security Phase Classification (IPC) projected that over half of South Sudan's population experienced high levels of acute food insecurity (IPC phase 3 or worse) in October and November 2022, including 2.2 million people in IPC phase 4 (emergency) and 61 000 people in IPC phase 5 (catastrophe). These numbers are expected to hit 7.8 million during April-July 2023.[61]

There is need therefore to implement strategic interventions to address the challenges facing health security in the country including disease outbreaks and humanitarian emergencies, which are exacerbated by the weak health systems and the political-socio-economic situation, that undermines the health and productivity of the population.

2.5 Determinants of Health

Health is defined as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO). Determinants of health simply put are the 'non-medical' factors that can affect health; these are the 'circumstances in which people are born, grow, live, work, and age'. They can either be social, environmental, or political factors. Addressing these determinants of health require a whole of government approach to identify and measure the impact of these

[61] WHO's Health Emergency Appeal 2023

determinants on health, raise public awareness on these determinants of health, and implement polices to address them. [62]

2.5.1 Social determinants of health

Higher income and social status are linked to better health, the greater the gap between the richest and poorest people, the greater the differences in health. Low education levels are also linked with poor health. Other social determinants of health include access to affordable health services of good quality, genetics, gender, employment/job security, culture, and food security.[63]

South Sudan performs poorly against these social determinants of health. The country's human development index of 0.385 (2021), is the lowest in the world. The country's economic productivity is declining, income inequalities are high (Gini coefficient of 44.1), more than three quarters of the population (76.4%) are below the international poverty line of $1.90 per person per day, literacy rates are among the lowest in the world at 34.5% for those 15 years and older – higher in males (40.3%) than females (28.9%), there is poor access to health services with only 44% of the population living within a 5 km radius of a health facility also depicted by the low facility density in the country (1.4 facilities per 10,000 population) and low service utilization rate (0.67 versus the minimum required of 5 visits per person per year), unemployment rates are high largely due to the low education levels, and the country has high levels of acute food insecurity affecting more than half the population (IPC phase 3 or worse) consequently resulting in high levels of malnutrition. Some cultural practices also exist that undermine health, such as early/girl child marriages and limited access to contraception especially for girls and women, predisposing them to reproductive health complications. These social determinants have adversely affected the health of South Sudanese resulting in high morbidity and mortality rates, with lack of financial risk protection, thereby constraining the country' progress towards achieving Universal Health Coverage.

2.5.2 Environmental determinants of health

The physical environment in which people live which includes housing conditions, infrastructure such as roads, and access to safe water and sanitation, contributes to healthier populations. With a mostly rural population (83%) in South Sudan, access to safe water and improved sanitation are estimated at only 40% and 10% respectively.[64] Public infrastructure, such as roads are lacking in most parts of the country, compromising access to over 60% of the population during rainy seasons.[65] Many communities continue to remain at risk of disease outbreaks including waterborne diseases, given the poor access to safe water and improved sanitation, and the perennial flooding the country experiences. Poor housing conditions also predispose to spread of diseases such as respiratory tract infections. Environmental health regulations are weak, with lack of proper waste disposal systems, resulting in environmental pollution and contamination with toxic substances that can predispose

[62] World Health Organization, Commission on Social Determinants of Health. Geneva: WHO; 2008. Closing the gap in a generation: health equity through action on the social determinants of health. CSDH final report.
[63] https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
[64] Water, Sanitation and Hygiene (WASH) in South Sudan Briefing note. UNICEF (2021)
[65] Government of the Republic of South Sudan. South Sudan Development Plan 2011–2013

to diseases, and provide breeding grounds for vectors therefore contributing to the spread of vector-borne diseases including malaria.

2.5.3 Political determinants of health

Peace and stability are pre-requisites for sustainable development and consequently, health. Governance structures also determine the kind of laws, legislations, and policies that will be established to guide health care in a country. South Sudan has experienced two major episodes of conflict in 2013 and 2016 and continues to face ethnic conflicts in different parts of the country. Such conflict has affected health service delivery and the health of the populations, through destruction of health facilities, death or displacements of health workforce, and population displacements limiting their access to health services. Conflict itself also directly leads to death, injuries, and disabilities. The risk of conflict and the need to maintain the hard-earned peace in South Sudan, has also resulted in prioritization of security, with a larger allocation of the general government budget allocated to security reducing the allocation to social sectors such as health which received only 2.5% of the budget allocation in the 2022/2023 financial year. It is hoped that successful implementation of the Revitalized Agreement on the Resolution of the Conflict in the Republic of South Sudan (R-ARCSS) will contribute towards ensuring peace and stability, that will contribute towards sustainable development and better health for the people of South Sudan. The government has also put in place legislations and developed policies and strategies such as the revised national development strategy, the national health policy, among others to guide implementation of the country's constitutional commitment to provide health care as a right for every citizen.

2.6 Investments in the Health Sector

2.6.1 Human Resources for Health

Health workforce are the backbone of any health system as delivery of quality health services requires adequate numbers and mix of skilled, and motivated health workforce. Although South Sudan reported an increase in the core health workforce density (the number of physicians, nursing, and midwifery personnel per 10,000 population) to 7.6 per 10,000 population[66] from 0.17 per 10,000[67] population in 2010, this is still far short of the WHO recommended norm of 44.5 per 10,000 to achieve UHC. A 2018 health workforce survey gave the following stock of some of the different categories of health workers in the country, which still reflect the dire shortage of trained health workers: 338 general physicians, 73 specialist physicians, 3,726 nurses/midwives/associates, 1306 clinical officers, 32 dentists/dental assistants, 360 pharmacists/pharmaceutical technicians/assistants, 272 laboratory technicians, 1,455 community health workers, 1,694 other health workers, and 2,897 management and support staff. [68]

[66] South Sudan, Services Availability and Readiness Assessment Report 2018. Ministry of Health and World Health Organization
[67] South Sudan, Ministry of Health, Health Sector Development Plan 2012 –2016.
[68] 2018 Health Workforce Survey in the African Region, South Sudan, WHO

Training of additional health workforce, mostly mid-level cadres has improved, although gaps still exist in having adequately equipped training facilities and teaching hospitals, and limited training institutions for professional categories and specialists. From 2017 to June 2021, a total of 5,297 health workers of various cadres were trained, the highest proportions being clinical officers (1,936; 36.5%) registered nurses (1,356; 25.6%), and registered midwives (1,138; 21.5%), with only 255 doctors (4.8%) trained over that period.[69] The government has established bi-lateral collaborations with universities in the region, to train specialist medical doctors, however, the country continues to face challenges of attraction and retention of these specialists due to the poor retention policies and remuneration packages. Differences in incentive structures among the various service providers has also led to mobility of health workers, leading to maldistribution and challenges in deployment and retention in rural areas. Efforts to increase production of health workforce will need to be scaled up through establishment of well-equipped training institutes, increased regional collaborations and development of favorable retention and remuneration policies. Additionally, there is need to ensure that the health workforce trained are able to deliver integrated health and nutrition services particularly at the primary health care levels for better efficiency in utilizing the existing workforce.

The Human Resources for Health Strategy which should provide a framework for planning and guiding the sector, is outdated (2007-2017), while lack of a national Human Resources for Health Information System (HRHIS) greatly hampers optimal management of the available health workforce.

2.6.2 Health Products

Public financing for procurement of essential medicines has diminished corresponding with the shrinking and chronically low government allocation to the health sector. The main sources of essential medicines are the primary health care programs funded by the World Bank and the Health Pooled Fund (HPF), while global health initiatives particularly the Global Fund for AIDs, TB, and Malaria (GFATM), GAVI, and others including nutrition partners continue to procure and distribute essential medicines and commodities for their respective programs/projects. This has resulted into fragmented multiple and parallel procurement and distribution systems in spite of efforts to unify the process by the establishment of the Government/Ministry of Health Central Medical Supplies Agency (CMSA). However, the CMSA bill is yet to be enacted, although it has already been reviewed by the Ministry of Justice. The National Medicines Donation Guidelines are outdated and need to be revised in line with the current context.

The country continues to experience shortages in essential medicines in health facilities as reported by the SARA 2018,[70] which scored availability of essential medicines at 14%, the lowest among all the dimensions of general service readiness. The shortage was more in rural, and government run facilities relative to urban and NGO run facilities. The 2021 HSPR however, reported an improvement of 73% availability of a core set of relevant essential medicines and commodities,

[69] Health Sector Performance Review Report, 2021
[70] South Sudan, Services Availability and Readiness Assessment Report 2018. Ministry of Health and World Health Organization

whereas the percentage of time out of stock for essential medicines and supplies was estimated at 27.1%. The percentage of pharmaceuticals that get expired at health facility level was estimated at 4.2%. Supply chain management capacities at sub-national levels, however, needs to be strengthened including forecasting practices. Challenges continue to exist in warehousing capacities at sub-national levels.

In 2012, the Drug and Food Control Authority (DFCA) was established through the DFCA Act 2012 however, its institutional capacity to regulate the sector remains low and requires resources to improve its capacity if the country is to prevent the proliferation of substandard and falsified products. Sporadic quality assurance activities are being conducted and a quality control laboratory established, however, the laboratory is not equipped with required reagents to measure and assure the quality of products, and no post marketing surveillance is being conducted.

While the 2019 Standard Treatment Guidelines and 2018 Essential Medicines List are being used to promote rational medicines use, there is no Essential Medical Devices and Assistive Products List or a Drug Disposal Protocol. The country has made progress in developing the first Pharmaceutical Policy and Strategy (2021) to provide an overall framework for governance, regulation and programming in the sector which has been lacking since 2006 when the previous Pharmacy Protocol was developed.

2.6.3 Infrastructure and Support Services

Health sector infrastructure in South Sudan is still not well developed; furthermore, the chronic conflict the country experienced before independence and the intermittent episodes of conflict post-independence have undermined the availability and sustainability of the requisite infrastructure to effectively deliver health services. The 2018 SARA survey revealed a low health facility density of 1.42 per 10,000 population (target is 2 facilities per 10,000 population) with inequities in distribution across the States ranging from 0.43 to 6.92 facilities per 10,000 population (**figure 5**). From the survey, most facilities have permanent buildings (62%), while 20% are temporary and 14% are semi-permanent. Basic amenities in health facilities are in short supply; in 2018, about half of all facilities had access to sanitation facilities (58%), while less than half had access to a consultation room (38%), communication equipment (38%), emergency transport (37%), improved water source (36%), a power source (13%), and a computer with internet (4%). Basic equipment is also not readily available across all health facilities; only 66% of facilities had a thermometer, 63% a stethoscope, and 56% and 51% had adult and child weighing scales respectively. The most commonly available diagnostic capacity items were malaria diagnostic capacity (86%) and urine test for pregnancy (43%). The availability of the following diagnostic capacity items was low: HIV diagnostic capacity (19%), urine dipstick-protein (13%), urine dipstick-glucose (12%), haemoglobin (9%), and blood glucose (8%). In general government and rural health facilities had lower scores in comparison to NGO or urban facilities.

The low health facility density, inadequate basic amenities, equipment, and diagnostic capacity constrains service delivery, contributing to the low service

utilization rate. Furthermore, there is a gap in availability of requisite norms, standards, and frameworks to regulate and monitor adherence to minimum infrastructure standards, with inadequate capacity and funding at the national and sub-national levels to support this. Periodic maintenance of infrastructure and equipment is not regularly done; and implementation of appropriate occupational health policies, which is lacking, remains a priority.

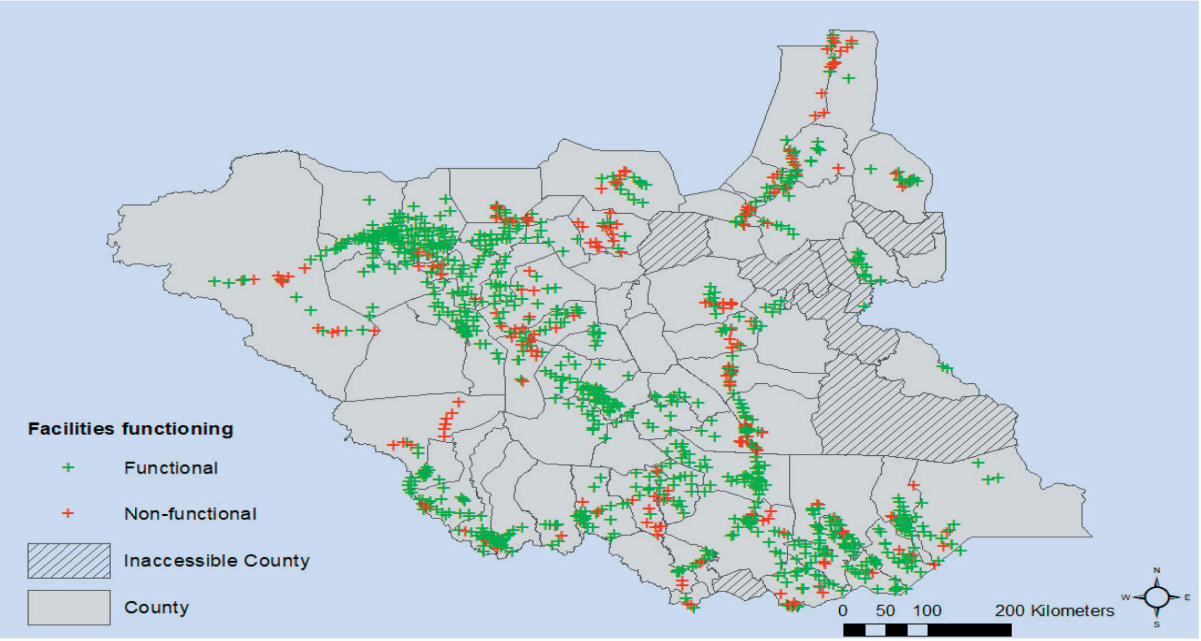


Figure 5: Distribution of functional and non-functional, accessible health facilities (N = 1293), South Sudan 2018, SARA survey

2.6.4 Service Delivery Systems

Health and nutrition services in South Sudan are delivered through a four-tier system: community health which is implemented through the Boma Health Initiative (BHI); primary care provided by Primary Health Care Units (PHCU) and Primary Health Care Centres (PHCC); secondary care through the County and State hospitals; and tertiary care through the teaching, referral, and specialized hospitals. Currently there are 1,395 functional facilities in the country: 967 PHCUs, 358 PHCCs, 70 Hospitals, with no functional specialized hospitals. According to the 2011 Health Facility Mapping, only around 44% of the population lived within a five kilometers radius of a health facility.[71] The Boma Health Initiative (BHI) was established to bring services closer to the communities; it delivers an integrated package of health promotion and disease prevention along with treatment for selected common conditions (malaria, pneumonia, and diarrhoea). The reach of BHI is estimated at only 25% of Bomas. The services to be offered by each facility level are defined in the BPHNS, and there are standard treatment guidelines for each level, however, adherence to the delivery of the BPHNS as defined for each level varies across the country, undermining equitable access to health services.

[71] The basic package of health and nutrition services for primary, secondary, and tertiary health care in South Sudan, 2019

Referral between the different levels of care is weak, mainly due lack of an established referral and ambulance system, poor communication, and poor road infrastructure. Due to the dire gap of specialist medical services in the country, medical tourism to other countries in the region is common.

The overall general service availability score in health facilities is low at 30.4%, with health infrastructure index and service utilization index at 43.2% and 15.05% respectively, whereas the general service readiness score is also low at 37%, implying poor quality of services given it measures the overall capacity of health facilities to provide general health services.[72] The capacity of health facilities to conduct basic laboratory diagnostic tests (all eight tracer tests) was only 4%, with a similar proportion (4%) of facilities offering blood transfusion services in 2018. In South Sudan nationally, there are 6.53 inpatient beds per 10,000 population (recommended target is 25), and 3.26 maternity beds per 1,000 pregnant women (recommended minimum target is 10), signifying, low access to both inpatient and delivery services. Service utilization is generally low, with the outpatient department visits per person per year estimated at 0.67, versus the minimum required of 5 visits per person per year.[73]

Stewardship and management of the health service delivery network is compromised by the limited government capacity and is more pronounced at primary health care level. Most CHDs charged with oversight over primary health care are disproportionately dependent on partners. Currently, two donor funded modalities, the Health Pooled Fund and the World Bank, support service delivery in close to 51% of health facilities in the country, mainly through NGOs. All nutrition services are provided by aid organizations as well as through parallel community structures (community nutrition volunteers), which need gradual transition to the Boma Health Initiative.

2.6.5 Governance of the Health Sector

The health sector stewardship is decentralized and premised on the three tiers of governance. The Ministry of Health, State Ministry of Health, and County Health Department are responsible for the sector leadership at the National, State and County levels, respectively.[74] The decentralized governance system challenges effective linkages between the levels with decision making premised at each level of governance.

The institutional and technical capacity for sector governance, however, remains limited, progressively worse at the subnational levels. At the national level, there are nine directorates each led by a Director General, under which are relevant departments headed by Directors, a number of positions of which are vacant. This has undermined functionality of health sector leadership as well as coordination at all

[72] South Sudan, Services Availability and Readiness Assessment Report 2018. Ministry of Health and World Health Organization.
[73] DHIS2/HMIS 2021
[74] National Health Policy, 2016. Ministry of Health, Republic of South Sudan

levels in spite of the existence of proposed coordination mechanisms which includes the Health Sector Steering Committee chaired by the Minister of Health at the National level that brings together all key health sector actors on a quarterly basis at a policy and decision-making level. Humanitarian coordination through the cluster system (Health and Nutrition) is relatively more well established, with presence at the subnational levels. Other coordination platforms are program specific including thematic Technical Working Groups (TWGs) which are mostly functional at the national level.

Whilst, the overall health sector policy and strategy as well as several sub-thematic strategies and guidelines are in place, comprehensive operational planning is not institutionalized, rendering systematic sector performance tracking and reviews suboptimal.

2.6.6 Data and Information

A well-functioning health information system is one that ensures the production, analysis, dissemination, and use of reliable and timely information on health determinants, health system performance, and health status. Progress has been made in institutionalizing the District Health Information Software (DHIS), from County to National level and migration to DHIS2.0 from DHIS1.4. However, some disease specific programs still run parallel/vertical reporting systems including NTDs, HIV, Nutrition, among others, resulting in the fragmentation of the health information system. Efforts are being made to integrate EWARS and the Nutrition Information System with the DHIS2, which should provide lessons for the integration of other parallel systems.

The paper-based Health Management Information System (HMIS) at facility level experiences perennial challenges of shortages of HMIS forms and tools which compromise the overall completeness and timeliness of reporting.[75] The 2018 SARA assessment of the HMIS reported the mean availability of systems assessment tracer items at 43%. Only 34%, 42% and 51% of health facilities had guidelines; staff trained on HMIS; and reported no stock outs of tally sheets, registers and reporting forms, respectively. Data use and provision of feedback remains poor with only 39% of facilities reporting analyzing and using data, while 57% of facilities reported receiving supervision and feedback on data quality. Completeness and timeliness in HMIS reporting has remained consistently low at 49.5% and 40.4% respectively.[76] Data quality remains sub-optimal.

The generation of comprehensive health sector data through critical surveys like the demographic and health survey was last done in 2010, making it challenging to derive national estimates of key outcome indicators. The conduct of Joint Annual Reviews (JAR) is not institutionalized, with only 2 reviews (2017 and 2021) conducted in the past five years. Programmatic reviews however occur on a more regular basis. The Health Information System Policy and Strategy are outdated, and currently being revised.

[75] 9th Annual Report. 2019 Health Management Information System. Ministry of Health. Republic of South Sudan
[76] Ministry of Health, Health Sector Performance Review Report 2021

2.6.7 Financing

South Sudan government budget allocation to the health sector remains low, far below the 2001 Abuja Declaration target (15%). The years of conflict and subsequent conflict resolution efforts have resulted into the security and public administration sectors being allocated the largest share of the government budget with lower budget allocations to the social sectors including health. In the past five years, the government budget allocation to the health sector has been below 5% except in the 2021/2022 fiscal year (FY) when it increased to 7.9% and again dropped to 2.5% in the 2022/2023 FY (**figure 6**).[77] There are however, huge distortions in the budgetary frameworks; for example, the total approved government budget for the FY 2021/2022 was SSP 802 billion of which only SSP 287 billion (36% of the budget) was for spending by sectors and direct/mandatory transfers accounted for SSP 515 billion (64% of the budget). Budget disbursements are also often delayed, and the funding inadequate, although execution rates may be high.

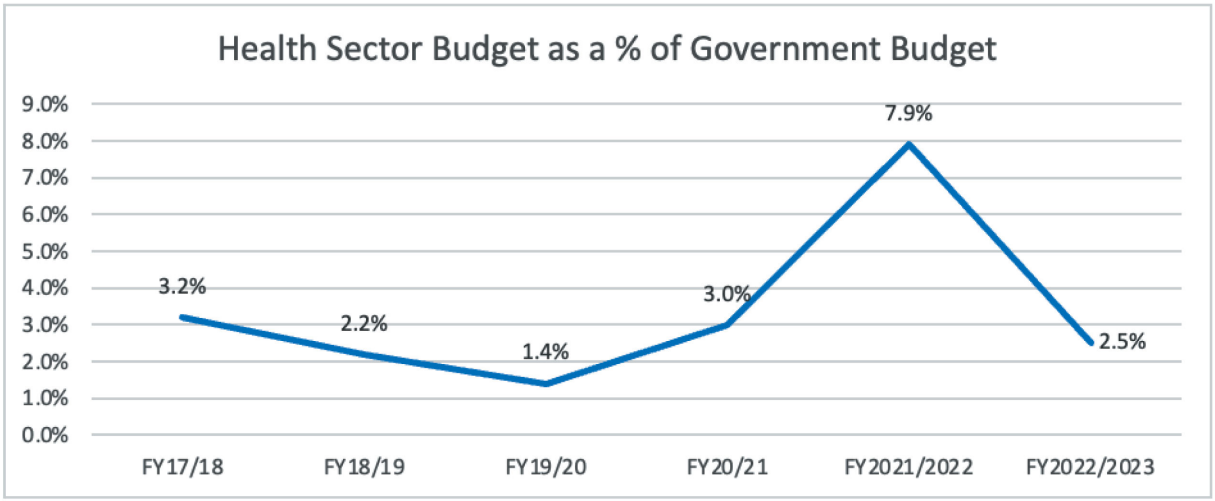


Figure 6: Government budget allocation to health, 2017/2018 to 2022/2023 FY

South Sudan relies heavily on external sources to fund the health system, accounting for over 60% of current health expenditure (CHE) since 2017. Most recent data (2020) estimate external sources at 63.6% of CHE which is more than double the country's income group average of 30.2%. Domestic public funding accounts for only 7.9% of CHE and private funding which includes out-of-pocket expenditure is estimated at 28.5% of CHE (**figure 7**).[78]

[77] Ministry of Finance and Planning, annual budget books: http://www.mofep-grss.org/documents/
[78] WHO Health Financing Progress Matrix: Background Indicators: https://www.who.int/teams/health-systems-governance-and-financing/health-financing/hfpm-background-indicators

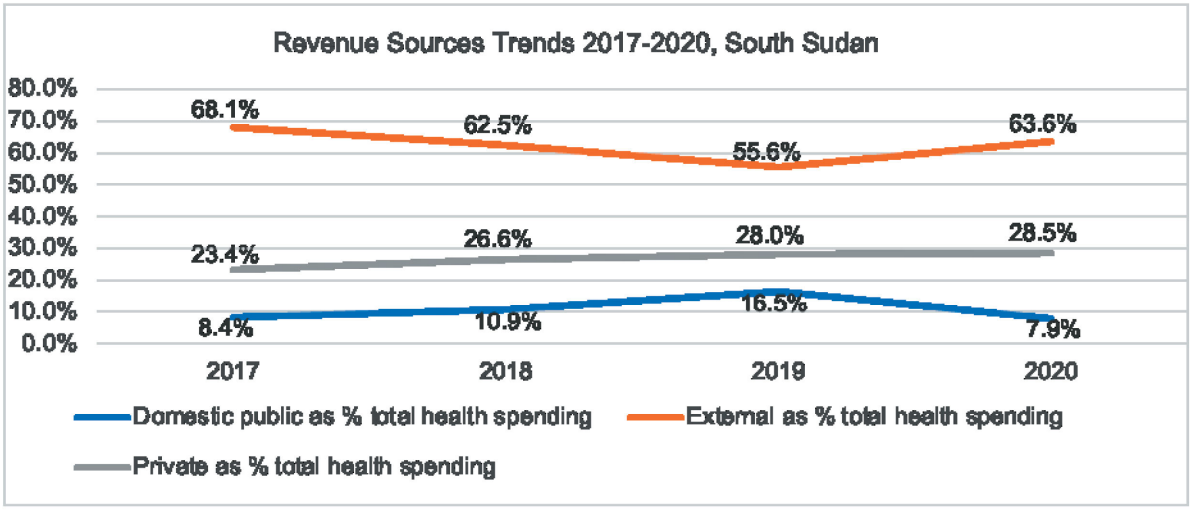


Figure 7: Revenue sources for current health expenditure in South Sudan, 2017-2020

Pooling of funds for service delivery is only implemented for the donor funding through the health pooled fund; other health financing pooling mechanisms are not in place at the moment. The country does not have a public health insurance system. The health financing strategy developed in 2020 has not yet been implemented due to funding constraints. The first Public Financial Management (PFM) assessment was conducted in 2022, to assess the health sector budget execution system which identified some weaknesses in the core dimensions assessed, and proposed recommendations to address them. PFM strengthening initiatives through donor support, are being implemented. Tracking of health expenditures is yet to be institutionalized: National Health Accounts was conducted once (2018-2019) for FY2016/2017 data; no Public Expenditure Review has been undertaken for the health sector since 2016.

2.6.8 Partnerships

Partners support the government in health service delivery, mainly through the Health Pooled Fund and World Bank who sub-contract implementing partners to deliver health services, covering just about half of the health facilities in the country. The Ministry of Health engages with the partners at the national and subnational levels to ensure that their support aligns to national health priorities, strategies, and plans, through the existing coordination platforms at the different levels; however, inter-sectoral and inter-ministerial collaboration remains weak; the COVID-19 National taskforce, and the 'One Health' approach that ensures integration and coordination across multiple sectors for disease surveillance, outbreak investigation and response, provide forums for inter-sectoral collaborations. Public private partnership for health remains weak with no framework established for such a partnership, although dialogue on this commenced in 2021.

2.7 Issues and Unfinished Business

The 2021 health sector performance review proposed several recommendations to improve health service delivery in the country. These remain a priority for implementation and are incorporated into this strategic plan along with key emerging issues from the situational analysis, given that most of them had not been implemented by the commencement of the development of this strategic plan. The recommendations are highlighted below by thematic area:

- **RMNCAHN:** Equitably scale up availability and access to quality RMNCAHN services especially expansion of CEmONC services; Establish obstetric fistula centers; Increase the production and retention of skilled health workers (particularly midwives) in public sector facilities with deployment of more personnel at subnational levels; Mobilize resources for expansion of BHI and harmonize boma health workers payments; Improve referral pathways at all levels of the health system; Strengthen RMNCAHN coordination mechanisms at subnational levels; Increase advocacy to strengthen RMNCAHN regulatory frameworks; Improve community engagement to address biases on contraception and immunization; Integrate nutrition service delivery in PHC.
- **Communicable Diseases: HIV/AIDS, TB, Malaria and NTDs:** Integrate parallel reporting systems for HIV/AIDS, TB, Malaria and NTDs into DHIS2 and revise the program indicators used for tracking progress to ensure consistency in data collection, entry and analysis at all levels; Scale up NTD, HIV/AIDS and TB services across the country and ensure provision of adequate space in health facilities to facilitate privacy and confidentiality as needed during service delivery; Strengthen subnational level coordination and integration of services to leverage on existing resources (including human resource and supply chain systems) to improve service delivery; Institutionalize relevant household surveys for collection of data to report on communicable diseases population-based indicators.
- **Non-Communicable Diseases:** Scale implementation of the Package of Essential NCDs and Mental Health interventions for primary health care, to strengthen integration and service delivery at facility level; Ensure appropriate multi-sectorial policies, strategies and plans are in place and implemented for effective coordination of the NCDs agenda in the country; Mobilize resources to support NCDs and mental health interventions; Improve NCDs surveillance through strengthening routine reporting in DHIS2 and conducting and institutionalizing the STEPS survey to document the magnitude of NCDs and NCDs risk factors in the general population.
- **Epidemic Preparedness and Response:** Provide incentives for rapid response teams to sustain surveillance and outbreak response activities at the subnational level; Strengthen communication from subnational to national level, with clear communication channels established, to avoid misinformation on alerts and outbreaks; Improve coordination among stakeholders and mobilize additional resources to support cross border/point of entry interventions.
- **Access to Health Services, Quality and Safety, and Health Infrastructure:** Scale-up access to health services through addressing the critical gaps identified by improving and expanding health infrastructure equitably, enforcing the

implementation of the BPHNS with provision of the required supplies for each level, ensuring adequate health financing including increasing the government allocation to the health sector, increasing human resources for health, and strengthening other key health system functions.

- **Human Resources for Health:** Scale-up and adequately equip health training institutes in the country; Fast track accreditation of already established health training institutes that are yet to be accredited; Establish relevant professional councils/bodies and strengthen the existing ones; Establish a nation-wide human resource information system and regularly conduct health workforce accounts. Strengthen health workers capacity to delivery integrated health and nutrition services.
- **Essential Medicines, Supplies and Technologies:** Build capacity of health workers on supply chain management; Strengthen regulatory frameworks for essential medicines, supplies and technologies; Accelerate the enactment of the CMSA bill; Strengthen the institutional capacity of DFCA and ensure the functionality of the national quality control laboratory.
- **Health Financing:** Advocate for increased government budget allocation to health towards achieving the Abuja declaration target of 15%; Strengthen public financial management capacities at national and subnational levels; Conduct and institutionalize National Health Accounts to enable tracking of health care expenditures; Introduce risk pooling schemes and other health financing mechanisms towards reducing out of pocket expenditure on health.
- **Health Information Systems:** Review program indicators in DHIS2 to ensure they are well defined, and they meet program needs, and update and ensure equitable distribution of the revised data collection tools; Integrate vertical/parallel reporting platforms into DHIS2, to implement the one data base and one monitoring and evaluation system approach; Build capacity of data clerks and data managers; Mobilize resources to conduct population-wide household surveys; Institutionalize regular program reviews including the Joint Annual Reviews of the health sector performance and key assessments such as the Data Quality Assessments.
- **Leadership and Governance:** Institutionalize annual operational planning at the national and subnational levels; Conduct regular leadership and management trainings for MoH personnel at all levels; Establish clear coordination structures at national and subnational levels and institutionalize health sector as well as multi/inter-sectoral coordination mechanisms; Develop and implement comprehensive capacity development plan for the Ministry of Health.
- **Partnerships for Health:** Establish a clear framework to guide operations of partners at the State and County levels that ensures alignment to priorities identified at the subnational level and to strengthen accountability; Strengthen and streamline coordination structures at the national and subnational levels ensuring overall government stewardship at both levels; Enforce the equitable delivery of the minimum basic package of health and nutrition services by partners and other defined service delivery packages; Strengthen and operationalize existing platforms that provide for inter-ministerial and inter-sectorial collaborations and synergies; Fast track the development of a Public Private Partnership for Health framework for synergy and complementarity for health service delivery.

CHAPTER 3: STRATEGIC FRAMEWORK

The Health Sector Strategic Plan (HSSP) 2023-2027 is premised on and provides a framework for the implementation of the second phase of the National Health Policy (NHP) 2016-2026. The NHP outlines the overall vision and government's commitments for health sector transformation and contribution to the national development aspirations of South Sudan. The vision, mission, and goal of the HSSP are informed by those of the NHP while its strategic approaches and interventions are aligned to the three policy objectives of the NHP.

3.1 Vision and Mission

Vision
A healthy and productive population of South Sudan living a dignified life.

Mission
To improve the health status of the people by effective delivery of the basic package of health and nutrition services (BPHNS).

3.2 Values and Guiding Principles

Values:
The core values include:

i. Health is a human right; equitable access to health services shall be pursued.
ii. Patient, staff, and community safety shall drive quality improvement decisions.
iii. Honesty, integrity, transparency, and accountability shall govern use of resources in the implementation of the health sector strategic plan.
iv. Commitment to the vision, mission, goals, and objectives shall be reflected in resource allocation, planning and prudent management.
v. Dignity and respect for all individuals seeking health care services shall be upheld.
vi. Teamwork and professional ethics shall underpin health service delivery.
vii. The environment shall be protected from medical waste to ensure sustainable development.

Guiding Principles:
The guiding principles for collective action in achieving the national health goals and objectives include:

i. Health and Health Services as a Human Right

The Transitional Constitution of the Republic of South Sudan recognizes health and health services as a human right. Government shall promote, respect, and protect the people's right to health and health services.

ii. Primary Health Care Approach

Primary Health Care shall remain the principal philosophy in developing the health system in the Republic of South Sudan and shall inform the content of the BPHNS.

iii. Decentralization

To ensure equitable access, health services in South Sudan shall be delivered and managed against a decentralized framework to increase health system responsiveness to local needs and allow for community participation in health services delivery.

iv. Partnerships

Successful implementation of the National Health Policy is dependent on effective partnerships. Government shall establish platforms and mechanisms for efficient partner coordination, inter-sectoral collaboration, and synergies for better results.

v. Gender Mainstreaming

Health service programming and delivery shall be gender sensitive. Deliberate efforts shall be made to protect the rights to health care of women, children, the elderly, people with special needs, physically and mentally impaired, refugees and Internally Displaced Persons and all in transit populations, minority groups, and the poor.

vi. Community Participation

Communities shall participate in health service delivery, health promotion and disease prevention activities such as door to door community mobilization and health action through community resource persons, community, and political leaders. Communities as owners of health services shall participate directly or by representation in the governance of health care institutions.

vii. Efficiency and Effectiveness

Evidence based policy formulation, implementation, planning and service delivery shall be promoted to increase effectiveness of interventions and efficient use of resources to achieve results.

viii. Respect for Values and Cultures

Cultural values and practices of the people of South Sudan that promote health shall be respected. Communities shall be dissuaded from harmful practices in culturally sensitive manner.

3.3 Goal and Strategic Objectives

Goal

A strengthened national health system and partnerships that overcome barriers to effective delivery of the BPHNS; and efficiently responds to quality and safety concerns of communities while protecting the people from impoverishment and social risk.

Strategic Objectives

i. Strategic Objective one:

To strengthen health service organization and infrastructure development for effective and equitable delivery of the BPHNS.

ii. Strategic Objective two:

To strengthen leadership and management of the health system and increase health system resources for improved health sector performance.

iii. Strategic Objective three:

To strengthen partnerships for healthcare delivery and health systems development.

3.4 Strategic Objectives; Specific Objectives; Strategies; Interventions

3.4.1 Strategic Objective 1

To strengthen health service organization and infrastructure development for effective and equitable delivery of the BPHNS.

3.4.1.1 Specific Objective one: To ensure universal health coverage through effective, affordable, and comprehensive delivery of the BPHNS.

The BPHNS comprises of the following program areas:

i. Program Area 1: Health Promotion, Boma Health Initiative, and School Health
ii. Program Area 2: Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition
iii. Program Area 3: Communicable Diseases and Neglected Tropical Diseases
iv. Program Area 4: Non-Communicable diseases, Mental Health, Oral, Eye, and Occupational Health
v. Program Area 5: Emergencies, Disasters, and Humanitarian response.

Program Area 1: Health Promotion, Boma Health Initiative and School Health

Objectives and Results for Health Promotion, Boma Health Initiative (BHI) and School Health

Objective	Indicator	Target (2027)
Address health inequities and social cultural barriers to healthcare access through health promotion	% of health promotion cadre trained on health promotion	50%
Strengthen and scale up implementation of the Boma Health Initiative	% of Boma's implementing BHI	80%
Ensure provision and utilization of school health services	Coverage of school health services	10%

Strategies and Interventions for Health Promotion, Community Participation and School Health

Objective 1: Address health inequities and social cultural barriers to healthcare access through health promotion	
Strategies	**Interventions**
Strengthen the MoH Health Promotion Unit Leadership	Identify gaps and build capacity of the management team at national and subnational levels (State/County/Payam/Boma) of

	the Health Promotion Unit.
	Update and finalize the national health promotion policy.
	Develop and implement the health promotion strategy to operationalize the national health promotion policy.
Strengthen intra & inter-sectoral collaboration to support health promotion	Strengthen the existing Risk Communication and Community Engagement and Social and Behavior Change Communication (SBCC) platforms for Health Promotion.
	Develop/update and implement the national health promotion workplan, guidelines and health education material.
	Scale up the role of social media in health promotion and MoH communication.
Community engagement for health promotion activities	Create awareness of healthy behaviours at community level.
	Develop community radio health promotion programs.
	Involve community religious, local leaders and women groups for health promotion & SBCC.
Objective 2: Strengthen and scale up implementation of the Boma Health Initiative	
Scale up Boma Health Initiative in phases to all boma's	Plan and scale up coverage of the Boma Health structures and services in the unserved areas.
	Recruit, and resource BHTs (Boma health workers, supervisors & Boma health committee) and ensure they are functional and retained.
	Ensure the delivery of health promotion, health education & curative services in the community.
Provide tools, basic medicines, health promotion materials and training for the Boma Health Teams	Develop and implement guidelines for multi-sectoral collaboration that supports community-based services, including health promotion.
	Strengthen supply chain for BHI.
	Plan & implement health promotion, communication, and basic service provision training modules.
Advocate and secure resources for implementing BHI activities	Secure financial and logistic support adequate for implementing BHI activities.
	Harmonize BHI incentives.
Strengthen community leadership for effective engagement, participation, and oversight of BHI implementation	Support & document quarterly meetings of the Boma oversight Committee to provide appropriate support.
	Strengthen BHI oversight structures & performance.
Objective 3: Ensure provision and utilization of school health services	
In collaboration with the education sector and related sectors - establish an integrated school health program	Strengthen national and subnational leadership, governance & resource allocations for school health.
	Develop the national school health policy and strategic plan.
	Provide an improved and integrated package of school health services at all levels.
	Plan & conduct regular school monitoring visits at national & subnational levels to scale up implementation & results.

Program Area 2: Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition

Objectives and Results for Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAHN)

Objective	Indicator	Target (2027)
Enhance access to and utilization of sexual and reproductive health services, including adolescent health services	Contraceptive prevalence rate	12%
	Unmet need for family planning among all females of reproductive age	10%
	% of facilities providing post abortion care	50%
	% of facilities providing Adolescent and youth friendly services	75%
Ensure reduction in Maternal Mortality and Morbidity through provision of and utilization of comprehensive maternal health services	Maternal Mortality Ratio (deaths per 100,000 live births)	750
	Antenatal care coverage at least four visits (%)	60%
	Births attended by skilled birth personnel (%)	50%
	Post-natal care coverage	50%
	% Functional CEmONC Facilities	70%
	% Functional BEmONC Facilities	70%
	% Functional MPDSR Committees	60%
Ensure reduction in neonatal and childhood mortality through provision and utilization of high impact quality newborn and child and nutrition health services	Under five years' mortality rate (per 1000 live births)	50
	Infant mortality rate (per 1000 live births)	40
	Neonatal mortality rate (per 1000 live births)	20
	Fully immunized coverage (%)	80%
	% Facilities delivering IMNCI	70%
Improve the nutritional status and reduce morbidity and mortality associated with malnutrition among the most vulnerable population	Children under 5 years who are stunted (%)	10%
	Children under 5 years who are wasted (%)	10%
	Exclusive breastfeeding rate 0-6 months of age	80%
	Percentage of children aged <59 months receiving Vitamin A supplements twice a year	90%

Strategies and Interventions for RMNCAHN

Objective 1: Enhance access to and utilization of sexual and reproductive health services, including adolescent health services	
Strategies	**Interventions**
Ensure access to & utilization of quality reproductive health services for women & youth	Promote access to and utilization of family planning services including by adolescent girls and youth.
	Strengthen family planning commodities security including development of national commodity strategy.
	Strengthen delivery of the integrated package of services for HIV/STIs with RMNCAH.
	Integrate post-abortion care into RMNCAH; Ensure the prevention of unsafe abortion & integrate post-abortion services at primary and secondary care levels.
Scale up youth friendly comprehensive AYSRH services	Strategically expand Adolescents friendly services/centres equitably in all States & Administrative Areas.
	Strengthen social mobilization for reproductive health & rights.
	Ensure a continuum of information and services with reproductive health packages.
Institute programs for screening and management of gynaecological conditions	Build the health system capacity for screening and case management (including complications) of obstetrics and gynaecological conditions.

including cancers	Promote Obstetric Fistula preventive interventions.
	Strengthen/expand services for treatment of obstetric fistula.
Ensure prevention, timely services, care & support for victims of Sexual and Gender Based Violence (SGBV)	Improve availability & access to SGBV services including prevention & support as per national guidelines.
	Develop action plans to address SGBV bottlenecks linking health with other sectors at national & subnational levels.
	Documentation of cases for generating data for advocacy and program planning.
Strengthen leadership and governance for effective delivery of RMNCAH services	Capacity building in leadership and governance for RMNCAH and Nutrition at all levels.
Objective 2: Ensure reduction in Maternal Mortality and Morbidity through provision of and utilization of comprehensive maternal health services	
Improve access to quality high impact maternal health and nutrition services for all pregnant women	Promote the provision and utilization of ANC4+.
	Ensure safe delivery by skilled births attendants (SBAs).
	Promote institutional deliveries and improve the requisite infrastructure.
	Promote a continuum of care from community services to institutional delivery by SBAs.
Strengthen referral and improved access for safe and quality EmONC accredited health facilities	Avail emergency obstetric and postnatal care for all pregnant women.
	Strengthen referral and feedback mechanisms.
	Support the establishment and functionality of Maternal and Perinatal Death Surveillance and Response (MPDSR) including creation of a legal framework, structures, and tools.
	Strengthen implementation of integrated RMNCAH outreaches for the mobile population.
	Improve provision of RMNCAH services in humanitarian and fragile settings including treatment of pregnant and lactating women for acute malnutrition.
Objective 3: Ensure reduction in neonatal and childhood mortality through provision and utilization of high impact quality newborn and child health and nutrition services	
Improve access to quality newborn health services to boost survival	Ensure availability of paediatricians in all States & teaching hospitals.
	Avail new-born resuscitation services in all hospitals, including referrals to new-born intensive care units in teaching hospitals.
	Provision of quality essential new-born care after birth.
Strengthen referral of severely ill new-born babies	Provide postnatal visit at least three times during new-born period.
	Create a hotline for referring new-born to intensive care unit services that is centrally coordinated.
Community mobilization and education of mothers (through ANC), families and communities on state of a healthy baby	Train on basics including keeping the baby warm & exclusive breastfeeding up to 6 months after birth.
Scale up access to high impact and cost-effective preventive, diagnostic & curative paediatric interventions to reduce morbidity & mortality	Expand and roll out IMNCI (including community case management) services in all facilities to boost <5yrs survival.
	Provide medicines & supplies for IMNCI/BHW.
	Train Health Workers + BHWs on IMNCI (including CCM).
Institutionalize specialized child health care services	Upgrade at least one hospital unit per State for specialized child health care.
	Update & provide materials & guidelines for Health workers.
Strengthen national expanded program on immunization – Reach Every child (REC)	Support & scale up routine immunization program and utilization.
	Introduce new vaccines (Rota, PCV, HPV, Malaria, Meningitis).
	Ensure functional cold chain system & availability of vaccines in health facilities.

	Conduct Integrated static, outreach & mobile immunization services.
Objective 4: Improve the nutritional status and reduce morbidity and mortality associated with malnutrition among the most vulnerable population	
Develop and review evidence based national nutrition policy, strategy & frameworks to improve nutrition	Update nutrition policy & related legislations & regulatory framework for improving nutrition (BMS Code, USI regulation and standards, Food and Beverage regulations).
	Develop/update and implement the national strategy for prevention of malnutrition including micronutrient deficiencies.
Scale up evidence-based high impact nutrition interventions at health facility and community levels including wasting prevention and management	Promote exclusive breastfeeding and adequate complementary feeding.
	Provide micronutrient supplements & specialized fortified foods.
	Build capacity of health and nutrition workers to deliver nutrition services.
	Build capacity of frontline workers (Boma Health Workers, Hygiene promotors, CNV etc.) to deliver integrated package of health and nutrition services.
	Conduct growth monitoring, promotion & screening for malnutrition.
	Implement school health and nutrition programmes including school feeding programs & include those with special nutritional needs.
Improve capacity, multisectoral coordination and systems to deliver quality nutrition services at national and subnational level	Strengthen capacity (quantity and quality) of nutrition cadres within MoH at national and sub-national levels to design, implement, and coordinate nutrition programmes.
	Strengthen multi-sectoral coordination through modalities such as SUN and others for improved nutrition outcomes.
	Promote integration of nutrition services in the health sector and across other sectors, as well as integration of nutrition reporting in the HMIS.

Program Area 3: Communicable Diseases and Neglected Tropical Diseases

Objectives and Results for Communicable Diseases and Neglected Tropical Diseases

Objective	Indicator	Target (2027)
Ensure reduction in morbidity and mortality due to malaria towards pre-elimination levels	Percentage of confirmed malaria cases treated	90%
	Proportion of pregnant women who received three or more doses of IPTp (IPTp≥3)	90%
	Percentage of children 6-59 months who slept under an ITN	90%
	Percentage of population at risk sleeping under an ITN	85%
Ensure reduction in the incidence and prevalence of Tuberculosis	TB Incidence rate (per 100,000 population)	100
	TB Notification Rate (per 100,000 population)	95
	TB effective treatment coverage	90%
	% HIV positive new and relapse TB patients on ART during TB treatment	100%
	% of people with confirmed RR-T and or MDR-TB that began second -line treatment.	80%
Ensure reduction in the incidence and prevalence of HIV/AIDS	Number of people newly infected with HIV per year.	6000
	% of people living with HIV who know their status	80%
	Antiretroviral therapy coverage/% of people on ARV	65%
	% of people living with HIV, receiving treatment, who have suppressed viral loads.	65%

	Coverage of pregnant women who receive ART for PMTCT (%)	85%
	Mother to child transmission rate (%)	8%
Ensure reduction in the incidence, morbidity, and mortality due to Viral Hepatitis	% of general population with comprehensive knowledge on viral hepatitis	50%
	% of pregnant women screened for Hepatitis B	80%
	Proportion of blood units screened for blood borne diseases	100%
	% of Hepatitis B treated	50%
	% of Hepatitis C cured	20%
Ensure reduction in the incidence, morbidity, and mortality due to Sexually Transmitted Infections (STIs)	% of pregnant women attending antenatal care screened for syphilis	85%
	% of girls fully HPV vaccinated	50%
	% of women screened for cervical cancer	20%
Ensure reduction in morbidity, disability, and mortality due to Neglected Tropical Diseases (NTDs)	Number of people requiring interventions against tropical diseases	2.5 million
	Integrated Treatment Coverage Index of preventive chemotherapy NTDs (onchocerciasis, soil transmitted helminths, lymphatic filariasis, trachoma and schistosomiasis).	90%
	Percentage of endemic counties where transmission of Human African Trypanosomiasis (sleeping sickness) has been interrupted.	24%
	Percentage of endemic counties reporting <1% case fatality rate due to primary visceral leishmaniasis	21%
	Guinea Worm Incidence	0

Strategies and Interventions for Communicable Diseases and Neglected Tropical Diseases

Objective 1: Ensure reduction in morbidity and mortality due to malaria towards pre-elimination levels	
Strategies	**Interventions**
Strengthen and sustain management and coordination capacity of the Malaria control program	Capacity building for Malaria leadership and governance.
	Strengthen partner coordination.
	Update, disseminate and implement Malaria policy, strategy, and guidelines.
Strengthen Malaria surveillance, monitoring & evaluation, and operational research	Strengthen Malaria routine information collection, reporting and use.
	Conduct insecticides and anti-malarial resistance monitoring.
	Conduct 2 Malaria Indicator Surveys
Achieve universal access to diagnosis and treatment of all presented malaria cases	Scale up access to parasitological diagnosis & treatment.
	Scale up chemoprevention in targeted areas.
Protect the population at risk by recommended malaria prevention	Universal distribution of long lasting ITNs (campaigns and routine).
	Conduct Indoor Residual Spraying (IRS) in targeted areas.
Increase community knowledge, attitudes, beliefs & practices for malaria prevention & control	Review and implement malaria SBCC strategy aligned to the findings of the knowledge, attitudes, beliefs & practices survey.
Objective 2: Ensure reduction in the incidence and prevalence of Tuberculosis	
Scale up prevention, case detection, diagnosis, and treatment at all levels	Expand access to preventive and quality assured TB diagnostic & treatment services.
	Establish Specimen transportation system for early diagnosis.

	Increase treatment success rate.
	Procure and distribute quality anti-TB drugs (first- and second-line drugs) & other supplies.
	Establish appropriate infrastructure for drug-resistant TB in each of the 36 DR-TB treatment centers.
	Strengthen surveillance and reporting of TB.
Integrate programs & services of TB and HIV care	Promote programmatic integration of HIV/STIs/TB/RMNCAH/NCDs at all levels.
	Conduct joint training across the targeted programs.
Support community systems for TB and HIV care	Ensure systematic contact tracing and management in the community.
	Train BHWs on TB/HIV care and support.
	Involve civil society in health promotion, care, and support for TB/HIV.
Objective 3: Ensure reduction in the incidence and prevalence of HIV/AIDS	
Ensure comprehensive HIV prevention services are accessible to key populations, including high risk groups, prisoners, and migrants	Expand services delivery to reach the most vulnerable and high-risk groups, such as the young girls, sex workers, etc.
	Expand combination or biomedical prevention interventions among priority populations.
	Provide comprehensive prevention packages that include behavioural and barriers to access to services.
Ensure access to innovative testing & effective HIV case finding	Promote evidence-based approaches for demand creation of HIV testing services.
	Scale up effective testing approaches to improve HIV case finding.
	Build capacity of health care workers and community structures (community-based organizations, community-based health workers) for treatment and provision of home care.
Expand coverage of ART at national & subnational levels	Ensure rapid ART initiation with WHO recommended treatment regimens for all people living with HIV (PLHIV).
	Expand high quality service package to high burden and priority populations through decentralized and differentiated service delivery.
	Ensure optimal treatment monitoring to address HIV drug resistance, drug toxicity and promote patient safety.
	Strengthen services for chronic care for a better quality of life.
	Promote community engagement and support to reduce interruptions in treatment and back to care campaigns.
Eliminate vertical transmission for HIV	Promote and expand HIV/Syphilis/Hep B rapid diagnostic testing among pregnant women to support integration and triple elimination.
	Ensure HIV testing services are integrated in all ANC/delivery/PNC clinics.
	Ensure that all pregnant women and who are living with HIV are on ART.
	Ensure the availability of and access to early infant diagnosis services, viral load, and paediatric testing through decentralization of point of care technologies.
Objective 4: Ensure reduction in the incidence, morbidity, and mortality due to Viral Hepatitis	
Strengthen advocacy, social mobilization and behavior change communication on viral hepatitis B and C prevention, testing & treatment	Scale up prevention through awareness creation campaigns among the general population, health care providers and key populations at risk for protection from viral hepatitis.
	Strengthen community & civil society engagement and risk communication to reduce stigma & discrimination associated with hepatitis in the community.

Effectively reduce blood borne infections of viral hepatitis B and C	Establish/scale up universal access to hepatitis B birth-dose and pentavalent vaccines.
	Integrate Hepatitis B and C testing among pregnant women for preventing the vertical (mother-to-child) transmission.
	Ensure primary prevention via blood & injection safety, hepatitis B and C vaccination for infants and at-risk populations including health workers.
Expand Hepatitis B and C screening to identify people with chronic hepatitis infections & treat them	Increase access to hepatitis B and C testing and treatment of cases.
	Ensure a reliable supply of quality-assured diagnostics, equipment & medicines.
	Strengthen community and civil society engagement in addressing Hepatitis B and C.
	Promote integrated service delivery.
Objective 5: Ensure reduction in the incidence, morbidity, and mortality due to Sexually Transmitted Infections (STIs)	
Scale up primary prevention and increase access to screening for sexually transmitted infections including in priority populations	Advocate and scale up triple elimination of mother-to-child transmission of HIV, hepatitis B virus and syphilis.
	Promote use of integrated guidelines and tools for key populations.
	Implement a comprehensive HPV vaccination program.
Increase access to high-quality, people centred case management of STIs	Provide effective & comprehensive case management for people with STIs & prevent onward transmission.
	Strengthen laboratory capacities and establish national integrated surveillance programs.
	Ensure access to cervical cancer screening for the target groups.
Strengthen integration of STIs services with BPHNS/RMNCAH+	Develop guidelines and tools for integration of STIs with HIV, TB, viral Hepatitis, and RMNCAH.
	Strengthen community systems for effective STIs prevention & early treatment.
	Strengthen timely collection, analysis, and reporting on STIs in DHIS2.
Objective 6: Ensure reduction in morbidity, disability, and mortality due to Neglected Tropical Diseases (NTDs)	
Strengthen leadership and capacity for NTDs programming and implementation	Finalize and implement the National NTDs masterplan 2023-2027.
	Strengthen leadership at the department of NTDs at national and subnational levels.
	Capacity building of program managers at all levels in NTDs program management, reviews, monitoring and evaluation.
	Capacity building of health care workers/ service providers at all levels in NTDs service provision and reporting.
	Capacity building of BHI teams on NTD interventions, community mobilization, surveillance and mass drug administration and reporting.
	Integrate NTDs data into health management information system/DHIS2.
Strengthen prevention, early detection, diagnosis, treatment, and care of NTDs	Scale up health education activities for NTDs prevention.
	Scale up early detection & diagnosis of NTDs with emphasis on hot spots.
	Scale up effective case management of NTDs with emphasis on hot spots.
	Strengthen community-based distribution of medicines for PC-NTDs.

Scale up Guinea worm eradication interventions to interrupt its re-emergence	Collaborate with relevant sectors to promote and scale up investment for access to safe water and sanitation.
	Collaborate with other sectors for prevention of guinea worm in animals.
	Promote active and passive surveillance for early detection through BHI.
	Implement reward system as incentive for case reporting and compliance to treatment.
	Contain all suspected and confirmed cases.
Strengthen integration, partnerships, and inter-sectoral collaboration	Establish/strengthen linkages/integration with vector control and environmental management.
	Strengthen coordination/collaborative framework with health sector stakeholders, partners, relevant sectors for harmonization and synergy of NTD program implementation.
	Strengthen cross-border collaboration with endemic neighboring countries.

Program Area 4: Non-Communicable Diseases, Mental Health, Oral, Eye, and Occupational Health

Objectives and Results for Non-Communicable Diseases, Mental Health, Oral, Eye, and Occupational Health

Objective	Indicator	Target (2027)
Ensure reduction in morbidity and mortality due to Non-Communicable Diseases	Raised blood pressure among adults	18%
	Cervical cancer screening coverage	30%
Ensure reduction in the incidence and prevalence of mental health illness and substance abuse	Coverage of services for severe mental health disorders	10%
Ensure provision and utilization of oral health care services	Coverage of oral health services	10%
Ensure provision and utilization of eye care health services to reduce the burden of avoidable blindness	Number of specialized eye care centers established	3
Ensure provision and utilization of occupational health services	Coverage of occupational health services	10%

Strategies and Interventions for Non-Communicable Diseases (NCDs), Mental Health, Oral, Eye and Occupational Health

Objective 1: Ensure reduction in morbidity and mortality due to Non-Communicable Diseases	
Strategies	**Interventions**
Promote healthy lifestyles and prevent NCDs and NCD Risk factors	Develop and implement a national multi-stakeholder Strategy for NCDs and NCD Risk factors.
	Establish the burden of NCDs and NCD risk factors and monitor trends.
	Adapt technical packages for control of NCD risk factors: Tobacco use, harmful use of alcohol, lack of physical activity, unhealthy diet, and prevention of road traffic injuries.
	Scale up cancer screening and human papillomavirus (HPV) vaccination.
	Promote and scale-up awareness raising for healthy lifestyle for

	prevention of NCDs.
Strengthen service delivery for NCDs at primary, secondary and tertiary levels	Integrate early diagnosis and management of common NCDs to PHC.
	Integrate management of severe NCDs to secondary care (State hospitals).
	Provide cancer care and rehabilitation services for NCD complications at tertiary hospitals.
	Establish centres of excellence – Diabetes centre and Cancer treatment centre (Regional centres of Excellence – infrastructure, HR, diagnostics, medicines).
Strengthen multisectoral collaboration on the control of NCD risk factors (tobacco, alcohol, and substance abuse & other NCDs + road safety)	Ensure that WHO Framework Convention for Control of Tobacco is adopted & ratified.
	Enact and implement alcohol laws and regulations.
	Ensure a concrete plan to reduce traffic morbidity & mortality is developed & implemented.
Objective 2: Ensure reduction in the incidence and prevalence of mental health illness and substance abuse	
Strengthen Mental Neurological and Substance abuse services in communities and Primary Health Care	Strengthen Mental Neurological and Substance abuse unit at national MoH & SMoH to lead programming and delivery of services.
	Adapt and implement suicide prevention strategy.
	Strengthen mental health and substance abuse services in the community, schools, Defence forces and line ministries.
	Implement community awareness raising programs on mental health and substance abuse.
Strengthen delivery of Mental Neurological and Substance abuse services in secondary and tertiary health care	Develop the Mental Health Act to create the legal environment for promotion of mental health and services delivery.
	Integrate mental health assessment and management to hospitals and PHC centres.
	Establish 3 regional referral mental health facilities to cope with the high burden of mental disease.
	Establish 3 regional drug rehabilitation centres
Integration of Mental Health and Psychosocial support in Emergency Settings	Strengthen coordination of mental health in emergency programme.
	Implement effective interventions in emergency settings MSP, PFA, SH+ (survivals).
	Capacity building of health care providers on mental health service provision in emergency settings.
	Scale up SBCC with mental health key messaging in emergency programming.
Objective 3: Ensure provision and utilization of oral health care services	
Scale up access to oral health care services through integration in primary, secondary, and tertiary healthcare services	Develop the oral health service delivery norms, standards, and guidelines for primary, secondary, and tertiary care.
	Build capacity of healthcare workers on basic oral care at all levels of care.
	Develop and implement a strategy and guidelines for oral health promotion and prevention.
	Procure relevant dental equipment appropriate for each level of care.
	Include dental supplies in the essential devices list.
Objective 4: Ensure provision and utilization of eye care health services to reduce the burden of avoidable blindness	
Expand access to Eye Care and Visual Health Services at all levels	Scale up eye care and visual health services including provision of medicines, supplies and equipment.

	Build capacity and ensure availability of adequate number of skilled eye care personnel at all levels.
	Advocate for development of eye care services at subnational level.
	Conduct mass eye screening including cataracts, refractive errors, and corrective surgeries
	Establish two regional Specialized Eye Care Centres in Wau and Malakal to serve as hubs for specialized eye care.
	Conduct periodic surgical camps for eye care cases.
Objective 5: Ensure provision and utilization of occupational health services	
Scale up access to occupational health services for high risk/vulnerable individuals	Collaborate with other ministries to ensure that all private and public workplaces are safe & secure.
	Develop and disseminate guidelines on occupational safety and hazards.
	Build capacity of health workers on basic occupational health.
	Institute and conduct occupational risk assessments and put measures to mitigate risks/hazards.

Program Area 5: Emergencies, disasters, and humanitarian response

Objectives and Results for Public Health Emergencies and humanitarian response

Objective	Indicator	Target (2027)
Ensure reduction in the incidence and mitigate the impact of public health emergencies	Proportion of alerts investigated in 48 hours	90%
	Number of functional Public Health Laboratories that can test outbreak prone diseases	5
	Number of functional Emergency Operations Center (EOCs) at national and subnational levels	7
	Average of 13 International Health Regulations (IHR) capacity scores	50%
	Proportion of outbreaks investigated, confirmed, and responded to	90%
	Case fatality rate (% of reported cases of epidemic diseases - cholera, measles, COVID-19 etc., which are fatal)	1%

Strategies and Interventions for Public Health Emergencies and humanitarian response

Objective 1: Ensure reduction in the incidence and mitigate the impact of public health emergencies	
Strategies	**Interventions**
Strengthen capacity for detection and response to health emergencies at all levels (national and subnational)	Strengthen Integrated Disease Surveillance and Response.
	Strengthen Public Health Emergency Operations Centers to ensure MoH leadership for effective multi-sectoral response coordination mechanism.
	Strengthen Rapid Response Teams for effective response at national and subnational levels.
	Build capacity of public health laboratory at national and

	subnational levels.
	Strengthen case management during emergency response including deployment of mobile medical teams.
	Improve availability and access of essential health services in vulnerable communities in humanitarian setting.
Strengthen capacity for preparedness to health emergencies at all levels (national and subnational)	Strengthen outbreak preparedness and international health regulations (IHR) core capacities.
	Develop All hazard contingency plans at national and state levels.
	Conduct simulation exercise and After-Action Review to test contingency plans.
	Develop/update/review country risk profiles for high threat public health events for each of the States.
	Conduct vaccination campaigns for vulnerable populations against common epidemic diseases (cholera, yellow fever, Ebola, Hep E, meningococcal meningitis, measles, COVID-19).
Reduce cross border spread of diseases	Scale up and strengthen surveillance at points of entry.
	Strengthen capacity of port health services for preparedness, detection and response to incoming threats.

3.4.1.2 Specific Objective Two: To Improve access, quality, and safety of health services delivery at all levels of *care*

Objectives and Results for Equitable Access, Quality and Safety

Objective	Indicator	Target (2027)
Enhance equitable access to the BPHNS at all levels	Total number of health facilities per 10,000 population	1.6
	% of population within 5kms of health facility	60%
	Service utilization rates (OPD visits per capita)	2
	Number of functional renovated health facilities	100
Improve quality and safety for delivery of the BPHNS at all levels	Quality-of-Care strategy in place and implemented	1
	Number of Quality-of-Care units established at National and State level	11
Improve diagnostic capacity and referral services	Number of functional ambulance teams	10
Improve availability and functionality of health infrastructure for BPHNS delivery	% of facilities equipped with infrastructure as per BPHNS norms	50%

Strategies and Interventions for Equitable Access, Quality and Safety

Objective 1: Enhance equitable access to the BPHNS at all levels	
Strategies	**Interventions**
Ensure rational, equitable development and distribution of health facilities (PHCU, PHCC and hospitals) at all levels	Establish regulations, norms, and standard operating procedures to guide establishment and management of health facilities.
	Rehabilitate and equip non-functional health facilities in phases.
	Develop long-term master plans for establishment and expansion of health facilities as well as annual/ medium-term plans for infrastructure investment.

	Develop and finance health facility-specific infrastructure maintenance plans.
Objective 2: Improve quality and safety for delivery of the BPHNS at all levels	
Establish and strengthen the institutional framework for quality of care at all levels of care	Establish a unit/department to lead quality of care programming and implementation at national and sub-national level.
	Develop a quality-of-care policy and strategy including development of service standards for all levels of care.
	Develop and implement relevant legislation/regulatory framework for quality of care.
Strengthen and expand the capacity for quality-of-care implementation	Develop and apply service standards, guidelines, and protocols for the different health facility types (PHCU, PHCC, Hospitals).
	Establish and implement a continuous quality improvement and accreditation system for all health facilities (PHCU, PHCC, Hospitals).
	Strengthen and scale up infection prevention and control capacities at all levels of care.
	Enhance community awareness and patient empowerment on quality of care.
	Build capacity of the health care workers on quality-of-care improvement.
Objective 3: Improve diagnostic capacity and referral services	
Expand access and utilization of diagnostics and specialized curative services	Establish national regulatory framework for diagnostic and imaging technologies, including Health Technology Assessment Institutional framework.
	Develop investment plan for diagnostic and imaging technologies.
	Develop and update list of essential diagnostic and imaging technologies.
	Develop and implement guidelines for rational procurement, distribution and use of diagnostics and imaging technologies.
	Establish and implement maintenance and replacement plans for diagnostic and imaging technologies.
	Establish regional specialized accident and emergency services.
	Expand availability and access to specialist medical services for inpatient care.
	Establish a pathology and forensic laboratory for improving medical care.
	Establish a national oncology center.
Strengthen referral mechanisms between the levels of care	Develop and implement guidelines for referral and feedback mechanisms between all levels of care.
	Establish a national ambulance services referral system.
	Establish a regulatory framework/legislation to ensure an equitable and cost-effective system for overseas referral.
Objective 4: Improve availability and functionality of health infrastructure for BPHNS delivery	
Establish Norms, Standards and regulatory framework for health infrastructure and equipment	Develop norms and standards for medical equipment, transport, ICT equipment and accredited design for the various health facilities (PHCU; PHCU; Hospitals) types.
	Develop an essential medical equipment, transport and Information and Communications Technology (ICT) list.
Ensure effective planning and maintenance of health infrastructure	Develop and implement a medium-term medical equipment, transport, and ICT investment plan in collaboration with relevant sectors.
	Develop and implement maintenance plans for medical equipment, transport, and ICT equipment.
	Build capacity of health workers on basic occupational health.
	Institute and conduct occupational risk assessments and put

	measures to mitigate risks/hazards.
Secure funding for and improve health infrastructure	Engage in sustained policy dialogue and advocacy for resource mobilization for health infrastructure: medical equipment, transport, ICT.
	Procure and equitably distribute medical equipment, transport, and ICT equipment.
	Strengthen inter-sectoral collaboration and advocacy for health infrastructure improvement.

3.4.2 Strategic Objective 2

To strengthen leadership and management of the health system and increase health system resources for improved health sector performance.

3.4.2.1 Specific Objective One: Human Resources for Health

Objectives and Results for Human Resources for Health

Objective	Indicator	Target (2027)
Scale up the production, strengthen management and development of the human resources for health required for effective delivery of the basic package of health and nutrition services	Health workforce density (per 10,000 of population)	10
	HRH Policy, Strategy and Manual developed and in use	1
	HRH Information system established and in use	1
	Number of professional regulatory bodies/councils established and functional	4
	Percentage of health science training institutions that are accredited	70%

Strategies and Interventions for Human Resources for Health

Objective 1: Scale up the production, strengthen management and development of the human resources for health required for effective delivery of the basic package of health and nutrition services	
Strategies	**Interventions**
Strengthen the health workforce governance, leadership & regulatory mechanisms	Strengthen HRH leadership and regulatory capacity at national and subnational levels through establishing/strengthening HRH units and capacity building of HRH unit staff.
	Strengthen capacity of HRH regulatory bodies and professional associations of the various cadres.
	Review and implement the HRH policy, strategy, and manual.
Strengthen HRH information for planning and management	Institutionalize and expand Human Resources for Health Information System (HRHIS)/health workforce registry to foster planning, management, and projections of relevant health workforce.
	Conduct a national health workforce account to inform HRH planning and management.
Scale up production of appropriate health workforce based on need	Review and update the training curricula for the various health cadres based on contemporary/global standard curriculum.
	Engage Ministry of Higher Education in the accreditation of Health Science Training Institutions (HSTI) to ensure the

	establishment of quality assurance and accreditation framework for HSTIs.
	Expand and upgrade the infrastructure of the current HSTI in line with regulatory standards.
	Establish new and upgrade existing skills laboratories with the existing HSTI.
	Recruit appropriate numbers and skill mix of tutors and clinical instructors for the HSTI based on regulatory standards.
	Establish appropriate clinical training sites for the HSTI.
	Establish affirmative action outreach programs to promote an equitable gender sensitive enrollment of students in HSTI.
	Establish and scale up appropriate task shifting programs based on need.
Scale up postgraduate/specialist training of appropriate cadre based on need	Support Juba College of Physicians and Surgeons training program, including upgrading the infrastructure in line with regulatory standards, and establishment of an E-learning program for in and pre-service training.
	Establish post graduate residence program within the country.
	Allocate 150 international residency training program scholarships for South Sudanese professionals abroad.
Ensure effective recruitment, deployment and retention policies and practices	Plan and fund equitable recruitment and deployment of the appropriate skill mix of health workers based on needs.
	Improve working conditions, remuneration and living conditions of health workers.
	Develop and implement a comprehensive and appropriate motivation and retention policy/ strategy.
Strengthen HRH multisectoral coordination and collaboration	Establish/strengthen HRH coordination forum at National and State levels.
	Strengthen partnership between Ministry of Health and Ministry of Education on HRH production/training.
	Establish Public Private Partnerships for HRH production/training.

3.4.2.2 Specific Objective Two: Essential Medicines, Supplies, Technologies, and Laboratory Systems

Objectives and Results for Essential Medicines, Supplies, Technologies, and Laboratory Systems

Objective	Indicator	Target (2027)
Promote sustainable and equitable access to pharmaceuticals and related health technologies	Availability of tracer medicines (% of health and nutrition products on essential drugs list available at Service Delivery points)	80%
	Percentage of pharmaceuticals expired at heath facility level	2%
	Percentage facilities reporting stock out of core set of essential and relevant medicines including nutrition supplies	15%
Strengthen a national quality laboratory system that is safe and reliable for effective diagnostic services	Proportion of laboratories reporting stock-outs of tracer reagents	<10%
	Proportion of laboratories conforming to minimum standards	70%
Strengthen the national blood transfusion services to ensure access to safe and adequate blood supplies	Number of hospital-based blood banks providing safe blood transfusion services	14
	Number of blood banks with adequate cold chain	14

Strategies and Interventions for Essential Medicines, Supplies, Technologies, and Laboratory Systems

Objective 1: Promote sustainable and equitable access to pharmaceuticals and related health technologies.	
Strategies	**Interventions**
Strengthen the governance structures, processes, and systems within the pharmaceutical sector	Build and strengthen the capacity of the directorate of pharmaceuticals at National level and corresponding structures at State level to provide effective leadership of the sector.
	Establish and/or strengthen pharmaceutical coordination structures at National and State level.
	Establish a High-Level Coordination Mechanism for the MoH and the major donors/partners (roundtable) including the SMoH.
	Advocate for incremental investments in the pharmaceutical sector from Government, Partners, and the Private Sector.
	Develop/deploy Pharmaceutical Information Management Systems to support monitoring and evaluation, including electronic system for inventory management.
Strengthen the pharmaceutical supply chain to deliver safe, efficacious, and affordable essential medicines and supplies and their rational use in a sustainable and equitable manner	Establish and institutionalize an autonomous South Sudan Central Medical Supplies Agency (CMSA) including passing CMSA bill; funding/budgetary allocation to CMSA; CMSA business & operational model.
	Advocate for and secure Government budgetary allocation and disbursement for financing medicines supply.
	Align and integrate all parallel supply chain systems within the framework of CMSA.
	Adopt and strengthen the pull system for supply of essential medicines and supplies.
	Establish functional committee under the Pharmaceutical Technical Working Group for the Selection of Medicines and Development of Guidelines (National Medicines Selection and Guidelines Sub-committee); and subsequently build capacity of components of medicines selection and transparently conduct selection.
	Regularly organize transparent multi-stakeholder quantification workshops to forecast country needs, with States and County analysis based on data from LMIS/Pharmaceutical Information Management System and annual supply chain review meetings.
	Update and Disseminate South Sudan National Medicines Donations Guidelines, with orientation on new modalities for donations.
	Regularly update and disseminate South Sudan Essential Medicines List and South Sudan Standard Treatment Guidelines and conduct orientation/training of prescribers on changes made and monitor compliance.
	Develop, disseminate, and regularly update a Priority essential medical devices and assistive products list.
	Develop/adapt Drugs and Therapeutics Committees operational manual and technical guidelines for South Sudan and establish/supervise the Drugs and Therapeutics Committees at all Teaching Hospitals/State Hospitals.
	Develop drug disposal protocol for South Sudan and conduct dissemination/orientation for all stakeholders.
	Design, implement, monitor public education campaign on rational use of medicines.

Strengthen the regulatory framework and quality management process within the pharmaceutical sector	Strengthen and build the capacity of the Drug and Food Control Authority (DFCA) at National and corresponding structures at State level to provide effective regulation and quality management of the sector.
	Review the DFCA Act 2012 and develop its implementation and enforcement framework.
	Establish and operationalize a comprehensive quality control and quality assessment laboratory network, including a central laboratory and smaller laboratories at the points of entry and regional mini laboratories.
	Establish a continuous improvement and strengthening program for the Quality Management System.
	Establish a Pharmacy Council to regulate pharmacists and Pharmacy Technicians.
	Develop regulatory standards for premises for pharmaceutical services at all levels including the practices of Pharmacy Technicians.
	Establish a national pharmaco-vigilance institutional framework with Central and State centers.
	Develop and implement Standards of Practice, including training on Standards through mandatory Continuing Professional Development for all pharmaceutical cadre including Pharmacy Technicians.
Build capacity and strengthen pharmaceutical systems to deliver sustainable and equitable access	Establish mechanism for monitoring medicines prices within the health system, with key focus on private sector supply chain.
	Conduct pharmaceutical sector costings to inform budgets and funding for the supply of medicines based on the minimum services package.
	Engage partners and government to mobilize resources, establish human capacity development for the pharmaceutical sector, recruit a pharmaceutical expert to support MoH policy and strategy implementation.
	Develop and implement HR Strategy for the pharmaceutical sector and advocate for improved conditions of service.
	Develop a continuous professional development program for pharmaceutical cadre.
	Build a business case for investment in pharmaceuticals and advocate for establishment of an infrastructure development fund for the pharmaceutical sector.
	Conduct in-depth assessment of the pharmaceutical private sector market structure (including assessment of economic impact and growth and national manufacturing potential).
	Establish and operationalize a multi stakeholder platform for addressing antimicrobial resistance (AMR).
	Develop and implement a policy and plan for AMR and Antimicrobial use as well as governance structures (antimicrobial resistance coordinating committee) and mechanisms for combating AMR.
	Develop policy and guidelines for selection and procurement of pharmaceuticals and related health technologies in emergencies and pandemics.
	Advocate for legislative provisions/regulations to support implementation of antimicrobial resistance and rational use of medicines.
	Conduct specific studies on the Pharmaceutical Sector for critical data including: ‘Pharmaceutical Sector Scan’; ‘Good governance of medicines’; ‘WHO level 2 assessment’; Product Quality; Supply chain; Mapping of Medicines Outlets; Pricing; Household surveys; Adherence to treatment guidelines, etc.

Objective 2: Strengthen the national quality laboratory system that is safe and reliable for effective diagnostic services	
Strengthen the laboratory institutional governance, regulatory frameworks, policies, and standards	Establish Directorate of Health Laboratory Services in the Ministry of Health with its organizational and management structure.
	Review & update national laboratory policies/guidelines and manuals essential for the regulatory framework with specifications and procedures for regulating public and private laboratories.
	Establish and operationalize laboratory inter-agency coordination committee.
	Establish and operationalize a National Regulatory Body for the national laboratory services, training, and practice.
	Develop and disseminate national standard operating procedures for all laboratory procedures including minimum essential packages of tests, techniques, major equipment, and appropriate staffing.
Ensure availability of appropriate laboratory infrastructure, equipment, and supplies at all levels	Develop standards for laboratory infrastructure including building design/size/departments/staffing and ensure compliance by all stakeholders.
	Develop guidelines for laboratory equipment, reagents, and utilities for all levels.
	Procure, supply, distribute and equip the public health laboratories with essential consumables/reagents/test kits as per the guidelines.
	Institute and implement a laboratory equipment preventive maintenance, decommissioning and disposal mechanisms.
Ensure laboratory quality management, safety, and waste management	Develop and disseminate guidelines on collection, storage, and transportation of specimens to higher level laboratories, the national and regional reference laboratories, and international laboratories.
	Scale up the national laboratory quality management system, including internal quality control, external quality assessment, quality audits, supervisory and mentoring systems.
	Review, update and implement existing Biosafety and Biosecurity manuals/policies and Standard Operating Procedures.
	Establish a national laboratory accreditation scheme, including Stepwise Laboratory Improvement Process Towards Accreditation.
Strengthen laboratory information systems, surveillance, and research	Develop a national integrated Laboratory Information Management System (LIMS) that is aligned to/inter-operable with the national Health Management Information System (HMIS), the District Health Information Software 2 (DHIS2).
	Develop and implement a national research agenda for the national laboratory services.
	Conduct relevant population surveillance for antimicrobial resistance and ensure integration with the national Integrated Disease Surveillance and Response (IDSR) system.
Strengthen the laboratory workforce capacity and practice	Develop and implement a human resource development plan for the national laboratory network.
	Review & update laboratory human resources nominal roll.
	Review and update curricula for pre-service training of all laboratory professionals.
	Institute continuous professional development programs for all laboratory professionals.

Objective 3: Strengthen the national blood transfusion services to ensure access to safe and adequate blood supplies	
Strengthen the blood transfusion services institutional governance, regulatory frameworks, policies, and standards	Establish and institutionalize an autonomous National Blood Transfusion Services (NBTS) including drafting its legal framework/governance legislation, organizational and management model, budget/sustainable financing.
	Development and implement a NBTS strategic plan.
	Establish a national blood transfusion coordination mechanism.
Strengthen national blood transfusion services infrastructure, equipment, and supplies	Conduct a needs assessment to strengthen the blood center infrastructure and blood banking facilities.
	Develop and disseminate guidelines, SOPs and processes for infrastructure development and equipment maintenance and Management.
	Develop and implement Procedures for equipment and ICT procurement and standardization.
	Develop and implement policies and plans for supply chain management for essential materials and supplies,
	Develop and implement policies and plans for safe waste management in NBTS and hospitals.
Scale up blood collection, blood testing and production of blood products	Develop and implement a community mobilization, awareness creation, donor recruitment and retention strategies and plans.
	Establish a system for donor education, donor screening/selection; blood collection, donor care; handling and storage of donated blood; and blood donor notification for test results, counseling, and referral for treatment.
	Strengthen capacity and networks of the blood donor recruiters/counselors for recruitment of voluntary non-remunerated blood donations.
	Expand and strengthen blood collection sites across the country, either integrated with larger healthcare facilities, or as stand-alone or mobile sites to increase blood collections.
	Develop and disseminate protocols, SOPs, donor questionnaire forms and training materials for donor selection, counseling, blood collection, handling and storage, transportation, and distribution of blood.
	Develop and implement protocols and algorithms for HIV and other Transfusion Transmitted Infections (TTI) based on internationally accepted standards.
	Establish and implement quality assurance systems and good laboratory practice, including the use of SOPs and protocols and appropriate documentation, in all aspects of TTI screening, sero-typing and cross matching.
	Establish a system based on good manufacturing practice in all aspects of blood component production, including maintenance of blood cold chain systems and blood inventory management.
	Build capacity for evaluation, selection, and validation of test kits for appropriate and effective assays to be used; and in the management of procurement, supply, central storage and distribution of test kits and critical consumables to ensure continuity in testing at all sites.
	Train NBTS laboratory technical staff in all aspects of testing for TTI, sero-typing, cross matching, blood components production, handling, storage, and transportation of blood products with emphasis on SOPs, efficient record- keeping, quality assurance and quality control systems.
Ensure effective and efficient transfusion and blood utilization	Develop and/or update national guidelines and standards for the safe and appropriate use of blood and blood products.
	Identify a center of excellence as a pilot site, for the establishment of a hospital transfusion committee and

	hemovigilance system to monitor use of blood, adverse transfusion events and overall patient outcomes.
	Develop a training of trainers (ToT) system and mentoring of hospital and NBTS staff by the pilot site, to increase number of functional hospital transfusion committees and develop a hemovigilance system.
	Collect, collate, and report on blood utilization from all hospitals receiving blood from the NBTS.
Strengthen quality assurance system for national blood transfusion service	Conduct a needs assessment of the status of quality system in NBTS and develop recommendations and plans for improvement.
	Establish an effective quality assurance system in blood centers and hospital blood banks.
	Facilitate collaboration to support the development of external quality control agreements between NBTS and internationally accredited laboratories.

3.4.2.3 Specific Objective Three: Health Financing

Objectives and Results for Health Financing

Objective	Indicator	Target (2027)
Ensure adequate and sustainable health financing for equitable access of essential health services by all South Sudanese without financial hardship	Health allocation as percentage of national budget	10%
	Percentage of MoH budget implemented (Budget execution rate)	100%
	Total Health Expenditure as percentage (%) of GDP	15%
	Externally sourced funding as % of current health expenditure	50%
	Out-of-pocket expenditure as a percentage of current health expenditure	20%

Strategies and Interventions for Health Financing

Objective 1: Ensure adequate and sustainable health financing for equitable access of essential health services by all South Sudanese without financial hardship	
Strategies	**Interventions**
Strengthen the health financing governance, leadership & policy frameworks	Strengthen/establish health financing departments/units' capacity at National and State levels to provide oversight for health financing programming and implementation.
	Establish and build capacity of health financing technical working groups at National and State level to strengthen coordination and oversight over health financing programming/implementation.
	Review, update and implement the Health Financing Strategy.
Increase sustainable funding for health	Advocate for and ensure progressive increased government budgetary allocation to health as well as timely and complete release of funds.
	Mobilize external/donor funding for health and ensure alignment and harmonization with national priorities.
	Explore and advocate for increased domestic revenue for health using innovative financing mechanisms such as taxes on alcohol, sugar, tobacco, and other taxes.

	Explore and generate evidence for establishing health insurance schemes to mobilize additional funding for health.
	Explore and use evidence-based advocacy and policy for limited/tailored user fees/cost recovery mechanisms for selected secondary/tertiary health services.
Strengthen public financial management systems within the health sector	Review, plan and implement feasible and actionable recommendations of the health sector public financial management assessment.
	Build capacity for public financial management at National and State levels.
	Advocate for and ensure effective participation of the health sector in the budgetary processes at National and State level.
	Establish/strengthen health expenditures tracking mechanisms including the State and County Transfers monitoring committees.
Support regular generation of health financing information for decision making	Conduct National Health Accounts every 2 to 3 years (inclusive of humanitarian funding) and ensure its use in policy dialogue for health financing reforms.
	Conduct regular health expenditure tracking surveys and expenditure reviews for public and partner resources.

3.4.2.4 Specific Objective Four: Health Information Systems

Objectives and Results for Health Information Systems

Objective	Indicator	Target (2027)
Strengthen the generation, analysis and use of health data and information for evidence-based decision making at all levels	Proportion of health facilities reporting on time	90%
	Completeness of reporting by facilities	90%
	IDSR timeliness	90%
	IDSR completeness	90%
	Proportion of health facilities reporting directly through DHIS2	90%
	Percentage of States that conducted Data Quality Assessment (DQA)	80%
	Birth notification coverage	55%
	Death notification coverage	55%
Strengthen monitoring and evaluation systems at all levels	Percentage of programs conducting annual performance reviews	80%

Strategies and Interventions for Health Information Systems

Objective 1: Strengthen the generation, analysis and use of health data and information for evidence-based decision making at all levels	
Strategies	**Interventions**
Strengthen the health information system governance, leadership & policy frameworks	Establish/strengthen health management information systems departments/units' capacity/organizational structure at National, State, County levels; and ensure appropriately qualified staff in place.
	Develop the institutional, policy and legislative frameworks and standards, guidelines and SOPs for data architecture, collection, reporting, management, financing, and staffing.
	Establish/ strengthen HMIS multi-sectoral technical working group for effective coordination.
Strengthen the systems for generation, storage, use and transmission of HMIS data	Procure, install, and use appropriate ICT infrastructure, hardware, and software to support data management in all health facilities.
	Procure and deploy the standard HMIS tools in all health service delivery points (public and private) and build capacity for their appropriate use.

	Develop the appropriate health information system architecture, relevant standards, and guidelines for application of ICT infrastructure for data collection and management at all levels.
	Develop and implement an effective data governance, data security and backup structure as well as ensuring system maintenance and sustainability.
	Ensure the integration and interoperability of the various data systems including HMIS/DHIS2, IDSR, Civil Registration and Vital Statistics (CRVS) and information sub-systems (LMIS, HRHIS).
	Build the capacity and skills of health staff on data management through pre- and in-service training programs, mentorship, coaching and exchange programs-best practice tours.
	Develop, disseminate, and advocate for use of information products for decision making at all levels including documentation of best practices.
	Capacity building of managers and staff on use of information and data for evidence-based decision-making.
	Institutionalize the conduct of data quality assessments and reviews.
Strengthen vital statistics systems	Strengthen CRVS through collaboration with relevant ministries to increase birth and death reporting; awareness creation on Medical Certification of Cause of Death and use of International Classification of Diseases (ICD)-11.
	Develop electronic recording, ICD-11 coding to improve the quality of identifying and reporting cause of death in health facilities and communities.
	Ensure availability of tools in all health facilities to increase births notification.
	Provide support and increase the percentage of facility deaths notified.
	Increase the proportion of community deaths registered with causes of death notified.
Strengthen health research and conduct surveys	Develop a regulatory framework and coordination mechanism for research.
	Set a research agenda and build the capacity for operational research among health professionals.
	Mobilize resources for health research.
	Promote application of research results to improve health interventions.
	Strengthen/institutionalize the conduct of population-based surveys including Demographic and Health Surveys, Mortality surveys etc.
Objective 2: Strengthen monitoring and evaluation systems at all levels	
Strengthen the Monitoring and evaluation institutional governance, regulatory frameworks, policies, and standards	Strengthen M&E units including revision of the M&E organizational structure and define roles and responsibilities at National, State and County levels.
	Build capacity of the M&E managers and staff at national and subnational levels, including in formulation and implementation of monitoring and evaluation plans.
	Integrate all current existing parallel partners/programs M&E mechanism into one national M&E system.
	Develop and implement one comprehensive health sector monitoring and evaluation work plan.
	Strengthen monitoring and evaluation coordination mechanisms (TWGs) and inter-sectoral collaboration at National, State and County levels.
Institutionalize health sector monitoring and evaluation activities	Conduct Joint Annual Health Sector Performance Reviews as well as program specific performance reviews; compile reports and engage in stakeholder policy dialogue.

	Conduct midterm and end term evaluations of the health sector strategic plans and program specific strategies.
	Conduct regular monitoring visits at all levels.
	Track, monitor and report progress towards health-related SDGs including universal health coverage.
	Regularly review and update health sector indicator reference guide/compendium.

3.4.2.5 Specific Objective Five: Leadership and Governance

Objectives and Results for Leadership and Governance

Objective	Indicator	Target (2027)
Strengthen the leadership and governance role of the Ministry of Health at all levels for effective health system performance and development	Ministry of Health and State Ministry of Health Organogram's reviewed and implemented.	14
	Ministry of Health costed Annual Operational Plan developed and implemented.	1
	% of State Ministries of Health with annual operational plans developed and implemented.	100%

Strategies and Interventions for Leadership and Governance

Objective 1: Strengthen the leadership and governance role of the health sector at all levels for effective health system performance and development	
Strategies	**Interventions**
Strengthen the institutional framework, authority, mandate, and accountability systems within the MoH, SMoH and CHD	Review & update the organizational structure of the health sector at national & subnational levels for effective management and oversight of operational needs.
	Define and align responsibilities of positions/actors and scope of authority in the updated organizational structure at all levels including aligning the scope of authority.
	Ensure appropriate staffing of the updated organizational structure of the health sector at all levels.
	Build capacity of health sector leadership/managers on Leadership and Management principles and practices at all levels.
	Define and strengthen the institutional frameworks and linkages between Ministry of Health and State Ministries of Health.
	Develop and implement appropriate performance monitoring systems including rewarding best practices and achievements.
Strengthen policy, strategy, legal and regulatory functions of the health sector	Ensure updated and relevant health sector and subsector/thematic policies, strategies and plans are in place and implemented.
	Build capacity for policy formulation, strategic and operational planning and budgeting at all levels including development of relevant guidelines for these processes.
	Develop, update & implement relevant laws/legal frameworks for health sector including enabling legal framework for universal health coverage; public health act, medical council bill, public health ordinances, by-laws, etc.
	Build capacity in MoHs to develop and revise appropriate laws/regulatory frameworks.
	Establish and strengthen regulatory bodies and professional councils/

	associations on their roles & responsibilities such as the South Sudan Medical Council etc.
	Institutionalize and strengthen health sector oversight, monitoring and supportive supervision capacity at all levels, including provision of regular feedback and learning loops across all levels of the system.

3.4.3 Strategic Objective 3

To strengthen partnerships for health service delivery and health systems development

Objectives and Results for Partnerships

Objective	Indicator	Target (2027)
Strengthen partnership for health service delivery and health systems development	Percentage of Health sector coordination meetings held at National level	100%
	Percentage of State Ministries of Health conducting regular coordination meetings	100%
	Percentage of Inter-ministerial/inter-sectoral coordination forum meetings held at National level	100%
	Public Private Partnership for Health Policy in Place	1

Strategies and Interventions for Partnerships

Objective 1: Strengthen partnership for health service delivery and health systems development	
Strategies	**Interventions**
Strengthen health sector coordination at all levels	Strengthen/establish health sector coordination departments/units' capacity at National and State levels to coordinate partners/stakeholders.
	Establish, build capacity, and ensure functionality of health sector coordination mechanisms/forums at National and State level.
	Develop/define and implement a comprehensive health sector coordination framework/architecture and guidelines clearly defining roles and responsibilities, and linkages between different coordination forums.
	Conduct regular joint partner/stakeholder performance monitoring, reviews, and supervision at all levels.
Ensure alignment of partnerships with national priorities and strategies	Develop and implement a Memorandum of Understanding (MOU)/compact between Ministry of Health and partners to ensure alignment and harmonization with National Health Policy/Health Sector Strategic Plan.
	Establish and regularly update an inventory of donor/partners support mapping mechanism clearly outlining 5Ws (Who, What, Where, When, Why).
Strengthen inter-ministerial and inter-sectoral collaboration	Establish an inter-ministerial/inter-sectoral forum addressing coordination for the determinants of health and implementation of the one health approach.
	Conduct inter-ministerial advocacy activities to address social determinants of health, one health approach, health financing and other relevant issues.
Strengthen Public-Private Partnerships for health systems development and service delivery	Conduct a comprehensive assessment and document the role of the private sector stakeholders in the health services delivery and health systems development.
	Conduct a national policy dialogue to generate consensus on the role of private sector in health services delivery and health systems

	development.
	Develop and implement a Public Private Partnership (PPP) engagement framework including legal and regulatory framework, policies, and guidelines for health sector.
	Conduct regular coordination meetings and dialogue with the PPP for health stakeholders.
	Establish and strengthen linkages with academic institutions to undertake relevant health sector research, monitoring and evaluations, and continuous professional education.
	Conduct joint monitoring (public and private) of health programs.

CHAPTER 4: MONITORING AND EVALUATION

4.1 Introduction

An overview of the HSSP monitoring and evaluation (M&E) logical framework, a set of core indicators and sources of information for data collection is presented in this chapter and Annex 1. The M&E framework has been developed in the context of the SDGs, UHC and the South Sudan National Health Policy 2016-2026.

The International Health Plus+ (2010) in collaboration with global health partners recommends a harmonized and coordinated country monitoring and evaluation of national health plans as summarized in **Figure 8**. It demonstrates how health inputs and processes (e.g., health workforce and infrastructure) are translated into outputs (e.g., interventions and available services), outcomes (e.g., service coverage) and impact (morbidity and mortality).

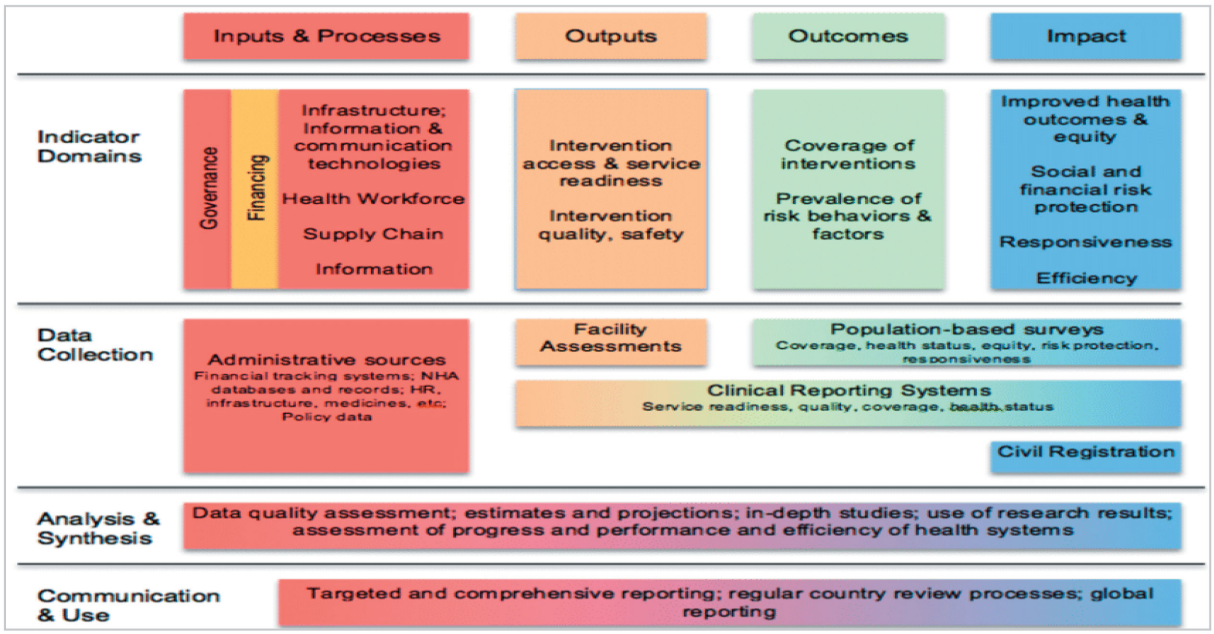


Figure 8: HSSP Monitoring and Evaluation logical framework

4.2 Data Architecture

The HSSP M&E framework proposes a harmonized health information system to improve the quality of data available for evidence-based decision making. Hence, the standardization of data collection tools and updating of the Indicator Reference List is recommended to create a common data architecture.

4.2.1 Data infrastructure

Data infrastructure and data flow needs to be strengthened to monitor progress towards attaining HSSP objectives and targets. All data sources (census, surveys, civil registration, HRHIS, financial, etc.) should be developed to their maximum capacity in order to capture and store all health-related data.

4.2.2 Human resource requirements

The situational analysis of the HMIS revealed overlapping roles and responsibilities between HMIS and M&E. There is need to establish HMIS unit under the office of the Director General for Policy, Planning, Budgeting and Research to support data management. Highly competent and skilled HMIS, M&E and research officers are needed to implement the HSSP M&E framework. In addition to data clerks' positions, new HMIS officers' posts should be created at national and subnational level to enhance data quality.

4.2.3 Responsibilities for HSSP M&E framework implementation

The HSSP requires the joint action of public and private health facilities to produce quality, timely data for evidenced–based decision-making. All health sector stakeholders and partners, under the leadership of the MoH at national and subnational level, are mandated to take responsibility to collectively use one health sector monitoring and evaluation system for tracking progress towards health sector priorities.

4.2.3.1 HMIS Officers

The HMIS unit will be responsible for the establishment, maintenance, harmonization, and alignment of Health Information Systems into a single unified system. The HMIS officers will also be accountable for data validity, reliability, precision, integrity, and timeliness to facilitate accurate reporting to the users of the data. They will also ensure that the data is of good quality through conducting regular data quality assessment and audits, investigating any inconsistencies in the data with the sources.

4.2.3.2 Monitoring and Evaluation Officers

The national M&E unit will be mandated to establish and oversee the common data architecture to ensure coordinated information generation, sharing and management. The M&E officers will be responsible for analyzing routinely collected data and strengthening data use for decision making at facility, community, subnational or national levels and producing health information products. The M&E officers will also ensure that strategic plans aligned to the HSSP, are developed at all levels, and provide technical assistance for program and HSSP evaluations.

4.2.3.3 Research Officers

The Research Unit will capitalize on the recommendations emanating from trend and statistical analyses, to formulate and implement a health sector research agenda.

4.2.4 Data Sources for HSSP

Routine data sources for HSSP M&E framework include health facility information systems, non-routine sources are households and other population-based surveys, CRVS and disease surveillance systems, health facility surveys and administrative data systems. Additional data sources will include program reports, training records and meeting minutes; Routine data will be collected on a monthly or quarterly basis, and survey indicators will be collected at baseline, midterm, and end term evaluation

of the HSSP implementation. The data sources for performance measurements against targets for the HSSP indicators are summarized in **Table 4** below.

Data sources	Type of data
National Bureau of Statistics	Population census Population bulletins Household Budget Surveys
Civil Status Office	Vital Statistics i.e., Births and deaths registrations
Health Facilities/services (Public/Private)	Service availability Service utilization Disease notification
Programs	Service coverage
Individual user records	Data on diseases and risk factors
Population surveys; User experience/ satisfaction etc.	Prevalence of disease, risk factors, service utilization/equity gaps
NHA, NHFWA	Data on resources (health financing and human resources)

Table 4: Data sources needed to report on HSSP indicators

4.3 Performance Monitoring and Review

The HSSP performance monitoring and review process is important to track progress towards attaining strategic objectives. It shall be conducted at regular intervals at community, health facility, Country, State and National level. The HSSP M&E framework recognizes that different stakeholders use different data for policy and evidence-based decision-making. Against this background, data generated from different sources needs to be translated into information for use at all levels. Information products and reports will be generated and disseminated to MoH and its stakeholders. The M&E technical working group shall be responsible for organizing and implementing quarterly and annual review meetings. **Table 5** illustrates the methods the MoH will adopt to monitor health sector performance.

Methodology	Frequency	Output	Focus	Level of monitoring and review
Performance monitoring	Quarterly	Quarterly performance reports	Conduct supportive supervision and mentorship; Track progress against planned activities and targets	Inputs, process, output, and outcome
Joint Annual review and planning	Semi-annual, Annual	Progress reports compiled and disseminated to stakeholders	Review progress towards targets and planned activities	Inputs, process, output, and outcome
Midterm review	Two and half years	Mid-term review report	M&E TWG will guide the midterm review process against targeted Impact	Inputs, process, output, outcome, and impact
End term evaluation	At the end of the HSSP	End term review report	Desk reviews, program data and surveys will be conducted	Input, output, outcome, and impact level

Table 5: HSSP performance review methods

4.3.1 Development of HSSP aligned annual operational plans

Annual operational plans and performance reports will be developed yearly at all National, County, State and Health Facility and Community level to facilitate performance monitoring and review processes. These plans will be aligned to the Health Sector Strategic Plan.

4.3.2 Quarterly Performance Review

Quarterly performance review meetings will be conducted at each level to monitor progress against planned activities and indicators. Performance review reports will be generated at health facility, States, Counties and National level. These reports will be reviewed and discussed by health management teams and its stakeholders during quarterly and annual performance review meetings. The information products that will be generated during the monitoring and review processes are, quarterly and annual progress reports.

4.3.3 Joint Annual Review and Planning

The national and subnational levels are expected to compile annual performance reports to monitor progress against planned activities, and indicator targets. These annual reports will be disseminated and discussed by MoH and its health stakeholders yearly during joint review meetings. The compilation of annual reports shall be coordinated by the office of the Director General for Policy, Planning, Budgeting and Research.

4.3.4 Midterm Review

A mid-term review will be undertaken after two to three years of HSSP implementation to determine the extent to which HSSP objectives and targets were met.

4.3.5 End term evaluation of the HSSP

The information from the mid-term review shall inform a re-alignment of strategies for the second half of the HSSP implementation, while the end-term evaluation shall inform the development or updating of the second National Health Policy and subsequent HSSP.

4.4 HSSP Core Performance indicators

Core indicators have been identified to guide the analysis and measure overall performance of the HSSP. These can be found in Annex 1 which shows a list of HSSP core indicators currently required to meet national and international reporting requirements.

CHAPTER 5: IMPLEMENTATION ARRANGEMENTS

The HSSP 2023-2027 has been developed as a framework to provide strategic direction for collective action by the government, its partners, and stakeholders to improve the health status of the people of South Sudan. The health sector faces several challenges that can affect implementation of the plan such as, the decentralized system of governance and poor linkages between the different levels, capacity gaps, inadequate public financing with overreliance on external/donor support, sub-optimal coordination at national and sub-national levels, and parallel reporting structures that are often program/donor specific. Successful implementation of the HSSP 2023-2027 therefore requires well defined implementation arrangements that rallies all stakeholders at national and sub-national levels, to the plan, its priorities and expected outcomes. This chapter presents the key structures, roles and responsibilities of different institutions that will be involved in implementation of this strategic plan.

5.1 Organization and management of the health sector governance for effective implementation

At the national level, the existing Health Sector Steering Committee (HSSC), which is the overarching coordination platform will oversee implementation of the HSSP 2023-2027. The HSSC is chaired by the Honorable Minister of Health and brings together: the MoH senior management board; South Sudan AIDS commission chairperson; representatives from - DFCA and Central Medical Stores, Parliamentary Health Committee, UN agencies, Multi-lateral and Bilateral donors, Health and Nutrition Clusters, NGO forum, Country Coordination Mechanism for Global Fund secretariat, Civil Society Organizations, Private sector, Academia, as well as representatives from relevant line Ministries as required e.g. Ministry of Finance and Planning, and Ministry of Humanitarian Affairs. It also provides for participation of representatives of the State Ministry of Health (SMoH) on a rotational basis. The HSSC which is at a policy and decision-making level, will be responsible for high level tracking of implementation of the HSSP 2023-2027, advocacy, resource mobilization, awareness creation, and engagement with key stakeholders. The quarterly HSSC meetings will need to be regularized, and progress in the implementation of the HSSP 2023-2027 established as a standing agenda. The Director General for Policy Planning, Budgeting and Research will be responsible for coordinating feedback on this agenda item, through presentation of high-level quarterly progress on implementation of the HSSP 2023-2027, based on inputs received from the M&E Unit and relevant program technical working groups (TWGs).

Thematic/program TWGs which are led by the respective Directors General and have participation of relevant stakeholders, will be responsible for providing technical oversight in the joint planning, implementation, monitoring and evaluation of the HSSP 2023-2027 for each program area. This will ensure that roles and responsibilities of each stakeholder are clearly defined, duplication is minimized, and accountability is strengthened. The TWGs will ensure that partners align to the national priorities as defined in the HSSP, as well as alignment of relevant program specific strategic plans to the HSSP 2023-2027. The TWGs will provide high-level inputs as relevant to the quarterly HSSC meetings.

At the subnational level through the established coordination platforms at the State and County levels, quarterly review meetings will be held at each level led by the SMoH and County Health Department (CHD) respectively, to review progress in the implementation of the operational plans derived from the overall HSSP. Facility representatives will be part of the County coordination forums.

Annually, Joint Annual Reviews will be conducted to review progress made in implementation and achievements for each year of the HSSP 2023-2027.

5.2 Stewardship Roles and Responsibilities

The Ministry of Health will take the overall leadership within the health sector for the implementation of the HSSP at National, State and County levels, with the support and participation of partners and other health sector stakeholders. The Minister of Health, State Minister of Health and CHD Director will chair the coordination forums at their respective levels. Partners may co-chair these forums as defined in the Terms of Reference (ToR) for the coordination forums at each level. The MoH technical teams (Directors General and Directors) will provide leadership for the relevant program TWGs. The role of the government is to rally all stakeholders to the HSSP 2023-2027 priorities, provide oversight for its implementation, monitoring and evaluation, and ensure that partners align to the defined priorities.

At the sub-national level, the SMoH will extract priority strategic activities from the HSSP 2023-2027 to develop annual operational plans. These plans will show detailed activities that are linked to key deliverables towards the achievement of the targets of the plans. Technical assistance will be provided to develop plans with realistic costing and stakeholder participation in facilitating the implementation. The Directorate of Policy, Planning, Budgeting and Research will ensure that the annual operational plans are developed and monitored using appropriate tools.

As South Sudan relies heavily on external funding, the active participation of donors is important, particularly at the policy and decision-making level (HSSC) to ensure that the support they provide through partner agencies is in line with the HSSP priorities. Partners shall align their programs and interventions to the HSSP 2023-2027 and ensure transmission of data and information for monitoring and evaluating the progress in implementation, to the national HMIS/DHIS2. They shall support the process of integration of parallel reporting systems towards the establishment of one M&E system in the country. Where there are capacity gaps in the Ministry of Health, partners shall also provide the relevant technical expertise/support required to ensure effective implementation of the HSSP.

Other key stakeholder representation (e.g., private sector, civil society, academia, parliamentary health committee, and other government line Ministries), shall be included in the existing coordination forums at each level as relevant to ensure their participation in the implementation process of the HSSP. These stakeholders are important to ensure advocacy on key priorities of the HSSP 2023-2027 at their respective forums e.g., the parliamentary health committee and Ministry of Finance can support in advocacy for additional resource allocation to the health sector from the overall government budget; the private sector can advocate for PPP; and academia can advocate and support research within the health sector.

5.3 Partnership and Coordination Arrangements

The Ministry of Health will sign Compacts/Co-operation Agreements with partner agencies to ensure their alignment with and support towards the implementation of the HSSP at all levels of the health system. At the sub-national levels, SMoH and CHD will provide oversight to implementing partners at their levels, ensuring they participate in the development and implementation of the annual operational plans. Partners shall not implement activities at the sub-national levels without the knowledge of the SMoH or relevant CHD.

At the National level, the MoH shall establish and strengthen the functionality of inter-sectoral/ministerial forums, to facilitate implementation of key interventions that requires cooperation with other sectors. These forums shall meet regularly as defined by their ToR, and MoH will ensure that their inputs contribute to and align to the HSSP 2023-2027.

Public participation and/or community participation shall be central to the implementation of the HSSP. Through the Boma Health Initiative, this shall be ensured through establishment and strengthening of the Boma Health Committees that will engage communities to ensure their views are taken into consideration in the implementation of the HSSP 2023-2027.

CHAPTER 6: FINANCIAL IMPLICATIONS

6.1 Costs

The costing of the HSSP 2023-2027 is based on the principle of prioritizing investments in key health sector programs. This will ultimately contribute to the establishment of a strong, resilient, accountable, high-performing health system supported by the political will to guide decision making and financial allocations.

6.1.1 Costing methodology

The costing of the HSSP 2023-2027 has been done using the "OneHealth Tool" (OHT). The tool was designed to strengthen health system analysis, planning, costing, and financing at the country level. Its objective is to assess public health investment needs in low- and middle-income countries and to facilitate the development of strategic plans for health sector planning. It harmonizes the content and format of existing tools for estimating costs and impacts of health programmes and interventions.

Overview of the One Health Tool

The analysis and budgeting process in the OHT is done at two levels namely: by the health programs/health services and by the components of the health system. Impact modules are also used to reflect the basic and analytical levels in terms of impacts and expected effects in the implementation of the HSSP.

Key assumptions

The OHT was used to cost the HSSP in two steps: the costing of the identified interventions by strategic objective; and the costing of the health system reforms identified during the national and sub-national consultations.

a) Costing of HSSP interventions

The costing of the HSSP interventions included the following main steps:

- Determination of the target populations for each intervention.
- Determination of the population in need within each target population
- Determination of the baseline coverage
- Baseline Year 2021
- Setting up of the new coverage frontiers to be reached at the end of the five years

The baseline and end line coverage data were taken from the situation analysis, obtained through literature review and stakeholder consultations. The base year used is 2021, however, where there was no data for that year, data from previous years was considered. The exchange rate applied for conversion of the government allocation to health was 1 US dollar to 400 SSP (based on the baseline fiscal year 2021/2022 exchange rate as reflected

in the approved government budget). The source of the population estimates is the Population Projections for South Sudan 2020-2040.[79]

b) Costing of health system reforms

The health system reforms to mitigate identified system bottlenecks, were costed using Excel with information on the unit costs of the system reforms based on data collated from program implementation. State specific reforms were aggregated to present the overall situation at the national level.

Proposed scenarios

Following setting up of the basic coverages of the key interventions for each health service included in the HSSP 2023-2027 and projections of their coverages, three scenarios for 2027 have been proposed as follows:

Scenario 1 (Business as usual) – highlights the costs and impacts if the country continues with the current coverage with minimal increment over the next 5 years.

Scenario 2 (Scale up of Interventions coverage up to 65%) – indicates that South Sudan will go for universal coverage of the essential packages up to 65%, at primary, secondary and tertiary levels.

Scenario 3 (Scale up to 90%) – the most optimistic scenario which implies that South Sudan will go beyond the essential package coverage at all levels, reaching 90% coverage.

Impact estimation

The Lives Saved Tool (LiST) integrated into the OneHealth tool, has been used to estimate the expected impact of the HSSP over the period in terms of reduction in maternal mortality, neonatal mortality, child mortality and stunting rates and the estimated number of cases averted.

Costing process limitations

The limitations of the HSSP costing process are outlined as follows:

- Insufficient or lack of recent coverage data for some interventions.
- Insufficient intervention coverage data disaggregation by State, which limited the costing of sub-national level data.
- Inadequate data on all partners planned financial commitments, which limited the analysis of budget space to estimates based on historical contributions for some partners.
- The high inflation/exchange rate of the SSP to the US dollar limiting the interpretation of costs in SSP and vice-versa.

[79] National Bureau of Statistics, South Sudan

6.1.2 Cost per scenario

The costing of the interventions in the HSSP has defined three different budgets based on the scenarios presented above: Scenario 3, the ambitious scenario, which intends to scale up all interventions with a target of over 90% coverage at all levels, has a budget of US$ 2.5 billion (**Annex 2a**), followed by Scenario 2, the alternative scenario, which scales up coverage to 65% has a budget of US$ 1.8 billion. The ambitious scenario intends to cover the entire population of South Sudan over the next 5 years as well as the renewal and rehabilitation of infrastructure at both National and State levels. Given the level of resource availability in the country and the duration of the plan (5 years) with the first and last year's devoted respectively to resource mobilization and evaluation of results, there will be then three years of effective implementation. It will be based on prioritizing the States with the poorest health outcomes while ensuring continuity of services in the others. More financial effort will be required for indirect costs (construction, rehabilitation, human resource reinforcement, etc.) than for increasing coverage with the alternative scenario, as opposed to the ambitious scenario of reaching 90% coverage which will require an increase in efforts both in increasing the coverage of interventions and in implementing the health systems reforms. Scenario 1 the 'Business-as-Usual' scenario, where no new action is taken, will require a budget of US$ 1.1 billion, as shown in the **figure 9** below.

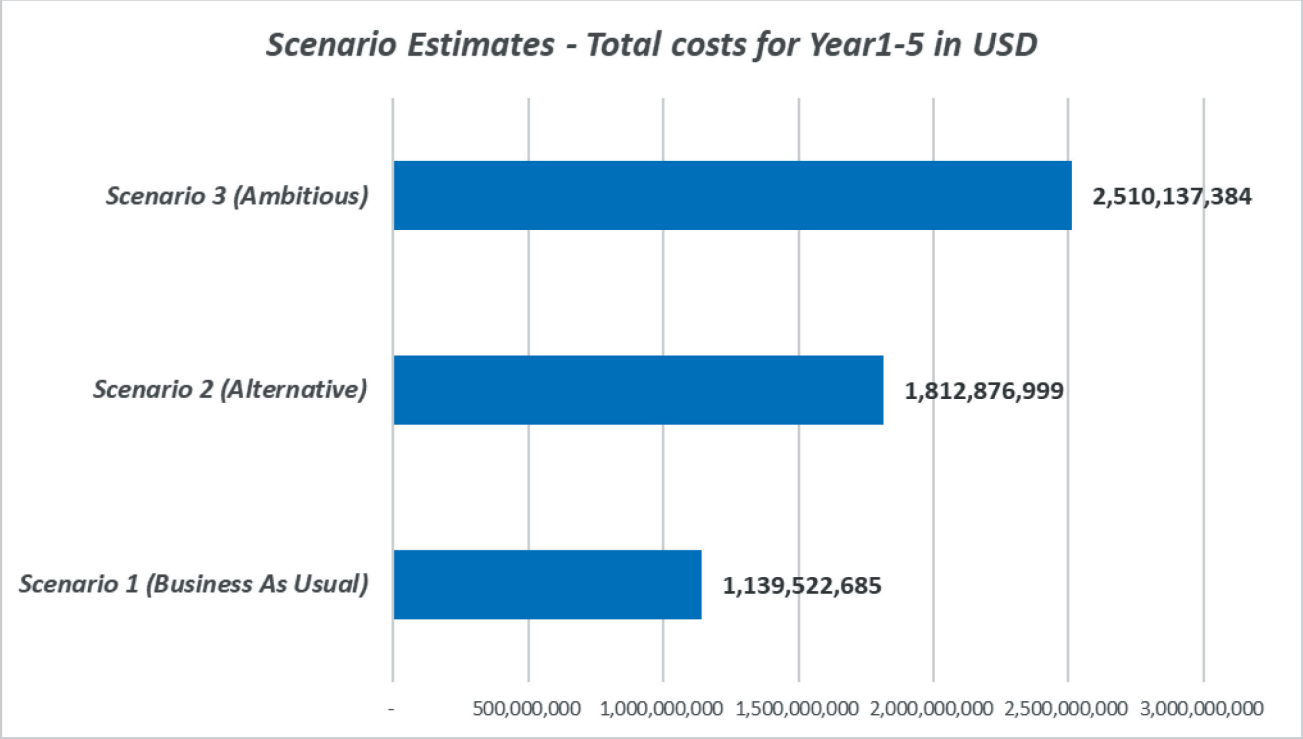


Figure 9: Total cost estimates for the HSSP 2023-2027 based on the three scenarios

Cost by Scenario and by Year

The breakdown of each budget by scenario and by year is shown in **table 6** below. The average cost per year for scenario 3 (ambitious), scenario 2 (alternative) and scenario 1 (business as usual) will be US$ 502 million, US$ 362 million, and US$ 227 million respectively which corresponds to a distribution of US$ 31, US$ 23, and US$ 14 dollar per capita over the period respectively.

	Cost by Year (USD)					Total Cost Year 1 - 5 (USD)	Average cost per Year (USD)	Cots per capita (USD)
	Year 1	Year 2	Year 3	Year 4	Year 5			
Scenario 3 (Ambitious)	449,266,775	586,185,995	473,713,104	515,741,955	485,229,556	2,510,137,384	502,027,477	31
Scenario 2 (Alternative)	324,470,448	423,356,552	342,126,131	372,480,301	350,443,568	1,812,876,999	362,575,400	23
Scenario 1 (Business as Usual)	203,952,853	266,109,832	215,050,711	234,130,475	220,278,814	1,139,522,685	227,904,537	14

Table 6: HSSP 2023-2027 cost evolution by year and by scenario

The first year of the HSSP will focus on resource mobilization, whereas the second year has a significant cost increment as it marks the start of implementation of the bulk of the interventions, such as construction.

Impacts estimation of the HSSP 2023-2027 by scenario

The LiST impact module of the OHT tool presents the results in terms of additional lives saved by scenario. The current maternal mortality ratio, neonatal and under-five mortality rates, and stunting rates are estimated at 1,223 deaths per 100,000 live births; 39.63 and 98.69 deaths per thousand live births; and 16.3% respectively. These baseline data were used to estimate the impact. As shown in **table 7** below, the most ambitious scenario saves the most lives (67,396), followed by the alternative scenario with 48,675 lives saved and finally the business-as-usual scenario with 30,596 lives saved. In terms of stunting cases averted, there will be 233,590, 168,704 and 106,042 stunting cases averted by the ambitious, alternative, and business-as-usual (BAU) scenarios respectively.

	Year2	Year 3	Year 4	Year 5	Total lives saved/ Stunting cases averted	Total maternal and <5 years lives saved
Ambitious Scenario						
Maternal lives saved	480	719	855	910	2,964	67,396
Total < 5 years (0-59 months) lives saved	12,887	15,583	17,578	18,384	64,432	
Stunting cases averted	21,791	46,150	71,090	94,559	233,590	
Alternative Scenario						
Maternal lives saved	347	519	618	657	2,141	48,675
Total < 5 years (0-59 months) lives saved	9,307	11,254	12,695	13,277	46,534	
Stunting cases averted	15,738	33,331	51,343	68,293	168,704	
Business as Usual Scenario						
Maternal lives saved	218	326	388	413	1,346	30,596
Total < 5 years (0-59 months) lives saved	5,850	7,074	7,980	8,346	29,250	
Stunting cases averted	9,892	20,951	32,273	42,927	106,042	

Table 7: Estimated impact (lives saved) by scenario and by year

Cost effectiveness per scenario

In terms of cost per life saved, the ambitious scenario appears to be the most advantageous, followed by the alternative scenario, with the BAU scenario being the least cost effective (**table 8**). The ambitious scenario reflects the reality of the needs, taking into consideration the current level of inflation, the average population growth rate, the level of

resource mobilization, as well as the level of needs for rehabilitation and construction of health infrastructure.

Cost-Effectiveness Analysis				
	Total Cost (USD)	*Total lives saved (Maternal & <5 years only)*	*Costs per lives saved (Maternal & <5 years only)*	*Maternal & <5 years Lives saved per 1$*
BAU Scenario	1,139,522,685	30,596	37,245	0.8
Alternative Scenario	1,812,876,999	48,675	37,245	1.3
Ambitious Scenario	2,510,137,384	67,396	37,245	1.8

Table 8: Cost-effectiveness analysis by scenario

Implementation Costs by program and by scenario

The **table 9** below gives the details in terms of costs of implementing the priority interventions by program and by scenario. In addition, the direct costs, and the costs of health system reforms represent 57.61% and 42.39% of the total budget costs respectively. The distribution of the total budget shows that the components with a high percentage of the budget are respectively, infrastructure (17.94%), essential medicines, supplies and technologies (15.08%), Reproductive, maternal, newborn, and adolescent health (14.08%), Malaria (13.44%), Nutrition (11.24%), HIV/AIDS (7.67%), followed by human resources for health (6.23%). **Figure 10** presents a graphical representation of this distribution.

Program Domain	*Scenario 1 (Business As Usual)*	*Scenario 2 (Alternative)*	*Scenario 3 (Ambitious)*	*%*
Health Promotion	*12,614,595*	*20,068,674*	*27,787,395*	*1.11%*
Boma Health Initiative	*10,214,286*	*16,250,000*	*22,500,000*	*0.90%*
Reproductive, maternal, newborn, and adolescent health (RMNAH)	*160,491,316*	*255,327,093*	*353,529,821*	*14.08%*
Child Health	*12,515,716*	*19,911,367*	*27,569,585*	*1.10%*
Nutrition	*128,071,336*	*203,749,852*	*282,115,180*	*11.24%*
Occupational Health	*2,114,151*	*3,363,421*	*4,657,045*	*0.19%*
Oral Health	*450,583*	*716,837*	*992,544*	*0.04%*
School Health	*1,181,214*	*1,879,203*	*2,601,974*	*0.10%*
Malaria	*153,163,066*	*243,668,514*	*337,387,174*	*13.44%*
Tuberculosis	*29,132,950*	*46,347,874*	*64,173,980*	*2.56%*
HIV/AIDS	*87,433,153*	*139,098,198*	*192,597,505*	*7.67%*
Sexually Transmitted Infections	*3,317,005*	*5,277,053*	*7,306,689*	*0.29%*
Viral Hepatitis B & C	*2,808,632*	*4,468,278*	*6,186,847*	*0.25%*
Prevention & control of diseases of high epidemic potential	*7,496,401*	*11,926,092*	*16,513,051*	*0.66%*
Prevention and control of neglected tropical diseases	*22,100,843*	*35,160,432*	*48,683,675*	*1.94%*
Noncommunicable Diseases	*4,163,441*	*6,623,656*	*9,171,216*	*0.37%*
Mental Health	*4,947,312*	*7,870,723*	*10,897,925*	*0.43%*
Improve quality of health services and safety measures	*10,659,210*	*16,957,834*	*23,480,078*	*0.94%*
Improve quality of diagnostic & curative referral services	*1,602,040*	*2,548,700*	*3,528,969*	*0.14%*
Eye Care	*1,989,470*	*3,165,065*	*4,382,398*	*0.17%*
Infrastructure	*204,418,983*	*325,212,018*	*450,293,564*	*17.94%*
Human Resources	*70,960,877*	*112,892,305*	*156,312,422*	*6.23%*
Essential Medicines, Supplies and Technologies	*171,878,965*	*273,443,808*	*378,614,504*	*15.08%*
National Lab and Blood Banks	*12,702,032*	*20,207,778*	*27,980,000*	*1.11%*
Health Financing Towards UHC	*1,760,173*	*2,800,275*	*3,877,304*	*0.15%*

Health Information System	*9,002,516*	*14,322,185*	*19,830,717*	*0.79%*
Monitoring and Evaluation	*8,515,061*	*13,546,688*	*18,756,952*	*0.75%*
Leadership and Governance	*3,491,158*	*5,554,115*	*7,690,313*	*0.31%*
Strategic partnership	*326,202*	*518,958*	*718,557*	*0.03%*
Total Annual Budget	***1,139,522,685***	***1,812,876,999***	***2,510,137,384***	***100.00%***

Table 9: Budget by program domain and by scenario (in USD)

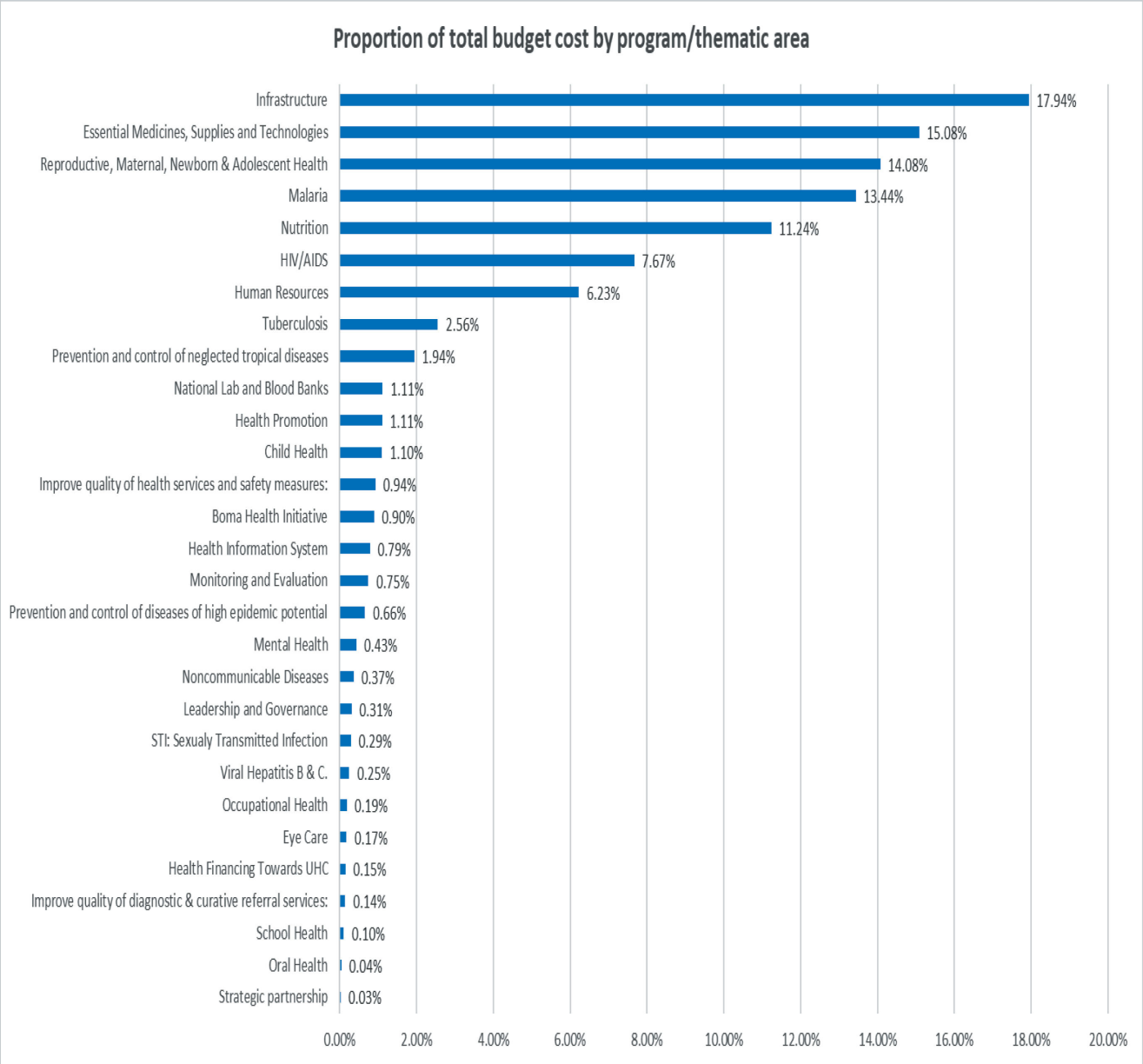


Figure 10: Proportion of total budget by program/thematic area

HSSP Implementation cost per year using ambitious scenario as a reference

The breakdown of the scenario budget shows that the second year has the largest budget, due to the launch of large-scale activities such as the construction of health structures and rehabilitation. The first year is mainly devoted to mobilizing resources and preserving the good achievements. The HSSP cost was calculated combining the direct and health system reform (Indirect) costs. The breakdown of the direct cost for delivery of the BPHNS interventions by programme area (**Annex 2b**) indicates, that 45.39% of the direct program cost accounts for Communicable Diseases and Neglected Tropical Diseases, followed by 24.45% for RMNAH and 21.42% for Child Health and Nutrition. The other program areas

account for just about 9% of the direct costs. The overall direct cost for the implementation of the BPHNS will require about US$ 1.4 billion over five years from 2023 to 2027 or an average annual investment of US$ 289 million per year. The similar breakdown by components for the health system reforms show (**Annex 2c**) that infrastructure accounts for the highest proportion of the costs (42.32%), followed by Essential Medicines, Supplies and Technologies (35.58%), and Human Resources for Health (14.69%). The proportion of the total cost for the other remaining health system components is less than 10%.

6.2 Available Financing

The analysis of the projected funds of the previous Health Sector Strategic plan 2017-2022 (**Annex 2d**), highlights two types of changes from 2019: firstly, the contribution of most partners appears to be decreasing with an average annual reduction ranging from 8% to 37%; secondly, humanitarian aid allocated to health increased slightly with an average annual increase of 5%. It is also noted that although the overall proportion of allocation to the health sector from the national budget has been inconsistent, the absolute amount allocated has increased from one fiscal year to another allowing for projection of the allocation to the sector over the next five years.

The 2022 humanitarian response plan highlights a funding requirement of US$129 million for health.[80] This response plan also shows that the percentage of funding needs received has varied over the past 8 years (2013 to 2021) from 72% (2013) to 92% in 2016 and an average of 66% of humanitarian response funds received over the period of 2019 to 2021, the lowest rate received being 65% in 2018. The projection of future commitments based on available data was estimated from this analysis. The mapping of the available resources shows the potential availability of resources close to US$ 1.66 billion or an annual amount of US$ 332 million as shown in **table 10**.

Investment Sources	Year 1	Year 2	Year 3	Year 4	Year 5	Total (USD) (Year 1 – Year 5)
Government	*73,906,371*	*78,340,753*	*83,041,199*	*88,023,670*	*93,305,091*	*416,617,084*
Development funding	*135,367,295*	*128,903,098*	*123,506,125*	*118,913,451*	*114,944,517*	*621,634,486*
GAVI	*3,150,544*	*1,977,121*	*1,240,741*	*778,626*	*488,626*	*7,635,658*
GFATM	*13,840,810*	*11,932,481*	*10,287,267*	*8,868,889*	*7,646,074*	*52,575,521*
Health Pooled Fund	*44,325,940*	*44,325,940*	*44,325,940*	*44,325,940*	*44,325,940*	*221,629,700*
US Gov	*35,200,000*	*35,166,730*	*35,133,491*	*35,100,283*	*35,067,107*	*175,667,611*
World Bank	*1,240,000*	*826,500*	*550,889*	*367,185*	*244,741*	*3,229,315*
UN agencies	*37,610,001*	*34,674,326*	*31,967,797*	*29,472,528*	*27,172,029*	*160,896,681*
Humanitarian (cluster) funding	*124,923,200*	*124,923,200*	*124,923,200*	*124,923,200*	*124,923,200*	*624,616,000*
Health	*74,923,200*	*74,923,200*	*74,923,200*	*74,923,200*	*74,923,200*	*374,616,000*
Nutrition	*50,000,000*	*50,000,000*	*50,000,000*	*50,000,000*	*50,000,000*	*250,000,000*
Total Commitment (Government, Development, Humanitarian)	***334,196,866***	***332,167,051***	***331,470,524***	***331,860,321***	***333,172,808***	***1,662,867,570***
Average Annual potential commitment (USD)						**332,573,514**

Table 10: Projected available financing by investment source

[80] South Sudan Humanitarian Response Plan, 2022

6.3 Financial Gaps and Resource Mobilization Strategy

The fiscal space is defined as 'the margin that allows the government to allocate resources in pursuit of a particular objective without jeopardizing the sustainability of its fiscal position or the stability of the economy'.[81] It is recognized that when fiscal space has been created, resources are freed up and can be allocated to priority public spending programs such as health care.

Financial Gap Analysis

Based on the funding commitments mentioned above (**table 10**), the financing gap is outlined in **table 11** below. The budgetary commitments are lower than the financial needs of the HSSP (based on the ambitious scenario), resulting in an overall financing gap of nearly US$ 847 million over 5 years, or about US$ 169 million per year. This shortfall represents 34% of the HSSP's financial needs to be sought over the period 2023-2027.

	Year 1	Year 2	Year 3	Year 4	Year 5	Total Cost in USD (Year 1-5)	Annual cost (USD)
Financing Needs (Ambitious Scenario)	449,266,775	586,185,995	473,713,104	515,741,955	485,229,556	2,510,137,384	502,027,477
Potential available Budget (Total Commitment for Health)	334,196,866	332,167,051	331,470,524	331,860,321	333,172,808	1,662,867,570	332,573,514
Financing Gap	115,069,909	254,018,944	142,242,580	183,881,634	152,056,748	847,269,814	169,453,963

Table 11: Funding gap analysis

Analysis of the financial gap funding strategy

There are many strategies that can be used to expand fiscal space through a variety of sources and channels. As part of this plan, the analysis of bottlenecks in the health sector in South Sudan showed that the main challenges to health financing relate to the low proportion of the budget allocated to health, low budget execution capacity, low resource execution linked to low revenue forecasting capacity, and non-alignment of partner funding. In order to address these issues, the following have been identified as factors that can potentially expand fiscal space: (i) favourable macroeconomic conditions with increased government budget allocation to health; (ii) increase in the health sector's own resources (e.g., innovative financing); (iii) rationalization or better efficiency in existing health expenditures; and (iv) creation of a system for harmonizing and capturing the States' own revenues.

1. Favorable macroeconomic conditions with increased government budget allocation to health

The national budget for the fiscal year 2021/2022, showed a significant increase in the total budget allocation to the health sector from SSP 4.1 billion (or 3.0% of the total available resources) in FY 2020/2021 to SSP 27.6 billion (7.9% of the total available resources). As seen above, the gap to be filled, based on potential commitments to health is US$ 169 million per year. The analysis below allows us to highlight some financing strategies to fill this gap.

[81] Definition of fiscal space according to Peter Heller of the IMF, 2005

Assumption of growth in the health budget

From the above, three assumptions are made to analyse the budget allocation to health: the baseline hypothesis, suggests an increase to 10% in the health budget, the medium hypothesis increases it to 12% and the optimistic hypothesis to 15% while keeping the contribution of partners constant in the baseline hypothesis and varying it in the medium and optimistic hypotheses.

The baseline assumption allocates 10% of the national budget to health and keeps the partners' contribution constant; the increase in the health budget allows for 27% of the deficit to be financed, reducing the overall deficit to an average of US$ 124 million annually (**table12**).

Baseline assumption	**10% Government budget allocation to Health**					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total budget in million US$ (Year 1 - 5)**
Government's contribution in million US$ (31%)	97	106	117	129	142	591
Partner contribution in million USD$ (69%)	260	260	260	260	260	1,300
Total potential available budget commitment (in million US$)	357	366	377	389	402	1,891
Financing needs (in million US$)	449	586	474	516	485	2,510
Financing gap (in million US$)	92	220	97	127	83	619
Annual average financing gap						124

Table 12: Baseline assumption - health sector budget increase (10%) and its impact on reducing the financial gap of the HSSP 2023-2027

The medium hypothesis, allocating 12% of the national budget to health, while the partners' contribution is progressively reduced by 5% each year, reduces the deficit by 24%. The new deficit with this hypothesis will amount to US $ 129 million annually (**table 13**).

Baseline assumption	**12% Government budget allocation to Health**					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total budget in million US$ (Year 1 - 5)**
Government's contribution in million US$ (40%)	117	132	147	165	185	746
Partner contribution in million USD$ (60%)	247	235	223	212	201	1,118
Total potential available budget commitment (in million US$)	364	367	370	377	386	1,864
Financing needs (in million US$)	449	586	474	516	485	2,510
Financing gap (in million US$)	85	219	104	139	99	646
Annual average financing gap						129

Table 13: Medium assumption - health sector budget increase (12%) and its impact on reducing the financial gap of the HSSP 2023-2027

The optimistic hypothesis intends to reach the global benchmark of the Abuja Declaration, i.e., to devote 15% of the national budget to health, while maintaining the decrease in the contribution of the partners by 5%. The new deficit to be made up will be 90 million US dollars annually, i.e., a 47% decrease in the deficit (**table 14**).

Baseline assumption	**15% Government budget allocation to Health**					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total budget in million US$ (Year 1 - 5)**
Government's contribution in million US$ (46%)	148	166	186	208	233	941
Partner contribution in million USD$ (54%)	247	235	223	212	201	1,118

Potential available budget commitment (in million US$)	395	401	409	420	434	2,059
Financing needs (in million US$)	449	586	474	516	485	2,510
Financing gap (in million US$)	54	185	65	96	51	451
Annual average financing gap						90

Table 14: Optimistic assumption - health sector budget increase (15%) and its impact on reducing the financial gap of the HSSP 2023-2027

2. Increase in resources specific to the health sector e.g., through innovative financing

There are two main categories of innovative financing: (i) mechanisms designed to generate new resources such as through international taxes e.g., tobacco tax, financial transaction tax, air ticket tax, fertilizer tax, taxes on fats and sugar products, carbon tax, etc.; and (ii) mechanisms designed to mobilize private investment.

3. Rationalization or better efficiency in existing health expenditures

Improved efficiency in the management of health expenditures would reduce a significant rate of financial wastage and generate significant resources for health. According to the National Budget Brief for the fiscal year 2021/2022,[82] several resource governance issues compromise the government's ability to strengthen its social service systems, including non-payment or delayed payment of transfers, grants, and salaries in some States. Insufficient equity in transfers, discriminates against States with dispersed populations, remote, vulnerable, and displaced communities, which need more support and resources.

4. Creation of a system for harmonizing and capturing the States' own revenues

The establishment of a harmonized, computerized system of reporting and disclosure of own-source revenues at the Central and State levels will improve transparency and budget mobilization.

[82] National budget Brief Fiscal Year 2021/2022, https://3309b9.n3cdn1.secureserver.net/wp-content/uploads/2022/12/UNICEF-South-Sudan-National-Budget-Brief-FY2021_2022-FINAL.pdf?time=1672733844

ANNEXES

Annex 1: Monitoring and Evaluation Indicator Matrix

	Indicator HSSP 2023-2027	Baseline	Data Source for Baseline	Targets					Source	Data collection frequency
				2023	2024	2025	2026	2027		
Impact Indicators (Health Status)										
Mortality by age and sex										
1	Life expectancy at birth	55	World Bank (2020)	55	56	56	57	57	CRVS/Survey	Annually
2	Adult mortality rate between 15 and 60 years of age (deaths per 1000 population)	321.4	WHO/Global Health Observatory (GHO) 2016	320	315	310	305	300	CRVS/Survey	Annually
3	Under five years' mortality rate (per 1000 live births) [SDG 3.2.1]	98.69	UN IGME (2021)	90	80	70	60	50	CRVS/Survey	Annually
4	Infant mortality rate (per 1000 live births)	63.76	UN IGME (2021)	59	54	49	44	40	CRVS/Survey	Annually
5	Neonatal mortality rate (per 1000 live births) [SDG 3.2.2]	39.63	UN IGME (2021)	36	32	28	24	20	CRVS/Survey	Annually
6	Still birth rate (per 1000 live births)	28.8	UNICEF	27	26	24	22	20	CRVS/DHIS	Annually
Mortality by cause										
1	Maternal mortality ratio (per 100,000 live births) [SDG 3.1.1]	1223	UN MMEIG (2020)	1128	1033	938	843	750	CRVS/Survey	Annually
2	Tuberculosis (TB) mortality rate per 100,000	28	Global TB report (2021)	25.4	22.8	20.2	17.6	15	Survey	Annually
3	AIDS-related deaths	7,553	South Sudan HIV Estimates (2022)	7000	6500	6000	5600	5000	SPECTRUM	Annually
4	Malaria mortality rate (per 100,000 at risk population)	66.39	WHO GHO (2020)	63	60	57	54	50	World Malaria Report	Annually
5	Mortality rate attributed to cardiovascular disease, cancer, diabetes, or chronic respiratory diseases (NCDs) mortality [SDG 3.4.1]	20%	WHO Report (2018)	20%	19%	18%	17%	16%	CRVS/Survey	Annually
6	Suicide mortality rate (per 100,000 population) [SDG 3.4.2)	4	WHO Report (2018)	4	3.5	3	3	3	CRVS/Survey	Annually

7	Death rate due to road traffic injuries (per 100,000) [SDG 3.6.1]	37	World Bank	35.6	34.2	32.8	31.4	30	CRVS/Survey	Annually
Nutrition										
1	Children under 5 years who are stunted [SDG 2.2.1]	16.3%	FSNMS 26	14.%	13%	12%	11%	10%	Survey	Annually
2	Children under 5 years who are wasted [SDG 2.2.2]	16.1%	FSNMS 27	14%	13%	12	11%	10%	Survey	Annually
Fertility										
1	Adolescent fertility rate (10-14 & 15-19 years) [SDG 3.7.2]	54	World Bank (2020)	51.2	48.4	45.6	42.8	40	Survey	Annually
2	Total fertility rate (Births per woman)	4.5	World Bank (2020)	4.4	4.3	4.2	4.1	4.0	Survey	Annually
Morbidity										
1	HIV incidence rate per 1000 population [SDG 3.3.1]	0.8	South Sudan HIV Estimates (2022)	0.75	0.70	0.65	0.60	0.55	South Sudan HIV Estimates	Annually
2	HIV prevalence rate	1.94	South Sudan HIV Estimates (2022)	1.9	1.8	1.7	1.6	1.5	South Sudan HIV Estimates	Annually
3	Hepatitis B surface antigen prevalence	5.6%	WHO	5.1%	4.6%	4.1%	3.5%	3.0%	Survey	Annually
4	TB incidence rate (per 100,000) [SDG 3.3.2]	227	WHO global report (2021)	200	175	150	125	100	WHO Report	Annually
5	Malaria parasite prevalence among children aged 6-59 months	32%	MIS 2017	22%	19%	16%	13%	10%	MIS	3-yearly
6	Malaria incidence rate (per 1000 population) [SDG 3.3.3]	286.9	WHO GHO	234.8	223.6	212.4	201.2	190	DHIS2	Annually
7	Total number of cancer cases per year	6312	WHO-IARC (2020)	6250	6187	6124	6062	6000	WHO-IARC	Annually
Outcome indicators (Service coverage)										
Reproductive, Maternal, Child, Newborn & Adolescent Health (RMNCAH)										
1	Unmet needs for family planning	20%	UNFPA	18%	16%	14%	12%	10%	Survey	Annually
2	Demand for family planning satisfied with modern methods [SDG 3.7.1]	21%	UNFPA	23%	25%	27%	29%	31%	Survey	Annually
3	Contraceptive prevalence rate (any method)	6%	UNFPA	7	8%	9%	10.5%	12%	Survey	Annually
4	Proportion of facilities providing Adolescent and youth friendly services	46%	Program Report	56%	60%	65%	70%	75%	Survey/DHIS2	Annually
5	Proportion of facilities providing post abortion care	No data	Program Report	30%	35%	40%	45%	50%	Program Report	Quarterly
6	Percentage of functional CEmONC Facilities	3%	SARA (2018)	15%	29%	43%	57%	70%	Survey	Every 2 years
7	Percentage of functional BEmONC Facilities	39%	SARA (2018)	46%	52%	58%	64%	70%	Survey	Every 2 years
8	Percentage of functional MPDSR Committees	No data	Program Report	40%	45%	50%	55%	60%	Program Report	Quarterly
9	Antenatal care coverage at least four visits (%)	23%	DHIS2 (2021)	30%%	37%	44%	52%	60%	DHIS2/HMIS	Quarterly
10	Births attended by skilled birth personnel [SDG 3.1.2]	15%	DHIS2 (2021)	22%	29%	36%	43%	50%	DHIS2/HMIS	Quarterly
11	Proportion of institutional births	14%	DHIS2/HMIS	23%	30%	38%	44%	50%	DHIS2/HMIS	Quarterly
12	Caesarean section rate (%)	2.2%	DHIS2 (2021)	2.9%	3.5%	4.0%	4.5%	5%	DHIS2/HMIS	Quarterly

13	Post-natal care coverage	35.5%	DHIS2 (2021)	38%	41%	44%	47%	50%	DHIS2/HMIS	Quarterly
14	Care seeking for symptoms of pneumonia	47%	SHHS (2010)	50%	52%	55%	57%	60%	Survey	Every 2 years
15	Coverage of diarrhoea treatment (ORS)	79%	SARA (2018)	80%	81%	82%	83%	85%	Survey	Every 2 years
16	Percentage of facilities delivering IMNCI	47%	SARA (2018)	54%	58%	62%	66%	70%	Survey	Every 2 years
Injuries or harmful traditional practice										
1	Intimate partner violence prevalence [SDG 5.2.1]	22%	UNFPA	20%	18%	17%	16%	15%	Reports	Quarterly
2	Non-partner sexual violence prevalence [SDG 5.2.2]	33%	UNICEF	30%	27%	25%	23%	20%	Reports	Quarterly
Immunization										
1	Immunization coverage rate Pentavalent 3 [SDG 3.b.I]	49%	WHO/UNICEF estimates (2021)	60%	65%	70%	75%	80%	WHO/UNICEF estimates	Annually
2	Fully immunized coverage	18.9%	EPI Coverage Survey (2017)	32%%	44%	56%	68%	80%	Survey	Annually
Nutrition										
1	Early initiation of breastfeeding	77.2%	FSNMS 26	79.7%	82.2%	84.7%	67%	90%	Survey	Annually
2	Exclusive breastfeeding rate 0-6 months of age	62%	FSNMS 27	66%	70%	74%	77%	80%	Survey	Annually
3	Minimum acceptable diet among children 6-23 months	9%	FSNMS 27	11%	15%	17%	20%	25%	Survey	Annually
4	Percentage of children aged <59 months receiving Vitamin A supplements twice a year	84%	FSNMS 27	86%	87%	88%	89%	90%	Survey	Annually
5	Percentage of Household consuming adequately iodized salt	60%	World Bank	62%	64%	66%	68%	70%	Survey	Annually
6	Anaemia prevalence in children (0-59 months)	61%	MoH reports	59%	57%	54%	53%	50%	Survey	Annually
7	Anaemia prevalence in women of reproductive age	35.6%	WHO	33%	31%	29%	27%	25%	Survey	Annually
Control of Communicable disease										
HIV/AIDS										
1	Number of people newly infected with HIV per year [SGD 3.3.1]	10,933	South Sudan HIV Estimates (2022)	10,000	9,000	8,000	7,000	6,000	South Sudan HIV Estimates	Annually
2	People living with HIV who know their status (1st 95%)	39%	South Sudan HIV Estimates (2022)	40%	50%	65%	75%	80%	South Sudan HIV Estimates	Annually
3	Antiretroviral therapy coverage (2nd 95%)	32%	South Sudan HIV Estimates (2022)	40%	45%	52%	60%	65%	South Sudan HIV Estimates	Annually
4	HIV viral load suppression (3rd 95%)	27%	South Sudan HIV Estimates (2022)	35%	40%	45%	50%	65%	South Sudan HIV Estimates	Annually
5	Coverage of pregnant women who receive ART for PMTCT (%)	53%	South Sudan HIV Estimates (2022)	60%	65%	70%	80%	85%	South Sudan HIV Estimates	Annually
6	Mother to child transmission rate (%)	26.3%	South Sudan HIV Estimates (2022)	22%	18%	14%	10%	8%	South Sudan HIV Estimates	Annually
Viral Hepatitis										
1	% of general population with comprehensive knowledge on viral hepatitis	No data	Not Applicable	10%	20%	30%	40%	50%	Program Report	Annually
2	% of pregnant women screened for Hepatitis B	No data	Not Applicable	40%	50%	60%	70%	80%	DHIS2	Quarterly
3	Proportion of blood units screened for blood borne	No data	Not Applicable	100%	100%	100%	100%	100%	DHIS2	Quarterly

	diseases									
4	% of Hepatitis B treated	<2%	DHIS2	10%	20%	30%	40%	50%	DHIS2	Quarterly
5	% of Hepatitis C cured	No Data	DHIS2	2%	5%	10%	15%	20%	DHIS2	Quarterly
Sexually Transmitted Infections										
1	% of pregnant women attending antenatal care screened for syphilis	No data	Not Applicable	50%	60%	70%	80%	85%	DHIS2	Quarterly
2	% of girls fully HPV vaccinated	No data	Not Applicable	10%	20%	30%	40%	50%	DHIS2	Quarterly
3	% of women screened for cervical cancer	No data	Not Applicable	4%	8%	12%	16%	20%	DHIS2	Quarterly
Tuberculosis										
1	TB notification rate (per 100,000 population)	62	Word Bank	68	72	80	88	95	WHO Report	Annually
2	TB prevalence rate (per 100,000 population)	140	WHO	130	120	115	110	100	WHO Report	Annually
3	Multidrug Rifampicin resistance tuberculosis (MBD/RR-TB) cases	4.6%	WHO	4.5%	4.4%	4.3%	4.2%	<5%	DHIS2	Annually
4	% of people with confirmed RR-T and or MDR-TB that began second-line treatment	No data	Not Applicable	40%	50%	60%	70%	80%	DHIS2	Quarterly
5	TB effective treatment coverage	65%	TB Program Review Report	70%	75%	80%	85%	90%	DHIS2	Annually
6	TB patients co-infected with HIV on ART	96%	TB Program Review Report /WHO GHO	97%	97%	98%	99%	100%	DHIS2	Annually
Malaria										
1	Proportion of pregnant women who received three or more doses of IPTp (IPTp≥3)	31%	MIS 2017	70%	76%	81%	86%	90%	DHIS2	Quarterly
2	Proportion of patients with suspected malaria who received a parasitological test (RDT and/ or microscopy)	50%	DHIS2 2019	80%	85%	90%	95%	100%	DHIS2	Annually
3	Proportion of confirmed malaria cases that received first-line antimalarial treatment	80%	World Malaria Report	80%	85%	85%	90%	90%	DHIS2	Quarterly
4	Proportion of pregnant women (15-49yrs) sleeping under an ITN	51%	MIS 2017	80%	83%	85%	88%	90%	MIS	3-yearly
5	Proportion of children 6-59 months who slept under an ITN	42%	MIS 2017	80%	83%	85%	88%	90%	MIS	3-yearly
6	Proportion of population at risk that slept under an ITN the previous night	59.3%	MIS 2017	70%	74%	78%	82%	85%	MIS	3-yearly
7	Indoor residual spraying (IRS) coverage	2.1%	MoH Report	4.0%	6.0%	7.5%	8.5%	10%	MIS	3-yearly
Neglected Tropical Diseases										
1	Number of people requiring interventions against tropical diseases (SDG 3.3.5)	7.5 million	Program Report	6.5 million	5.5 million	4.5 million	3.5 million	2.5 million	Program Report	Annually
2	Integrated Treatment Coverage Index of preventive chemotherapy for NTDs (onchocerciasis, soil transmitted helminths, lymphatic filariasis, trachoma and schistosomiasis)	78%	Program Report	81%	83%	86%	88%	90%	Program Report	Annually

3	Percentage of endemic counties where transmission of Human African Trypanosomiasis (sleeping sickness) has been interrupted	0% (0/17)	Program Report	0%	6%	12%	18%	24%	Program Report	Annually
4	Percentage of endemic counties reporting <1% case fatality rate due to primary visceral leishmaniasis	0% (0/31)	Program Report	0%	3%	6%	12%	21%	Program Report	Annually
5	Percentage of endemic counties where transmission of trachoma has been interrupted.	3% (1/33)	Program Report	3%	18% (6/33)	27% (9/33)	52% (17/33)	52% (17/33)	Program Report	Annually
6	Percentage of endemic counties where transmission of LF has been interrupted.	0% (0/50)	Program Report	0%	22% (11/50)	28% (14/50)	36% (18/50)	40% (20/50)	Program Report	Annually
7	Guinea Worm Incidence	6	Program Report	2	1	0	0	0	Program Report	Annually
Non-Communicable Diseases and Mental Health										
1	Cervical cancer screening coverage	10%	WHO 2021	14%	18%	22%	26%	30%	DHIS2	Quarterly
2	Raised blood pressure among adults	20.1%	Sudan Household Survey 2006	20%	20%	19%	18%	18%	STEPS	5 years
3	Raised blood glucose (diabetes) among adults	6.5%	International Diabetes Federation 2021	6.5%	5.5%	5%	4.5%	4%	STEPS	5 years
4	Total alcohol per capita (age 15+ years) consumption [SDG3.5.2]	12	WHO	11.6	11.2	10.8	10.4	10%	STEPS	5 years
5	Age standardized prevalence of current tobacco use	15.6%	WHO Estimate	15%	14%	13%	12%	12%	STEPS	5 years
6	Coverage of services for severe mental health disorders	1%	Civil society	2%	4%	6%	8%	10%	DHIS2	Quarterly
7	Percentage of new outpatients attributed to gender-based violence	No data	Not Applicable	<10%	<8%	<6%	<4	<2%	DHIS2	Quarterly
8	Percentage of new outpatients attributed to road traffic accident injuries	1%	MoH report	1%	1%	0.8%	0.7%	0.5%	DHIS2	Quarterly
9	Percentage new outpatient cases attributed to other injuries	5%	MoH reports	5%	5%	4%	3%	2%	DHIS2	Quarterly
Oral, Eye and Occupational Health services										
1	Coverage of oral health services	2%	MoH reports	3%	5%	6%	7%	10%	Reports	Annually
2	Number of specialized eye care centers established	1	MoH reports	1	2	2	3	3	Reports	Annually
3	Coverage of occupational health services	No data	Not Applicable	2%	4%	6%	8%	10%	Program Report	Annually
Epidemic Emergencies & Disasters										
1	Proportion of alerts investigated in 48 hrs	81%	EWARS	822%	84%	86%	88%	90%	EWARS	Quarterly
2	Number of functional PHL	1	MoH reports	1	2	3	4	5	MoH reports	Annually
3	Number of functional Emergency Operations Center (EOCs) at national and subnational levels	1	MoH reports	2	3	5	6	7	MoH reports	Annually
4	Average of 13 International Health Regulations (IHR) capacity scores	34.40	IHR Capacity Assessment	37%	40%	43%	47%	50%	IHR Capacity Assessment	2-3 years
5	Proportion of outbreaks investigated, confirmed,	88%	IDSR	88.2%	88.4%	88.6%	88.8%	90%	IDSR	Quarterly

	and responded to									
6	Case fatality rate (% of reports cases of epidemic diseases -cholera, measles, COVID-19 etc. which are fatal)	2%	IDSR	1.8%	1.6%	1.4%	1.2%	1%	IDSR	Quarterly
Health Promotion, Boma Health Initiative and School Health										
Program Indicators										
1	Proportion of health promotion cadre trained on health promotion	No data	Not Applicable	10%	20%	30%	40%	50%	Program Report	Annually
2	Percentage of Boma's implementing BHI	25%	MoH reports	35%	45%	55%	68%	80%	Program Report	Annually
3	Coverage of school health services	No data	Not Applicable	2%	4%	6%	8%	10%	Program Report	Annually
Environmental Factors										
1	Population using safely managed drinking water services [SDG 6.1.1]	40%	UNICEF (2019)	44%	48%	52%	56%	60%	Survey	Every 2 years
2	Population using safely managed sanitation services [SDG 6.2.1]	10%	UNICEF (2019)	13%	14%	16%	18%	20%	Survey	Every 2 years
Access to health services (Output Indicators)										
1	General service availability score[83]	30.4%	SARA (2018)	34%	38%	42%	46%	50%	Survey	Every 2 years
2	Coverage of essential health service (Index) [SDG 3.8.1]	32	WHO	35	37.5	40	42.5	45	WHO	Annually
3	Service utilization rate (OPD visits per capita per year)	0.67	DHIS2 (2021)	0.9	1.2	1.5	1.8	2	DHIS2	Annually
4	% of population within 5kms of health facility	44%	MoH reports	48%	51%	54%	57%	60%	Survey	Every 2 years
5	Hospital bed density per 10,000 populations	6.5	SARA (2018)	7	9	11	13	15	Survey	Every 2 years
6	Number of Quality-of-Care units established	0	Not Applicable	1	3	6	9	11	Program Report	Annually
Input Indicators										
Health Infrastructure										
1	Total number of health facilities per 10,000 populations	1.42	SARA (2018)	1.44	1.48	1.52	1.56	1.6	Survey	Every 2 years
2	% of facilities equipped as per BPHNS norms	No data	Not Applicable	10%	20%	30%	40%	50%	Survey	Annually
3	Number of functional renovated health facilities	No data	Not Applicable	20	40	60	80	100	Program Report	Annually
4	Number of functional ambulance teams	No data	Not Applicable	2	4	6	8	10	Program Report	Annually
5	% of health facilities with access to sanitation facilities	58%	SARA (2018)	60%	63.5%	67.5%	71.5%	75%	Survey	Every 2 years
Health Workforce										
1	Health worker density (per 10,000 population)	7.61	SARA (2018)	8	8.5	9	9.5	10	HRHIS	Annually
2	HRH Policy, Strategy and Manual developed and in use	0	MoH reports	0	1	1	1	1	Program Report	Annually
3	HRH Information system established and in use	0	MoH reports	0	1	1	1	1	Program Report	Annually
4	Number of professional regulatory bodies established and functional	0	MoH reports	0	3	4	4	4	Program Report	Annually
5	Percentage of health science training institutions	No data	Not Applicable	10%	20%	30%	50%	70%	Program Report	Annually

[83] General Service Availability refers to the physical presence of the delivery of services and encompasses three domains of tracer indicators: health infrastructure, health workforce, and service utilization.

	that are accredited									
Health Information										
1	Birth notification coverage	35%	MoH Reports	40%	44%	48%	52%	55%	CRVS/Survey	Annually
2	Death notification coverage	No data	Not Applicable	35%	40%	45%	50%	55%	CRVS/Survey	Annually
3	Proportion of health facilities reporting on time	40.4%	HMIS reports	50%	60%	70%	80%	90%	DHIS2	Quarterly
4	Completeness of reporting by facilities	49.5%	HMIS reports	55%	60%	70%	80%	90%	DHIS2	Quarterly
5	IDSR timeliness and completeness	54%	HMIIS reports	60%	68%	76%	83%	90%	DHIS2	Quarterly
6	Proportion of health facilities directly reporting through DHIS2	No data	Not Applicable	20%	37%	55%	73%	90%	DHIS 2	Quarterly
7	Percentage of States that conducted DQA	No data	Not Applicable	40%	50%	60%	70%	80%	DQA reports	Annually
Monitoring and Evaluation										
1	Percentage of programs with work plans aligned to the HSSP	0	M&E reports	40%	50%	60%	70%	80%	Program Report	Annually
2	Percentage of programs which review their performance according to the HSSP and produce reports at least annually	0	M&E reports	40%	50%	60%	70%	80%	Program Report	Annually
Medicines and Health Supplies (Health products)										
1	Health facilities that have a core set of relevant essential medicines and commodities available and affordable [SDG 3.d.3]	73%	MoH Reports	76%	77 %	79 %	81%	85%	DHIS2	Quarterly
2	Percentage of pharmaceuticals expired at heath facility level	4.2%	MoH Reports	3.8%	3.3%	2.8	2.4%	2%	eLMIS	Quarterly
3	Percentage facilities reporting stock out of core set of essential and relevant medicines including nutrition supplies	27.1%	MoH Reports	25%	22%	19%	17%	15%	eLMIS	Quarterly
National Laboratory and Blood Transfusion Services										
1	Proportion of Laboratories reporting stock-outs of tracer reagents	No data	Not Applicable	<50%	<40%	<30%	<20%	<10%	eLMIS	Quarterly
2	Proportion of laboratories conforming to minimum standards	No data	Not Applicable	50%	55%	60%	65%	70%	MoH Reports	Annually
3	Number of hospital-based blood banks providing safe blood transfusion services	No data	Not Applicable	6	8	10	12	14	MoH Reports	Annually
4	Number of blood banks with adequate cold chain	No data	Not Applicable	6	8	10	12	14	MoH Reports	Annually
Health Financing										
1	Health allocation as percentage of national budget	2.5%	MoFP Budget book	6%	7%	8%	9%	10%	Program Report	Annually
2	Percentage of MoH budget implemented (Budget execution rate)	96%	MoH/MoFP report	96.5%	97%	98%	99%	100%	Program Report	Annually
3	Total Health Expenditure as % of GDP (target is 15%)	6%	WHO GHED	8%	10%	12%	13%	15%	WHO GHED	Annually
4	Externally sourced funding as % of current health expenditure	63.6%	WHO GHED	60.9%	58.2%	55.4%	52.7%	50%	WHO GHED	Annually
5	Out-of-pocket expenditure as % of current health expenditure	23.2%	WHO GHED	22%	22%	21%	21%	20%	WHO GHED	Annually

Leadership and Governance										
1	Ministry of Health Organogram reviewed and implemented	0	MoH Reports	1	1	1	1	1	Program Report	Annually
2	State Ministry of Health Organograms reviewed and implemented	0	MoH Reports	2	13	13	13	13	Program Report	Annually
3	Ministry of Health costed Annual Operational Plan developed and implemented	0	MoH Reports	0	1	1	1	1	Program Report	Annually
4	% of State Ministries of Health with annual operational plans developed and implemented.	0	MoH Reports	100%	100%	100%	100%	100%	Program Report	Annually
Partnerships										
1	Percentage of Health Sector Steering Committee Meetings held at National level	50%	MoH reports	100%	100%	100%	100%	100%	Meeting Minutes	Quarterly
2	Percentage of State Ministries of Health conducting regular coordination meetings	58.3%	MoH reports	60%	70%	80%	90%	100%	Meeting Minutes	Quarterly
3	Percentage of Inter-ministerial/Inter-sectoral coordination forum meetings held at National level	No data	Not Applicable	60%	70%	80%	90%	100%	Meeting Minutes	Quarterly
4	% Health Ministerial Advisory Board Meetings	50%	MoH Reports	50%	100%	100%	100%	100%	Meeting Minutes	Biannual
5	Public Private Partnership for Health Policy and Strategy in Place	0	MoH Reports	0	1	1	1	1	Program Report	Annually

Annex 2: Economic and Financial Determinants Sub Index

a) HSSP 2023-2027 Budget by Strategies and Interventions by Year (Ambitious Scenario 3)

Strategic Objectives by Program	*Year 1*	*Year 2*	*Year 3*	*Year 4*	*Year 5*	*Total (Year1 -5)*	*Proportion of total budget*
Health promotion, Boma Health Initiative and School Health	***9,816,892***	***13,380,304***	***8,155,935***	***13,380,304***	***8,155,935***	***52,889,369***	***2.11%***
Health promotion	***5,938,823***	***5,433,393***	***5,490,893***	***5,433,393***	***5,490,893***	***27,787,395***	***1.11%***
Strengthen national leadership of the MoH Health Promotion Unit to effectively deliver health promotion and health education services	1,012,259	564,329	564,329	564,329	564,329	3,269,575	0.13%
Strengthen intra & inter-sectoral collaboration to support health promotion	183,204	125,704	183,204	125,704	183,204	801,020	0.03%
Community engagement for health promotion activities	4,743,360	4,743,360	4,743,360	4,743,360	4,743,360	23,716,800	0.94%
Boma Health Initiative	***3,176,143***	***7,471,899***	***2,190,030***	***7,471,899***	***2,190,030***	***22,500,000***	***0.90%***
Scale up Boma Health Initiative in phases to all bomas	936,808	6,623,394	936,808	6,623,394	936,808	16,057,211	0.64%
Provide tools, basic medicines, promotion material and training for the Boma Health Teams	1,255,543	217,508	269,430	217,508	269,430	2,229,420	0.09%
Advocate and secure resources for implementing BHI activities	303,235	303,235	303,235	303,235	303,235	1,516,174	0.06%
Strengthen community leadership for effective engagement, participation, and oversight of BHI implementation	680,557	327,761	680,557	327,761	680,557	2,697,195	0.11%
School Health	***701,926***	***475,012***	***475,012***	***475,012***	***475,012***	***2,601,974***	***0.10%***
In collaboration with the education sector and related sectors - establish an integrated school health program	701,926	475,012	475,012	475,012	475,012	2,601,974	0.10%
Reproductive, Maternal, Newborn and Adolescents' Health	***77,695,241***	***67,856,931***	***70,060,359***	***67,856,931***	***70,060,359***	***353,529,821***	***14.08%***
Reproductive (+Adolescents) Health	***16,488,286***	***15,675,131***	***15,827,387***	***15,675,131***	***15,827,387***	***79,493,322***	***3.17%***
Ensure access to and utilization of quality reproductive services for women & youth	555,036	458,466	458,466	458,466	458,466	2,388,900	0.10%
Strengthen leadership and governance for effective delivery of RMNCAH services	292,800	292,800	292,800	292,800	292,800	1,464,000	0.06%

Scale up youth friendly comprehensive AYSRH services	4,356,776	4,356,776	4,356,776	4,356,776	4,356,776	21,783,880	0.87%
Institute programs for screening and management of gynaecological conditions including cancers	5,797,440	5,797,440	5,797,440	5,797,440	5,797,440	28,987,200	1.15%
Ensure prevention, timely services, care, and support for victims of Sexual and Gender Based Violence (SGBV)	5,486,234	4,769,649	4,921,905	4,769,649	4,921,905	24,869,342	0.99%
Maternal Health	***49,843,465***	***40,818,311***	***42,869,482***	***40,818,311***	***42,869,482***	***217,219,051***	***8.65%***
Ensure access to quality high impact maternal health and nutrition services for all pregnant women	23,588,471	23,588,471	23,588,471	23,588,471	23,588,471	117,942,356	4.70%
Strengthen referral for safe delivery in EmONC accredited health facilities	26,254,994	17,229,840	19,281,011	17,229,840	19,281,011	99,276,696	3.96%
Newborn Health	***11,363,490***	***11,363,490***	***11,363,490***	***11,363,490***	***11,363,490***	***56,817,448***	***2.26%***
Ensure access to quality newborn health services to boost survival	6,563,748	6,563,748	6,563,748	6,563,748	6,563,748	32,818,742	1.31%
Strengthen referral of severely ill new-born babies	3,158,804	3,158,804	3,158,804	3,158,804	3,158,804	15,794,020	0.63%
Community mobilization and education of mothers (through ANC), families and communities on state of a healthy baby	1,640,937	1,640,937	1,640,937	1,640,937	1,640,937	8,204,686	0.33%
Child Health and Nutrition	***7,984,253***	***184,202,253***	***17,734,253***	***82,029,753***	***17,734,253***	***309,684,765***	***12.34%***
Child Health	***5,513,917***	***5,513,917***	***5,513,917***	***5,513,917***	***5,513,917***	***27,569,585***	***1.10%***
Scale up access to high impact and cost-effective preventive, diagnostic & curative paediatric interventions to reduce morbidity & mortality	152,256	152,256	152,256	152,256	152,256	761,280	0.03%
Institutionalize specialized child health care services	908,585	908,585	908,585	908,585	908,585	4,542,925	0.18%
Strengthen national expanded program on immunization – Reach every child (REC)	4,453,076	4,453,076	4,453,076	4,453,076	4,453,076	22,265,380	0.89%
Nutrition	***2,470,336***	***178,688,336***	***12,220,336***	***76,515,836***	***12,220,336***	***282115180***	***11.24%***
Develop and review evidence based national nutrition policy, strategy and frameworks to improve nutrition	35,000	125,000	35,000	10,000	35,000	240,000	0.01%
Scale up evidence-based high impact nutrition interventions at health facility and community levels including wasting prevention and management	574,500	15,382,000	10,324,500	12,882,000	10,324,500	49,487,500	1.97%
Improve capacity, multisectoral coordination and systems to deliver quality nutrition services at national and subnational level	1,778,000	1,541,000	1,778,000	1,541,000	1,778,000	8,416,000	0.34%

Communicable Diseases and Neglected Tropical Diseases	***117,128,519***	***122,732,558***	***133,407,700***	***134,935,618***	***148,131,474***	***656,335,870***	***26.15%***
Malaria	***54,715,932***	***60,461,105***	***66,809,521***	***73,824,521***	***81,576,095***	***337,387,174***	***13.44%***
Strengthen and sustain management and coordination capacity of the Malaria control program	5,467,898	6,042,027	6,676,440	7,377,466	8,152,100	33,715,930	1.34%
Strengthen malaria surveillance, monitoring & evaluation, and operational research	18,623,338	20,578,789	22,739,561	25,127,215	27,765,573	114,834,476	4.57%
Achieve universal access to diagnosis and treatment of all presented malaria cases	23,826,086	26,327,825	29,092,246	32,146,932	35,522,360	146,915,448	5.85%
Protect the population at risk by recommended malaria prevention	2,087,741	2,306,954	2,549,184	2,816,849	3,112,618	12,873,346	0.51%
Increase community knowledge, attitudes, behaviours and practices for malaria prevention and control	4,710,870	5,205,511	5,752,090	6,356,059	7,023,445	29,047,974	1.16%
Tuberculosis	***10,875,092***	***11,378,761***	***16,307,459***	***10,605,000***	***15,007,668***	***64,173,980***	***2.56%***
Scale up prevention, case detection, diagnosis, and treatment at all levels	7,469,338	7,795,507	10,611,165	7,745,281	8,216,376	41,837,667	1.67%
Integrate programs & services of TB and HIV care	624,755	351,833	477,551	433,309	4,002,145	5,889,594	0.23%
Support community systems for TB and HIV care	2,780,998	3,231,422	5,218,743	2,426,410	2,789,147	16,446,720	0.66%
HIV/AIDS	***38,210,500***	***38,210,500***	***38,210,500***	***38,210,500***	***39,755,505***	***192,597,505***	***7.67%***
Ensure comprehensive prevention services to reduce new HIV infections	9,850,000	9,850,000	9,850,000	9,850,000	9,850,000	49,250,000	1.96%
Ensure access to innovative testing & effective HIV case finding	6,960,250	6,960,250	6,960,250	6,960,250	8,505,255	36,346,255	1.45%
Expand coverage of ART at national & subnational levels	8,000,000	8,000,000	8,000,000	8,000,000	8,000,000	40,000,000	1.59%
Eliminate vertical transmission for HIV	13,400,250	13,400,250	13,400,250	13,400,250	13,400,250	67,001,250	2.67%
Sexually Transmitted Infections	***2,731,681***	***1,143,752***	***1,143,752***	***1,143,752***	***1,143,752***	***7,306,689***	***0.29%***
Scale up primary prevention and increase access to screening for sexually transmitted infections including priority populations	823,152	270,000	270,000	270,000	270,000	1,903,152	0.08%
Increase access to high-quality, people centred case management of STIs	675,552	675,552	675,552	675,552	675,552	3,377,760	0.13%
Strengthen integration of STIs services with BPHNS/RMNCAH+	1,232,977	198,200	198,200	198,200	198,200	2,025,777	0.08%
Viral Hepatitis B & C	***1,251,305***	***1,345,661***	***1,122,110***	***1,345,661***	***1,122,110***	***6,186,847***	***0.25%***
Strengthen advocacy, social mobilization and behavior change communication on viral hepatitis B and C prevention, testing and treatment	29,033	688,073	29,033	688,073	29,033	1,463,243	0.06%

Effectively reduce blood borne infections of viral hepatitis B and C	772,267	207,583	643,072	207,583	643,072	2,473,578	0.10%
Expand Hepatitis B and C screening to identify people with chronic hepatitis infections & treat them	450,005	450,005	450,005	450,005	450,005	2,250,027	0.09%
Prevention and control of neglected tropical diseases	***9,344,009***	***10,192,779***	***9,814,359***	***9,806,184***	***9,526,344***	***48,683,675***	***1.94%***
Strengthen leadership and capacity for NTDs programming and implementation	1,076,603	3,452,473	3,322,788	3,324,788	3,328,388	14,505,040	0.58%
Strengthen prevention, early detection, diagnosis, treatment, and care of NTDs including Guinea work eradication interventions	6,507,608	4,698,838	4,571,513	4,508,678	4,494,658	24,781,295	0.99%
Strengthen integration, partnerships, and inter-sectoral collaboration	1,759,798	2,041,468	1,920,058	1,972,718	1,703,298	9,397,340	0.37%
Non-Communicable Diseases, Mental, Oral, Eye, and Occupational Health	***6,208,813***	***5,950,117***	***5,909,823***	***5,727,873***	***6,304,503***	***30,101,128***	***1.20%***
Non-communicable diseases	***1,616,000***	***1,616,000***	***1,785,680***	***1,973,176***	***2,180,360***	***9,171,216***	***0.37%***
Promote healthy lifestyles and prevent non-communicable diseases (NCDs) and NCD Risk factors	961,400	961,400	1,062,347	1,173,893	1,297,152	5,456,193	0.22%
Strengthen service delivery for NCDs at primary, secondary and tertiary levels	630,000	630,000	696,150	769,246	850,017	3,575,412	0.14%
Strengthen multisectoral collaboration on the control of NCD risk factors (tobacco, alcohol, and substance abuse & other NCDs + road safety)	24,600	24,600	27,183	30,037	33,191	139,611	0.01%
Mental Health	***1,820,345***	***2,703,960***	***2,124,540***	***2,124,540***	***2,124,540***	***10,897,925***	***0.43%***
Strengthen Mental Neurological and Substance Use (MNS) in communities and Primary Health Care	1,405,094	1,405,094	1,115,384	1,115,384	1,115,384	6,156,338	0.25%
Strengthen delivery of MNS in secondary and tertiary health care.	124,575	883,616	593,906	593,906	593,906	2,789,907	0.111%
Integration of Mental Health and Psychosocial support (MHPSS) in Emergency Settings	290,676	415,251	415,251	415,251	415,251	1,951,680	0.08%
Oral Health	***607,108***	***96,359***	***96,359***	***96,359***	***96,359***	***992,544***	***0.04%***
Scale up access to oral health care services through integration in primary, secondary, and tertiary oral healthcare services	607,108	96,359	96,359	96,359	96,359	992,544	0.04%
Eye Care	***1,188,352***	***613,789***	***983,235***	***613,789***	***983,235***	***4,382,398***	***0.17%***
Expand access to Eye Care and Visual Health Services at all levels	1,188,352	613,789	983,235	613,789	983,235	4,382,398	0.17%
Occupational Health Services	***977,009***	***920,009***	***920,009***	***920,009***	***920,009***	***4,657,045***	***0.19%***
Scale up access to occupational health services for high risk/vulnerable individuals	977,009	920,009	920,009	920,009	920,009	4,657,045	0.19%

Public Health Emergencies and Humanitarian Response	***4,005,235***	***3,103,032***	***3,390,096***	***2,624,591***	***3,390,096***	***16,513,051***	***0.66%***
Strengthen capacity for detection and response to health emergencies at all levels (national and subnational	3,116,702	1,913,764	2,501,563	1,913,764	2,501,563	11,947,356	0.48%
Strengthen capacity for preparedness to health emergencies at all levels (national and subnational)	300,734	601,469	300,734	123,028	300,734	1,626,700	0.06%
Reduce cross border spread of diseases	587,799	587,799	587,799	587,799	587,799	2,938,995	0.12%
Equitable Access, Quality and Safety	***127,238,391***	***89,108,313***	***117,022,762***	***70,693,313***	***73,239,833***	***477,302,611***	***19.01%***
Enhance equitable access to the BPHNS at all levels	***92,300,000***	***60,800,000***	***84,300,000***	***42,000,000***	***48,000,000***	***327,400,000***	***13.04%***
Ensure rational, equitable development and distribution of health facilities (PHCU, PHCC and hospitals) at all levels	92,300,000	60,800,000	84,300,000	42,000,000	48,000,000	327,400,000	13.04%
Improve quality and safety for delivery of the BPHNS at all levels	***6,883,041***	***5,431,242***	***5,431,242***	***5,431,242***	***303,313***	***23,480,078***	***0.94%***
Establish and strengthen the institutional framework for quality of care at all levels of care	881,559	-	-	-	-	881,559	0.04%
Strengthen and expand the capacity for quality-of-care implementation	6,001,482	5,431,242	5,431,242	5,431,242	303,313	22,598,519	0.90%
Improve diagnostic capacity and referral services	***1,052,098***	***369,493***	***918,942***	***369,493***	***818,942***	***3,528,969***	***0.14%***
Expand access and utilization of diagnostics and specialized curative services	1,052,098	323,439	423,439	323,439	323,439	2,445,854	0.10%
Strengthen referral mechanisms between the levels of care	-	46,054	495,503	46,054	495,503	1,083,115	0.04%
Improve availability and functionality of health infrastructure for BPHNS delivery	***27,003,252***	***22,507,578***	***26,372,578***	***22,892,578***	***24,117,578***	***122,893,564***	***4.90%***
Establish Norms, Standards and regulatory framework for health infrastructure and equipment	410,000	260,000	260,000	260,000	260,000	1,450,000	0.06%
Ensure effective planning and maintenance of health infrastructure	10,348,252	11,188,252	13,228,252	15,328,252	16,118,252	66,211,260	2.64%
Secure funding for and improve health infrastructure	16,245,000	11,059,326	12,884,326	7,304,326	7,739,326	55,232,303	2.20%
Human Resources for Heath	***32,365,043***	***30,781,688***	***31,388,450***	***30,866,978***	***30,910,264***	***156,312,422***	***6.23%***
Strengthen the health workforce governance, leadership & regulatory mechanisms	646,313	81,984	81,984	81,984	81,984	974,249	0.04%
Strengthen HRH information for planning and management	355,680	96,570	96,570	96,570	96,570	741,960	0.03%
Scale up production of appropriate health workforce based on need	6,524,576	6,524,576	6,524,576	6,524,576	6,524,576	32,622,880	1.30%

Scale up post graduate/specialist training of appropriate cadre based on need	4,438,880	4,243,293	4,285,726	4,328,583	4,371,869	21,668,351	0.86%
Ensure effective recruitment, deployment and retention policies and practices	14,659,447	14,659,447	14,659,447	14,659,447	14,659,447	73,297,234	2.92%
Strengthen HRH multisectoral coordination and collaboration	5,740,147	5,175,818	5,740,147	5,175,818	5,175,818	27,007,748	1.08%
Essential Medicines, Supplies & Technologies, Laboratory & Blood Transfusion Services	***53,627,333***	***59,305,088***	***77,498,086***	***99,482,796***	***116,681,201***	***406,594,504***	***16.20%***
Essential Medicines, Supplies and Technologies	***49,937,333***	***55,175,088***	***71,778,086***	***92,412,796***	***109,311,201***	***378,614,504***	***15.08%***
Strengthen the governance structures, processes, and systems within the pharmaceutical sector	2,379,629	744,605	558,337	555,082	1,071,286	5,308,939	0.21%
Strengthen the pharmaceutical supply chain to deliver safe, efficacious, and affordable essential medicines and supplies and their rational use in a sustainable and equitable manner	37,398,333	50,842,105	69,261,406	90,140,819	106,523,020	354,165,683	14.11%
Strengthen the regulatory framework and quality management process within the pharmaceutical sector	4,068,172	1,748,389	1,563,389	1,433,418	1,433,418	10,246,786	0.41%
Build capacity and strengthen pharmaceutical systems to deliver sustainable and equitable access	6,091,199	1,839,989	394,954	283,477	283,477	8,893,096	0.35%
Strengthen the national quality laboratory system	***1,500,000***	***1,850,000***	***2,850,000***	***3,500,000***	***3,800,000***	***13,500,000***	***0.54%***
Strengthen the laboratory institutional governance, regulatory frameworks, policies, and standards; Ensure availability of appropriate laboratory infrastructure, equipment and supplies at all levels	1,050,000	1,400,000	2,100,000	2,450,000	2,450,000	9,450,000	0.38%
Strengthen laboratory information systems, surveillance, and research	315,000	315,000	525,000	735,000	945,000	2,835,000	0.11%
Strengthen the laboratory workforce capacity and practice	135,000	135,000	225,000	315,000	405,000	1,215,000	0.05%
Strengthen the national blood transfusion services	***2,190,000***	***2,280,000***	***2,870,000***	***3,570,000***	***3,570,000***	***14,480,000***	***0.58%***
Strengthen the blood transfusion services institutional governance, regulatory frameworks, policies, and standards; Strengthen national blood transfusion services infrastructure, equipment, and supplies	990,000	1,080,000	1,170,000	1,170,000	1,170,000	5,580,000	0.22%
Strengthen quality assurance system for national blood transfusion service Scale up blood collection, blood testing and production of blood products	700,000	700,000	700,000	1,400,000	1,400,000	4,900,000	0.20%
Ensure effective and efficient transfusion and blood utilization	500,000	500,000	1,000,000	1,000,000	1,000,000	4,000,000	0.16%

Health Financing towards UHC	***846,300***	***969,689***	***599,523***	***712,750***	***749,041***	***3,877,304***	***0.15%***
Strengthen the health financing governance, leadership & policy frameworks	248,229	248,229	180,002	180,002	180,002	1,036,464	0.04%
Increase sustainable funding for health	406,456	428,231	293,229	406,456	406,456	1,940,829	0.08%
Strengthen public financial management systems within the health sector	164,034	229,358	98,711	98,711	98,711	689,524	0.03%
Support regular generation of health financing information for decision making	27,581	63,872	27,581	27,581	63,872	210,486	0.01%
Health Information System, Monitoring and Evaluation	***10,067,940***	***7,604,732***	***6,565,368***	***6,232,500***	***8,117,130***	***38,587,670***	***1.54%***
Health Information System	***6,295,719***	***3,375,040***	***3,392,459***	***3,375,040***	***3,392,459***	***19,830,717***	***0.79%***
Strengthen the health information system governance, leadership & policy frameworks	1,451,630	1,451,630	1,451,630	1,451,630	1,451,630	7,258,150	0.29%
Strengthen the systems for generation, storage, use, and transmission of HMIS data	4,553,763	1,633,084	1,650,503	1,633,084	1,650,503	11,120,937	0.44%
Strengthen vital statistics and systems; health research and conduct surveys	290,326	290,326	290,326	290,326	290,326	1,451,630	0.06%
Monitoring and Evaluation	***3,772,220***	***4,229,692***	***3,172,908***	***2,857,460***	***4,724,671***	***18,756,952***	***0.75%***
Strengthen the Monitoring and evaluation institutional governance, regulatory frameworks, policies, and standards	2,060,922	1,357,888	1,615,866	1,205,632	1,615,866	7,856,175	0.31%
Institutionalize health sector monitoring and evaluation activities	1,711,298	2,871,804	1,557,042	1,651,828	3,108,804	10,900,778	0.43%
Leadership and Governance	***1,972,167***	***1,128,870***	***1,832,683***	***1,128,870***	***1,627,723***	***7,690,313***	***0.31%***
Strengthen the institutional framework, authority, mandate, and accountability systems within the MoH, SMoH and CHD	833,728	694,244	694,244	694,244	694,244	3,610,702	0.14%
Strengthen policy, strategy, legal and regulatory functions of the health sector	1,138,439	434,626	1,138,439	434,626	933,479	4,079,611	0.16%
Strategic Partnership	***310,649***	***62,420***	***148,066***	***69,678***	***127,743***	***718,557***	***0.03%***
Strengthen health sector coordination at all levels	-	50,807	50,807	-	50,807	152,421	0.01%
Ensure alignment of partnerships with national priorities and strategies	31,936	11,613	31,936	11,613	11,613	98,711	0.00%
Strengthen inter-ministerial and inter-sectoral collaboration	65,323	-	65,323	58,065	65,323	254,035	0.01%
Strengthen Public-Private Partnerships for health systems development and service delivery	213,390	-	-	-	-	213,390	0.01%
Total Annual Budget (in $ USD)	**449,266,775**	**586,185,995**	**473,713,104**	**515,741,955**	**485,229,556**	**2,510,137,384**	

b) HSSP direct costs distribution by program area

Strategic Objectives by Program	Year 1	Year 2	Year 3	Year 4	Year 5	Total (Year1 -5)	Average cost per year	%
Health promotion, Boma Health Initiative and School Health	9 816 892	13 380 304	8 155 935	13 380 304	8 155 935	52 889 369	10,577,874	3.66%
Health promotion	5 938 823	5 433 393	5 490 893	5 433 393	5 490 893	27 787 395	5,557,479	1.92%
Boma Health Initiative	3 176 143	7 471 899	2 190 030	7 471 899	2 190 030	22 500 000	4,500,000	1.56%
School Health	701 926	475 012	475 012	475 012	475 012	2 601 974	520,395	0.18%
Reproductive, Maternal, Neonatal and Adolescents' Health	77 695 241	67 856 931	70 060 359	67 856 931	70 060 359	353 529 821	70,705,964	24.45%
Reproductive (+Adolescents) Health	16 488 286	15 675 131	15 827 387	15 675 131	15 827 387	79 493 322	15,898,664	5.50%
Maternal Health	49 843 465	40 818 311	42 869 482	40 818 311	42 869 482	217 219 051	43,443,810	15.02%
Newborn Health	11 363 490	11 363 490	11 363 490	11 363 490	11 363 490	56 817 448	11,363,490	3.93%
Child Health and Nutrition	7 984 253	184 202 253	17 734 253	82 029 753	17 734 253	309 684 765	61,895,953	21.42%
Child Health	5 513 917	5 513 917	5 513 917	5 513 917	5 513 917	27 569 585	5,513,917	1.91%
Nutrition	2 470 336	178 688 336	12 220 336	76 515 836	12 220 336	282 115 180	56,382,036	19.51%
Communicable Diseases and Neglected Tropical Diseases	117 128 519	122 732 558	133 407 700	134 935 618	148 131 474	656 335 870	131,267,174	45.39%
Malaria	54 715 932	60 461 105	66 809 521	73 824 521	81 576 095	337 387 174	67,477,435	23.33%
Tuberculosis	10 875 092	11 378 761	16 307 459	10 605 000	15 007 668	64 173 980	12,834,796	4.44%
HIV/AIDS	38 210 500	38 210 500	38 210 500	38 210 500	39 755 505	192 597 505	38,519,501	13.32%
Sexually Transmitted Infections	2 731 681	1 143 752	1 143 752	1 143 752	1 143 752	7 306 689	1,461,338	0.51%
Viral Hepatitis B & C	1 251 305	1 345 661	1 122 110	1 345 661	1 122 110	6 186 847	1,237,369	0.43%
Prevention and control of neglected tropical diseases	9 344 009	10 192 779	9 814 359	9 806 184	9 526 344	48 683 675	9,736,735	3.37%
Non-Communicable Diseases, Mental, Oral, Eye, and Occupational Health	6 208 813	5 950 117	5 909 823	5 727 873	6 304 503	30 101 128	6,020,226	2.08%
Non-communicable diseases	1 616 000	1 616 000	1 785 680	1 973 176	2 180 360	9 171 216	1,834,243	0.63%

Mental Health	*1 820 345*	*2 703 960*	*2 124 540*	*2 124 540*	*2 124 540*	*10 897 925*	*2,179,585*	*0.75%*
Oral Health	*607 108*	*96 359*	*96 359*	*96 359*	*96 359*	*992 544*	*198,509*	*0.07%*
Eye Care	*1 188 352*	*613 789*	*983 235*	*613 789*	*983 235*	*4 382 398*	*876,480*	*0.30%*
Occupational Health Services	*977 009*	*920 009*	*920 009*	*920 009*	*920 009*	*4 657 045*	*931,409*	*0.32%*
Public Health Emergencies and Humanitarian Response	*4 005 235*	*3 103 032*	*3 390 096*	*2 624 591*	*3 390 096*	*16 513 051*	*3,302,610*	*1.14%*
*Equitable Access, Quality and Safety**	*7 935 139*	*5 800 735*	*6 350 184*	*5 800 735*	*1 122 255*	*27 009 047*	*5,401,809*	*1.87%*
Improve quality and safety for delivery of the BPHNS at all levels	*6 883 041*	*5 431 242*	*5 431 242*	*5 431 242*	*303 313*	*23 480 078*	*4,696,016*	*1.62%*
Improve diagnostic capacity and referral services	*1 052 098*	*369 493*	*918 942*	*369 493*	*818 942*	*3 528 969*	*705,794*	*0.25%*
Total Annual Budget (in $ USD)	*230,774,091*	*403,025,930*	*245,008,350*	*312,355,805*	*254,898,875*	*1,446,063,051*	*289,212,610*	

**Infrastructure-related intervention costs reflected under health systems reform costs*

c) Health Systems reform cost (Indirect cost)

Health System Reform Cost (Indirect costs)	*Year 1*	*Year 2*	*Year 3*	*Year 4*	*Year 5*	*Total Year1 -5)*	*Average cost per year*	*%*
Infrastructure	*119,303,252*	*83,307,578*	*110,672,578*	*64,892,578*	*72,117,578*	*450,293,564*	*90,058,713*	*42.32%*
Human Resources	*32,365,043*	*30,781,688*	*31,388,450*	*30,866,978*	*30,910,264*	*156,312,422*	*31,262,484*	*14.69%*
Essential Medicines, Supplies and Technologies	*49,937,333*	*55,175,088*	*71,778,086*	*92,412,796*	*109,311,201*	*378,614,504*	*75,722,901*	*35.58%*
National Lab and Blood Banks	*3,690,000*	*4,130,000*	*5,720,000*	*7,070,000*	*7,370,000*	*27,980,000*	*5,596,000*	*2.63%*
Health Financing Towards UHC	*846,300*	*969,689*	*599,523*	*712,750*	*749,041*	*3,877,304*	*775,461*	*0.36%*
Health Information System	*6,295,719*	*3,375,040*	*3,392,459*	*3,375,040*	*3,392,459*	*19,830,717*	*3,966,143*	*1.86%*
Monitoring and Evaluation	*3,772,220*	*4,229,692*	*3,172,908*	*2,857,460*	*4,724,671*	*18,756,952*	*3,751,390*	*1.76%*
Leadership and Governance	*1,972,167*	*1,128,870*	*1,832,683*	*1,128,870*	*1,627,723*	*7,690,313*	*1,538,063*	*0.72%*
Strategic partnership	*310,649*	*62,420*	*148,066*	*69,678*	*127,743*	*718,557*	*143,711*	*0.07%*
Total Health Reforms Cost (Indirect Cost)	*218,492,684*	*183,160,065*	*228,704,754*	*203,386,150*	*230,330,680*	*1,064,074,333*	*212,814,867*	

d) Previous HSSP 2017-2022 Available and Projected Funding in USD

Investment Source	2017	2018	2019	2020	2021	2022	Total
Government (MoH/MoFEP)	6,537,774	11,368,844	TBD	TBD	TBD	TBD	17,906,618
GAVI	13,030,000	8,730,000	24,000,000	8,000,000	TBD	TBD	53,760,000
GFATM	39,100,000	37,200,000	27,800,000	21,600,000	TBD	TBD	125,700,000
Health Pooled Fund	78,942,540	68,589,420	67,295,280	63,412,860	54,353,880	40,118,340	372,712,320
USAID	32,365,261	34,446,000	35,300,000	35,200,000	35,200,000	35,200,000	207,711,261
World Bank	9,425,746	12,602,819	4,500,000	29,660,000	70,000,000	1,240,000	127,428,565
UN agencies	56,465,080	49,215,450	48,745,498	41,574,499	37,901,727	37,610,001	271,512,255
SIDA	2,103,800		4,207,600	4,207,600	4,207,600		14,726,600
Humanitarian (Health Cluster HRP)	124,000,000	130,000,000	120,000,000	130,000,000	140,000,000	140,000,000	784,000,000
Humanitarian Health (DFID)	781,042	872,486	1,270,012	TBD	TBD	TBD	2,923,540
	362,751,243	**353,025,019**	**333,118,390**	**333,654,959**	**341,663,207**	**254,168,341**	**1,978,381,159**

Annex 3: List of Institutions that participated in the HSSP 2023-2027 Development

1. Ministry of Health (National, State and County)
2. Drug and Food Control Agency
3. South Sudan AIDS Commission
4. Juba Teaching Hospital
5. Al-Sabah Teaching Hospital
6. Professional Associations: Reproductive Health Association, Obstetric and Gynecologist Association, Nursing and Midwifery Association, and the Medical Council
7. Country Coordination Mechanism (CCM)
8. University of Juba
9. World Bank
10. Bi-lateral donors: Canada, Sweden, Foreign Commonwealth and Development Office (UK), EU, GAVI, USAID
11. Health Pooled Fund / Crown Agents
12. Center for Disease Control and Prevention
13. United Nations Children's Fund
14. United Nations Development Program
15. United Nations Population Fund
16. Joint United Nations Program on HIV/AIDS (UNAIDS)
17. World Food Program
18. Intergovernmental Authority on Development
19. Health Cluster
20. Nutrition Cluster
21. Médecins Sans Frontières (MSF)
22. Chemonics GHSC-PSM
23. International centre for aids care and treatment program (ICAP)
24. IMA World Health – MOMENTUM Integrated Health Resilience
25. International Medical Corps
26. Malaria Consortium
27. Action Against Hunger
28. Care International
29. Amref
30. Cordaid
31. Crada
32. Concern Worldwide
33. Nile Hope Development Organization
34. South Sudan Red Cross
35. The Mentor Initiative
36. Christian Blind Mission
37. Healthnet TPO
38. IntraHealth
39. Private Sector