REPUBLIC OF SOUTH SUDAN

ANNUAL HEALTH SECTOR PERFORMANCE REPORT 2024-2025

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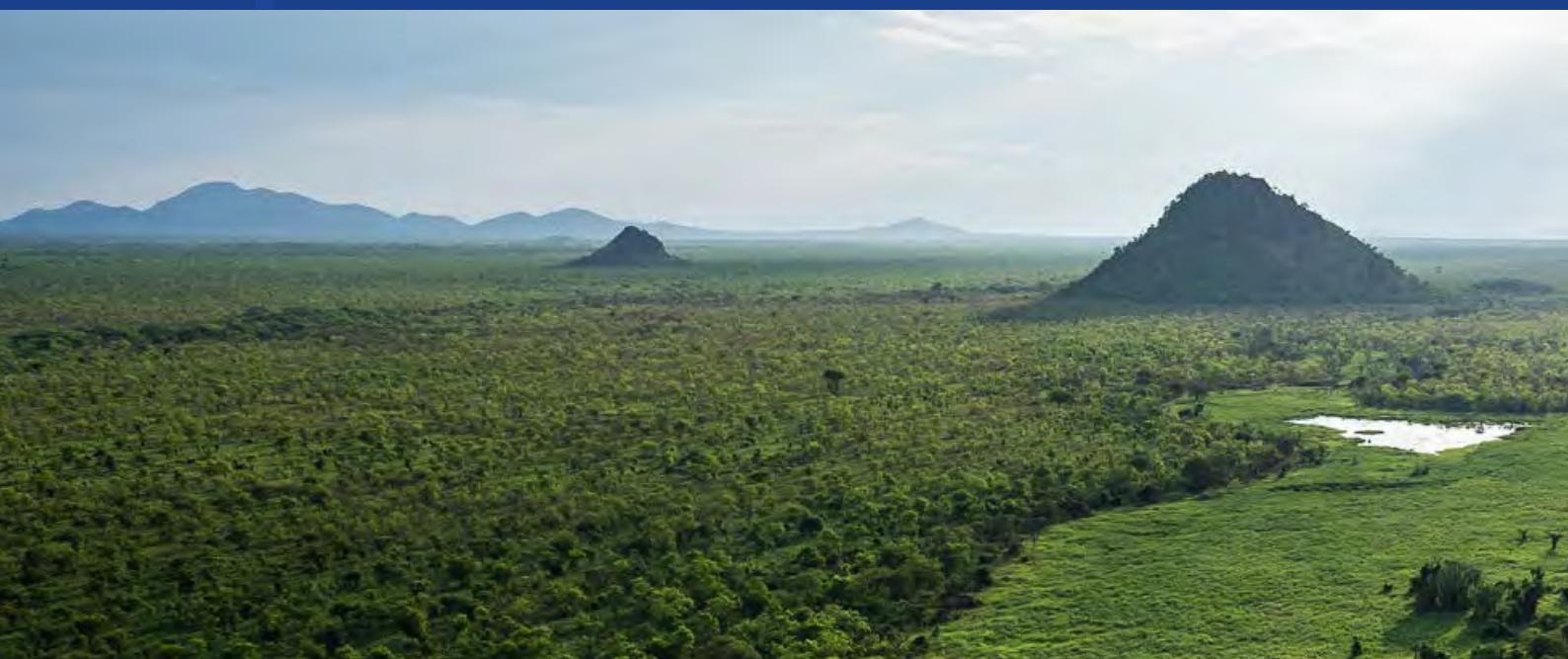
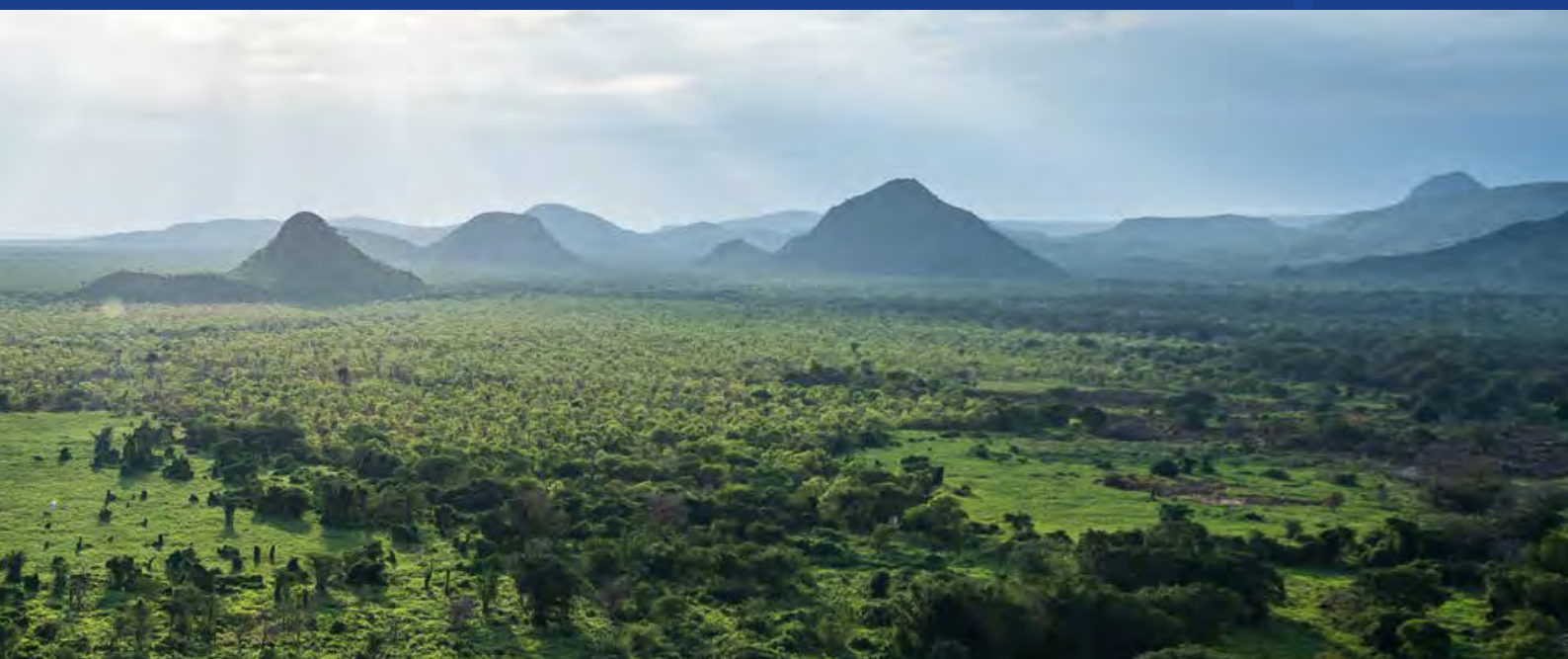
TABLE OF **CONTENTS**





List of tables

TABLE OF **CONTENTS**

List of figures

TABLE OF **CONTENTS**

FOREWORD

Honorable Sarah Cleto Rial
Minister of Health
Republic of South Sudan

The Ministry of Health of the Republic of South Sudan bears the solemn responsibility of safeguarding the health and well-being of our people. This mandate is not only a constitutional obligation but also a moral imperative to ensure that every citizen, regardless of location or circumstance, has access to essential health services without financial hardship. Our vision is rooted in the Health Sector Strategic Plan (HSSP) 2023-2027, which provides a clear roadmap for achieving Universal Health Coverage (UHC) and fulfilling our commitments under the Sustainable Development Goals (SDGs).

The journey toward building a resilient health system has not been easy. Our country continues to face complex challenges, including protracted conflict, humanitarian crises, economic constraints, and the effects of climate change. These factors have placed immense pressure on our health infrastructure and workforce. Yet, in the face of adversity, the health sector has demonstrated remarkable resilience and determination. This resilience is a testament to the dedication of our health professionals and the unwavering support of our partners.

The Ministry remains committed to strengthening governance and leadership within the health sector. We recognize that health is not merely a sectoral issue; it is a cornerstone of national development and stability. A healthy population is essential for economic growth, social cohesion, and peace. I wish to express my deepest appreciation to our development partners, humanitarian actors, civil society organizations, and communities for their steadfast support. Your contributions, whether through technical assistance, financial resources, or direct service delivery, have been instrumental in sustaining health services and improving outcomes for our people. The Ministry values these partnerships and calls for their continued strengthening as we move forward.

Looking ahead, our priorities are clear. We must accelerate efforts to expand access to primary health care, improve maternal and child health, address the growing burden of non-communicable diseases, and enhance emergency response capacity. Investing in robust health information systems is essential for evidence-based decision-making and accountability. This report is based on data captured in DHIS2, our official national health information platform. I urge all stakeholders to rely on DHIS2 and avoid parallel data platforms. I also encourage our partners to strengthen DHIS2 through timely and accurate reporting. Achieving these objectives demands not only adequate resources but also a collective commitment to equity, quality, and sustainability.

Together, we can build a health system that serves as a foundation for a healthier, more prosperous South Sudan. I invite all stakeholders to join us in this endeavor, guided by the principles of solidarity, partnership, and shared responsibility.

ACKNOWLEDGEMENT

Hon. Dr. Kennedy Gaaniko Baime
Undersecretary, Ministry of Health
Republic of South Sudan

On behalf of the Ministry of Health, I wish to express my deepest appreciation to all those who contributed to the development of the South Sudan Annual Health Sector Performance Report. This report reflects the collective effort and commitment of many individuals and institutions who worked tirelessly to ensure its completion. We acknowledge the leadership and guidance provided by the Ministry of Health teams at national and state levels, working closely with the World Health Organization (WHO) team in South Sudan, UNICEF and other stakeholders. Your collaboration has been instrumental in ensuring that this report is comprehensive, evidence-based and aligned with the Health Sector Strategic Plan 2023-2027. Special recognition goes to the technical working groups, programme managers and data teams who participated in data collection, validation and writing workshops. Their dedication and professionalism have made this report possible.

Contributors to the report include

Ministry of Health (MoH): Under my leadership as the Undersecretary, the technical coordination of this report was led by Dr John Rumunu (DG, MoH). The following were the contributors: Amanya Jacob, Dr Gift Natana, Dr Bul Malual Bul, Dr Ezbon W Apary, Acheir Adup Mou, Opia Mary, Deng Mawien, Joyce Kuron, Daniel Ngor, John Malueth Ayii, Moses Mila, Matur Them, Dr Angelo Aruop, Dr Joseph Lasu, Dr Aluel Mangar, David Williams, Dr Joseph Giir, Luka Dut Mou, Stephen Athanasio, Khamisa Ayoub, Joyce Amanamoi, Imoya Eliza, Dr Michael Mading, Anthony Loguran, Elizabeth Adit, Yak Yak Bol, Samuel Thok Chol, Manyang Amos, Lexon Mabrouk, Kamulete Horasio Kenyi, Dr John Aban Chol Nyijok, Agany Monychol and Bakhit Lemi. The Ministers of Health for each State and Administrative Area, together with their teams, also provided progress from their respective locations. These included Central Equatoria State; Hon. Najwa Juma Mursal, Eastern Equatoria State; Hon. Thomas Koteen, Western Equatoria State; Hon. James Abdalharuna, Lakes State; Hon. Nelson Makoi Makur, Warrap State; Hon. Abak Yel Madot, Abyei AA; Hon. Dr Ayom Korchek Ayom, Upper Nile State; Hon. Yedjwok Edwaud Agang, Unity State;Hon. Jal Puok Nhial, Ruweng AA; Hon. Elizabeth Achol Bol, Jonglei State; Dr Reath Koang Reath, Greater Pibor AA; Hon. James Chacha, Northern Bahr el Ghazal State; Hon. Dr Riing Riing Lual, Western Bahr el Ghazal State; Hon. Francis Michael Hassan.

WHO: Under the leadership of Dr Humphrey Karamagi (WR, South Sudan), the following worked with the MoH team to support the process: Dr Moses Ongom, Dr Mutale Senkwe, Dr Aggrey Bategereza, Dr Joseph Mung'atu, Dr Paula Nuer, Dr Robert Bagi, Dr Katare Swaibu, Barbra Akita, Dr Isabella Maina, Anabay Mamo, Muriel Anye, Dr Jimmy Abirigo, Dr Margaret Paul, Dr Thomas Akim Ujjiga, Dr Lucy Meseka, Dr Pontius Bayo, Pita Jane, Dr Geofrey Owino, Sokona Sy, Dr Achai Deng, Stephen Chol Garang, Dr Mustafa Lasu, Andrew Baguma and Dr Freddy Kitutu.

In addition, Charles Ngemani from **UNICEF** worked with the team to support the Human Resources for Health (HRH) component of the work. The HSTP PMU, led by Dr Deng Akoi, Lily Tombe and Yousif Deng, also participated in the process, ensuring integration of information from the HSTP into this sector report.

Your contributions demonstrate the power of partnership and shared responsibility in advancing health sector goals. As we move forward, let us continue to work together to strengthen health systems and improve health outcomes for all South Sudanese.

PREFACE

Dr. John Pasquale Rumunu
Director General, Policy, Planning, Budget,
Research, Monitoring and Evaluation
Ministry of Health
Republic of South Sudan

The Directorate of Policy, Planning, Budgeting and Monitoring & Evaluation within the Ministry of Health is mandated to provide strategic leadership in policy development, health sector planning, budgeting processes and performance monitoring. This mandate ensures that health sector priorities are clearly defined, resources are aligned with national strategies, and progress is tracked through robust monitoring and evaluation systems. Our work is central to promoting accountability, transparency and evidence-based decision-making across the health sector.

The Annual Health Sector Performance Report is one of the most important accountability tools for the Ministry of Health and its partners. It provides a comprehensive review of progress towards the objectives of the Health Sector Strategic Plan (HSSP) 2023-2027, highlighting achievements, gaps and lessons learned during the reporting period. The report draws on multiple data sources, including routine health information systems, programme-specific databases and findings from surveys and assessments. These data were validated through consultative processes involving technical working groups, programme managers and stakeholders at national and subnational levels.

This report serves several critical purposes. First, it enables policymakers and programme managers to assess sector performance against agreed targets and identify areas requiring corrective action. Second, it informs planning and budgeting processes, ensuring that future investments are guided by evidence and aligned with sector priorities. Third, it strengthens accountability by providing a transparent record of progress for government, partners and the public.

The findings presented in this report underscore both progress and persistent challenges. While gains have been made in areas such as community health, maternal and child health and emergency preparedness, significant gaps remain in service coverage, health workforce capacity and financing. These realities call for sustained commitment, stronger coordination and innovative approaches to overcome systemic barriers and accelerate progress towards UHC.I wish to acknowledge the collaborative effort that made this report possible. The contributions of technical teams, state health departments, development partners and humanitarian actors reflect the shared responsibility we all bear for improving health outcomes in South Sudan. I encourage all stakeholders to use this report as a basis for informed decision-making, resource mobilization and strategic action.

As we move forward, let us reaffirm our commitment to building a resilient health system that delivers equitable, quality and sustainable services for all. Evidence must remain at the centre of our decisions, and partnership must continue to drive our progress.

ACRONYMS

AOP	Annual Operational Plan
ANC	Antenatal Care
ART	Antiretroviral Therapy
AYFS	Adolescent and Youth-Friendly Services
BEmONC	Basic Emergency Obstetric and Newborn Care
BHI	Boma Health Initiative
BPHNS	Basic Package of Health and Nutrition Services
BHW	Boma Health Worker
BMI	Body Mass Index
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CES	Central Equatoria State
CT	Computed Tomography
CVD	Cardiovascular Disease
DHIS2	District Health Information System 2
DMPA-SC	Subcutaneous Depot Medroxyprogesterone Acetate
DTC	Drugs and Therapeutics Committee
EOC	Emergency Operations Centre
EPI	Expanded Programme on Immunization
EWARS	Early Warning, Alert and Response System
eLIMS	electronic Laboratory Information Management System
FP	Family Planning
FPET	Family Planning Estimation Tool
FSNMS	Food Security and Nutrition Monitoring System
FY	Fiscal Year
GBV	Gender-Based Violence
GF	Global Fund
GHO	Global Health Observatory
HAT	Human African Trypanosomiasis
HIS	Health Information System

ACRONYMS

HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HPF	Health Pooled Fund
HRH	Human Resources for Health
HSI	Health Science Institution
HSSP	Health Sector Strategic Plan
HSTP	Health Sector Transformation Project
ICU	Intensive Care Unit
IDSR	Integrated Disease Surveillance and Response
IGME	Inter-agency Group for Child Mortality Estimation
IHR	International Health Regulations
IPC	Integrated Phase Classification
ITN	Insecticide-Treated Net
JEE	Joint External Evaluation
MDA	Mass Drug Administration
MIS	Malaria Indicator Survey
MMR	Maternal Mortality Ratio
MMDP	Morbidity Management and Disability Prevention
MoH	Ministry of Health
MRI	Magnetic Resonance Imaging
MSF	Médecins Sans Frontières
MUAC	Mid-Upper Arm Circumference
NAPHS	National Action Plan for Health Security
NBS	National Bureau of Statistics
NCDs	Non-communicable diseases
NICU	Neonatal Intensive Care Unit
NTDs	Neglected Tropical Diseases

OPD	Outpatient Department
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PICU	Paediatric Intensive Care Unit
PMTCT	Prevention of Mother-to-Child Transmission
PMU	Project Management Unit
PNC	Postnatal Care
PPP	Public-Private Partnership
RDT	Rapid Diagnostic Test
RMNCAH+N	Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition
SBCC	Social and Behaviour Change Communication
SDGs	Sustainable Development Goals
SPAR	State Party Self-Assessment Annual Reporting
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSRC	South Sudan Red Cross
TB	Tuberculosis
TIS	Trachoma Impact Survey
TOT	Training of Trainers
TWG	Technical Working Group
U5MR	Under-five Mortality Rate
UHC	Universal Health Coverage
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USD	United States Dollar
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

The Annual Health Sector Performance Report provides a comprehensive review of progress towards the objectives of the Health Sector Strategic Plan (HSSP) 2023-2027, which aims to advance Universal Health Coverage (UHC) while aligning with the Sustainable Development Goals (SDGs). The Ministry of Health remains committed to equity, resilience and sustainability in health service delivery despite persistent challenges, including protracted conflict, humanitarian crises, economic constraints and climate-related shocks. These factors have placed immense pressure on health infrastructure and the health workforce, yet the sector has demonstrated resilience through strong partnerships and coordinated interventions.

South Sudan's health system operates in a context of high vulnerability, with a population exceeding 15 million, predominantly rural, and health indicators among the lowest globally. Maternal and child mortality rates remain high, and the burden of communicable diseases, malnutrition and emerging non-communicable diseases continues to strain services. Structural constraints such as inadequate infrastructure, workforce shortages, limited financing and insecurity further complicate service delivery.

The report draws on data from routine health information systems, surveys and programme-specific databases, validated through technical working groups and stakeholder consultations. Performance was assessed against HSSP targets using a rescaled index approach, providing an objective measure of progress. The analysis reveals a national health sector performance index of 59.66%, demonstrating measurable progress against national targets while at the same time highlighting the substantial distance remaining to achieve the health-related SDGs by 2030.

Performance Overview and SDG Context:

The health sector performance presents a mixed picture: while it demonstrates resilience through coordinated interventions and partnerships, critical gaps persist. Comparative analysis against SDG targets reveals particularly concerning disparities. The maternal mortality ratio is estimated at 692 deaths per 100,000 live births which, although reduced from the baseline of 1,223, remains nearly ten times the SDG target of 70. The under-five mortality rate stands at 98.7 deaths per 1,000 live births, unchanged from the baseline and almost four times the SDG target of 25. These indicators underscore the scale of the challenge beyond national benchmarks.

Programme Area Performance:

Performance across programme areas shows significant variation. Health Promotion, Boma Health Initiative and School Health (96.95%) emerges as a standout success, with the Boma Health Initiative now covering 52% of bomas and more than 10,500 Boma Health Workers trained. Emergencies, Disasters and Humanitarian Response (75.10%) demonstrates strengthened capacity through expanded surveillance and rapid response teams. Communicable Diseases and Neglected Tropical Diseases (70.07%) shows measurable gains in specific areas, with malaria case treatment coverage reaching 97%, HIV viral load suppression at 81.3% and Guinea worm cases reduced to just two.

However, these achievements are counterbalanced by substantial challenges. Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (63.24%) reveals critical service gaps: skilled birth attendance remains very low at 19.5%, modern contraceptive prevalence is only 6.4% and unmet need for family planning has increased to 29.6%. Nutrition indicators show exclusive breastfeeding at 73.3%, yet wasting affects 17.4% and stunting 15.5% of children under five. Performance in Non-communicable Diseases, Mental Health, Oral, Eye and Occupational Health (41.84%) is particularly weak: hypertension prevalence has risen to 29.5%, cervical cancer screening coverage is just 11.5% and mental health service coverage is extremely low at 0.4%.

Health System Foundations:

The performance of core health system pillars reveals fundamental constraints to sustainable progress. The domain of Access, Quality and Safety (57.74%) reflects persistent barriers, with only 56% of the population living within five kilometres of a health facility and service utilisation low at 0.78 outpatient visits per capita.

Within the Health Systems domain (54.00%), performance varies considerably. Essential Medicines, Supplies, Technologies and Laboratory Systems (50.00%) show targeted successes, although stock-outs of essential medicines persist in 27% of facilities. Human Resources for Health (60.89%) faces major challenges, with health workforce density at 7.9 per 10,000 population–below the national target and far below the WHO SDG benchmark of 44.5. Health Information Systems (63.18%) have improved, with reporting completeness at 63%, but timeliness remains at 52% and integrated disease surveillance reporting is critically low at 14.5%.

Leadership, Governance and Partnerships (53.00%) and Health Financing (42.86%) represent particularly severe systemic weaknesses. Government allocation to health is only 2% of the national budget, far below the Abuja Declaration target of 15%. Out-of-pocket expenditure has risen to 34.4% of current health expenditure, creating significant financial barriers to care and undermining progress towards UHC.

	Programme areas	Performance
01	Health promotion, Boma Health initiative and school health	96.95%
02	Reproductive Maternal, newborn, child and adolescent health and nutrition	63.24%
03	The communicable diseases and neglected tropical diseases	70.07%
04	The Non communicable diseases, mental health, oral, eye and occupational health	41.84%
05	Emergencies, disasters and humanitarian response	75.10%
	Access, Quality and safety	**57.74%**

	Health Systems	Performance
01	Human resources for health	60.89%
02	Essential medicines, supplies, Technologies and laboratory systems	50.00%
03	Health financing	42.86%
04	Health Information systems	63.18%
05	Leadership, Governance and partnerships	53.00%
	Health sector performance index	**59.66%**

Strategic priorities for the remaining HSSP period must focus on expanding community health services, integrating TB, HIV and NTD programs, investing in diagnostics and health infrastructure and, most critically, increasing domestic health financing to reduce reliance on external aid. Only by addressing these foundational system weaknesses can the health sector translate hard-won programmatic gains into resilient, equitable and sustainable health outcomes for the people of South Sudan and begin to close the gap to the 2030 SDG agenda.

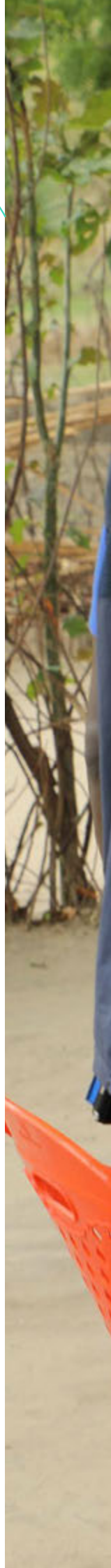
CHAPTER 1. BACKGROUND AND INTRODUCTION

1.1 GENERAL BACKGROUND

The health sector in South Sudan is anchored in the Health Sector Strategic Plan (HSSP) 2023-2027, which sets the vision for achieving Universal Health Coverage (UHC) and improving health outcomes for all citizens. The plan emphasizes equity, resilience, and sustainability in health service delivery, aligning with national priorities and global commitments such as the Sustainable Development Goals (SDGs).

Over recent years, the Ministry of Health (MoH), in collaboration with development and humanitarian partners, has worked to expand access to essential health services and strengthen health systems. Strategic investments have focused on improving governance, building institutional capacity and enhancing service delivery through initiatives such as the Boma Health Initiative (BHI), which institutionalizes health services at the community level, thereby bringing them closer to communities. Efforts have also been directed towards improving maternal, newborn, child and adolescent health, scaling immunization and integrating health information systems for better decision-making.

The sector has prioritized quality and safety in service delivery, alongside emergency preparedness and response, recognizing the need for resilience in the face of recurrent crises. These actions reflect a commitment to accelerate progress towards UHC by improving coverage, quality, and financial protection. The Annual Health Sector Performance Report serves as a key accountability tool to measure progress, identify gaps, and guide strategic decisions for the remaining period of the HSSP.




World Health Organization
USAID
MenScreen

1.2 THE CONTEXT

South Sudan's health sector operates in a dynamic environment shaped by demographic, epidemiological and socio-economic factors. According to the National Bureau of Statistics (NBS), the country has an estimated population of over 15 million, predominantly rural, with limited access to basic health services. Health indicators remain among the lowest globally, with high maternal and child mortality rates and a significant burden of communicable diseases such as malaria, tuberculosis (TB), and HIV. Malnutrition persists as a major public health concern, while non-communicable diseases and mental health conditions are emerging challenges.

The health system faces structural constraints, including inadequate infrastructure, shortages of skilled health workers, and limited financing. Many facilities lack essential equipment and medicines, and insecurity in some areas disrupts service delivery. Despite these challenges, progress has been made in expanding community-based services, improving immunization coverage, and strengthening health information systems.

Humanitarian dynamics continue to influence health service delivery, with frequent displacement, food insecurity and climate-related shocks increasing vulnerability. These factors underscore the need for a resilient health system capable of maintaining essential services while responding to emergencies.

The HSSP 2023-2027 provides a roadmap for addressing these challenges through investments in governance, financing, human resources, health information systems, and quality of care. Understanding this context is critical for interpreting sector performance and prioritizing actions for the remaining period of the plan.

1.3 THE RATIONALE FOR THE REPORT

The Annual Health Sector Performance Report provides a comprehensive review of progress made towards achieving the objectives of the HSSP 2023-2027 and national health priorities. It serves as an accountability mechanism for the Ministry of Health and partners by documenting achievements, gaps and lessons learned during the reporting period. The report enables evidence-based decision-making by presenting performance against agreed indicators, highlighting trends and identifying areas requiring corrective action. It also informs resource allocation, policy adjustments and planning for the remaining period of the HSSP, ensuring alignment with UHC and the SDGs.

1.4 THE PROCESS

The development of this report followed a participatory and consultative approach, stewarded by the Ministry of Health and involving multiple stakeholders at national and subnational levels. Data were extracted from routine health information systems, including District Health Information System 2 (DHIS2), Integrated Disease Surveillance and Response (IDSR), and programme-specific databases, and were complemented by findings from surveys, assessments, and reviews. Technical working groups and programme managers validated the data through review meetings and a writing workshop.

The process involved analysis of available data to assess sector performance against the 2025 HSSP targets. This provided a comprehensive picture of the country's health sector performance indicators, including trend analysis up to 2025. Progress on the strategies and interventions that had been planned under each of the HSSP objectives was also assessed. Draft narratives and indicator tables were consolidated by the Ministry of Health, with support from partners, and reviewed to ensure consistency with HSSP targets.

Computation of performance

For the evaluation of performance against the set targets, one objective approach is to rescale achievements into a range between 0 and 1. The rescaling is based on the level of performance achieved. Let the achievement of an indicator be X; the data may be numbers, rates, percentages, or ratios. The rescaled values are therefore:

$$= \frac{X}{\text{Target}} \%$$

For instance, an achievement of 71 against a target of 85 would be 71/85, equivalent to 83% or 0.83. This performance value indicates how far progress has been made toward achieving the 2025 target. The domain indices were computed as the average of their components. For instance, under the RMNCAH+N domain, the index was the average performance of all its components. Additionally, the overall index was computed as the average of all the domain areas.

In addition to tracking performance, an in-depth analysis was conducted on selected thematic areas, including (i) the Health Sector Transformation Project (HSTP), a key project that supports delivery of essential health and nutrition services and health systems strengthening, (ii) the status of hospital services, (iii) malaria, and (iv) the Boma Health Initiative (BHI). The purpose of this focus was to highlight progress in these areas while emphasizing their importance for achieving health outcomes.

The technical coordination of this work was carried out through a Technical Working Group (TWG) under the stewardship of the Ministry of Health Directorate of Policy, Planning, Budgeting, Research and M&E. The TWG reported to a secretariat chaired by the Undersecretary of the Ministry of Health and operated under the overall oversight of the Health Sector Steering Committee, chaired by the Minister of Health.

1.5 REPORT OUTLINE

The Annual Health Sector Performance Report serves as a comprehensive accountability tool for the Ministry of Health and its partners. It reviews progress toward the objectives of the Health Sector Strategic Plan (HSSP) 2023-2027, presenting achievements, gaps, and lessons learned during the reporting period. The report draws on multiple data sources, including routine health information systems such as District Health Information System 2 (DHIS2), programme-specific databases, and findings from surveys and assessments. Data validation was conducted through consultative processes involving technical working groups, programme managers, and stakeholders at national and subnational levels.

The first chapter provides the background and introduction. It sets the context of South Sudan's health sector, describing demographic and epidemiological characteristics, systemic constraints such as inadequate infrastructure, workforce shortages, and limited financing, as well as the impact of insecurity and humanitarian shocks. It explains the rationale for the report and outlines the participatory process used for its development, including data collection, validation, and analysis aligned with HSSP targets.

The second chapter focuses on progress against health service outcomes. It reviews measurable changes in health status and service utilization across major programme areas, including health promotion and community health through the Boma Health Initiative (BHI), reproductive, maternal, newborn, child, and adolescent health and nutrition, communicable diseases and neglected tropical diseases, non-communicable diseases and mental health, and emergency and humanitarian response. It also includes a section on equitable access, quality, and safety, highlighting how service delivery performance affects population-level outcomes. This section highlights how interventions have translated into tangible benefits for the population.

The third chapter examines progress against health systems objectives. It looks at systemic enablers that support service delivery, such as human resources for health, essential medicines and laboratory systems, health financing, health information systems, and leadership, governance, and partnerships. This section provides insight into the capacity of the health system to deliver essential services effectively and equitably.

The fourth chapter presents thematic deep dives into priority areas such as the Health Sector Transformation Project (HSTP), malaria management, maternal and newborn health, the Boma Health Initiative (BHI), and the state of health service provision institutions. These analyses provide a focused view of progress and challenges in areas critical to achieving health sector goals.
The fifth chapter summarizes sector performance against the set targets and compares this performance to the SDG targets for 2030. Additionally, the chapter highlights priorities for 2026-2027.

CHAPTER 2.
THE PROGRESS AGAINST HEALTH SERVICE OUTCOMES

Health service outcomes refer to measurable changes in health status and service utilization resulting from the delivery of essential health interventions. They indicate how well the health system translates resources and policies into tangible benefits for the population, such as reduced mortality, improved coverage of preventive and curative services, and enhanced equity in access.

By tracking progress against agreed indicators, policymakers and programme managers can identify gaps, allocate resources effectively, and implement corrective actions. This ensures that health services are not only available but also accessible, affordable, and of acceptable quality. This chapter reviews sector performance across major programme areas: Health Promotion and Community Health (BHI), focusing on expansion of community-based services and health education; Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH+N), focusing on coverage of antenatal care (ANC), skilled birth attendance, immunization, and nutrition interventions; Communicable Diseases and Neglected Tropical Diseases (NTDs), focusing on progress in malaria, TB, HIV, and NTD control; Non-communicable Diseases and Mental Health, focusing on the emerging burden and service coverage for chronic conditions; and Emergency and Humanitarian Response, focusing on preparedness and response to outbreaks and crises.

The following table shows a summary of achievement of service outcome indicators.

Achievement of health service outcome indicator

Indicator	baseline	Achievement	Target 2027
Contraceptive prevalence rate	6%	6.4%	12%
Antenatal care coverage, at least 4 visits (%)	23%	31.8%	60%
Births attended by skilled health personnel (%)	15%	19.5%	50%
Fully immunized coverage (%)	18.9%	N/A	80%
Children under 5 years who are stunted (%)	16.30%	15.5%	10%
Proportion of pregnant women who received three or more doses of IPTp (IPTp ≥3)	31%	22.16%	90%
Percentage of population at risk sleeping under an ITN	59.3%	62.33%	85%
TB effective treatment coverage	65%	80%	90%
% of people with confirmed RR-TB and/ or MDR-TB that began second-line treatment	No data	41%	80%
Antiretroviral therapy coverage	32%	50%	65%
Coverage of pregnant women who receive ART for PMTCT (%)	53%	60.74%	85%
% of pregnant women attending antenatal care screened for syphilis	No data	37.27%	85%
Integrated Treatment Coverage Index of preventive chemotherapy NTDs	78%	36%	90%
Raised blood pressure among adults	20.10%	29.50%	18%
Cervical cancer screening coverage	10%	11.50%	30%
Coverage of oral health services	2%	0.33%	10%
Average of 13 International Health Regulations (IHR) capacity scores	34.40(IHR Capacity assessments)	43%	50%
Proportion of outbreaks investigated, confirmed, and responded to	88%(IDSR)	67%	90%

2.1 PROGRAMME AREA 1: HEALTH PROMOTION, BOMA HEALTH INITIATIVE AND SCHOOL HEALTH

Health promotion in South Sudan aims to reduce preventable diseases and improve the well-being of communities by promoting essential practices such as handwashing, safe water use, proper sanitation, mosquito-net use, and good nutrition. It also supports maternal and child health through antenatal care, immunization, breastfeeding, and safe delivery practices. These efforts help households protect themselves from common illnesses and strengthen overall health outcomes.

The Boma Health Initiative (BHI) is South Sudan's national community health strategy, launched in March 2017 to institutionalize health services at the community level. It focuses on delivering health promotion, preventive care, and selected basic curative services to households, especially in remote areas. Through trained Boma Health Workers (BHWs), the initiative ensures that health messages and services reach communities that have limited access to formal health facilities.

Achievement against HSSP (2023-2027) targets

● **Red**: limited or no progress (<50% of 2025 target); ● **Orange**: some progress, but not enough to achieve the target (50 to 99% of 2025 target); ● **Green**: good progress, target (2025) achieved or even surpassed

***Table 1**: Achievement against targets: Health promotion, BHI and School health*

Objective	Indicator	Baseline	Achievement 2025	Target (HSSP)		Performance and color	Data source	Comment
				2025	2027			
Address health inequalities and social cultural barriers to healthcare access through health promotion	% of health promotion cadre trained on health promotion	N/A	38%	30%	50%	● 126.7%	BHI programme report	These are BHWs who are trained and mainly carry out health promotion.
Strengthen and scale up implementation of BHI	% of Bomas implementing BHI	42%	52%	55%	80%	● 94.5%	BHI programme report	
Ensure provision and utilization of school health services	Coverage of school health services	No data	No data	6%	10%	-		Requires a survey.
Programme index						● 96.95%		

OBJECTIVE 1:

To address health inequities and sociocultural barriers to health care access through health promotion

Since its inception, the BHI has expanded to reach 52% of bomas, with about 10,560 BHWs delivering integrated BHI packages across the country.

The child health package remains the best-performing area, with average treatment coverage above 60% of reachable under-five populations. States such as Lakes, Warrap, EES, and WES reported the highest reach (>70%) and strong pneumonia/diarrhea case management performance. So far, about 895,000 households have been visited and provided with health promotion and education messages.

Reporting and Performance of BHI reporting form in DHIS2

In 2024, national reporting performance was low, with 44.2% of expected reports submitted and an on-time reporting rate of 41.3%. At the state level, Warrap State recorded the highest reporting rate at 77.3%, while Abyei reported no activity (0%). On-time reporting varied across states, with Lakes at 66.5% and Western Equatoria at 63.7%, compared to Central Equatoria at 35% and Upper Nile at 21.7%.

OBJECTIVE 2:

To strengthen and scale up implementation of the Boma Health Initiative

A total of 3,193 Boma Health Workers (BHWs) were trained on phase 1 and phase 2 packages, significantly expanding the country's community-based health care capacity and enabling more households, especially in remote rural areas, to access essential preventive, promotive, and basic curative services. The BHI currently covers at least 1,203 bomas across South Sudan.

The BHI has a functional Technical Working Group (TWG) that provides oversight for BHI implementation and coordination. Twelve TWG meetings were conducted to coordinate the implementation of activities.

In October, a BHI review was conducted to examine implementation progress, assess the effectiveness of BHWs, evaluate coverage across bomas, and gather recommendations for strengthening community health services.

A national health promotion strategy for 2025-2029 was developed and is awaiting launch, printing, and dissemination. In addition, a maturity assessment of community health/BHI was carried out to assess the maturity of the community health system (health system building blocks) within the BHI and to identify areas for improvement.

Table 2: BHI interventions

S/no	Intervention	Reached
01	ANC referrals	59524
02	MUAC Screened U5	1090866
03	Immunization zero dose identified and referred	30458
04	Household reached with HEP	895,000

OBJECTIVE 3:

Ensure provision and utilization of school health services

Although efforts to ensure the provision and utilization of school health services have been inadequate, important steps have been initiated. Plans are in place, including the development of a draft school health policy, guidelines for school health screening and referral, a menstrual hygiene guideline that has been developed and launched, and a comprehensive sexuality education curriculum that has been finalized. School health campaigns on handwashing, menstrual hygiene, and environmental hygiene have also been conducted.

It is important to emphasize that school health plays a vital role in supporting the well-being and academic success of children. As the country continues to recover from years of conflict, poverty, and limited access to health services, schools should become an important platform for improving the health of young learners. Healthy students are better able to concentrate, participate in lessons, and perform well academically, making school health a key foundation for quality education and national development.

Challenges

Persistent stock-outs of essential medicines, including AS/AQ, amoxicillin, ORS, and zinc, continue to limit treatment effectiveness and increase reliance on clinical diagnosis. Supply chain and logistics systems remain weak and fail to adequately support consistent service delivery. Additionally, high turnover and attrition of BHWs are driven by irregular incentive payments and the lack of clear career pathways and certification. Further compounding these challenges are delays in completing BHI phases from phase 3 onward.

2.2 PROGRAMME AREA 2: REPRODUCTIVE MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH AND NUTRITION

RMNCAH+N is a cornerstone of the health sector strategy in South Sudan. This programme addresses the most critical determinants of survival and well-being for women, children, and adolescents, aiming to reduce preventable mortality and morbidity while improving nutritional status across vulnerable populations.

It encompasses interventions that span the continuum of care, from family planning and antenatal services to skilled birth attendance, postnatal care, immunization, and nutrition support. These services are essential for breaking cycles of poor health outcomes, reducing maternal and child deaths, and promoting healthy growth and development.

This section reviews progress against 20 key indicators grouped under four areas: Sexual and Reproductive Health (SRH), focusing on access to family planning and adolescent-friendly services; Maternal and Newborn Health, focusing on coverage of antenatal care, skilled birth attendance, and emergency obstetric services; Child Health, focusing on immunization, integrated management of childhood illnesses, and reduction of under-five mortality; and Nutrition, focusing on exclusive breastfeeding, vitamin A supplementation, and reduction of stunting and wasting.

Achievement against HSSP (2023-2027) targets

- **Red**: limited or no progress (<50% of 2025 target); - **Orange**: some progress, but not enough to achieve the target (50 to 99% of 2025 target); - **Green**: good progress, target (2025) achieved or even surpassed

__Table 3__: Achievement against targets: RMNCAH+N

Objective	Indicator	Baseline	Achievement 2025	Target (HSSP)		Performance- and colour	Data source	Comment
				2025	2027			
Enhance access to and utilization of sexual and reproductive health services, including adolescent health services	Contraceptive prevalence rate	6%	6.40%	9%	12%	71.1%	FPET	7.1% for any method
	Unmet need for family planning among women of reproductive age	20%	29.60%	14%	10%	-111.4%	FPET	This may indicate increased awareness and, therefore, increased demand that has not been met on the supply side.
	% of facilities providing postabortion care	No data	10%	40%	50%	25.0%	DHIS2	This reflects facilities reporting admissions for abortion complications
	% of facilities providing adolescent and youth friendly services	46%		65%	75%			no data

Objective	Indicator	Baseline	Achievement 2025	Target (HSSP)		Performance- and colour	Data source	Comment
				2025	2027			
Ensure reduction in maternal mortality and morbidity through provision and utilization of comprehensive maternal health services	Maternal Mortality Ratio (deaths per 100,000 live births)	1223	692	938	750	126.2%	UNIAG	Although the point estimate for MMR is better than the target, there is a wide uncertainty interval (400-1,254)
	Antenatal care coverage, at least 4 visits (%)	23%	31.80%	44%	60%	72.3%	DHIS2	
	Births attended by skilled health personnel (%)	15%	19.50%	36%	50%	54.2%	DHIS2	
	Postnatal care coverage	35.50%	34.20%	44%	50%	77.7%	DHIS2	
	% Functional CEmONC facilities	3%	NA	43%	70%			No recent data.
	% Functional BEmONC facilities	39%	NA	58%	70%			No recent data.
	% Functional MPDSR committees	No data	36%	50%	60%	72.0%		
Ensure reduction in neonatal and childhood mortality through provision and utilization of high impact quality newborn and child nutrition health services	Under five years' mortality rate (per 1,000 live births)	98.69	98.7	70	50	-41.0%	UNICEF	
	Infant mortality rate (per 1,000 live births)	63.76	57.7	49	40	82.2%	UNIAG	
	Neonatal mortality rate (per 1,000 live births)	39.63	39.4	28	20	59.3%	UNIAG	
	Stillbirth rate	28.8	28	24	22	83.3%	IGME	
	Fully immunized coverage (%)	18.90%	N/A	56%	80%			
	% Facilities delivering IMNCI	47%	N/A	62%	70%			No recent survey.
Improve the nutritional status and reduce morbidity and mortality associated with malnutrition among the most vulnerable population	Children under 5 years who are stunted (%)	16.30%	15.50%	12%	10%	70.8%	FSNMS Round 30	FSNMS round 31 is not yet released.
	Children under 5 years who are wasted (%)	16.10%	17.40%	12%	10%	55.0%	FSNMS Round 30	FSNMS round 31 is not yet released.
	Exclusive breastfeeding rate 0-6 months of age	62%	73.30%	74%	80%	99.1%	FSNMS Round 30	FSNMS round 31 is not yet released.
	Percentage of children aged <59 months receiving Vitamin A supplements twice a year	84%	79.10%	88%	90%	89.9%	FSNMS Round 30	FSNMS round 31 is not yet released.
Programme index						63.24%		

OBJECTIVE 1:

Enhance access to and utilization of sexual and reproductive health and rights (SRHR) services including adolescent health services

Modern Contraceptive prevalence rate:

Progress against this indicator has been minimal, with the modern contraceptive prevalence rate increasing only slightly from 6.0% at baseline to 6.4% (71.1% of the 2025 target) and 7.1% for any method, according to recent estimates using FPET.

Unmet need for family planning among women of reproductive age:

Unmet need for contraceptives increased from 20% at baseline to 29.6%, missing the 2025 target (14.0%) by 15.6 percentage points. While an increased unmet need for contraceptives early in a country's programme maturity may indicate increased demand for contraceptives, it often highlights gaps in the health system's ability to deliver consistent, quality services. The low rate of contraceptive use contributes to the high rates of maternal and child mortality due to closely spaced pregnancies and unsafe abortions. It also leads to increased vulnerability for women and girls, including higher risks of gender-based violence and reduced opportunities for education and employment.

Proportion of facilities providing post abortion care:

This indicator could not be adequately measured, as no recent service availability survey has been carried out. However, about 10% of health facilities are reporting care for abortion complications through DHIS2, which represents only 25% achievement of the 2025 target.

Proportion of facilities providing adolescent and youth friendly services:

There has been no recent service availability survey, which limits the ability to track progress on this indicator. However, mortality rates among adolescents aged 10-14 years decreased from 19 to 8 per 1000 live births while, among 15-19-year-olds it dropped from 29 to 15 per 1,000 live births between 2000 and 2023 [1].

Nearly half of all girls marry before the age of 18, and approximately one-third of girls are pregnant before turning 15 years of age [2]. Approximately, one in three girls is married or has begun childbearing by age 19, with adolescent birthrate remaining high at 97 births per 1,000 girls aged 15-19 in 2023 compared to the global figure of 39 [3].

Efforts to improve SRHR services:

The Ministry of Health, in collaboration with partners, implemented measures to improve access to SRHR services. Commodities valued at over 2.7 million US dollars were procured to support service delivery. Capacity building included training 255 Boma Health Workers (BHWs) on rights-based family planning, including counseling for DMPA-SC self-injection. Additionally, 57 individuals were trained as trainers for family planning service provision, incorporating DMPA-SC, and 57 service providers from selected states received training.

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1 **Levels & Trends in Child Mortality. Report 2023**. Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation.

2 United Nations Children's Fund (UNICEF). Some things are not fit for children - marriage is one of them. UNICEF; 2020 Oct 5. Available from: https://www.unicef.org/southsudan/press-releases/some-things-are-not-fit-for-children

3 World Bank group_ Gender data portal; Available from: https://genderdata.worldbank.org/en/economies/south-sudan

A total of 533 health workers completed competency-based training on family planning, sexual and reproductive health, and adolescent- and youth-friendly services.

Access to quality family planning services was expanded through private health facilities, with capacity building provided to 32 facilities and 11,230 clients reached with information and services. Gender-based violence case management was integrated under the One Stop Center model, with 13 centers located in hospitals across the country providing 5,148 women and girls with comprehensive services, including medical care, psychosocial support, and legal assistance.

Challenges

Access to and utilization of quality SRHR services continues to be constrained by multiple systemic and contextual factors. Years of conflict have disrupted the health care system, resulting in shortages of trained personnel, contraceptive commodities, and functional health facilities, particularly in rural areas. These limitations reduce the availability of essential services and hinder consistent delivery.

Sociocultural barriers remain a major constraint, with deeply rooted cultural and religious beliefs discouraging contraceptive use. Myths and misconceptions related to side effects, infertility, and social stigma further limit uptake of family planning services. In addition, lack of awareness persists, as many women and men have limited information about contraceptive options and their benefits. Community-level outreach and education on family planning remain inadequate.

Gender dynamics also influence access, as decision-making power often resides with men, and women may require approval from husbands or family members to use contraception. Political instability compounds these challenges, with ongoing insecurity and population displacement disrupting health service delivery and interrupting supply chains for contraceptives.

OBJECTIVE 2:

Ensure reduction of maternal morbidity and mortality through provision and utilization of comprehensive maternal health services

Maternal Mortality Rate (MMR) (deaths per 100,000 live births)

Maternal mortality remains a critical concern, with only modest improvements over the past decade. The country still has one of the world's highest maternal mortality ratios, at an estimated 692 deaths per 100,000 live births in 2023.

The overall trend shows a long-term decline (Fig. 1), yet the point estimate is still high, with a very wide uncertainty interval of 400-1,254 according to recent estimates [4]. The drop from 2000 to 2023 reflects improvements in health care access, maternal care, and humanitarian efforts.

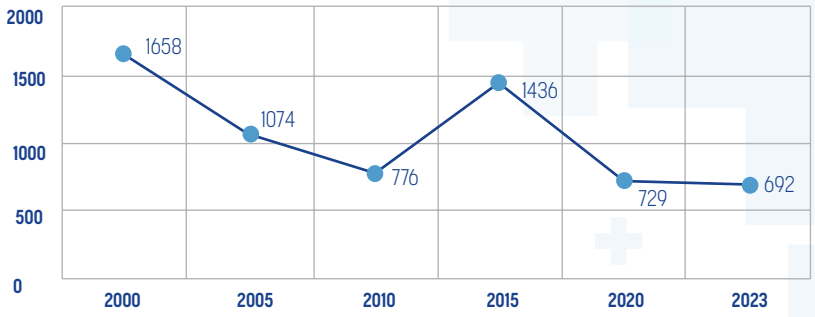

Figure 1: Trends of MMR from 2000-2023 (Source: UNIAG 2025)

The major causes of maternal mortality over the past five years have been complications of abortion and obstetric haemorrhage, especially after childbirth (Fig. 2).

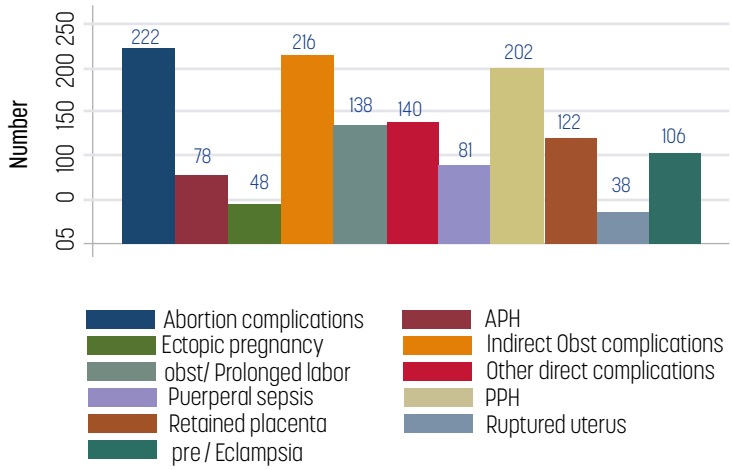

Figure 2: Major causes of maternal mortality (2020-2024) (DHIS 2)

4 Trends in maternal mortality 2000 to 2023: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2023.

Between Fiscal Years (FY) 2021/22 and 2024/25, Eastern Equatoria, Jonglei, and Western Bahr El Ghazal states reported the highest numbers of maternal deaths through DHIS2, while Central Equatoria, Upper Nile, Lakes, and the three administrative areas reported the lowest numbers (Fig. 3). There may be challenges with completeness of reporting; for example, Central Equatoria, which has one of the highest numbers of expected pregnancies and hosts the largest tertiary health facility, would be expected to report a higher number of maternal deaths.

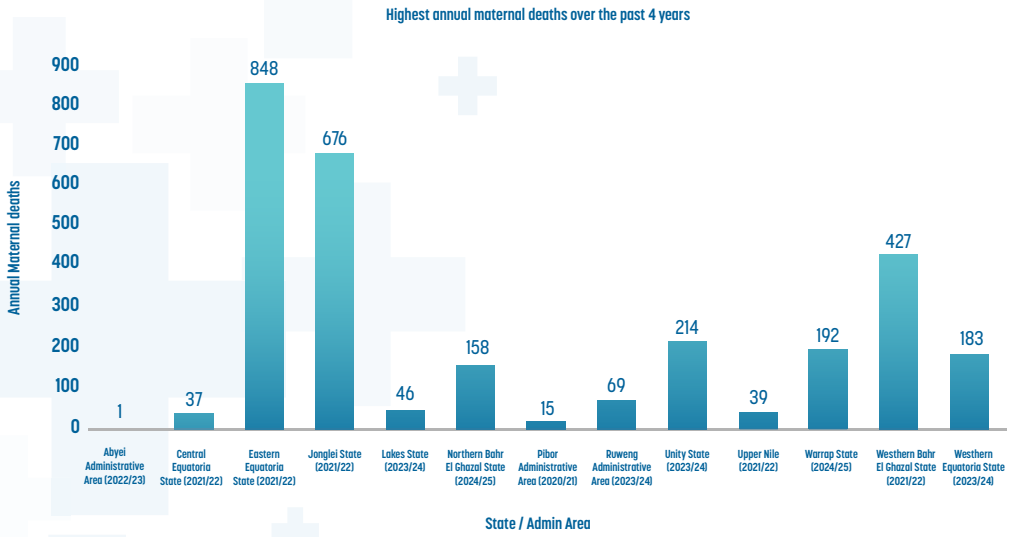

***Figure 3**: Highest annual maternal deaths between 2021-2024 (Source: DHIS2)*

Antenatal care coverage at least 4 visits (%)

Progress against this indicator was moderate, increasing from 23% at baseline to 31.8% against a 2025 target of 44% (Fig. 4).

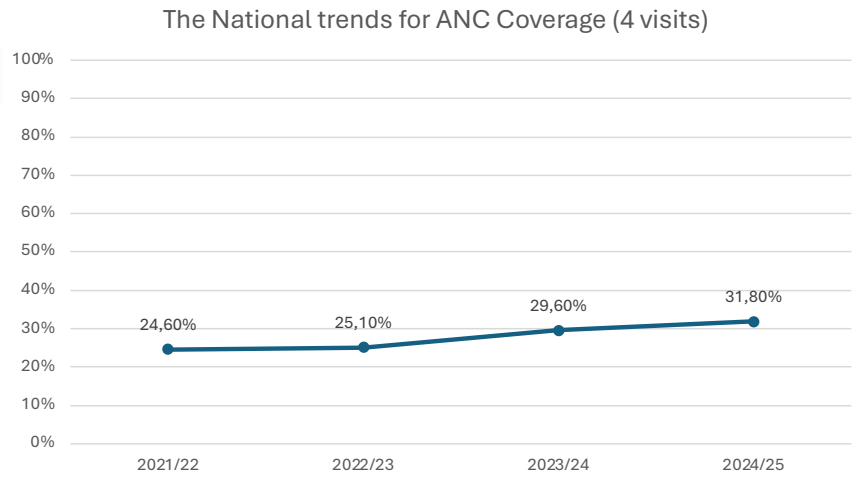

***Figure 4**: Trends of ANC 4 visits coverage (Source: DHIS2)*

At subnational level, coverage of four or more ANC visits was highest in Northern Bahr El Ghazal (64.8%), Unity State (55.7%), and Abyei Administrative Area (48.8%), and lowest in Central Equatoria (12.6%), Eastern Equatoria (13.5%), and Greater Pibor Administrative Area (17.4%) (Fig. 5).

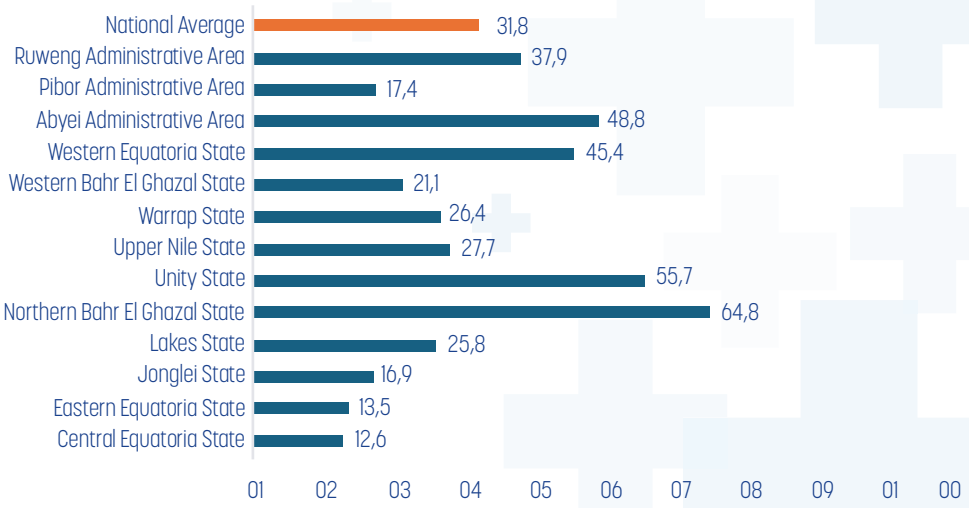

***Figure 5**: ANC 4 coverage by State and Administrative Area (DHIS 2)*

Over the past four years, Northern Bahr El Ghazal has shown consistently high coverage but has not achieved further growth in fourth ANC visit coverage since 2021, while states like Unity State, Western Equatoria, Abyei, and Ruweng Administrative Areas have shown consistent growth in ANC coverage.

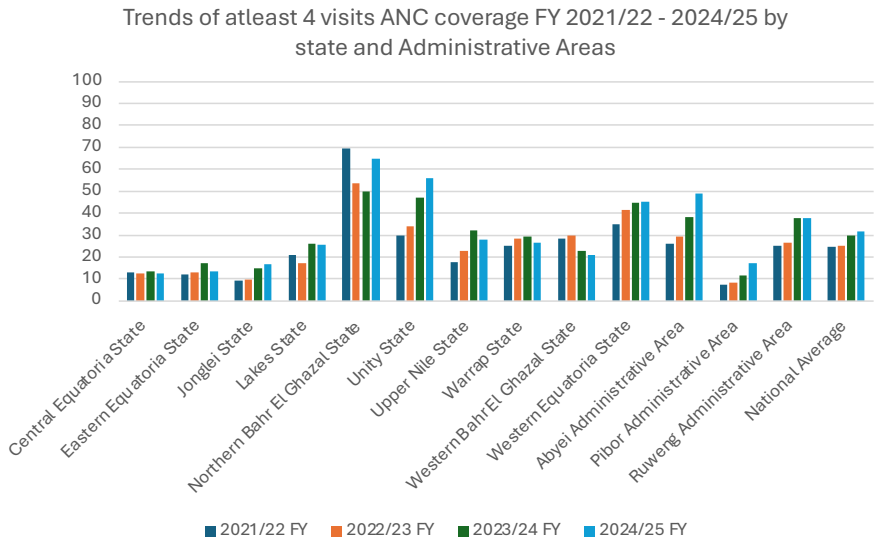

***Figure 6**: Trends of at least 4 visits ANC coverage (DHIS2)*

Births attended by skilled birth personnel (%)

Progress in skilled birth attendance has been slow, increasing from 15% at baseline to 19.5% against the 2025 target of 36% (see Fig. 7).

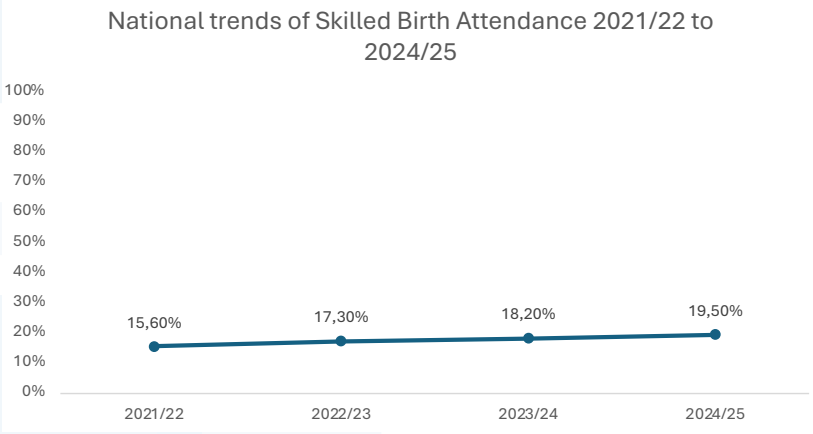

***Figure 7**: Skilled birth attendance trends (DHIS2)*

In FY 2024/25, skilled birth attendance coverage was highest in Ruweng Administrative Area (32.7%), Western Equatoria (30.8%), and Lakes State (24.9%), and lowest in Warrap State (13.8%), Abyei Administrative Area (14.9%), Greater Pibor Administrative Area (15.1%), and Eastern Equatoria (15.1%) (Fig. 8).

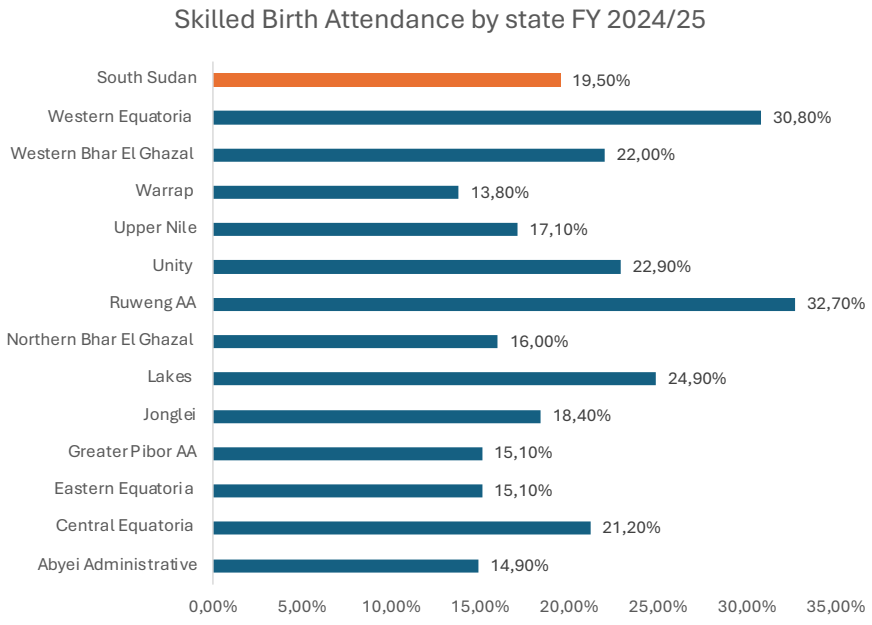

***Figure 8**: Skilled birth attendance by State and Administrative Area (DHIS2)*

Although overall rates are low, Abyei and Greater Pibor Administrative Areas have shown significant increases in SBA coverage compared to their baselines, alongside Jonglei State. Ruweng Administrative Area, Western Equatoria, and Western Bahr El Ghazal have maintained relatively higher levels of SBA coverage (Fig. 9).

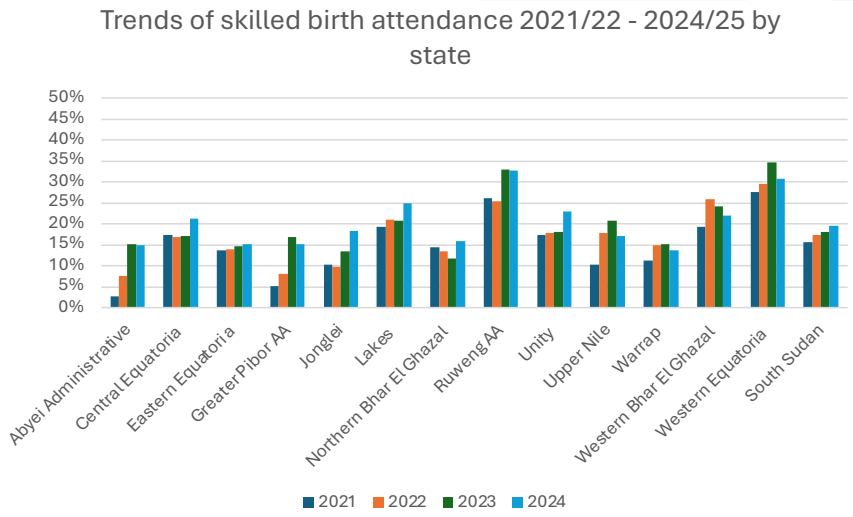

***Figure 9**: Skilled birth attendance trends by State and Administrative Area (DHIS2)*

Post-natal care coverage

Achievement on this indicator fell short of the 2025 target, decreasing from 35.5% at baseline to 34.2% against a target of 44%. However, estimates using DHIS2 data show some growth from 14.5% in FY 2021/22 to 36.1% in FY 2023/24, before dropping slightly to 34.2% in FY 2024/25 (Fig. 10).

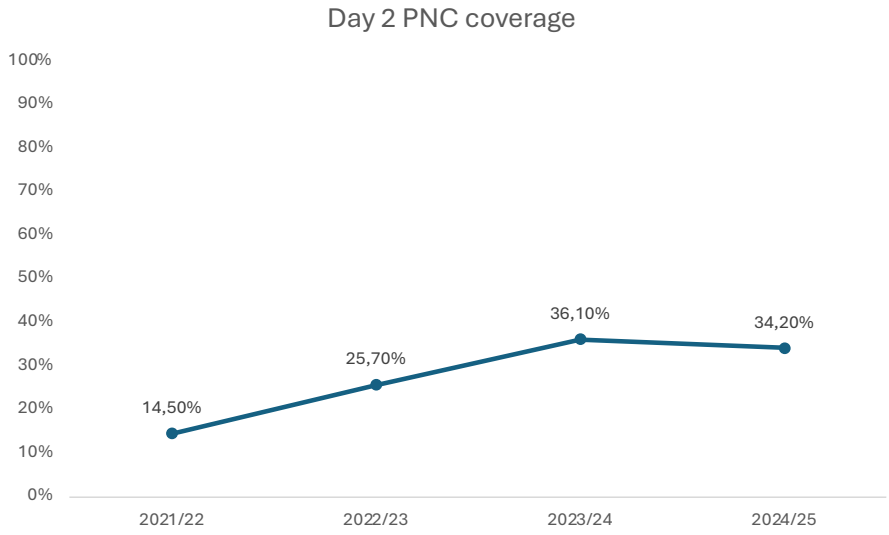

***Figure 10**: Day 2 PNC national trends (DHIS2)*

Day 2 PNC coverage varies significantly by state, with Western Equatoria (93%), Ruweng Administrative Area (78.1%), and Lakes State (58%) having the highest coverage, while Northern Bahr El Ghazal (13%), Abyei Administrative Area (13.2%), and Warrap State (19.2%) show the lowest coverage (Fig. 11).

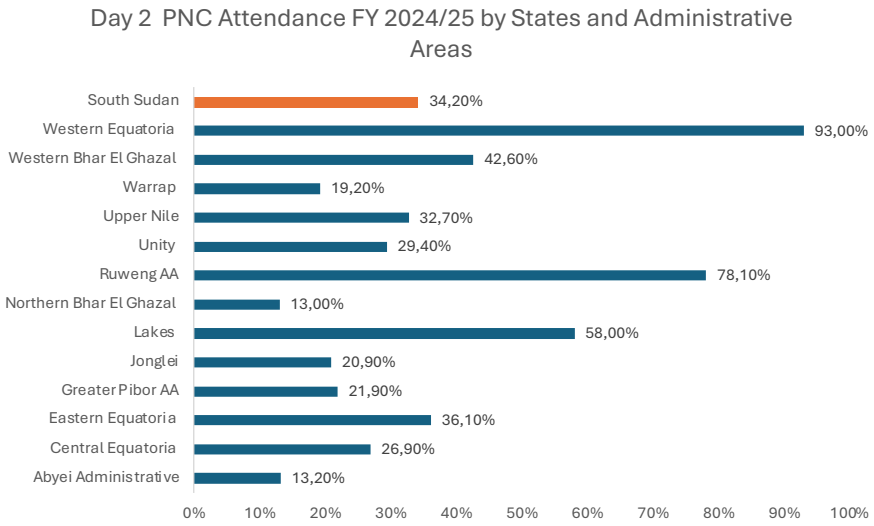

***Figure 11**: Day 2 PNC coverage by State and Administrative Area (DHIS2)*

Over the past four years, Lakes State, Ruweng Administrative Area, and Western Equatoria have shown significant increases in Day 2 PNC coverage (Fig. 12).

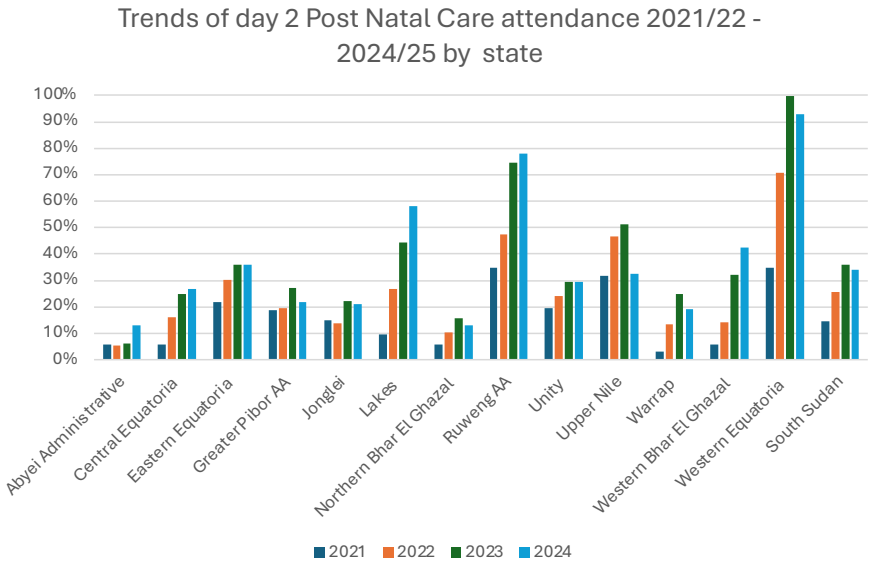

***Figure 12**: Trends of day 2 PNC coverage (DHIS2)*

Percentage of functional comprehensive emergency obstetric and newborn care (CEmONC) facilities

There has been no recent survey to measure progress on this indicator. However, over the period 2022/23-2024/25, the main obstetric complications were abortion complications (32%), obstetric hemorrhage (21%), and obstructed labor (12%).

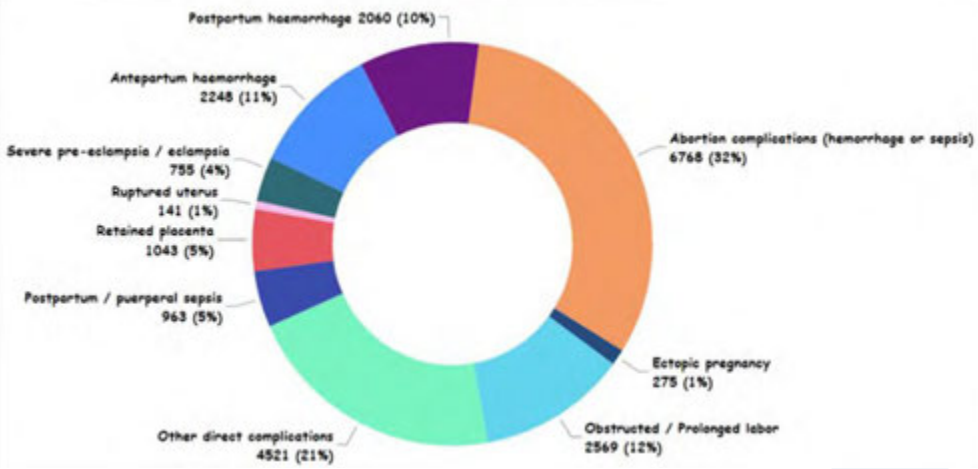

Figure 13: Obstetric complications admitted in health facilities (DHIS2)

During the same period, FYs 2022/23-2024/25, a total of 14,252 cesarean sections were performed for various indications across the country, with Central Equatoria contributing the highest number (5,404) (Fig. 14).

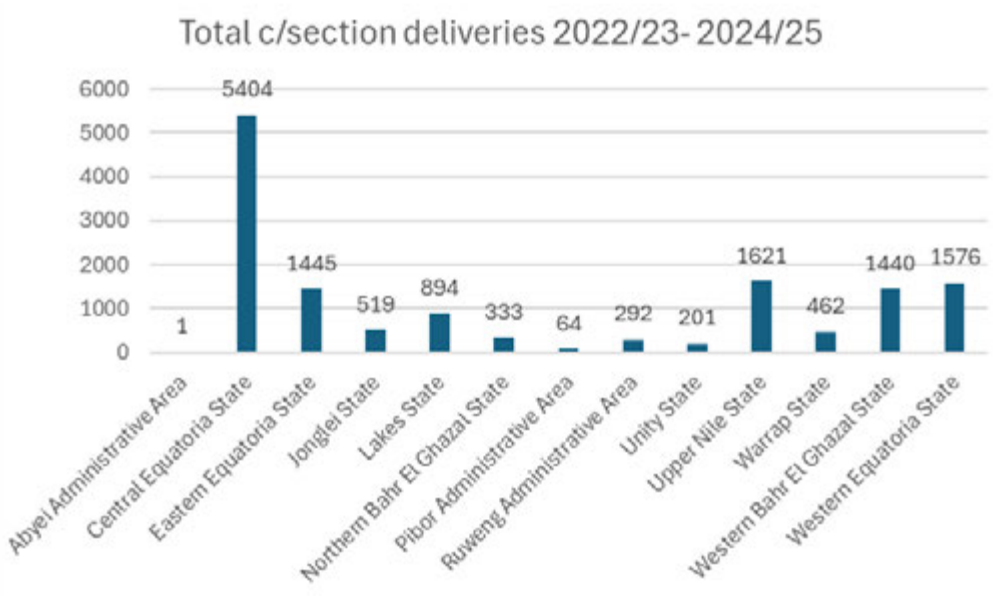

Figure 14: Total caesarean section deliveries (DHIS2)

Access to caesarean section services is generally low in the country, averaging 0.63% compared to the expected range of 5-15% (WHO, 2009); only Central Equatoria has a caesarean section rate of more than 1%.

Table 4: Ceasarean section rates by State and Administrative Area

State/Administrative Area	2021	2022	2023	2024
Abyei Administrative	ND	ND	ND	0.02%
Central Equatoria	1.56%	1.35%	1.38%	1.91%
Eastern Equatoria	0.51%	0.42%	0.54%	0.59%
Greater Pibor Administrative Area	0.03%	0.09%	0.17%	0.25%
Jonglei	0.12%	0.19%	0.17%	0.43%
Lakes	0.58%	0.49%	0.45%	0.46%
Northern Bhar El Ghazal	0.23%	0.13%	0.05%	0.10%
Ruweng Administrative Area	0.74%	0.62%	0.89%	0.82%
Unity	0.09%	0.07%	0.09%	0.14%
Upper Nile	0.05%	0.50%	0.73%	0.73%
Warrap	0.17%	0.12%	0.11%	0.19%
Western Bhar El Ghazal	1.17%	1.33%	1.52%	0.93%
Western Equatoria	0.81%	0.53%	0.76%	0.90%
South Sudan	**0.53%**	**0.49%**	**0.54%**	**0.63%**

Percentage of functional Maternal and Perinatal Death Surveillance and Response (MPDSR) committees

According to the mid-year review by the Ministry of Health, progress on the functionality of MPDSR committees remains limited. At least 36% of health facilities expected to have MPDSR committees are functional, and eight out of ten states have established state-level MPDSR committees.

To achieve these results, the Ministry of Health and partners implemented several capacity-building initiatives. Forty trainers of trainers (TOTs) were trained to support health workers in managing obstetric and newborn emergencies. An additional 42 health workers received training on the Health Management Information System (HMIS) tool. Forty TOTs were trained to enable the rollout of post-abortion care training at health facilities to improve the quality of post-abortion care. Furthermore, 249 committee members were trained on MPDSR processes.

Challenges

The high maternal mortality rate reflects broader structural and systemic issues related to conflict, poverty, wider socio-economic determinants and weak healthcare systems.

OBJECTIVE 3:

Ensure reduction in neonatal and childhood mortality through provision and utilization of high impact quality newborn and child health and nutrition services

Under five years' mortality rate (per 1,000 live births)

There has generally been no progress on this indicator, mortality rates remaining at 98.7 deaths per 1,000 live births, with more males dying compared to females (figure 15). According to a recent report, malaria, diarrhea, and pneumonia together account for over 75% of under-five child deaths in South Sudan [5]. Respiratory infections, worsened by indoor air pollution, significantly contribute to mortality.

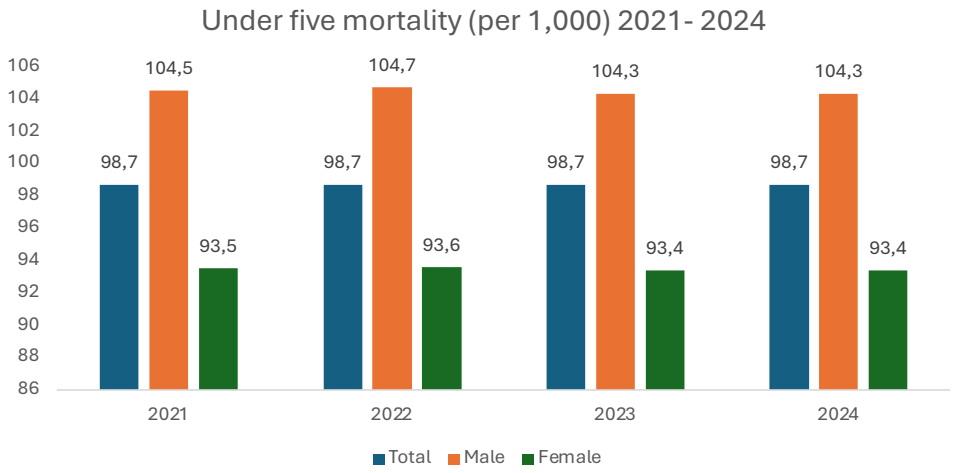

***Figure 15**: Under 5 mortality rate (per 1,000) (DHIS2)*

5 United Nations Children's Fund (UNICEF). Child survival - South Sudan. UNICEF; [cited 2025 Sept 9]. Available from: https://www.unicef.org/southsudan/topics/child-survival

Infant mortality rate (per 1,000 live births)

Progress against this indicator has been slow, with the trend showing a gradual decline over time from 60.9 in 2021 to 57.7 in 2024 (figure 16) [6].

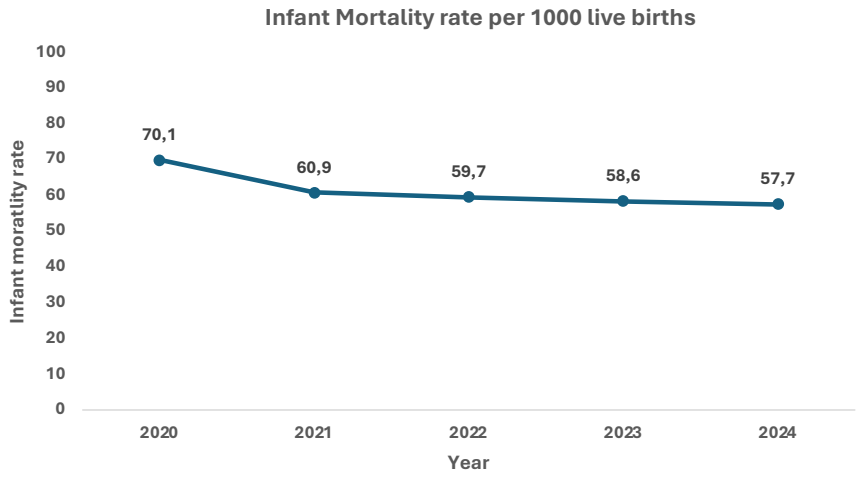

Figure 16: Infant mortality rate (UNIAG)

Neonatal mortality rate (per 1000 live births)

Neonatal mortality remains high, with a moderate reduction from approximately 56 to 39 deaths per 1,000 live births between 2000 and 2023 (Fig. 17), while the stillbirth rate dropped from 39 to 28 per 1,000 births over the same [7].

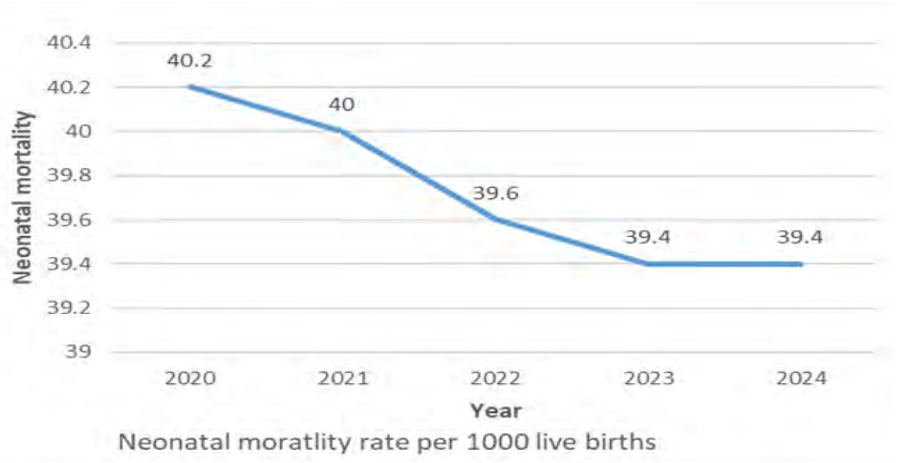

Figure 17: Trend in neonatal mortality rate

6 Levels & Trends in Child Mortality. Report 2023. Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation.

7 Levels & Trends in Child Mortality. Report 2023. Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation.

Neonatal morbidities and mortalities are mainly due to preterm deliveries (38%), newborn sepsis (26%), birth asphyxia (20%), neonatal pneumonia (6%), and neonatal jaundice (2%) (DHIS2).

The Ministry of Health and partners have instituted several measures to reduce infant and under-five (U5) mortality, including deployment of the R21 malaria vaccine, first rolled out in 2024 to reduce malaria-related child deaths. In addition, the Ministry of Health and partners are supporting training of community health workers, expanding vaccination efforts, and improving maternal care. In the same vein, Integrated Management of Childhood Illness (IMCI) is being implemented.

Access to specialized neonatal care remains limited, particularly in rural areas. Early postnatal care is vital for detecting and addressing complications that may arise after delivery for both the mother and the baby.

Immunization

There has been some limited progress in immunization coverage for most antigens, with a moderate increase between FY 2021/22 and 2023/24, followed by a slight drop in 2024/25 (Fig. 18). This decrease might be due to data collection challenges during the transition between HPF and HSTP projects.

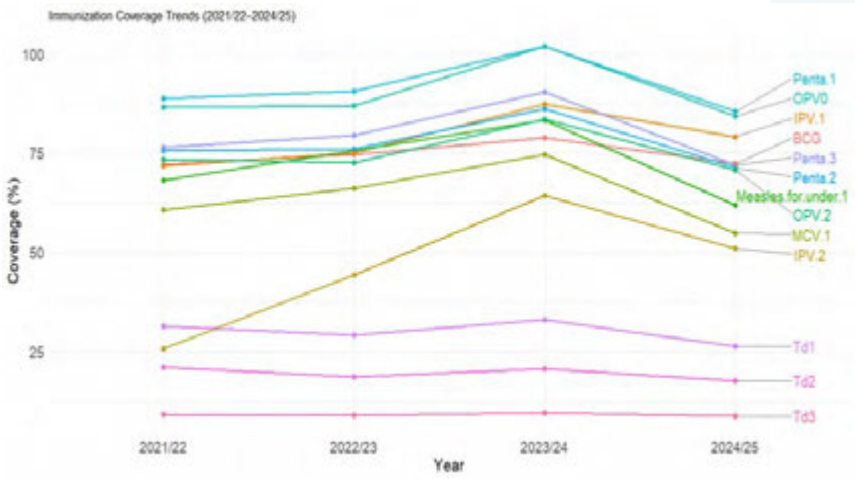

***Figure 18**: Immunization coverage trends (DHIS2)*

Challenges

Access to maternal and newborn health services is constrained by several factors. Skilled birth attendance remains low, with trained health workers attending only about 19-40% of births. Facility readiness is weak, as many health centers lack essential supplies, equipment, and adequately trained staff for neonatal care. Ongoing conflict, population displacement, and poor infrastructure further exacerbate these challenges, resulting in approximately 60% of health facilities being nonfunctional, particularly in rural areas and among displaced populations.

OBJECTIVE 4:

Improve the nutritional status and reduce morbidity and mortality associated with malnutrition among the most vulnerable populations

Malnutrition among children under five in South Sudan, as well as among pregnant and breastfeeding women, remains a serious public health challenge, with prevalence rates exceeding the WHO 15% emergency threshold. An estimated 2.1 million children under five years are at risk of malnutrition, including 670,000 at risk of severe wasting and 1.4 million at risk of moderate wasting. An estimated 70% of acute malnutrition cases are concentrated in the five states of Jonglei, Northern Bahr el Ghazal, Upper Nile, Unity, and Warrap, with six counties classified in Integrated Phase Classification (IPC) phase 5.

Key contributing factors include suboptimal infant and young child feeding practices (very low minimum acceptable diet [MAD] of 2.1%), high child morbidity due to limited access to health services, persistently high levels of food insecurity (42% of the population projected to be in IPC phase 3 and above), poor water, sanitation, and hygiene (63% of the population have access to an improved water source and only 9.9% have access to improved sanitation facilities), and ongoing violence and conflict. The Ministry of Health, together with its partners, has undertaken significant efforts to strengthen malnutrition prevention through multisectoral collaboration while continuing the provision of life-saving treatment services. A significant improvement has been observed in infant and young child feeding practices, particularly in exclusive breastfeeding rates. Exclusive breastfeeding among infants aged 0-6 months has increased from 62% to 73.3%, bringing the country closer to the 2025 target of 74%. This reflects positive progress in promoting optimal infant feeding practices and contributes to efforts to reduce malnutrition.

However, wasting among children under five remains a significant public health concern. The trend has deteriorated from 16.1% in the Food Security and Nutrition Monitoring System (FSNMS) round 26 to 17.4% in round 30 (2024). Vitamin A supplementation coverage for children under 59 months is 79.1%, falling short of the 2025 target of 88%, indicating limited progress. Stunting among children under five stands at 15.5% (FSNMS round 30). Despite the target of reducing stunting to 10%, there has been no significant progress compared to FSNMS round 26, largely due to limited interventions.

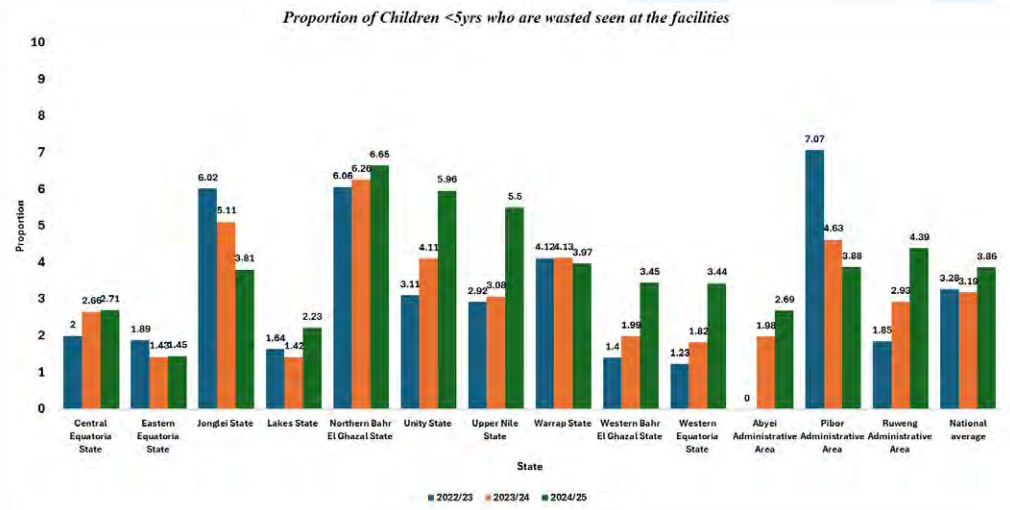

***Figure 19**: Proportion of under-five children wasted reported from health facility records (DHIS2)*

Jonglei, Northern Bahr el Ghazal, Unity, Upper Nile, and Pibor remain among the states with the highest proportions across the three years. Jonglei recorded a steady increase from 6.06% in 2023 to 6.65% in 2025. Similarly, Northern Bahr el Ghazal and Pibor also show an upward trend.

In contrast, states like Western Bahr el Ghazal, Abyei, and Western Equatoria consistently show lower wasting proportions compared to other regions, although slight increases are observed in 2025. Central and Eastern Equatoria show moderate levels, with slight increases over time.

Across nearly all states, the numbers rise gradually from 2023 to 2025. This rising pattern suggests either improved detection capacities or a real deterioration in nutrition outcomes, possibly linked to worsening food insecurity, displacement, or reduced programme coverage. The upward trend across many states underscores the continued need for targeted nutrition interventions, particularly in chronically high-burden areas such as Jonglei, Upper Nile, Unity, and Northern Bahr el Ghazal.

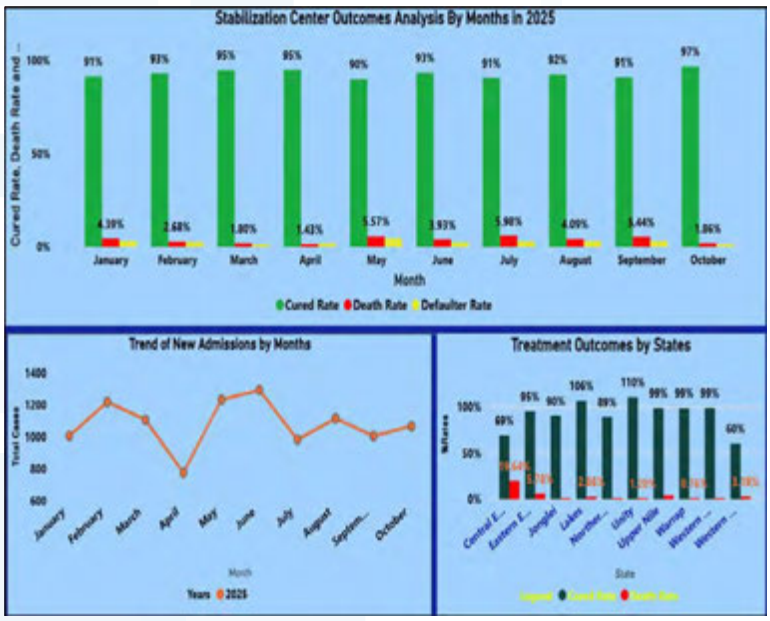

Figure 20: Stabilization centers outcome analysis 2025 (NIS)

Figure 20 shows nutrition programme performance from January to October 2025. Recovery rates remain strong (90-97%), with low death rates overall, except for slight increases in May (5.57%) and July (5.98%). Defaulter rates are consistently below 6%. Admissions fluctuate, peaking in March, May, and June, and dropping in April.

State-level results vary: Unity, Lakes, Upper Nile, Warrap, and Western Bahr el Ghazal report excellent cured rates (99-110%) and low deaths, while Central Equatoria (69% cured, 19.64% deaths) and Western Equatoria (60% cured) perform poorly and need urgent attention. Eastern Equatoria shows good recovery (95%) but slightly high deaths (5.78%).

Key Interventions for Nutrition

Policy, Guidelines, and Regulatory Frameworks

Several policies and regulatory measures were advanced to strengthen nutrition services. Baby-Friendly Hospital Initiative guidelines were developed to promote improved infant nutrition, reduce malnutrition and infection risks, and enhance health outcomes for mothers and newborns. National operational guidelines for implementing the 2023 WHO recommendations were developed and piloted in Lakes and Northern Bahr el Ghazal. The Nutrition pre-service curriculum and the National Nutrition Policy (2025-2035) were launched, with plans underway for dissemination to senior stakeholders, including parliamentarians, executives, academia, civil society, and the private sector. Additional efforts included development of the Breastmilk Substitute Code to regulate inappropriate marketing of breastmilk formula, ongoing development of the Salt Iodization Deficiency Strategy, and revision of the Maternal, Infant, and Young Child Nutrition guideline, job aids, and training package.

Capacity Building and Quality Improvement

Efforts to strengthen capacity and improve quality of care focused on stabilization centers with high mortality rates. A quality-of-care improvement tool was introduced in facilities such as Alsabah Children's Hospital, which accounts for approximately 50% of deaths in stabilization centers. Training was provided to 47 frontline health workers to equip facilities with the skills required for protocol-driven, high-quality treatment. Targeted supervision missions and on-the-job coaching were conducted in high-burden locations, resulting in improved adherence to treatment protocols, better infection control practices, and more accurate record-keeping.

Service Delivery and Clinical Care

Medical and nutrition supplies, including pediatric and severe acute malnutrition kits, were provided to support the treatment of children with severe acute malnutrition. Monthly pediatric death audits at Alsabah Children's Hospital have become a cornerstone of evidence-based management, helping to identify preventable causes of child mortality and guide targeted interventions in stabilization centers. Ongoing audits at Alsabah Children's Hospital have led to early identification of gaps in clinical care, improved case management practices, and implementation of corrective measures.

Community-Based and Preventive Interventions

Preventive measures included vitamin A supplementation and deworming campaigns for children aged 12 to 59 months. Initiatives to scale up the use of locally available foods for young children were also implemented to improve dietary diversity and reduce malnutrition.

Monitoring, Evaluation, and Surveillance

Annual Food Security and Nutrition Monitoring System (FSNMS) assessments were conducted to monitor the nutritional status of children under five years. IPC analyses for acute food insecurity and malnutrition were carried out to inform Humanitarian Needs Response Planning and guide decision-making.

Challenges

Access to nutrition services continues to face multiple operational and systemic constraints. Restricted access to high-burden areas due to persistent insecurity and seasonal flooding has hindered service delivery and outreach. Delays in supply chain logistics, particularly for pediatric and severe acute malnutrition kits, have disrupted timely treatment and affected facility readiness. High staff turnover among trained personnel has eroded institutional memory and continuity in quality care practices. Inconsistent data reporting from subnational levels, driven by limited supervision and logistical barriers, has affected programme monitoring and responsiveness.

Additional challenges include overwhelmed stabilization centers during peak admission periods, which strain capacity and compromise patient management. Insufficient funding has constrained the scale and sustainability of nutrition interventions across the country. Humanitarian aid diversion, including the sale of nutrition supplies intended to save lives, further undermines programme effectiveness. Limited capacity within the health sector technical programme workforce and the existence of parallel reporting systems for nutrition information (NIS and DHIS2) continue to complicate coordination and data integration.

2.3 PROGRAMME AREA 3: COMMUNICABLE DISEASES AND NEGLECTED TROPICAL DISEASES

Communicable diseases and neglected tropical diseases remain major causes of illness and death in South Sudan. This programme focuses on reducing the burden of malaria, tuberculosis (TB), HIV/AIDS, hepatitis, sexually transmitted infections, and neglected tropical diseases (NTDs) such as trachoma, lymphatic filariasis, and Guinea worm disease. It encompasses interventions for prevention, diagnosis, treatment, and integrated disease control, aiming to reduce transmission and improve case management.

This section reviews progress against key indicators for malaria control, TB detection and treatment, HIV testing and viral suppression, and NTD programme performance, highlighting achievements, gaps, and systemic challenges that influence programme effectiveness.

Achievement against HSSP (2023-2027) targets

- **Red**: limited or no progress (<50% of 2025 target);
- **Orange**: some progress, but not enough to achieve the target (50 to 99% of 2025 target);
- **Green**: good progress, target (2025) achieved or even surpassed

***Table 5**: Achievement against targets: Communicable diseases and Neglected Tropical Diseases*

Objective	Indicator	Baseline	Achievement 2025	Target (HSSP)		Performance and color	Data source	Comments
				2025	2027			
Ensure reduction in morbidity and mortality due to malaria toward pre-elimination levels Percentage of confirmed malaria cases treated	Percentage of confirmed malaria cases treated	80%	97%	85%	90%	114.1%	DHIS2	
	Proportion of pregnant women who received three or more doses of IPTp (IPTp≥ 3)	31%	22.16%	81%	90%	27.4%	DHIS2	
	Malaria incidence rate (per 1,000 population)	337	348	212.4	190	-63.8%	DHIS2	
	Percentage of children 6-59 months who slept under an ITN	42%	67.41%	85%	90%	79.3%	Malaria Indicator Survey (MIS) 2023	
	Percentage of population at risk sleeping under an ITN	59.30%	62.33%	78%	85%	79.9%	MIS 2023	
	Malaria parasite prevalence among children aged 6-59 months	32%	17.80%	16%	10%	88.8%	MIS 2023	
	Proportion of pregnant women (15-49yrs) sleeping under an ITN	51%	57.25%	85%	90%	67.4%	MIS 2023	
	Proportion of patients with suspected malaria who received a parasitological test (RDT and/ or microscopy)	50%	93%	90%	100%	103.3%	DHIS2	
	Indoor residual spraying (IRS) coverage	2.10%	ND	7.50%	10%			
Ensure reduction in the incidence and prevalence of Tuberculosis	TB Incidence rate (per 100,000 population)	227	320	150	100	-113.3%	WHO global report 2025	
	TB prevalence rate (100000 population)	140%	No data	115%	100%			
	TB Notification Rate (per 100,000 population)	62	186	80	95	232.5%	DHIS2	
	TB effective treatment coverage	65%	80%	80%	90%	100.0%	WHO Global Health Observatory	
	% HIV positive new and relapse TB patients on ART during TB treatment		55.99%	60%	100%	93.3%	DHIS2	
	% of people with confirmed RR-TB and/ or MDR-TB that began second-line treatment	No data	41%	60%	80%	68.3%	Health statistical abstract	Used Treatment Coverage (%) for MDR
	Multidrug Rifampicin resistance tuberculosis (MBD/RR-TB) incidence	4.60%	6.5	4.3	<5%	48.8%	WHO global TB report 2025	

Objective	Indicator	Baseline	Achievement 2025	Target (HSSP)		Performance and color	Data source	Comments
				2025	2027			
Ensure reduction in the incidence and prevalence of HIV/AIDS	Number of people newly infected with HIV per year	10,933	8700	8000	6000	91.3%	Health statistics abstract	
	% of people living with HIV who know their status	39%	55%	65%	80%	84.6%	Spectrum Estimates	
	Antiretroviral therapy coverage	32%	50%	52%	65%	96.2%	Spectrum Estimates	
	% of people living with HIV, receiving treatment, who have suppressed viral loads	27%	81.30%	45%	65%	180.7%	DHIS2	
	Coverage of pregnant women who receive ART for PMTCT (%)	53%	60.74%	70%	85%	86.8%	DHIS2	
	Mother to child transmission rate (%)	25%	14.71%	14%	8%	94.9%	DHIS2	
Ensure reduction in the incidence, morbidity, and mortality due to viral Hepatitis	% of general population with comprehensive knowledge on viral hepatitis	No data		30%	50%			
	% of pregnant women screened for Hepatitis B	No data		60%	80%			
	Proportion of blood units screened for blood borne diseases	No data		60%	100%			
	% of Hepatitis B treated	2%		30	50%			
	% of Hepatitis C cured	No data		10	20%			
Ensure reduction in the incidence, morbidity, and mortality due to Sexually Transmitted Infections	% of pregnant women attending antenatal care screened for syphilis	No data	37.27%	70%	85%	53.2%		
	% of girls fully HPV vaccinated	No data		30	50%			
	% of women screened for cervical cancer	No data		12	20%			
Ensure reduction in morbidity, disability, and mortality due to NTDs	Number of people requiring intervention against Tropical diseases (SDG 3.3.5)	7.5	9.8	4.5	2.5	-117.8%	UN SDG, WHO GHO	
		Million	Million	Million	Million			
	Integrated Treatment Coverage Index of preventive chemotherapy NTDs (onchocerciasis, soil transmitted helminthiasis, lymphatic filariasis, trachoma and schistosomiasis)	78%	36%	86%	90%	41.9%	Programme Report	
	Percentage of endemic counties where transmission of trachoma has been interrupted	3%	27%	27%	52%	100.0%	Programme Report	
		1/33	9/33					
	Percentage of endemic counties where transmission of LF has been interrupted	0%	28%	28%	40%	100.0%	Programme Report	The programme is yet to conduct the Epidemiological Monitoring Survey (EMS) to determine the next step in 2026 in 11 IUs.
		0/50	14/50					
	Percentage of endemic counties where transmission of Human African Trypanosomiasis (sleeping sickness) has been interrupted	0%	81%	12%	24%	675.0%	Programme report	No sufficient surveillance in place
	Percentage of endemic counties reporting <1% case fatality rate due to primary visceral leishmaniasis	0%	77%	6%	21%	1283.3%		
	Guinea Worm Incidence	6	2	0	0	0.0%		
Programme performance						70.1%		

Malaria

Malaria remains a major public health concern in South Sudan, accounting for a significant proportion of outpatient consultations and hospital admissions. During the reporting period, treatment coverage for confirmed malaria cases reached 97%, surpassing the HSSP 2025 target of 85%. Diagnostic capacity improved, with 93% of suspected cases tested using parasitological methods (rapid diagnostic test–RDT–or microscopy), reflecting strengthened adherence to national guidelines.

Malaria incidence stands at 348 cases per 1,000 population, slightly above the baseline, while parasite prevalence among children aged 6-59 months declined to 17.8% from 32% at baseline. National malaria case trends show a slight reduction from 5.3 million cases in 2023 to 5.29 million in 2024, with treated cases increasing to over 5.1 million in 2024/25. These improvements reflect ongoing efforts in case management and prevention, supported by integrated community- and facility-based interventions.

Despite national progress, state-level trends reveal disparities in malaria's burden and prevention coverage. Northern Bahr el Ghazal, Warrap, and Upper Nile consistently report the highest malaria case counts, with Northern Bahr el Ghazal reaching 698,787 cases in 2024, while Abyei and Greater Pibor Administrative Area remain lowest but show gradual increases.

***Table 6**: Total malaria cases (DHIS2)*

State/Administrative Area	2020	2021	2022	2023	2024
Central Equatoria	507,877	648,342	670,478	663,347	605,431
Eastern Equatoria	424,217	511,106	459,103	403,970	481,662
Jonglei	227,754	176,090	304,978	289,022	290,240
Lakes	327,216	384,131	353,483	294,523	272,029
Northern Bahr El Ghazal	826,696	1,053,751	623,212	525,123	698,787
Unity	356,556	339,044	396,886	544,038	444,085
Upper Nile	342,887	331,036	341,414	631,771	618,026
Warrap	582,821	740,641	719,256	674,480	632,937
Western Bahr El Ghazal	400,562	480,804	458,235	406,126	466,783
Western Equatoria	490,629	551,247	490,514	519,437	455,740
Abyei Administrative Area	13,292	70,800	60,012	85,741	83,379
Greater Pibor Administrative Area	61,398	65,636	65,805	69,300	83,011
Ruweng Administrative Area	94,292	114,045	159,289	216,584	163,613
South Sudan	**4,656,197**	**5,466,673**	**5,102,665**	**5,323,463**	**5,295,723**

Treatment performance improved across most states, with Unity and Upper Nile showing sharp increases in treated cases between FY 2022/23 and FY 2024/25, indicating better access to services and improved reporting.

***Table 7**: Total malaria cases treated (DHIS2)*

State/Administrative Area	2021	2022	2023	2024
Central Equatoria	423,801	509,067	518,814	552,625
Eastern Equatoria	421,295	415,459	403,430	449,741
Jonglei State	179,100	349,287	475,484	399,334
Lakes State	271,372	412,474	348,249	382,908
Northern Bahr El Ghazal	809,175	555,547	530,121	603,529
Unity State	213,042	365,667	475,368	369,765
Upper Nile State	298,630	305,535	573,050	549,628
Warrap State	817,960	813,424	775,169	776,517
Western Bahr El Ghazal State	254,547	337,466	370,637	376,000
Western Equatoria State	332,162	410,912	440,205	414,783
Abyei Administrative Area	28,121	33,736	73,121	81,491
Greater Pibor Administrative Area	52,018	50,687	82,505	95,170
Ruweng Administrative Area	6,819	67,438	96,000	87,514
South Sudan	**4,108,042**	**4,626,701**	**5,162,151**	**5,139,004**

Preventive interventions have shown progress, with insecticide-treated net (ITN) utilization among children aged 6-59 months at 67.4% and among pregnant women at 57.3%, according to the MIS 2023. However, intermittent preventive treatment in pregnancy (IPTp) coverage for three or more doses remains low at 22.2%, indicating the need for further scale-up of ANC-based malaria prevention. Preventive interventions remain uneven. Western Equatoria leads IPTp coverage at 52.3%, while Jonglei (12.8%) and Abyei (7.3%) lag far behind, highlighting gaps in ANC-based malaria prevention.

***Table 8**: Proportion of pregnant women who received 3 or more doses of IPTp during the ANC visit (DHIS2)*

State/Administrative Area	2021/22 FY	2022/23 FY	2023/24 FY	2024/25 FY
Central Equatoria	24.53	35.68	49.07	39.68
Eastern Equatoria	28.13	44.04	33.93	37.44
Jonglei	14.19	16.65	16.63	12.80
Lakes	15.44	19.02	24.39	21.47
Northern Bahr El Ghazal	9.96	16.49	13.02	16.32
Unity	13.55	14.06	23.90	16.34
Upper Nile	18.82	20.89	21.73	15.30
Warrap	14.54	19.25	15.52	17.22
Western Bahr El Ghazal	17.66	25.51	23.86	23.17
Western Equatoria	31.41	76.23	62.25	52.30
Abyei Administrative Area	27.12	7.53	9.40	7.32
Greater Pibor Administrative Area	37.16	25.31	13.72	11.59
Ruweng Administrative Area	0.34	6.98	10.33	17.18
South Sudan	**19.45**	**25.20**	**24.44**	**22.16**

HIV

Burden and Trends

HIV remains a major public health challenge in South Sudan. In 2025, an estimated 8,700 new infections occurred nationally, compared to the HSSP target of 8,000. The proportion of people living with HIV who know their status is 55%, below the 2025 target of 65%. ART coverage stands at 50%, slightly below the target of 52%.

State-level data show wide variations in HIV burden. Central Equatoria consistently reports the highest number of HIV-positive clients, declining from 5,888 in FY 2021/22 to 4,201 in FY 2024/25, while Lakes State also reports high numbers, dropping from 4,437 to 2,843 over the same period. In contrast, Abyei Administrative Area and Greater Pibor Administrative Area remain very low, with Abyei increasing slightly from 9 to 62 and Pibor declining from 338 to 83. Unity State shows fluctuations, peaking at 5,131 in FY 2022/23 before reducing to 1,899 in FY 2024/25. These trends indicate uneven progress in HIV testing and case detection across states.

***Table 9**: Total Clients Tested for HIV positive by State and administrative areas (DHIS2)*

State/Administrative Area	2021/22 FY	2022/23 FY	2023/24 FY	2024/25 FY
Central Equatoria	5,888	5,756	4,825	4,201
Eastern Equatoria	1,347	1,402	1,402	1,186
Jonglei	1,879	1,042	860	724
Lakes	4,437	3,091	2,836	2,843
Northern Bahr El Ghazal	394	270	363	325
Unity	3,385	5,131	2,024	1,899
Upper Nile	633	1,742	1,642	1,571
Warrap	683	668	319	347
Western Bahr El Ghazal	489	385	324	398
Western Equatoria	1,655	1,461	1,274	1,473
Abyei Administrative Area	9	25	43	62
Greater Pibor Administrative Area	338	194	108	83
Ruweng Administrative Area	317	714	266	257
South Sudan	**21,453**	**21,882**	**16,287**	**15,370**

Case Management

ART initiation improved nationally, with 84.7% of eligible individuals starting treatment in FY 2024/25, compared to 58.6% in FY 2021/22. State-level trends show strong performance in Western Equatoria (97%) and Central Equatoria (98%), while Western Bahr el Ghazal declined to 34.4% in FY 2024/25 after earlier gains. Unity State reached 97.1% in FY 2023/24 but dropped to 88.2% in FY 2024/25.

Table 10: Proportion of individuals who started newly on ART by state and administrative areas (DHIS2)

State/Administrative Area	2021/22 FY	2022/23 FY	2023/24 FY	2024/25 FY
Central Equatoria	91.0	94.3	95.4	98.0
Eastern Equatoria	100.0	90.4	94.3	95.2
Jonglei State	39.7	70.4	94.1	96.4
Lakes State	70.5	55.2	80.2	95.4
Northern Bahr El Ghazal	65.4	64.6	72.5	88.5
Unity State	50.0	64.7	97.1	88.2
Upper Nile	47.8	63.8	76.1	85.3
Warrap State	37.2	58.9	105.7	53.0
Western Bahr El Ghazal	43.8	61.3	67.3	34.4
Western Equatoria State	81.3	97.0	94.9	97.0
Abyei Administrative Area	92.1	63.2	18.6	83.9
Greater Pibor Administrative Area	15.0	33.1	99.4	94.4
Ruweng Administrative Area	27.6	43.1	88.2	91.7
South Sudan	**58.6**	**66.2**	**83.4**	**84.7**

Viral load suppression nationally stands at 81.3%, meeting the target of 81%. State-level data show Northern Bahr el Ghazal achieving 93.54%, while Western Bahr el Ghazal dropped to 69.51% in FY 2024/25. Central Equatoria remained stable at around 84-85%, and Greater Pibor Administrative Area improved to 90.98%.

Table 11: HIV Viral load suppression (PVLS) (DHIS2)

State/Administrative Area	2021/22 FY	2022/23 FY	2023/24 FY	2024/25 FY
Central Equatoria	91.34	86.12	85.87	84.64
Eastern Equatoria	82.58	91.24	83.54	86.08
Jonglei	75.66	91.63	84.14	88.21
Lakes	69.01	60.78	72.40	66.55
Northern Bahr El Ghazal	60.19	92.54	73.92	93.54
Unity	75.42	69.09	72.12	80.50
Upper Nile	53.90	78.95	82.47	70.42
Warrap	81.26	100.00	93.18	89.72
Western Bahr El Ghazal	92.33	84.94	82.21	69.51
Western Equatoria	82.07	84.59	82.63	79.52
Abyei Administrative	69.78	75.25	85.85	77.78
Greater Pibor Administrative	80.53	78.99	75.50	90.98
Ruweng Administrative	100.00	63.64	78.05	79.52
South Sudan	**78.01**	**81.37**	**80.91**	**81.30**

Prevention Interventions

PMTCT coverage was 60.74% nationally, below the target of 70%. State-level variations are substantial: Eastern Equatoria reached 81.27%, while Western Equatoria reported only 12.24% in FY 2024/25. Lakes State improved to 110.20%, likely due to data anomalies or overreporting, while Warrap remained low at 42.41%.

Table 12: PMTCT_ART Coverage (%) - % of Positives who started or continued ART (DHIS2)

State/Administrative Area	2021/22 FY	2022/23 FY	2023/24 FY	2024/25 FY
Central Equatoria	40.94	57.79	32.48	43.71
Eastern Equatoria	56.85	76.49	16.45	81.27
Jonglei	36.77	179.28	126.12	44.41
Lakes	62.98	49.36	62.93	110.20
Northern Bahr El Ghazal	172.02	246.97	179.06	128.00
Unity	44.96	71.03	103.05	81.24
Upper Nile	61.75	137.77	139.84	112.53
Warrap	53.83	4.52	2.66	42.41
Western Bahr El Ghazal	52.63	35.35	23.70	32.57
Western Equatoria	23.84	38.89	25.56	12.24
Abyei Administrative Area	42.75	35.76	80.15	51.40
Greater Pibor Administrative Area	312.50	713.96	10.71	30.30
Ruweng Administrative Area	23.33	28.96	32.60	19.38
South Sudan	**75.78**	**128.93**	**64.25**	**60.74**

Mother-to-child transmission remains high nationally at 14.71%, compared to the target of 8%. State-level data show Jonglei with the highest rate at 79.17%, while Lakes State reported the lowest at 0.37%. Central Equatoria increased sharply to 12.92%, and Greater Pibor Administrative Area rose to 24.73%, indicating persistent gaps in PMTCT effectiveness.

Table 13: Mother to child transmission rate (DHIS2)

State/Administrative Area	2021/22 FY	2022/23 FY	2023/24 FY	2024/25 FY
Central Equatoria	2.24	2.79	0.98	12.92
Eastern Equatoria	4.76	35.50	7.55	10.00
Jonglei	19.02	11.95	12.00	79.17
Lakes	1.96	17.61	2.33	0.37
Northern Bahr El Ghazal	7.77	2.44	4.08	6.82
Unity	13.20	10.44	23.57	0.45
Upper Nile	15.58	14.11	13.73	16.90
Warrap	9.74	10.59	9.54	12.13
Western Bahr El Ghazal	2.47	10.45	17.87	11.38
Western Equatoria	0.59	26.91	6.25	8.31
Abyei Administrative Area	5.67	22.98	5.81	4.07
Greater Pibor Administrative Area	6.32	15.07	21.57	24.73
Ruweng Administrative Area	4.20	6.67	2.86	3.94
South Sudan	**7.19**	**14.42**	**9.86**	**14.71**

Data source: DHIS2

TB

Burden and Trends

The estimated TB incidence rate increased from a baseline of 227 per 100,000 population to 320 per 100,000 in 2025, against the HSSP target of 150 by 2025 and 100 by 2027. Notification rates improved from 108 per 100,000 in 2021/22 to 190 per 100,000 in 2023/24, with a slight decline to 186 per 100,000 in 2024/25, reflecting progress in case detection but still remaining below targets. Effective treatment coverage stands at 80%, meeting the 2025 target but requiring further scale-up to reach 90% by 2027.

State-level data (Table 14) show wide disparities. In FY 2024/25, Abyei Administrative Area reported the highest rate at 463 per 100,000, followed by Central Equatoria at 296 per 100,000 and Northern Bahr el Ghazal at 240 per 100,000. The lowest rates were observed in Pibor at 53 per 100,000 and Western Equatoria at 115 per 100,000. These variations highlight inequities in access to diagnostic and treatment services, compounded by insecurity and population displacement.

Table 14: TB-Case notification rate of all forms of TB per 100,000 population (DHIS2)

State/Administrative Area	2021/22 FY	2022/23 FY	2023/24 FY	2024/25 FY
Central Equatoria	191	262	298	296
Eastern Equatoria	112	133	166	196
Jonglei	39	46	87	91
Lakes	148	141	134	145
Northern Bahr El Ghazal	171	154	229	240
Unity	134	135	327	259
Upper Nile	65	176	338	172
Warrap	116	113	134	133
Western Bahr El Ghazal	117	129	150	141
Western Equatoria	33	68	130	115
Abyei Administrative Area	180	248	274	463
Greater Pibor Administrative Area	20	59	55	53
Ruweng Administrative Area	84	108	141	118
South Sudan	**108**	**136**	**190**	**186**

Case Management

Treatment coverage for drug-susceptible TB has improved nationally, but gaps remain in multidrug-resistant tuberculosis (MDR-TB) management. Only 41 percent of confirmed MDR/RR-TB cases initiated second-line treatment, far below the target of 60 percent by 2025 and 80 percent by 2027. MDR-TB incidence increased to 6.5 percent, exceeding the target of less than 5 percent, signaling the need for stronger surveillance and adherence support.

Integration of TB and HIV services remains suboptimal. Among HIV-positive new and relapse TB patients, 55.99% were on antiretroviral therapy (ART) during TB treatment, against a target of 100%. While ART coverage for people living with HIV has improved to 50% and viral load suppression has reached 81.3%, gaps in co-management persist, particularly in hard-to-reach areas. Strengthening community-level integration and PMTCT services is critical to reducing dual morbidity and mortality.

Neglected Tropical Diseases

NTD indicators show varied progress toward the 2025 targets. The number of people requiring intervention is 9.8 million compared to the target of 4.5 million. Integrated treatment coverage stands at 36% against a target of 86%. Transmission interruption for trachoma is 27% (target 27%) and for lymphatic filariasis is 28% (target 28%), meeting the set targets. Human African Trypanosomiasis interruption reached 81% versus the 12% target, and a visceral leishmaniasis case fatality rate below 1% was achieved in 77% of endemic counties against a 6% target. Guinea worm incidence reduced to two cases, with the target being zero for 2025.

Reported NTD cases at outpatient departments increased nationally from 80,783 in 2021 to 103,421 in 2024. Jonglei State recorded the highest rise, reaching 42,185 cases in 2024 compared to 22,117 in 2021. Central Equatoria also showed consistent growth from 9,304 to 16,973 cases. In contrast, Eastern Equatoria declined from 4,329 in 2023 to 2,697 in 2024. Lakes State fluctuated, with a sharp increase to 4,958 in 2024 after a low of 1,037 in 2023. Abyei and Greater Pibor Administrative Area reported relatively low numbers throughout, while Ruweng showed a decline from 10,167 in 2021 to 4,041 in 2024.

Table 15: *Number of NTD cases in the OPD (DHIS2)*

State/Administrative Area	2021	2022	2023	2024
Central Equatoria	9,304	13,764	15,542	16,973
Eastern Equatoria	3,401	4,177	4,329	2,697
Jonglei	22,117	19,487	33,250	42,185
Lakes	3,560	1,037	1,484	4,958
Northern Bahr El Ghazal	2,647	2,829	3,972	2,583
Unity	16,909	7,937	12,177	10,347
Upper Nile	3,934	5,593	7,524	5,622
Warrap	2,549	2,870	2,914	2,249
Western Bahr El Ghazal	1,577	1,478	1,178	1,739
Western Equatoria	3,861	6,366	4,519	7,829
Abyei Administrative Area	670	1,776	429	654
Greater Pibor Administrative Area	87	296	1,471	1,544
Ruweng Administrative Area	10,167	4,427	5,662	4,041
South Sudan	**80,783**	**72,036**	**94,452**	**103,421**

Animal bite cases suspected to be rabies rose nationally from 4,649 in 2021 to 8,611 in 2024. Warrap State reported the highest number in 2024 at 1,642 cases, followed by Northern Bahr el Ghazal with 1,461 and Unity with 1,100. Central Equatoria increased steadily from 298 to 975 cases. Jonglei showed a significant rise from 77 to 530 cases over the same period. Pibor and Abyei Administrative Areas maintained low case counts, while Ruweng declined from 395 in 2021 to 153 in 2024.

***Table 16**: Animal bites (suspected rabies) recorded in the OPD (DHIS2)*

State/Administrative Area	2021	2022	2023	2024
Central Equatoria	298	419	711	975
Eastern Equatoria	442	490	554	426
Jonglei	77	160	172	530
Lakes	187	228	351	280
Northern Bahr El Ghazal	755	725	1350	1461
Unity	723	1138	922	1100
Upper Nile	200	701	860	1014
Warrap	766	1186	1308	1642
Western Bahr El Ghazal	486	440	396	564
Western Equatoria	225	243	384	334
Abyei Administrative Area	73	80	111	97
Greater Pibor Administrative Area	23	46	71	36
Ruweng Administrative Area	395	258	139	153
South Sudan	**4,649**	**6,112**	**7,329**	**8,611**

Snakebite cases remained high nationally, fluctuating between 7,963 and 8,065 over the four years. Northern Bahr el Ghazal consistently reported over 1,000 cases annually, while Unity showed a sharp decline from 1,853 in 2021/22 to 666 in 2024/25. Upper Nile increased from 850 to 1,519 cases, and Jonglei rose markedly to 1,171 in 2024/25. The Greater Pibor Administrative Area recorded minimal cases, peaking at 60 in 2023/24. Ruweng and Abyei maintained low numbers compared to other states.

***Table 17**: Number of Snake bites recorded in the OPD (DHIS2)*

State/Administrative Area	2021	2022	2023	2024
Central Equatoria	250	291	347	319
Eastern Equatoria	384	395	397	416
Jonglei	531	505	777	1,171
Lakes	419	477	485	380
Northern Bahr El Ghazal	1,294	1,090	1,082	1,071
Unity	1,853	1,220	727	666
Upper Nile	850	1,486	1,599	1,519
Warrap State	1,268	1,452	942	1,297
Western Bahr El Ghazal	341	345	339	468
Western Equatoria	486	414	398	463
Abyei Administrative Area	34	38	69	52
Greater Pibor Administrative Area	2	35	60	24
Ruweng Administrative Area	309	213	200	219
South Sudan	**8,019**	**7,963**	**7,423**	**8,065**

Leprosy cases decreased nationally from 1,205 in 2021/22 to 892 in 2024/25. Central Equatoria dropped from 454 in 2022/23 to 112 in 2024/25, while Northern Bahr el Ghazal declined from 503 to 127 over the same period. Upper Nile peaked at 290 in 2023/24 before reducing to 118 in 2024/25. Jonglei showed a temporary increase to 80 in 2023/24 but fell to 24 in 2024/25. Abyei and Pibor reported very few cases, and Ruweng remained consistently low.

***Table 18**: Number of Leprosy cases reported in OPD (DHIS2)*

State/Administrative Area	2021	2022	2023	2024
Central Equatoria	170	454	159	112
Eastern Equatoria	167	231	269	143
Jonglei	7	20	80	24
Lakes	30	97	21	22
Northern Bahr El Ghazal	503	285	223	127
Unity	22	24	5	10
Upper Nile	45	202	290	118
Warrap	47	122	32	158
Western Bahr El Ghazal State	95	94	65	127
Western Equatoria	108	180	112	46
Abyei Administrative Area	3		9	4
Pibor Administrative Area				
Ruweng Administrative Area	9	13	7	2
South Sudan	**1,205**	**1,722**	**1,274**	**892**

Challenges

Implementation of communicable disease and NTD programs continues to face multiple constraints. Funding remains inadequate, with almost all interventions lacking allocations from the annual Ministry of Health budget. Insecurity, including communal violence, limits access to services during implementation; while flooding and displacement of targeted populations further disrupt service delivery. Coverage estimates are affected by denominator challenges, as population figures rely on outdated data from the 2008 census. Limited capacity among health workers affects the quality-of-service delivery, and surveillance and data management systems remain weak.

Additional barriers include insufficient community awareness and persistent stigmatization, which reduce uptake of services. Integration with other health programs is limited, affecting efficiency and coordination. Supply chain and management gaps, such as inadequate storage and long lead times, continue to hinder the timely availability of essential commodities.

2.4 PROGRAMME AREA 4: NON COMMUNICABLE DISEASES, MENTAL HEALTH, ORAL, EYE AND OCCUPATIONAL HEALTH

Non-communicable diseases and related conditions are an emerging health challenge in South Sudan, contributing to a growing burden of morbidity and mortality. This programme addresses chronic conditions such as hypertension, diabetes, and cardiovascular diseases, alongside mental health disorders, oral health, eye care, and occupational health services. It focuses on prevention, early detection, and management of these conditions within primary health care and specialized services.

Achievement against HSSP (2023-2027) targets

- **Red**: limited or no progress (<50% of 2025 target);
- **Orange**: some progress, but not enough to achieve the target (50 to 99% of 2025 target);
- **Green**: good progress, target (2025) achieved or even surpassed

***Table 19**: Achievement against targets: Non communicable diseases, mental health, oral, eye and occupational health*

Objective	Indicator	Baseline	Achievement 2025	Target (HSSP)		Performanceand colour	Data source	Comment
				2025	2027			
Ensure reduction in morbidity and mortality due to NonCommunicable Diseases	Raised blood pressure among adults	20.10%	29.50%	19%	18%	44.7%	DHIS2, South Sudan Health Statistics Report (2024)	Blood pressure prevalences remain high as related to the target.
	Cervical cancer screening coverage	10%	11.50%	22%	30%	52.3%	Reports, Published Article	Cancer screening is active in four health facilities with low coverage data. Published article gives the prevalence indicated
Ensure reduction in the incidence and prevalence of mental health illness and substance abuse	Coverage ofservices for severe mental health disorders	1%	0.40%	6%	10%	6.7%	DHIS2	
Ensure provision and utilization of oral health care services	Coverage of oral health services	2%	0.33%	6%	10%	5.5%	DHIS2	
Ensure provision and utilization of eye care healthservices to reduce the burden of avoidable blindness	Number of specialized eye care centres established	1	2	2	3	100.0%	Administrative reports from MOH	Two specialised eye care centre's are at the National level (JTH, Buluk eye clinic)
Ensureprovision and utilization of occupational health services	Coverage of occupational health services	No data	ND	6%	10%			
Programmeindex						41.84%		

Noncommunicable disease risk factors remain elevated, based on available indicators and global estimates. Total alcohol consumption among adults aged 15 years and above was approximately 2.9 liters per capita in 2021 and increased slightly to 3.2 liters in 2024. Tobacco use among adults remained above 12%, with higher prevalence among males compared to females. Raised blood pressure affected more than one-quarter of adults, with prevalence increasing from 27.8% to 29.5%.

Overweight and obesity among adults showed gradual increases, with prevalence exceeding 22% and 7.5%, respectively. Similarly, among school-age children and adolescents, the prevalence of overweight and obesity was 5% and 2%, respectively. Diabetes prevalence in adults aged 20–79 years stabilized at 4.5%. By contrast, average salt intake remained nearly double the WHO-recommended limit (9.5–9.8 grams per day). Insufficient physical activity affected roughly one-fifth of adults, with higher prevalence among females than males.

***Table 20**: Risk factors for NCDs (statistics report 2024)*

Year		2021	2022	2023	2024
	Total Alcohol Consumption (litres per capita, age 15+)	2.9	3	3.1	3.2
Tobacco Use Among Adults (15+ Years)	Total Tobacco Use (% age 15+)	12.60%	12.80%	13.00%	13.20%
	Male (%)	21.20%	21.50%	21.80%	22.10%
	Female (%)	4.10%	4.20%	4.30%	4.40%
Raised Blood Pressure Among Adults (Age 18+)	Prevalence (% age-standardized)	27.80%	27.80%	28.90%	29.50%
	Male (%)	30.20%	30.20%	31.50%	32.00%
	Female (%)	25.40%	25.40%	26.30%	27.00%
Overweight and Obesity in Adults (Age 18+)	Overweight (% BMI 25)	22.10%	22.10%	23.40%	24.00%
	Obesity (% BMI 30)	7.50%	7.50%	8.20%	8.50%
	Male (%)	18.90%	18.90%	20.20%	20.80%
	Female (%)	25.40%	25.40%	26.30%	27.00%
Overweight and Obesity in School-Age Children and Adolescents (Age 5-19)	Overweight (% BMI-for-age >+1 SD)	5.10%	5.10%	5.40%	5.60%
	Obesity (% BMI-for-age >+2 SD)	1.70%	1.70%	1.90%	2.00%
Raised Blood Glucose / Diabetes Among Adults (Age 20-79)	Diabetes Prevalence (% of adults 20-79)	4.50%	4.50%	4.60%	4.60%
	Male (%)	4.80%	4.80%	4.90%	4.90%
	Female (%)	4.20%	4.20%	4.30%	4.30%
Salt Intake Per Capita	Salt Intake (grams/day per adult)	9.5 g	9.5 g	9.7 g	9.8 g
	WHO Recommended Limit	5 g/day	5 g/day	5 g/day	5 g/day
Insufficient Physical Activity in Adults (18+)	Total Prevalence (% age-standardized)	20.60%	20.80%	21.00%	21.20%
	Male (%)	17.20%	17.40%	17.60%	17.80%
	Female (%)	24.00%	24.20%	24.40%	24.60%

source: South Sudan Health Statistics Report (2025)

In the 2024/25 period, South Sudan has continued to strengthen its public health system amid persistent humanitarian and economic pressures. Indicators of raised blood pressure among adults remain a growing concern, with many adults showing early signs such as persistent headaches, dizziness, chest discomfort, and fatigue. Limited screening services mean hypertension is often detected late, leading to increased risks of stroke and heart disease. Community outreach programs and basic primary health care facilities are gradually improving detection, but coverage is still uneven, particularly in remote counties. Hypertension detection through patient examination has been routinely done in clinical settings and reported through DHIS2 but remains limited in scope. It is expected that, after the PEN M master capacity-building training for medical and clinical officers nationwide, NCD management will be more effectively integrated into primary health care, thereby enhancing service coverage and reporting.

Coverage for cervical cancer services has expanded slowly through partnerships with international health organizations. The introduction of a new guideline for screening at ANC sites, along with intermittent visual inspection with acetic acid (VIA), has improved early detection. However, access to diagnostic and treatment services remains limited to major urban centers. HPV vaccination is yet to be introduced.

Support for mental health disorders has gained more attention, especially as communities continue to cope with conflict-related trauma. Psychosocial support units within primary health care centers and mobile mental health teams have broadened service coverage. Despite progress, specialized psychiatric care is scarce, and stigma continues to hinder service uptake. Severe mental health disorders are managed with limited resources and few specialized cadres, despite a high burden of related conditions. The mental health strategic plan (2025-2029) is expected to provide longer-term solutions.

In the area of oral health, awareness campaigns and basic dental care services are slowly expanding, although shortages of trained dental professionals and equipment limit coverage. Preventive education remains the primary strategy in rural areas.
Occupational health initiatives have emphasized workplace safety training, especially in agriculture, construction, and humanitarian operations. Policies exist, but enforcement and monitoring capacity remain weak.

Non-communicable diseases (NCDs) trends and distribution over the states and administrative areas

Dental, eye and ear services coverage

The analysis drew on outpatient department (OPD) records covering four consecutive reporting years (July 2021-June 2025), focusing on conditions across three domains: dental health (dental caries), ear health (hearing loss), and eye health (other eye conditions, diabetic retinopathy, glaucoma, and blindness). Together, these data provide a time-series view of service utilization for noncommunicable but disabling conditions, highlighting trends in oral, auditory, and visual health that directly affect quality of life and inform planning for resource allocation and universal health coverage.

Table 21: The number of Dental, eye and ear services by state and administrative areas (DHIS2)

State/Administrative Area	2021/22	2022/23	2023/24	2024/2025
Abyei Admin Area		1,811	4,449	9,054
Central Equatoria	31,449	27,560	30,449	32,869
Eastern Equatoria	26,703	24,836	38,236	25,521
Jonglei	11,577	12,802	15,890	13,384
Lakes	10,016	11,932	12,214	9,614
Northern Bahr El Ghazal	12,886	9,709	13,455	13,543
Pibor Admin Area	1,415	3,205	2,645	3,297
Ruweng Admin Area	8,224	10,055	18,186	13,919
Unity State	30,272	40,040	48,196	39,636
Upper Nile	12,612	37,030	59,144	43,586
Warrap	12,017	14,157	17,628	17,351
Western Bahr El Ghazal	10,462	13,519	10,321	10,700
Western Equatoria	25,054	32,892	39,596	31,129
South Sudan	**193,631**	**241,122**	**316,841**	**267,453**

Between July 2021 and June 2025, outpatient visits for dental, ear, and eye conditions in South Sudan rose from 193,631 to a peak of 316,841 in 2023/24, before slightly declining to 267,453 in 2024/25. Coverage relative to population followed a similar trajectory, increasing from 1.41% in 2021/22 to nearly 2.0% in 2023/24, then easing to 1.76% in 2024/25.

Striking variations emerge across states: Upper Nile recorded the sharpest growth, rising from 12,612 cases (1.17%) to 59,144 cases (3.94%) in 2023/24, while Ruweng Administrative Area consistently showed the highest coverage, peaking at 8.87% in 2023/24 despite smaller absolute numbers. By contrast, Northern Bahr el Ghazal and Warrap remained persistently low, with coverage below 1% across all years, underscoring inequities in access.

These patterns reveal both encouraging expansions in service uptake and persistent gaps in coverage, highlighting priority areas for strengthening dental, ear, and eye health services.

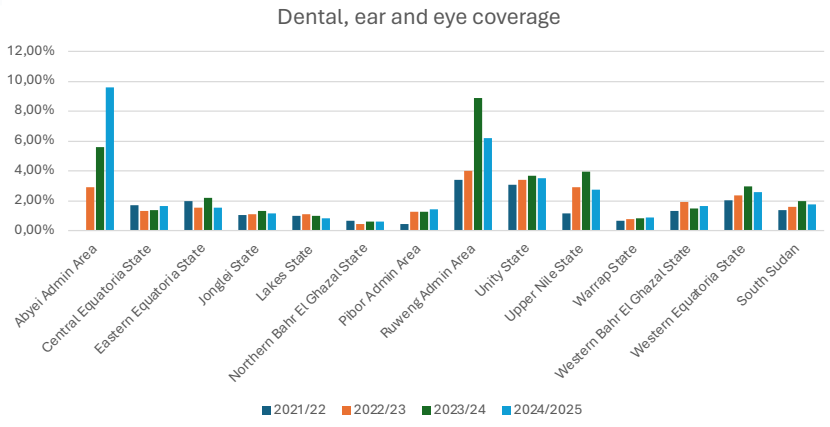

Figure 21: Coverage of Dental, eye and ear services by state and administrative areas (DHIS2)

Injuries

The injuries dataset consolidates outpatient and inpatient/community (IPD-Comm) records across four reporting years (July 2021-June 2025), capturing the burden of trauma and violence in South Sudan. It represents the sum of all reported cases from multiple categories: injuries/trauma due to other causes, injuries from road traffic accidents, gunshot and shell injuries, and rape and gender-based violence (GBV). Together, these elements provide a comprehensive picture of both accidental and intentional injuries, reflecting the dual challenges of public health risks and conflict-related trauma. By aggregating these conditions, the section highlights trends in injury-related service utilization, the scale of violence and accidents affecting communities, and the implications for health system response and resilience.

__Table 22__: Trends for injuries across the states and administrative areas (DHIS2)

State/Administrative Area	2021	2022	2023	2024
Abyei Administrative Area		9,002	9,122	11,071
Central Equatoria	29,429	33,916	34,139	35,921
Eastern Equatoria	31,465	30,990	32,709	28,535
Jonglei	6,151	7,509	11,434	12,665
Lakes	15,920	18,801	17,020	17,540
Northern Bahr El Ghazal	17,322	15,404	23,930	25,500
Greater Pibor Administrative Area	829	2,068	2,024	4,001
Ruweng Administrative Area	7,205	8,560	10,124	8,665
Unity	18,157	24,477	31,678	30,627
Upper Nile	24,190	38,792	41,052	87,068
Warrap	21,658	21,574	23,196	23,715
Western Bahr El Ghazal	10,572	13,718	12,741	14,041
Western Equatoria	17,241	20,939	24,061	21,020
South Sudan	**204,698**	**244,383**	**274,933**	**318,725**

Injuries services in South Sudan show a clear upward trend, with reported cases rising from 204,698 in 2021/22 to 318,725 in 2024/25 and national coverage increasing from 1.49% to 2.09% over the same period. This reflects both growing service utilization and a widening recognition of trauma-related health needs. The most striking figures come from Upper Nile State, where cases surged to 87,068 in 2024/25 and coverage reached 5.46%, far above the national average, while the Abyei Administrative Area recorded exceptionally high coverage at 14.62% in 2022/23 despite smaller absolute numbers. By contrast, states such as Northern Bahr el Ghazal and Warrap consistently reported coverage below 1.2%, highlighting persistent inequities in access to injury care. Overall, the data underscore both the growing demand for trauma-related services and the uneven distribution of coverage, pointing to areas where health system strengthening is most urgently needed.

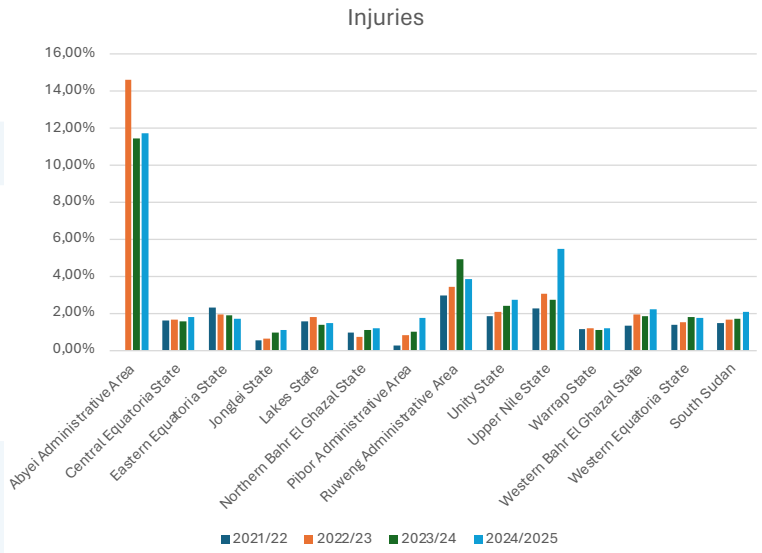

***Figure 22**: Trends and distribution of injuries (DHIS2)*

Cardiovascular Disease (CVD) Conditions

The cardiovascular disease dataset consolidates outpatient department (OPD) records across four reporting years (July 2021-June 2025), capturing the burden of major heart and vascular conditions in South Sudan. It represents the sum of cases from four critical categories: stroke/cerebrovascular accidents (CVA), chronic heart diseases, ischemic heart diseases, and heart failure. Together, these conditions account for a substantial share of noncommunicable disease morbidity, reflecting both acute emergencies such as stroke and heart failure and long-term chronic conditions requiring sustained management.

By aggregating these elements, the section provides a comprehensive view of CVD service utilization, highlights trends in the growing burden of heart disease, and underscores the importance of strengthening prevention, early detection, and treatment services to reduce premature mortality and align with SDG 3.4, which targets the reduction of deaths from noncommunicable diseases.

Table 23: CVDs trends over the years (DHIS2)

State/Administrative Area	2021	2022	2023	2024
Abyei Administrative Area		10	84	57
Central Equatoria	282	591	459	906
Eastern Equatoria	134	239	138	127
Jonglei	81	122	99	275
Lakes	126	224	170	211
Northern Bahr El Ghazal	212	215	101	71
Greater Pibor Administrative Area	1	1	8	9
Ruweng Administrative Area	211	232	80	40
Unity	267	637	1595	113
Upper Nile	258	759	388	558
Warrap	77	113	144	131
Western Bahr El Ghazal	490	260	575	134
Western Equatoria	493	400	750	273
South Sudan	**2630**	**3767**	**4722**	**2829**

The cardiovascular disease (CVD) data reveal several striking patterns across South Sudan. Nationally, cases rose from 2,630 in 2021/22 to a peak of 4,722 in 2023/24 before dropping to 2,829 in 2024/25, with coverage remaining very low at 0.02–0.03% of the population. Some states stand out sharply: Unity State recorded an extraordinary spike to 1,595 cases in 2023/24, with coverage reaching 0.12%, before collapsing to just 113 cases in 2024/25, suggesting either a reporting anomaly or a sudden shift in service access. Upper Nile State also showed consistently high numbers, peaking at 759 cases in 2022/23, while Western Equatoria and Western Bahr el Ghazal registered large fluctuations—Western Equatoria rising to 750 cases in 2023/24 and Western Bahr el Ghazal to 575 cases in the same year—before both declined sharply. By contrast, Northern Bahr el Ghazal and Greater Pibor Administrative Area reported persistently low cases and negligible coverage, underscoring gaps in detection or access. Overall, the data highlight both the growing recognition of CVDs as a health burden and the stark disparities in service utilization, with certain states experiencing dramatic swings while others remain almost invisible in the reporting system.

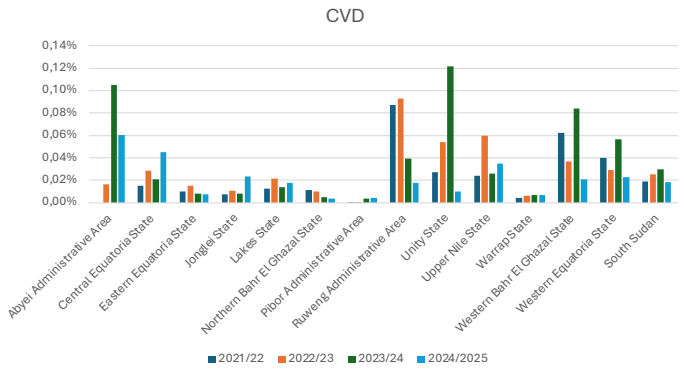

Figure 23: Trends of CVD conditions

Asthma

The trends in reported cases show a steady national increase, with South Sudan rising from 23,810 cases in 2021/22 to 39,558 in 2024/25, and coverage improving from 0.17% to 0.26%. Several states stand out in this trajectory. Upper Nile State experienced the sharpest growth, more than tripling from 2,515 cases in 2021/22 to 8,695 in 2024/25, with coverage climbing from 0.23% to 0.54%, reflecting both rising demand and improved service reach. Unity State consistently reported the highest absolute numbers, peaking at 5,912 cases in 2023/24 while maintaining coverage near 0.45-0.49%. Western Equatoria also showed strong growth, reaching 4,250 cases in 2024/25, with coverage rising to 0.35%.

***Table 24**: Trends of the Asthma services by states and administrative areas (DHIS2)*

State/Administrative Area	2021	2022	2023	2024
Abyei Administrative Area		37	92	201
Central Equatoria	2,536	3,114	3,096	3,403
Eastern Equatoria	2,125	2,070	2,430	2,465
Jonglei	2,308	2,374	2,626	3,615
Lakes	1,023	1,192	1,333	1,346
Northern Bahr El Ghazal	2,162	1,596	2,097	2,797
Greater Pibor Administrative Area	84	267	261	2,301
Ruweng Administrative Area	847	1,216	1,486	1,281
Unity	4,413	5,548	5,912	5,479
Upper Nile	2,515	5,740	8,482	8,695
Warrap	1,219	1,762	1,599	1,857
Western Bahr El Ghazal	1,885	2,674	1,751	1,688
Western Equatoria	2,976	3,629	4,016	4,250
South Sudan	**23,810**	**31,222**	**35,480**	**39,558**

In contrast, Greater Pibor Administrative Area stands out for its dramatic surge from just 84 cases in 2021/22 to 2,301 in 2024/25, with coverage jumping to 1.00%–the highest nationally despite its smaller population base. Meanwhile, states such as Northern Bahr el Ghazal and Warrap remained relatively low, with coverage below 0.13%, pointing to persistent gaps in access. Overall, the data highlight both encouraging expansion of service utilization and stark disparities, with certain areas experiencing rapid growth while others remain underserved.

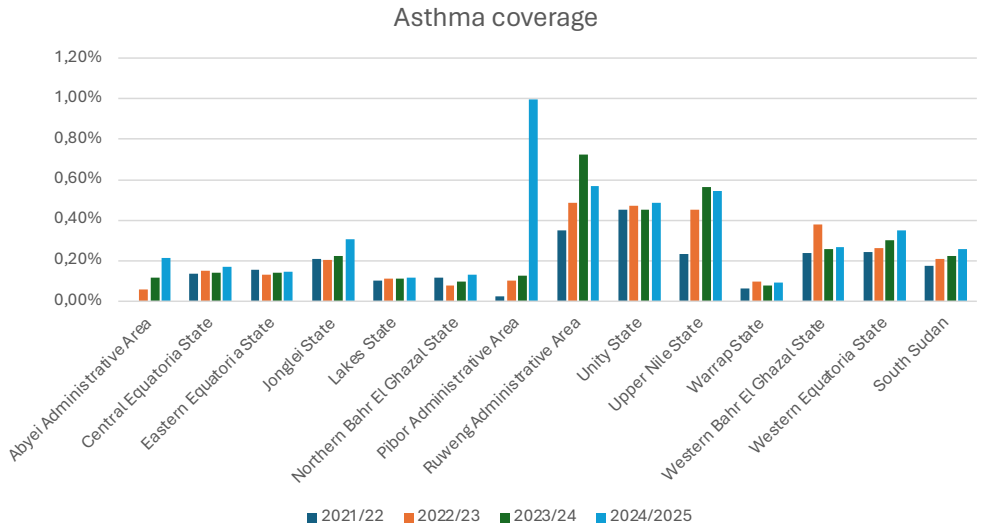

***Figure 24**: Asthma service coverage across the administrative areas (DHIS2)*

Diabetes mellitus

The trends and distribution of services across South Sudan show both growth and uneven access. Nationally, cases rose from 9,191 in 2021/22 to a peak of 14,647 in 2023/24, before stabilizing at 14,627 in 2024/25, with coverage improving modestly from 0.07% to 0.10%. Central Equatoria consistently dominated in absolute numbers, climbing from 7,265 cases in 2021/22 to 12,109 in 2024/25, with coverage rising to 0.61%, the highest among the larger states.

***Table 25**: Trends of Diabetes mellitus services (DHIS2)*

State/Administrative Area	2021	2022	2023	2024
Abyei Administrative Area		2	347	75
Central Equatoria	7,265	6,538	10,848	12,109
Eastern Equatoria	98	183	174	137
Jonglei	21	94	104	137
Lakes	270	367	373	435
Northern Bahr El Ghazal	207	235	127	152
Greater Pibor Administrative Area	6	22	8	3
Ruweng Administrative Area	182	242	315	355
Unity	91	136	437	420
Upper Nile	33	309	654	518
Warrap	87	320	345	102
Western Bahr El Ghazal	1,329	1,798	1,634	848
Western Equatoria	179	337	419	405
South Sudan	**9,191**	**9,917**	**14,647**	**14,627**

Western Bahr el Ghazal showed early prominence with 1,798 cases in 2022/23, but then declined to 848 in 2024/25, and its coverage dropped from 0.26% to 0.13%, reflecting reduced service reach. Smaller states such as Ruweng demonstrated steady growth, reaching 355 cases in 2024/25, with coverage improving to 0.16%, while Upper Nile surged from just 33 cases in 2021/22 to 654 in 2023/24 before easing slightly. In contrast, Greater Pibor Administrative Area remained extremely low, with only 3 cases in 2024/25 and negligible coverage. Overall, the distribution highlights a strong concentration of services in Central Equatoria and selected states, modest but steady gains in Unity, Ruweng, and Upper Nile, and persistent gaps in peripheral areas, underscoring the need for more equitable expansion of service coverage.

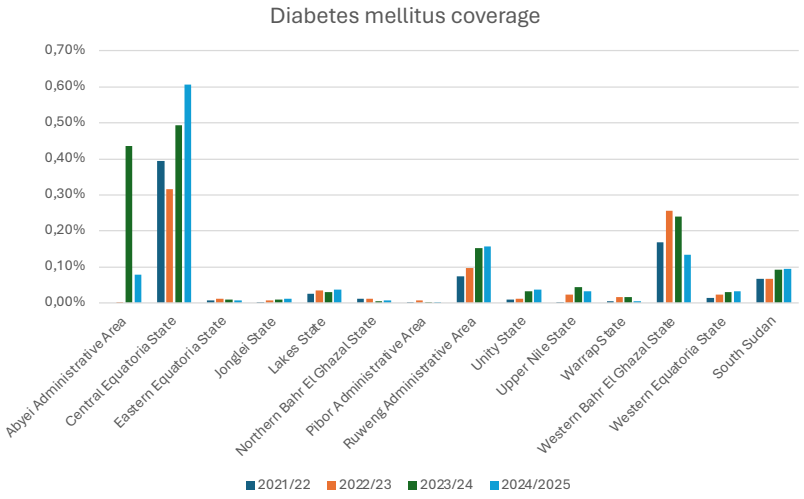

***Figure 25**: Trends and distribution of diabetes mellitus service coverage (DHIS2)*

Hypertension

Hypertension services in South Sudan show a clear upward trend in reported cases, rising nationally from 12,614 in 2021/22 to nearly 20,000 cases annually by 2023/24 and 2024/25, with coverage improving modestly from 0.09% to 0.13% of the population. The distribution reveals striking variations across states. Western Bahr el Ghazal consistently reported some of the highest case numbers, peaking at 4,385 in 2023/24, with coverage reaching 0.67%, the highest nationally.

***Table 26**: Trends and distribution of the hypertension services (DHIS2)*

State/Administrative Area	2021	2022	2023	2024
Abyei Administrative Area		90	541	466
Central Equatoria	3,028	4,335	3,520	4,169
Eastern Equatoria	843	1,047	1,151	1,030
Jonglei	176	319	453	398
Lakes	528	451	537	677
Northern Bahr El Ghazal	462	430	354	350
Greater Pibor Administrative Area	14	17	1	2
Ruweng Administrative Area	413	465	866	1,038
Unity	1,006	1,964	1,960	1,806
Upper Nile	1,764	1,798	2,639	2,810
Warrap	320	386	493	374
Western Bahr El Ghazal	2,348	3,595	4,385	4,244
Western Equatoria	1,934	2,964	2,782	2,177
South Sudan	**12,614**	**17,663**	**19,670**	**19,599**

Central Equatoria also maintained large volumes, exceeding 4,000 cases in 2024/25, though coverage remained moderate at 0.21%. Upper Nile showed steady growth, climbing to 2,810 cases in 2024/25, while Ruweng Administrative Area recorded a sharp rise, with coverage increasing from 0.17% in 2021/22 to 0.46% in 2024/25 despite smaller absolute numbers. By contrast, Northern Bahr el Ghazal, Warrap, and Pibor consistently reported very low coverage (≤0.02%), underscoring persistent gaps in detection and service reach. Overall, the data highlight hypertension as a growing noncommunicable disease burden, with strong concentrations in a few states but uneven access across the country, pointing to the need for more equitable expansion of screening and management services.

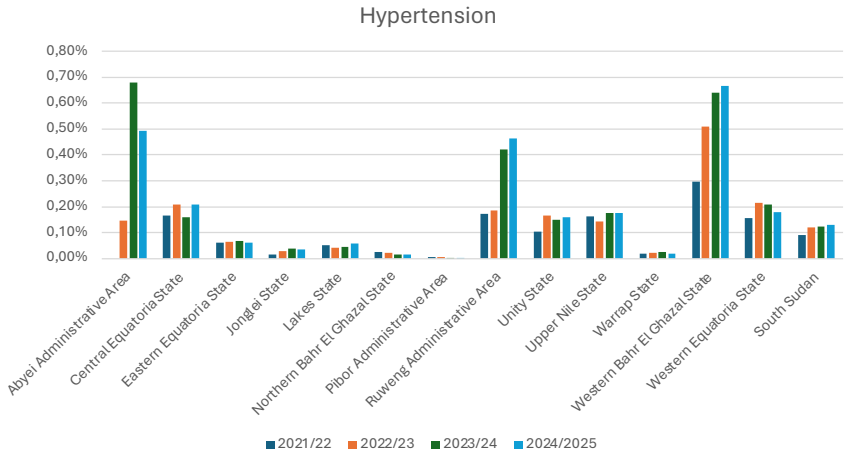

***Figure 26**: The trends and distribution of hypertension services (DHIS2*

Menta health

TMental health services in South Sudan show both growth and uneven distribution across states. Nationally, reported cases rose from 63,034 in 2021/22 to a peak of 71,753 in 2022/23, before stabilizing at 65,492 in 2024/25, while coverage remained modest, fluctuating between 0.43% and 0.48% of the population. The most striking figures come from Western Equatoria State, which consistently recorded over 20,000 cases annually and coverage above 1.7%, peaking at 25,433 cases and 1.92% coverage in 2023/24. Eastern Equatoria also reported high volumes, exceeding 12,000 cases in 2022/23, with coverage around 0.64-0.78%, while Western Bahr el Ghazal maintained strong service reach, with coverage above 0.9%.

***Table 27**: Trends and distribution of mental health services (DHIS2)*

State/Administrative Area	2021	2022	2023	2024
Abyei Administrative Area		32	211	53
Central Equatoria	5,773	5,870	4,344	4,996
Eastern Equatoria	8,496	12,573	12,138	10,617
Jonglei	1,355	1,629	2,021	1,789
Lakes	2,809	2,282	2,461	1,705
Northern Bahr El Ghazal	7,279	7,040	4,468	2,845
Greater Pibor Administrative Area	13	169	49	45
Ruweng Administrative Area	370	562	1,075	461
Unity	3,452	3,803	3,625	2,811
Upper Nile	1,075	2,435	3,576	4,100
Warrap	3,337	2,779	4,127	5,190
Western Bahr El Ghazal	5,286	7,363	7,003	6,165
Western Equatoria	21,422	23,729	25,433	23,068
South Sudan	**63,034**	**71,753**	**71,549**	**65,492**

By contrast, states such as Greater Pibor Administrative Area and Abyei recorded extremely low case numbers and negligible coverage, underscoring gaps in access. Declines in Northern Bahr el Ghazal (from 7,279 cases in 2021/22 to 2,845 in 2024/25) and Lakes State (from 2,809 to 1,705 cases) suggest reduced service utilization or reporting challenges. Overall, the data highlight mental health as a significant and growing service area, with strong concentrations in Western Equatoria and Eastern Equatoria but persistent inequities in coverage across other states.

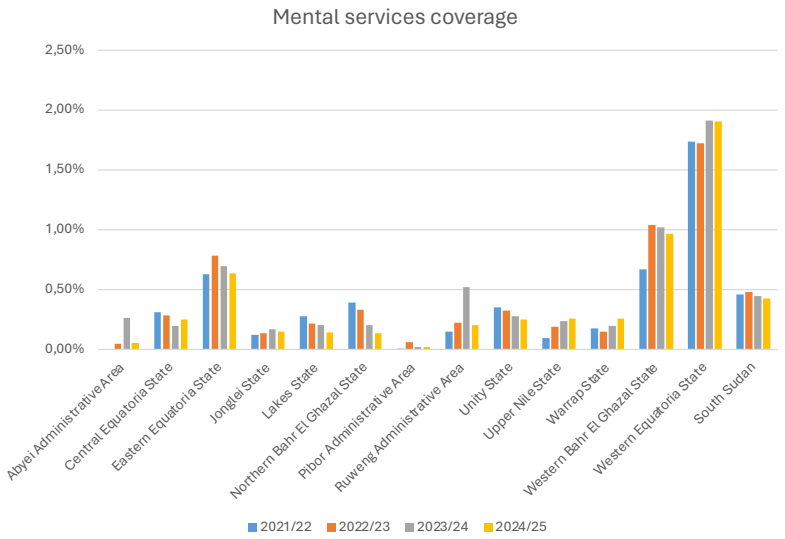

***Figure 27**: The trends and distribution of mental health services distribution (DHIS2)*

Challenges

Health outcomes in this programme area are constrained by limited health infrastructure, severe workforce shortages, inadequate funding with heavy reliance on external aid, and weak data systems for monitoring coverage and outcomes.

Hypertension has been driven by rapid urbanization, changing dietary habits, overweight and obesity, alcohol and tobacco use, stress, ongoing conflict, and low awareness. Documentation in DHIS2 is insufficient, as it misses data from referral clinics and private institutions and there is no central point of consolidation. There is no national database for cancer, and diagnostic and treatment centers are largely nonexistent, leading to referrals abroad for management; even so, screening for cervical cancer is almost nonexistent.

Mental health interventions and cervical cancer screening are hampered by a lack of trained staff, medication shortages, inadequate data systems, and insufficient mental health care facilities. These challenges are compounded by low government prioritization and funding constraints. Conflict and instability further disrupt services, while stigma and cultural barriers continue to limit service uptake.

2.5 PROGRAMME AREA 5: EMERGENCIES, DISASTERS AND HUMANITARIAN RESPONSE

Public health emergencies and humanitarian crises remain major challenges to health service delivery in South Sudan. This programme area focuses on strengthening preparedness, surveillance, and response to outbreaks, disasters, and population displacement. Key interventions include early detection and investigation of alerts, rapid deployment of response teams, stronger laboratory capacity, and functional Emergency Operations Centers (EOCs).

This section reviews progress against indicators such as timeliness of alert verification, outbreak investigation and response rates, International Health Regulations (IHR) core capacity scores, and case fatality rates for epidemic-prone diseases, highlighting achievements and gaps in emergency readiness and resilience.

Achievement against HSSP (2023-2027) targets

- **Red**: limited or no progress (<50% of 2025 target);
- **Orange**: some progress, but not enough to achieve the target (50 to 99% of 2025 target);
- **Green**: good progress, target (2025) achieved or even surpassed

***Table 28**: Achievement against targets: Emergencies, disasters and humanitarian response*

Objective	Indicator	Baseline	Achievement 2025	Target (HSSP)		Performance-and colour	Data source	Comment
				2025	2027			
Ensure reduction in the incidence and mitigate the impact of public health emergencies	Proportion of alerts investigated in 48 hours	81%(EWARS)	63%	86%	90%	73.3%	EWARS	Week 1 to 45 of 2025 EWARS Alert verification rates. Reduction in rates is due to prioritization of response to multiple outbreaks
	Number of functional Public Health Laboratories that can test outbreak prone diseases	1 (MOH Reports)	1	3	5	33.3%	MOH report	Progress noted on the national public health lab with expended testing and capacity building and Quality Assurance support
	Number of functional Emergency Operations Center (EOCs) at national and subnational levels	1(MOH Report)	2	5	7	40.0%	MOH report	Two functional EOCs (national and Wau) established
	Average of 13 International Health Regulations (IHR) capacity scores	34.40(IHR Capacity assessments)	43%	43%	50%	100.0%	Report; eSPAR/JEE assessments	Progress achieved through annual eSPAR and JEE assessments; development of NAPHS (2025-2030) and One Health Strategic Plan
	Proportion of outbreaks investigated, confirmed, and responded to	88%(IDSR)	67%	88.60%	90%	75.6%	IDSR weekly bulletins	6 active outbreaks in 2025. (Anthrax, Cholera, cVDPV2/Polio, Hepatitis E, Measles, and Mpox). Measles and Mpox response did not meet the 7-1-7 indicator
	Case fatality rate (% of reported cases of epidemic diseases - cholera, measles, COVID-19 etc., which are fatal)	2%(IDSR)	Cholera (1.7%)	1.4%	1%	78.6%	IDSR	
			HEV (1.3%)			107.7%		
			Mpox (0%)			100.0%		
	Performance					75.10%		

OBJECTIVE:

Ensure reduction in the incidence and mitigate the impact of public health emergencies

The country has made significant progress in strengthening public health emergency preparedness and response under the HSSP framework. Key achievements include faster alert investigation, expanded laboratory and Emergency Operations Center capacity, and improved IHR core competencies through structured assessments and contingency, preparedness, and response planning. Outbreak response performance remains strong, with high investigation and confirmation rates, while case fatality rates for epidemic diseases have declined. These gains reflect sustained investments in surveillance, rapid response, and multisectoral coordination, supported by WHO and partners, and position the health system to achieve the 2027 targets and build resilience against future health threats.

Strengthening Emergency Preparedness and Response Capacities

Significant improvements have been made in emergency response systems. Currently, 73.2% of alerts are investigated within 48 hours, supported by Rapid Response Teams and strengthened surveillance structures, moving the country toward the 86% target.

***Table 29**: Completeness and timeliness of IDSR (IDSR bulletin week 42)*

State	Total facilities	Number of facilities reported (Completeness wk42	Comparison of the reporting period				Cumulative since year start (2025 level)	
			Timeliness		Completeness			
			Week 42	Week 41	Week 42	Week 41	Timeliness	Completeness
Lakes	112	112	100%	98%	100%	100%	96%	100%
NBGZ	92	90	89%	95%	98%	99%	81%	90%
Unity	85	86	72%	79%	101%	83%	96%	99%
WBGZ	112	101	42%	79%	90%	88%	62%	86%
WES	191	182	81%	77%	95%	88%	78%	97%
Jonglei	120	110	92%	80%	92%	89%	84%	91%
Warrap	114	98	55%	75%	86%	92%	61%	84%
EES	112	101	71%	78%	90%	96%	57%	83%
RAA	16	16	31%	31%	100%	100%	49%	92%
CES	152	146	95%	93%	96%	97%	92%	94%
AAA	17	17	100%	94%	100%	100%	79%	89%
Upper Nile	143	129	73%	57%	90%	81%	66%	81%
PAA	10	16	100%	88%	100%	100%	94%	97%
Total	**1,282**	**1,204**	**78%**	**80%**	**93%**	**91%**	**77%**	**91%**

Rapid Response Teams (RRTs) comprising epidemiologists, public health officers, and laboratory personnel were deployed to outbreak-affected locations to conduct investigations and risk assessments for cholera, Mpox, hepatitis E virus (HEV), and anthrax. Collaborative efforts between the Ministry of Health, WHO, and partners have strengthened outbreak detection, reporting, and response capacity. Key interventions included the HEV outbreak response in Western Bahr el Ghazal (Wau and Jur River Counties), Northern Bahr el Ghazal, Renk, and Amiet in Abyei; rapid cholera response in Renk County and across 54 counties in nine states and three administrative areas; Mpox response in Juba, Malakal, and Rumbek Centre; and timely management of anthrax outbreaks in Warrap and Western Bahr el Ghazal. In addition, oral cholera vaccine (OCV) campaigns were implemented in 46 counties to reduce transmission risk.

***Figure 28**: Confirmed and active outbreaks by county as of Oct 2025 (IDSR)*

Critical public health events were addressed through formal rapid risk assessments, completed and disseminated within one week. For example, in Renk County, a dedicated team conducted a cholera risk assessment and coordinated interventions. Signals verified under the International Health Regulations (2005) within 24-48 hours were enabled by robust surveillance systems at county and state levels. This included incentives for health workers, capacity building on IDSR 3rd edition, provision of essential tools and logistics, and sample collection kits to support timely investigation and verification of alerts. In addition, health care workers were trained, isolation units were set up, and key guidelines and communication tools were developed. These interventions strengthened surveillance, case management, infection prevention and control (IPC), and risk communication, contributing to better preparedness, informed decision-making, and resource mobilization across multiple health emergencies.

Laboratory capacity has improved significantly, even though the country still has only one fully functional national public health laboratory. A national laboratory network was established with PCR testing capabilities in Juba and Nimule. In addition, continuous support through equipment provision, training, and quality assurance has been provided to laboratories by the Ministry of Health and partners.

Emergency Operations Centers (EOCs) have expanded from one to two functional hubs, at the national level in Juba and the subnational level in Wau, ensuring stronger coordination during health emergencies. The operationalization of these EOCs has significantly enhanced command, control, and communication, reducing decision-making time and improving coordination between national and state levels. These centers have become critical for strengthening incident management and demonstrate the value of having dedicated coordination points for public health emergencies.

IHR core capacities have improved, with the average score increasing from 34.4% to 43%. This progress has been supported by annual eSPAR and Joint External Evaluation (JEE) assessments, development of the National Action Plan for Health Security (NAPHS 2025-2030), and implementation of the One Health Strategic Plan. Key efforts included provision of technical expertise to strengthen core capacities such as surveillance, laboratory services, risk communication, points of entry, and emergency response, as well as support for national assessments and reviews including SPAR, JEE, and simulation exercises.

Multisectoral collaboration was facilitated through the One Health approach, engaging line ministries and partners and promoting government commitment and resource mobilization to meet IHR requirements. Emergency preparedness and response plans were strengthened in line with IHR core capacities, alongside enhancements to event-based and indicator-based surveillance systems.

Outbreak response performance remains strong, with 75.60% of outbreaks investigated, confirmed, and responded to, nearing the 88.6% target and reflecting strengthened surveillance and rapid deployment mechanisms. During the cholera outbreak, emergency systems were swiftly activated, deploying Rapid Response Teams (RRTs) to all cholera-affected locations and implementing an oral cholera vaccination campaign that reached over 10 million people across 46 counties. Surveillance was reinforced through engagement of health facilities, expanded use of rapid diagnostic tests, and analysis of stool samples. Treatment infrastructure was scaled up with Oral Rehydration Points, Cholera Treatment Units, and Cholera Treatment Centres, supported by the dispatch of emergency supplies.

Risk communication was prioritized through public announcements, community mobilization, and distribution of IEC materials, coordinated via national meetings involving humanitarian partners. In the course of the Sudan crisis response, health services were provided for over 1.2 million refugees and returnees, including trauma care and management of communicable diseases. A trauma unit was established, two rounds of oral cholera vaccination were conducted reaching over 244,206 individuals, and more than 546,000 people were screened at points of entry. Cross-border coordination with WHO Sudan ensured joint outbreak responses and delivery of over 300 metric tons of essential supplies.

Furthermore, Mpox preparedness efforts were strengthened through activation of the Public Health Emergency Operations Centre and the Incident Management System, guided by a validated national plan. This included deployment of RRTs, establishment of PCR testing capacity,

training of 86 clinicians, setup of isolation units, implementation of IPC measures, and reinforcement of border health surveillance.

The case fatality rate for epidemic diseases declined from a baseline of 2% to 1.7% for cholera and 1.3% for hepatitis E, with zero fatalities for Mpox, reflecting improved clinical management and timely interventions. These achievements and coordinated interventions demonstrate the country's commitment to building a resilient health system, its ability to address multiple concurrent public health threats, and its progress in mitigating the impact of public health emergencies.

Progression of the Current Outbreak

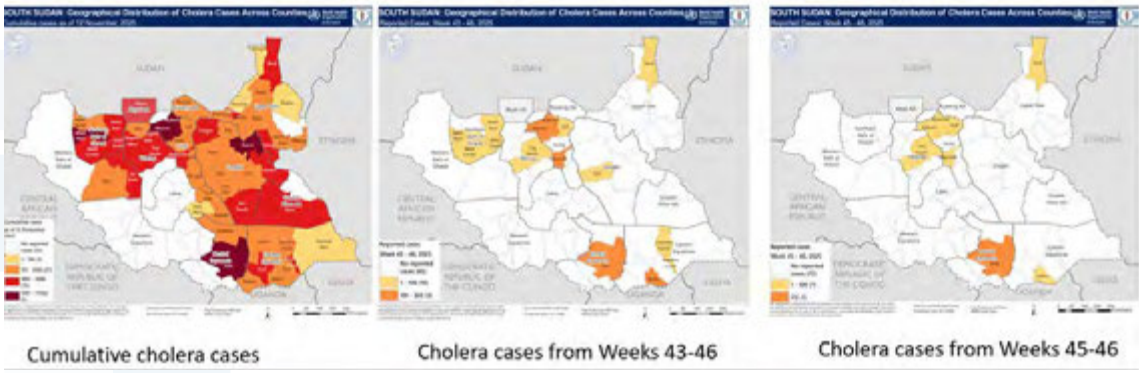

***Figure 29**: Progression of cholera outbreak*

Implementation of health security and emergency response activities faced multiple constraints across financing, governance, service delivery, and system capacity. Funding remained low and unpredictable due to donor budget cuts, while concurrent emergencies–including cholera, hepatitis E virus, Mpox, and the Sudan crisis–overstretched available resources. Governance challenges included frequent leadership transitions within the Ministry of Health, which disrupted continuity of activities, and weak coordination between humanitarian and development actors, affecting the transition to the Health Sector Transformation Plan.

Service delivery was constrained by insecurity and conflict, limiting access to hard-to-reach areas. The Sudan crisis contributed to mass displacement and cross-border disease importation, placing additional pressure on fragile health services. Emergency preparedness and response capacity were limited, with delayed alert investigations–only 63% completed within 48 hours against a target of 86%–due to competing priorities from multiple outbreaks. Rapid deployment and sustained response in remote areas remained inadequate.

Health infrastructure and systems also faced gaps, including limited laboratory capacity with only one fully functional national public health laboratory and a lack of decentralized testing facilities. EOCs were insufficient, with only two functional centers compared to a target of seven, limiting subnational coordination. Oxygen production and biomedical engineering capacity for emergency care remained weak. Health information systems showed low IHR core capacity scores at 43% against a 50% target, with gaps in surveillance, risk communication, and points of entry.

EQUITABLE ACCESS, QUALITY AND SAFETY

Equitable access, quality, and safety are fundamental pillars of the health system, ensuring that services are available to all populations without discrimination and delivered to acceptable standards. This component aims to guarantee that health facilities are geographically accessible, adequately equipped, and staffed to provide the Basic Package of Health and Nutrition Services (BPHNS). It also ensures that care is safe, effective, and patient-centered, supported by systems for quality assurance and continuous improvement.

This section examines progress in expanding physical access to health facilities, improving service utilization, and strengthening infrastructure readiness. It also reviews efforts to institutionalize quality-of-care strategies, establish oversight mechanisms, and enhance referral systems. Key indicators include health facility density, population coverage within five kilometers of a facility, outpatient service utilization rates, infrastructure compliance with BPHNS norms, and development of quality-of-care policies and units. The analysis highlights achievements and gaps that influence equity, service quality, and patient safety across the health system.

Achievement against HSSP (2023-2027) targets

- **Red**: limited or no progress (<50% of 2025 target);
- **Orange**: some progress, but not enough to achieve the target (50 to 99% of 2025 target);
- **Green**: good progress, target (2025) achieved or even surpassed

***Table 30**: Achievement against targets: Equitable access, quality and safety*

Objective	Indicator	Baseline	Achievement 2025	Target (HSSP)		Performance-and colour	Data source	Comment
				2025	2027			
Enhance equitable access to the BPHNS at all levels	Total number of health facilities per 10,000 population	1.42	1.3	1.52	1.6	85.5%	DHIS2	The health facilities density is affected by functionality
	% of population within 5kms of health facility	44%	56%	54%	60%	103.7%	DHIS2	Discussions & consultation ongoing on whether there are new HFs
	Service utilization rates (OPD visits per capita)	0.67	0.78	1.5	2	52.0%	DHIS2	
	Number of functional renovated health facilities		ND	60	100			
Improve quality and safety for delivery of the BPHNS at all levels	Quality-of-Care strategy in place and implemented	0	0.5	1	1	50.0%	DHIS2	Policy drafts developed and in place. To be implemented from 2026
Improve quality and safety for delivery of the BPHNS at all levels	Number of Quality-of-Care units established at National and State level	0	0	6	11	0.0%	DHIS2	
Improve diagnostic capacity and referral services	Number of functional ambulance teams		1	6	10	16.7%	DHIS2	
Improve availability and functionality of health infrastructure for BPHNS delivery	% of facilities equipped with infrastructure as per BPHNS norms		67%	30%	50%	223.3%	DHIS2	Used maternal services as the proxy
Performance index						57.7%		

The pursuit of equitable access, improved quality, and strengthened infrastructure for BPHNS has progressed unevenly across key system indicators. Evidence from DHIS2 and related programme reports highlights both incremental gains and persistent gaps.

Enhance equitable access to the BPHNS at all levels

Access to health services shows mixed performance. Although the density of health facilities per 10,000 population slightly declined from 1.42 to 1.3 by 2025, this reduction is closely tied to challenges related to the functionality of existing facilities rather than a decline in absolute numbers. Conversely, geographical accessibility has improved. The proportion of the population living within five kilometers of a health facility increased from 44% to 56%, surpassing the 2025 target of 54%. This indicates progress in the equitable distribution of services, likely influenced by recent infrastructure investments and renovation efforts. Similarly, service utilization, measured through outpatient visits per capita, rose from 0.67 to 0.78, though still far below the 2025 target of 1.5, showing that service availability has not yet fully translated into optimal use.

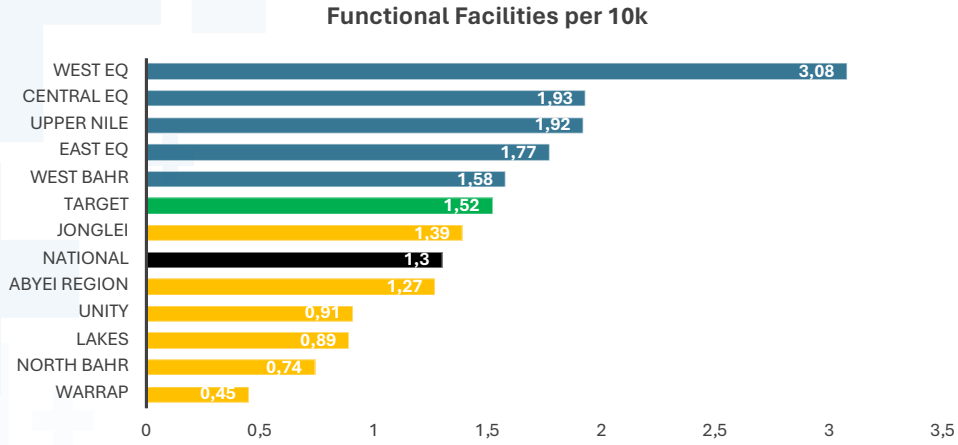

Figure 30: Functional facilities per 10km (DHIS2)

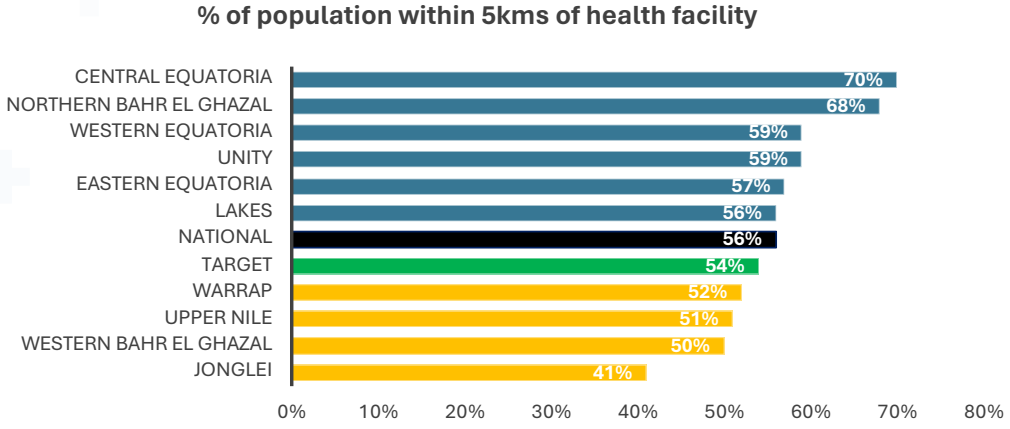

Figure 31: percentage of population 5 km around the health facilities (DHIS2)

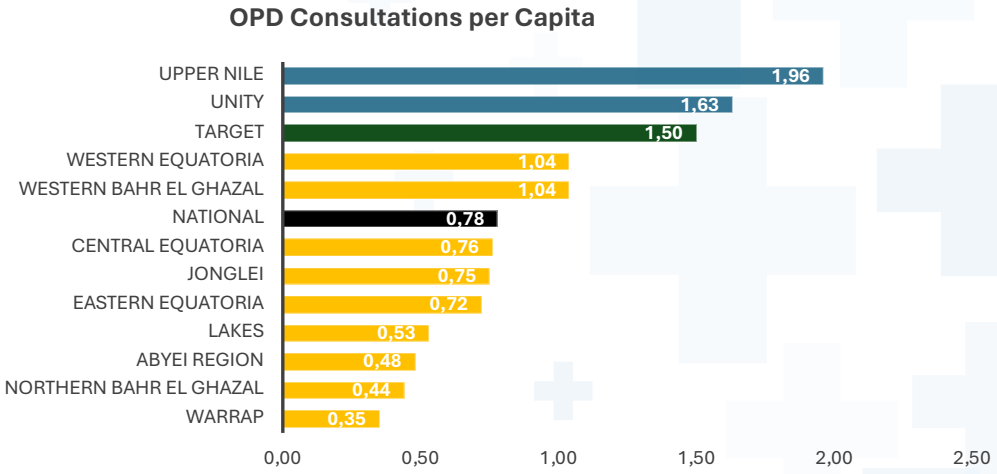

Figure 32: OPD consultations per capita (DHIS2)

Improve quality and safety for delivery of the BPHNS at all levels

Quality and safety indicators show mixed progress. Although a dedicated quality-of-care strategy was initially absent, implementation reached a partial score of 0.5 by 2025. A draft National Quality of Care Policy and Strategy has since been prepared, with implementation expected to begin in 2026. This represents a later-than-planned move toward full operationalization and signals the need for renewed focus and sustained effort to ensure consistent improvements in service quality across the system.

Improve quality and safety for delivery of the BPHNS at all levels

Similarly, the quality-of-care units planned at both national and state levels remain entirely undeveloped, with none of the intended eleven units created. This shortfall underscores persistent structural weaknesses and reveals considerable gaps in oversight, coordination, and accountability mechanisms that are essential for ensuring consistent clinical quality across all levels and service delivery settings throughout the country.

Improve diagnostic capacity and referral services

Diagnostic and referral readiness remains severely limited. With only one functional ambulance team currently operational, the system falls far short of the 2025 goal of six teams. This substantial gap highlights persistent weaknesses in emergency referral capacity and underscores the need for expanded resources, better coordination, and strengthened infrastructure to ensure timely, effective care during critical medical situations and for essential service delivery across South Sudan.

Improve availability and functionality of health infrastructure for BPHNS delivery

In contrast, infrastructure readiness shows notably stronger progress, with 67% of assessed facilities now complying with BPHNS infrastructure standards, using maternal health service availability as a practical proxy. This achievement exceeds the 2025 benchmark of 50% and indicates substantial advances in foundational service preparedness, showing that many facilities are increasingly equipped to deliver essential care. It suggests that sustained investments are producing measurable improvements in health system capacity and resilience.

While progress in physical accessibility and infrastructure strengthening is evident, considerable deficiencies persist in quality assurance systems, service functionality, and referral capacity, undermining the broader goals of the health sector strategy.

Challenges

Despite an increase in the number of health facilities, many remain nonfunctional or only partially functional, reducing effective service delivery. The quality-of-care strategy is only partially operational, and no dedicated quality-of-care units have been established at national or state levels, limiting systematic oversight. Utilization rates remain below targets, reflecting barriers such as staffing shortages, limited service availability, and low community trust. The shortage of functional ambulance teams further restricts timely access to higher-level care.

Key quality and safety strategies have been drafted but are not yet implemented, resulting in delayed progress. In addition, reliance on maternal service indicators as a proxy may mask deficiencies in other service domains, limiting comprehensive performance assessment.


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CHAPTER 3.
PROGRESS AGAINST THE HEALTH SYSTEMS OBJECTIVES

Health system capacity refers to the ability of a country's health system to deliver essential health services effectively, efficiently, and equitably.
It encompasses the availability and functionality of core components: human resources, infrastructure, medicines and supplies, financing, governance, and health information systems. A strong health system ensures that services are accessible, of high quality, and resilient to shocks such as disease outbreaks, humanitarian crises, and economic disruptions.

The role of health system capacity is foundational to achieving Universal Health Coverage (UHC) and improving health outcomes. It determines whether health facilities can provide the BPHNS, whether emergency and referral systems function during crises, and whether data-driven decisions guide resource allocation. Without adequate capacity, even well-designed health programs cannot achieve their intended impact.

This chapter reviews progress against the health systems objectives outlined in the HSSP 2023-2027. It focuses on systemic enablers that support service delivery, including: Human Resources for Health (HRH): workforce density, policy frameworks, and training institutions; Essential Medicines and Laboratory Systems: availability of tracer medicines, diagnostic capacity, and supply chain performance; Health Financing: budget allocations, execution rates, and financial protection; Health Information Systems (HIS): reporting completeness, integration, and digitalization; and Leadership, Governance, and Partnerships: coordination mechanisms and accountability structures.

The following table shows a summary of achievement against selected health systems indicators.


4
World Health Organization

Indicator	Baseline	Achievement	Target 2027
Total number of health facilities per 10,000 population	1.42	1.3	1.6
Health workforce density (per 10,000 population)	7.61(SARA 2018)	7.9	10
Percentage of facilities reporting stocks outs of core set of essential and relevant medicines including nutrition supplies	27.10%	45%	15%
Number of hospital-based blood banks providing safe blood transfusion services		30	14
Health allocation as percentage of national health budget	2.5	2%	10%
Out of pocket expenditure as a percentage of current health expenditure	23.2	34.40%	20%
Proportion of health facilities reporting directly through DHIS 2	N/A	30%	90%
Proportion of health facilities reporting on time	40.40%	52.15%	90%
Percentage of state Ministries of health with annual operational plans developed and implemented	0%	77%	100%
Percentage of state ministries of health conducting regular coordination meetings	58.30%	100%	100%

3.1 HUMAN RESOURCES FOR HEALTH

Human resources for health (HRH) form the backbone of the health system, as the availability, distribution, and competency of health workers directly determine the quality and reach of health services. The role of this component is to ensure that the health sector has an adequate, well-trained, and equitably deployed workforce to deliver health services and respond effectively to emerging health needs. A strong HRH system also supports resilience by maintaining service continuity during crises and enabling the scale-up of interventions.

This section reviews progress in strengthening HRH governance, policy frameworks, and workforce development. It examines indicators such as health worker density per 10,000 population; development and implementation of HRH policies and strategies; operationalization of HRH information systems; accreditation of health science institutions; and functionality of professional regulatory bodies. The analysis highlights achievements in workforce production and management, as well as persistent gaps in deployment, retention, and capacity building that affect service delivery across all levels of care.

Achievement against HSSP (2023-2027) targets

- **Red**: limited or no progress (<50% of 2025 target);
- **Orange**: some progress, but not enough to achieve the target (50 to 99% of 2025 target);
- **Green**: good progress, target (2025) achieved or even surpassed

***Table 31**: Achievement against targets: Human resource for health*

Objective	Indicator	Baseline	Achievement 2025	Target(HSSP)		Performance-and colour	Data source	Comment
				2025	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 population)	7.61(SARA 2018)	7.9	9	10	87.8%	State of HRH Report, WHO (2024)	Health workforce data to be updated once data collection and assessments are completed in 2026; used the latest available information
	HRH policy, strategy and manual developed and in use		0.3	1	1	30.0%	MoH- Programme report	Endorse the HRH strategy; Develop HRH Annual Work Plan aligned to Directorate AOP .
	HRH information system established and in use		0.7	1	1	70.0%	Programmereport	Nationwide scaleup and full operationalization planned for Q1-Q2 2026
	Number of professional regulatory bodies/councils established and functional		2	4	4	50.0%	MoH -Programme report	Progress remains slow due to lengthy bureaucratic procedures. A typical example is the Allied professional bill which has stalled.
	Percentage of Health Science Institutions (HSI) that are accredited	N/A	20%	30%	70%	66.7%	MoH -Programme report	Data to be updated once accreditation assessments are done in 2026
Performance index						60.9%		

During the performance period, notable progress was made in strengthening HRH to support effective delivery of the Basic Package of Health and Nutrition Services. Key achievements and challenges reflect both the long-term nature of HRH reforms and ongoing efforts to institutionalize systems and policies across the sector. Updated health workforce density data will require new assessments, which could be conducted in 2026. Although data for 2025 are incomplete, interventions continue to focus on health worker production, deployment, and retention, with the sector committed to achieving the HSSP target of 10 health workers per 10,000 population by 2027.

The country developed a ten-year HRH Strategy. While the strategy has been completed, it is yet to be formally endorsed by the relevant authorities. Once endorsed, HRH annual work planning will be aligned with the Directorate Annual Operational Plan to ensure coordinated implementation across health programs and training institutions.

Progress was also recorded in establishing the HRH Information System, which has reached approximately 70% completion.

Nationwide rollout and full operationalization are planned for the first and second quarters of 2026. When fully functional, the system will significantly enhance HRH planning, monitoring, and decision-making by improving the availability, quality, and use of workforce data. Tables 32-33 reflects various health worker cadres at health facility level by state.

***Table 32**: Human resources - State Ministry of Health filled positions*

Job Title	CES	EES	WES	NBGZ	WBGZ	Lakes	Warrap	UNS	JON	Unity
Director General	1	1	1	1	1	1	1	1	1	1
Directors	3	7	20	6	7	9	9	8	9	9
PHC Officer	1	1	11	10	3	1	1	1	1	1
EPI Officer	3	5	10	4	6	4	4	4	4	4
Sur Officer	1	9	15	6	4	7	7	14	12	9
M&E Officer	4	3	1	1	4	1	1	1	1	2
HR Officer	1	1	3	1	4	1	0	1	1	1
Clerk	5	3	-	5	6	23	2	5	-	1
Cleaner	83	4	20	20	9	31	7	24	-	7
Guard	3	3	10	6	8	8	5	3	-	2
Driver	23	2	8	5	7	10	4	2	-	1
Malaria Coordinator	1	1	1	1	1	1	1	1	-	1
HIV/TB Coordinator	1	1	1	1	1	1	1	1	-	1
NTD Coordinator	1	1	1	1	1	1	1	1	-	1
Nutrition FP	1	3	1	1	3	1	1	1	-	1
BHI Coordinator	2	3	1	1	1	1	1	1	-	1
WASH/IPC	2	1	1	1	3	1	1	0	-	1
MC Officer	1	0	0	0	1	1	1	0	-	1
Lab Officer	1	1	1	1	1	1	7	1	-	1
Health Promo Officer	2	1	1	1	2	1	5	1	-	1
Cold Chain Officers	2	3	3	1	4	2	2	2	-	2
Total	**142**	**52**	**109**	**74**	**77**	**103**	**63**	**73**	**29**	**49**

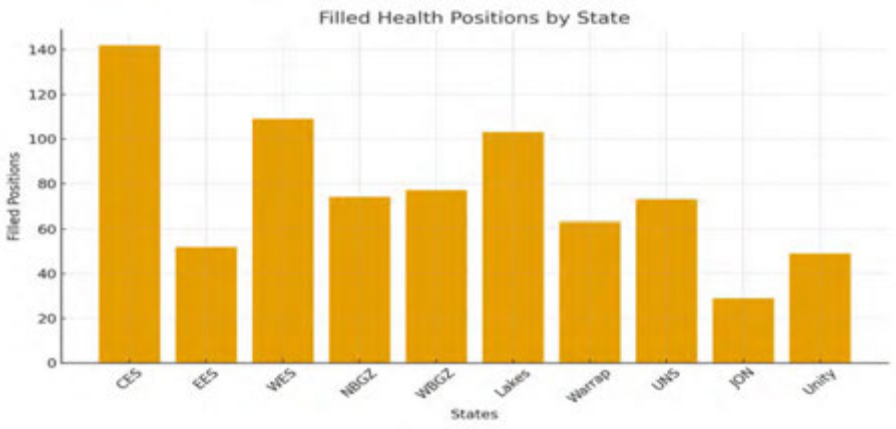

***Figure 33**: Filled health positions by state*

***Table 33**: Human resource - Health facilities (filled posts) by state*

Cadres	Total	CES	EES	WES	NBGZ	WBGZ	Lakes	Warrap	UNS	JON	Unity
Medical Officers	210	36	21	24	12	3	22	16	16	28	30
Clinical officers (specialist)	1039	234	75	66	138	46	82	77	77	88	132
Midwives Registered	417	50	37	61	61	24	56	27	27	14	36
Midwives Certificated	803	45	57	86	148	91	44	96	96	70	84
Nurses Registered	530	56	81	54	48	32	45	44	44	63	66
Nurse Certificated	1211	42	117	131	136	148	134	121	121	109	150
Counsellors	470	11	3	25	38	6	64	0	0	7	16
Public Health Officers	114	84	2	1	15	0	4	2	2	6	0
Nutritionist	1021	97	87	51	140	100	65	90	90	96	164
Lab Technologists	78	30	2	3	32	0	1	1	1	7	2
Lab Technicians	479	74	37	38	36	35	71	17	17	27	62
Lab Assistants	289	38	27	11	67	7	0	48	48	49	42
Pharmacists	123	29	2	5	32	0	35	4	4	12	4
Pharmacist Assistants	593	72	47	40	104	87	16	10	10	39	96
EPI Vaccinators	1254	93	130	183	120	142	55	100	100	142	207
Data Clerks	1091	68	85	99	150	91	164	93	93	101	158
Guards	1053	68	85	125	160	133	156	90	90	110	126
Cleaners	1512	158	187	159	142	139	176	105	105	134	230
Drivers	173	27	6	12	8	0	11	7	7	12	90
Radiographers	14	0	4	3	2	0	0	1	1	2	2
Sonographers	9	0	1	0		0	3	3	3	2	0
Total	**12183**	**1312**	**1093**	**1177**	**1589**	**1084**	**1204**	**952**	**952**	**1118**	**1697**

Source: State AOP Reports (2025)

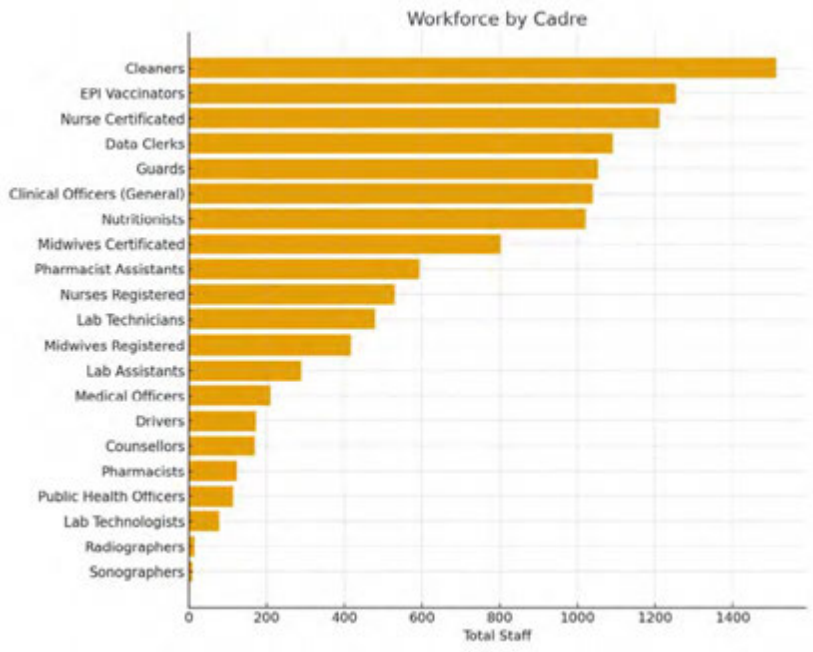

***Figure 34**: Workforce by cadre (State AOP reports 2025)*

Regulation of health professionals has been slower than anticipated. Only two of the four targeted bodies have been established. Delays are largely attributed to lengthy bureaucratic processes within responsible government institutions. A key example is the delay of the Medical Laboratory Professionals and Allied Professionals Bill, which continues to hinder momentum in regulatory reforms.

Work on accreditation of Health Science Institutions (HSIs) is advancing. A national accreditation framework has been finalized and shared with institutions, and ten HSIs have undertaken self-assessment. While the current accreditation level remains at approximately 30% against the national target of 70% by 2027, final verification of accreditation status will take place in 2026.

Overall, the period demonstrated solid progress in policy development and system strengthening, even as several indicators remain on a longer-term trajectory. Planned assessments, regulatory reforms, and system operationalization in the coming years will be critical to achieving the HRH objectives under the Health Sector Strategic Plan.

Challenges

HRH interventions continue to face systemic and operational constraints. Workforce data remain incomplete and fragmented, limiting accurate planning and monitoring. Functionality and scale-up of the electronic Human Resource Information System are inadequate, which hampers data-driven decision-making. The draft HRH strategy has not yet been endorsed, slowing implementation of coordinated reforms. Administrative bottlenecks within government processes have delayed progress on professional standards and regulatory frameworks.

Resource constraints, both financial and human, further affect implementation of HRH interventions, including data collection, system deployment, and accreditation activities. These gaps collectively undermine efforts to strengthen workforce management and improve service delivery.

3.2 ESSENTIAL MEDICINES, SUPPLIES, TECHNOLOGIES AND LABORATORY SYSTEMS

Essential medicines, supplies, technologies, and laboratory systems are central to safe, effective care. Strengthened health products supply chain systems ensure uninterrupted access to medicines, functional diagnostics, and reliable laboratory services–including blood transfusion through well-equipped blood banks. Access to health products–medicines, blood products, medical supplies, and diagnostics–is also about trust and dignity. For many communities, access to these health products is synonymous with access to healthcare. When they are missing, people feel let down and lose confidence in the system–like entering a restaurant with no food; regardless of the setting, its purpose is undermined. When health products are available and reliable, treatments work, patients are satisfied, and trust grows. When patients leave without needed medicines, they lose faith, delay future care, and negative word of mouth damages the health system's reputation. Together, these components enable accurate diagnosis, rational treatment, and life-saving interventions for those who seek care and promote trust and better health seeking behaviour in the community across all population cohorts.

This section reviews progress in strengthening health supply chains, reducing stock-outs of essential health products, expanding laboratory and blood bank functionality, and improving quality assurance.

Achievement against HSSP (2023-2027) targets

- **Red**: limited or no progress (<50% of 2025 target);
- **Orange**: some progress, but not enough to achieve the target (50 to 99% of 2025 target);
- **Green**: good progress, target (2025) achieved or even surpassed

***Table 34**: Achievement against targets: Essential medicines, supplies, technologies and laboratory systems*

Objective	Indicator	Baseline	Achievement 2025	Target (HSSP)		Progress (performance) - and colour	Data source	Comment
				2025	2027			
Promote sustainable and equitable access to pharmaceutical and related technologies	Availability of tracer medicines (1% of health and nutrition products on essential drugs list available at service delivery points)	73%	No data	79%	80%			Indicator is measured in a national representative survey
	% of pharmaceuticals expired at health facility level	4.20%	No Data	2.80%	2%			
	Percentage of facilities reporting stocks outs of core set of essential and relevant medicines including nutrition supplies	27.10%	45%	19%	15%			Modelled from 2024/25 DHIS2 data
Strengthen a national quality laboratory system that is safe and reliable for effective diagnostic services	Proportion of laboratories reporting stock out of tracer reagents	No data	No data	<30%	<10%			
	Proportion of laboratories conforming to minimum standards	No data	0	60%	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	No data	30	10	14		MoH M&E Department; State-level consultations	
	Number of blood banks with adequate cold chain	No data	30	10	14		MoH M&E Department; State-level consultations	
Performance index						50%		

OBJECTIVE 1:

Promote sustainable and equitable access to pharmaceutical and related technologies

Among health facilities that reported to DHIS2, 45% reported stock-out of selected essential medicines in the financial year 2024/25. The average number of stock-out days ranged from 48 days for Chlorhexidine solution 5% to 238 days for oral rehydration salts. Notably, the proportion of health facilities that reported essential medicines indicators in DHIS2 in 2024/25 was less then desired, averaging between 22 health facilities (Alele Determine HIV kit) and 177 health facilities (Artesunate + Amodiaquine (toddlers)).

Table 35: Stock out of essential medicines

Selected medicines used to estimate percentage of stock-out days	Average number of stock-out days	Number of health facilities that reported essential medicines indicators in DHIS2 for 2024/25				% reporting stock-out
		Average	MinimumM	aximum	Count	
Metronidazole 200mg	1291	10	0	751	65	59
Albendazole 200mg or 400mg	1951	71	0	737	68	40
Amoxicillin 250mg	1091	40	0	807	37	26
Artesunate + Amodiaquine (toddlers)	1211	77	6	650	57	32
Chlorhexidine solution 5%	48	1130		6164	03	5
Oral rehydration salt	238	1270		687	49	39
Paracetamol 100mg	70	1570		780	41	26
Combined oral contraceptives	79	97	2	433	29	30
Alere Determine HIV test	1892	20		67	22	100
Methyldopa	1316	20		350	38	61

Availability of essential health products in the country

HIV/AIDS and TB products: In FY 2024/25, a total of USD 19,303,451 in health products was consumed across HIV/AIDS, tuberculosis (TB), and cross-cutting supplies. HIV/AIDS accounted for USD 6,869,807 in medicines and USD 5,396,280 in diagnostics and laboratory reagents. TB utilized USD 2,549,035 for medicines and USD 1,224,751 for diagnostics. Cross-cutting items and equipment amounted to USD 3,263,578. These health products supported provision of health services to clients through three (3) teaching hospitals, seven (7) state hospitals and 276 health facilities received HIV/AIDS medicines or diagnostics, and 277 facilities received TB medicines or diagnostics.

Reproductive and maternal health products: With support from the United Nations Population Fund (UNFPA), health products including inter-agency reproductive health kits (USD 1,666,617) to facilitate the provision of priority sexual and reproductive health services in humanitarian contexts were distributed. Additionally, family planning products (USD 2,071,877), maternal health products (USD 921,385) and equipment (USD 205,104) were distributed through the central medical store agency.

Emergency health kits: In 2024, 589 metric tons of emergency health kits valued at USD 6,001,695, serving 4.2 million people nationwide were distributed. In 2025 to date, WHO has distributed 435 metric tons valued at USD 5,578,141, sufficient for over 2.2 million people. Distribution reached 58 counties, 42 implementing partners, and 91 health facilities–including 10 hospitals, 20 Primary Health Care Centers (PHCCs), 46 Primary Health Care Units (PHCUs)–and supported 15 mobile medical missions.

Governance structures, processes and systems

Governance and leadership for the sector established and functional at national level by Director General for Directorate of Pharmaceuticals and Medical Supplies (DPMS), Executive Director for Central Medical Store Agency (CMSA), Secretary General for the Drug and Food Control Authority and the Pharmaceutical Society of South Sudan, while there is a Director for Pharmaceuticals assisted by Director of CHD at state level.

The Pharmaceutical Management Technical Working Group (PMTWG) is functional and continues to bring together national Ministry departments, agencies and state level representatives, UN agencies, health sector and implementing partners to support the pharmaceutical sector with planning, coordination, and improvement of policies, guidelines, and regulations. Eight meetings were held generating action points that were followed up. The committee guided and provided expert advice on the selection, quantification of essential medicines for HIV/AIDS, TB, family planning products, malaria products and other essential medicines.

The DPMS and some members of the PMTWG were key members and contributors of the Operational Steering Committee (OSC) and High-Level Steering Committee of the MoH led HSTP guiding the prioritization of investments to increase access to life-saving essential medicines.

Strengthened Pharmaceutical Management Information Systems

Revised and standardized health product data capture and reporting tools for hospitals, PHCCs, and PHCUs, integrating nomenclature, coding, and service-level customization. Tools were aligned with DHIS2 to improve supply chain integration and service monitoring, focusing on products provided by the Ministry of Health and partners across public health facilities.

An eLMIS using open-source MSUPPLY was deployed in 81 health facilities across seven states, enabling real-time stock monitoring, order and patient management, and cold chain tracking. The offline-capable system integrates with DHIS2 for data visualization and performance monitoring. 271 health workers from 89 facilities have been trained so far.

The MoH M&E department introduced automated dashboards tracking key supply chain indicators–stock levels, expiries, consumption, and stock-outs. These dashboards intend to provide real-time visibility and support data-driven decisions by national and sub-national stakeholders, aiming to improve supply chain performance, reduce stock-outs, and enhance accountability across the health system.

Enhanced capacity of the Health Product Supply Chain

Substantial progress has been achieved in integrating the country's health products supply chain functions under the direction and leadership of the MoH, DPMS and CMSA, thus reducing fragmentation, duplication and inefficiency and contributing to building the national capacity. Physical integration to optimize the existing warehousing and distribution capacity is most advanced with HIV/AIDS and TB products supported by United Nations Development Programme / Global Fund (UNDP/GF), emergency products and medical countermeasures supported by WHO, reproductive and maternal health products are warehoused in

MoH stores. Also, consolidation and expansion of the warehouse capacity at the MoH allocated site in Gumbo has been prioritised.

The MoH has mobilised resources (USD 2m) from GAVI and Global Fund to expand warehousing capacity for dry storage and cold chain at Gumbo, Sherikat, Juba by 2000 square meters including racking, temperature regulation and solar power systems and to support ongoing integration and harmonisation with the health product supply chain in South Sudan.

Conducted four transparent, multi-stakeholder quantification workshops to select, quantity and forecast country needs for essential health products including diagnostics; for HIV/AIDS and TB health products supported by UNDP/GF, for malaria products supported by HSTP, for reproductive and maternal health products supported by UNFPA and for other essential medicines supported by HSTP.

The updated Standard Treatment Guidelines for PHCUs and PHCCs were developed through a multi-stakeholder, expert-led process, to guide diagnosis and treatment, reduce inappropriate prescribing, curtail antimicrobial resistance, and support health system planning by aligning resources with disease patterns, improving equity, clinical outcomes, and medicine availability. These STGs aim to standardize evidence-based, cost-effective care nationwide.

The South Sudan Essential Medicines List intended to meet the priority healthcare needs of the population has been reviewed and updated based on disease prevalence, efficacy, safety, and cost-effectiveness. Using this limited range of carefully selected health products has improved healthcare quality, enhanced medicine management, and reduced costs across the health product supply chain system.

Strengthened capacity to fight antimicrobial resistance

South Sudan launched its National Action Plan (NAP) for AMR in July 2025 incorporating the one-health approach. A multi-stakeholder and one health coordination committee was established and operationalized with a secretariat at the National Public Health Laboratory. Institutional reporting to the WHONET microbiology database has been an initiative, enabling standardized data analysis and global reporting. Capacity of the NPHL's Bacteriology Reference Laboratory (BRL) has been enhanced to standardize quality control and assurance systems and harmonize bacteriology testing. Additionally, hands-on training for laboratory personnel–covering culture techniques, quality management, biosafety, and reporting procedures–was completed during the year.

The updated South Sudan Essential Medicines list incorporated the WHO Aware Watch Reserve classification as a key intervention to promote appropriate antibiotic use. The Standard Treatment Guidelines have adopted the WHO AWaRe book clinical guidance for empiric antibiotic therapy at first presentation, when a "no-antibiotic" approach is appropriate, and the antibiotic choices, dosages, and treatment durations for likely bacterial pathogens in adults and children.

OBJECTIVE 2:

Strengthen a national quality laboratory system that is safe and reliable for effective diagnostic services

Strengthened laboratory institutional governance, regulatory framework

The Directorate of Diagnostic Laboratory Services (DDLS) was established to lead national health diagnostic laboratories in South Sudan but remains non-functional due to lack of office space and key director appointments. Drafted policy instruments include the National Diagnostics Policy, Strategic Plan, Essential Diagnostics List, and equipment guidelines. Approval is pending due to leadership turnover, low technical capacity, and funding gaps.

A health sector partners' coordination forum (bringing together MDAs, UN agencies, donors and implementing partners) was launched as a resource mobilization platform. The National Diagnostics TWG's Terms of Reference and annual workplan were developed and are pending approval. TWG members were appointed. The draft SS Medical Laboratory Practitioners' Council regulatory framework was completed and submitted to the MoH for forwarding to the Ministry of Justice.

Strengthened appropriate laboratory infrastructure, equipment, supplies and information management systems.

National standards for laboratory infrastructure and equipment were defined, with guidelines for building design, equipment, reagents, and utilities, to standardize laboratory design across all facility levels. The health laboratory network includes national, state, county hospitals, and PHCCs, supported by three training institutions. A national electronic Laboratory Information Management System (eLIMS) was introduced. GeneXpert platforms with a Viral Load Management System (VLMS) were deployed at 64 points of care testing sites nationwide.

Complete Blood Count (CBC) machines with reagents were acquired and commissioned at 27 health facilities; and chemistry analysis machines are operational at 23 health facilities. Infrastructure upgrades were made at NPHL and three state hospitals, namely Bol, Kuajok and Yambio. Despite efforts, health laboratory services remain largely centralized, with limited sub-national capacity. The eLIMS and VLMS face challenges of lack of computer access, electricity, and internet and non - integration with DHIS2 thus compromising real-time data visibility, tracking and accountability needed for data-driven decision-making.

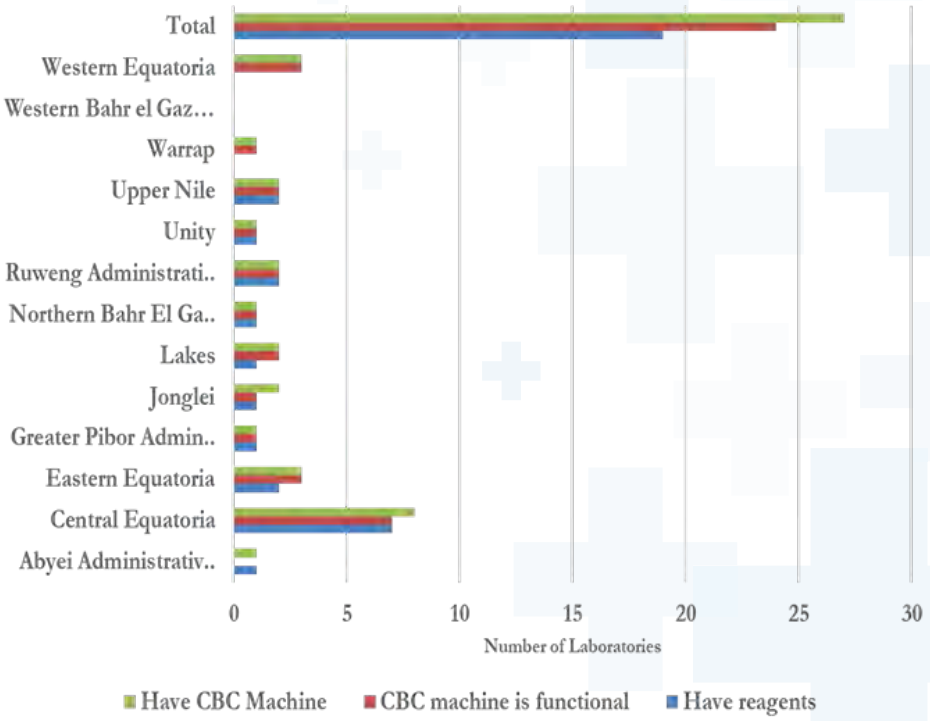

***Figure 35**: Facilities with CBC machines*

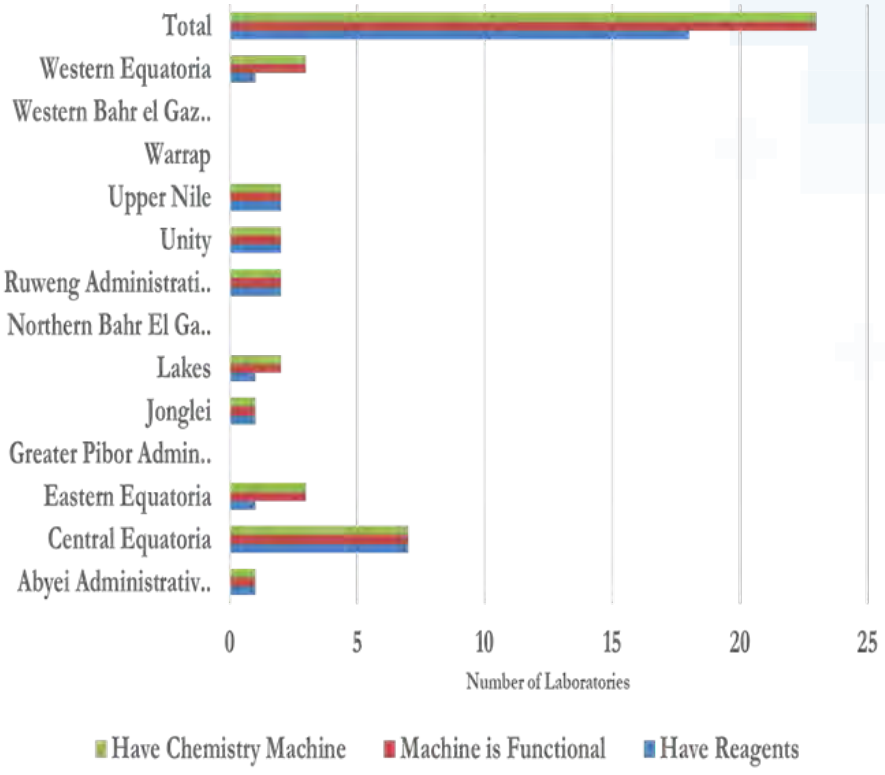

***Figure 36**: facilities with functional chemistry machines*

Strengthened laboratory quality management and safety systems

Key advancements to strengthen national laboratory quality and safety systems included the development of national guidelines for specimen collection, storage, and transportation to higher-tier and reference laboratories. A national laboratory quality manual was finalized and is awaiting formal approval. The Ministry of Health (MoH) and its partners trained various personnel, including the WHO AFRO Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) Internal Auditors and Mentors, method verification officers, QMS trainers-of-trainers, certified Kenya Accreditation Service (KENAS) technical assessors, and officers trained in IDSR protocols and QMS. This expanded skilled professionals' workforce will support the national laboratory accreditation process. Despite the available trained personnel, the national laboratory accreditation scheme remains under development, with a need for additional resources to support its full implementation and existing biosafety and biosecurity policies and SOPs require review, updates, and official endorsement.

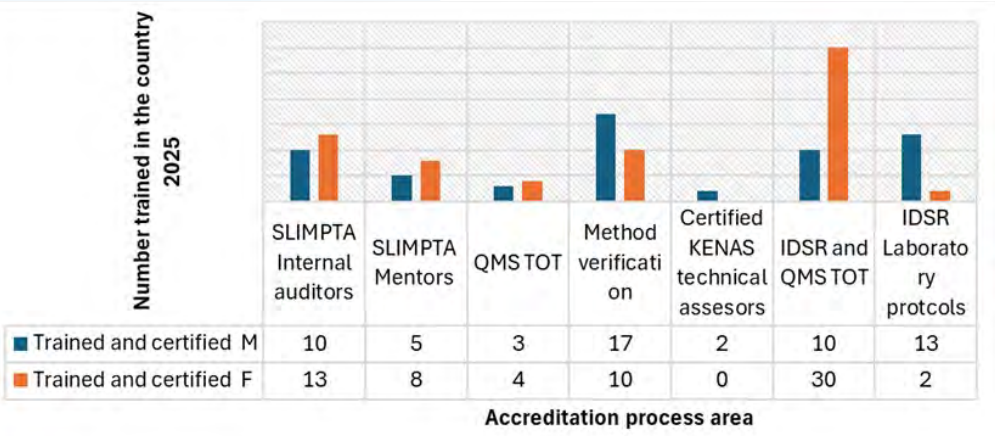

Figure 37: Number of trained and certified personnel on lab accreditation

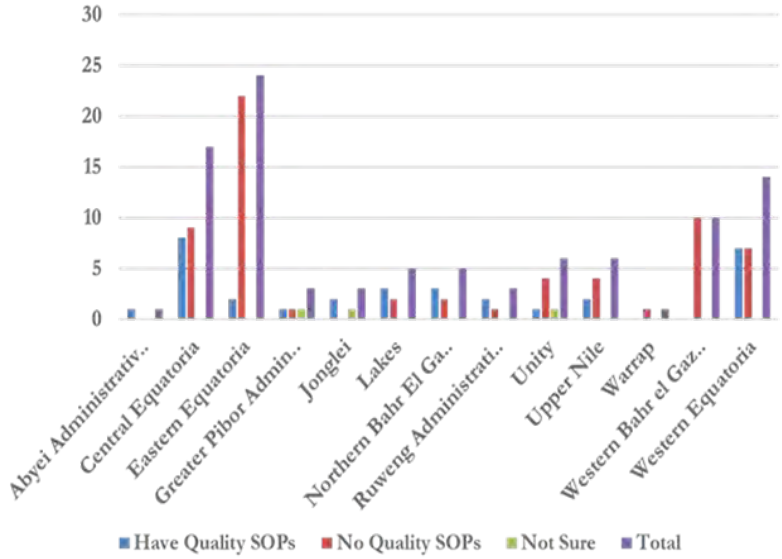

Figure 38: Health laboratories with quality policies and SOPs

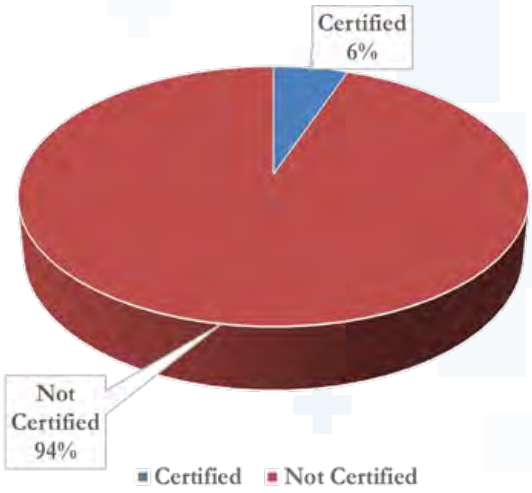

***Figure 39**: Proportion of health labs that are certified in South Sudan*

The national public health laboratory coordinated national multi-stakeholder, consultative prioritization efforts and comprehensive gap analysis to select, quantify, and forecast essential laboratory needs - equipment, reagents and supplies - for health laboratories at each level of care, in accordance with national guidelines. However, delays in the procurement, supply, and distribution of essential consumables, reagents, and test kits–despite partner support–resulted in stock-outs across several facilities during the financial year.

OBJECTIVE 3:

Strengthened the blood transfusion systems, and blood banks to ensure sustainable availability of blood products for those who need them

Significant progress was made in 2025 toward strengthening the national blood transfusion services and improving access to safe and adequate blood supplies across South Sudan. The Health Sector Strategic Plan (HSSP 2023-2027) identifies blood safety as a critical pillar for reducing maternal mortality, improving emergency response capacity, and enabling essential surgical and medical care. Two key performance indicators (KPIs) guide the sector's priorities: 1) Number of hospital-based blood banks providing safe blood transfusion services, 2) Number of blood banks with adequate cold chain capacity.

Against the 2025 targets of 10 health facilities, the sector achieved an exceptional milestone with 30 health facilities now operating functional hospital-based blood banks with adequate cold-chain systems–surpassing both the 2025 and 2027 targets (14 facilities) by a large margin. This represents a substantial strengthening of transfusion capability and marks one of the strongest performance areas in the health systems strengthening agenda.

Table 36: Distribution of Blood Banks by State

State	Hospitals with Blood Banks
Jonglei	Akobo Hospital, Bor State Hospital
Northern Bahr El Ghazal	Aweil State Hospital (MSF)
Unity State	Bentiu State Hospital (MSF), Mayom County Hospital
Central Equatoria	Juba Teaching Hospital, Juba Military Hospital, Al Sabbah Children Hospital, Yei Civil Hospital, Kejo-keji Civil Hospital
Upper Nile	Bunj Hospital, Malakal Teaching Hospital, MSF-Holland Hospital
Western Bahr El Ghazal	Wau Teaching Hospital, Daniel Comboni Hospital, Mary Help Hospital
Eastern Equatoria	Torit State Hospital, Kapoeta Civil Hospital
Warrap	Kuajok State Hospital, Marial-Lou County Hospital
Western Equatoria	Yambio State Hospital, St Theresa Mission Hospital, Lui Hospital
Others	Additional hospitals in Ruweng AA, Abyei AA, Pibor AA
Total	30

The expansion of hospital-based blood banks from the planned 10 facilities to 30 functional sites reflects coordinated investments by the Ministry of Health, supported by private sector actors and development partners. Private and faith-based facilities such as St. Daniel Comboni Hospital (Wau), Mary Help Hospital (Wau), and St. Theresa Mission Hospital (Yambio) have established robust blood banks, significantly increasing transfusion service availability for large catchment populations in Western Bahr el Ghazal and neighboring states. Humanitarian partners, notably Médecins Sans Frontières (MSF), continue to operate high-standard blood banks in Aweil, Malakal (replacing the destroyed government facility), Bentiu, and Agok, while also providing malaria screening of donor blood in high-transmission areas to complement national TTI protocols. WHO, UNDP, UNICEF, and other partners contributed infrastructure support, compliant refrigeration systems, solar backup solutions, laboratory supplies, training, and quality assurance inputs, strengthening cold chain, transportation, and reagent supply systems across all transfusing facilities.

Blood safety measures have been reinforced through mandatory screening for HIV 1/2, Hepatitis B (HBV), Hepatitis C (HCV), and Syphilis in all transfusing facilities, following WHO-recommended algorithms for low-resource settings. MSF-supported sites additionally screen for malaria due to endemic transmission risks. Screening capacity remains reliant on rapid diagnostic tests (RDTs) and immuno-chemiluminescence platforms such as the Abbott ARCHITECT i1000SR at the National Blood Transfusion Service (NBTS) in Juba. Investments in reagent security and procurement coordination have improved continuity of testing.

Cold chain strengthening was a major success driver, with reliable blood storage systems expanded to 30 facilities through solar and hybrid power solutions, training of laboratory personnel, and preventive maintenance initiatives coordinated

by state health authorities. These efforts have improved safety and reduced wastage, ensuring blood viability from donation to transfusion. Quality and governance improvements included standardization of TTI screening, implementation of voluntary donor selection protocols, enhanced coordination between hospitals, state authorities, and NBTS, and introduction of standardized registers and reporting templates. State-level consultations in Wau, Torit, Aweil, Yambio, Warrap, and Malakal identified gaps and opportunities for sustained improvements in governance and clinical transfusion practices.

Challenges

Despite these gains, challenges persist. Shortages of trained blood bank staff remain widespread, and reliance on family replacement donors continues in some facilities. National guidelines require revision and operationalization, while capacity for component preparation is limited, with most banks providing only whole blood. Quality assurance systems are inadequate, and many sites lack participation in external proficiency testing. The destruction of the Malakal Government Blood Bank remains a critical gap, leaving the facility dependent on MSF for transfusion services.

3.3 HEALTH FINANCING

Health financing ensures adequate, predictable, and sustainable resources for equitable access to essential health services, covering the costs of service delivery, public health functions, and system strengthening. Its role is to mobilize funds from domestic and external sources, allocate and execute budgets efficiently across program areas and levels of care, and provide financial protection by reducing out-of-pocket (OOP) payments and other private health expenditures. Effective health financing supports continuity of services, enables scale-up of priority interventions, and stabilizes the health system during shocks by maintaining cash flow for commodities, workforce, and operations.

The HSSP objective on health financing is to ensure adequate and sustainable health financing for equitable access to essential health services by all South Sudanese. During the period under review, the health financing landscape has been characterized by low budgetary allocation to health, overreliance on external funding, and increasing private health expenditure (including OOP). Table 37 highlights the achievements and progress made in this area.

Achievement against HSSP (2023-2027) targets

- **Red**: limited or no progress (<50% of 2025 target); - **Orange**: some progress, but not enough to achieve the target (50 to 99% of 2025 target); - **Green**: good progress, target (2025) achieved or even surpassed

***Table 37**:Achievement against targets: Health financing*

Objective	Indicator	Baseline (22/23)	Achievement 2024/25	Target (HSSP)		Progress (performance) - and colour	Data source	Interpretation
				2025	2027			
Ensure adequate and sustainable health financing for equitable access to essential health services by all South Sudanese without financial hardship	Health allocation as percentage of national health budget	2.5	2%	8%	10%	25.0%	MOFP approved budget book	Modest decline in allocation in the period From the baseline
	% of MOH budget implemented (budget execution rate)	96% (23.1%)	32%	98%	100%	32.7%	MOFP (IFMIS)	Improvement in budget execution but overall execution remains low; The baseline of 96 in the strategy was based on 2021/22 achievement, the actual baseline for 2022/23 was 23.1)
	Total health expenditure as a percentage (%) of GDP	6%	6.80%	12%	15%	56.7%		An increase from the baseline but off the target
	Externally sourced funding as % of current health expenditure	63.60%	49%	55.40%	50%	111.6%	WHO -Global health expenditure database (2025) data for 2022	Target achieved and surpassed (SSP target already achieved and efforts needs to be sustained
	Out of pocket expenditure as a percentage of current health expenditure	23.2	34.40%	21%	20%	-63.8%	Global health expenditure database base 2025) data for 2022	OOP on the rise. Perhaps driven by declining Government allocation -to health amidst declining external funding
Performance index						42.9%		

Health allocation as a percentage of National budget

The government budget allocation to the health sector has been on a declining trend. In the period under review, the government budget allocation to the health sector reduced from 4 % in 2022/23 FY to 2% in 2023/24 and remained the same in 2024/25 FY (Figure 41). This achievement is far below the target of 8% that was set for the year 2025 and underscores the under-investment in the health sector. The sector is unlikely to achieve the end of HSSP target of 10% if this trend is maintained.

***Table 38**: Health budgetary trends*

Health Financing Indicators	Health Budgetary Trends		
	2022/23	2023/24	2024/25
Health sector allocation (SSP)	33.5B	43.2B	77.1B
Total Government resources (SSP)	958,M	1.9T	4.2T
Health sector allocation as percentage of National budget	4%	2%	2%
MOH allocation (SSP)	33.B	41.4B	66.3B
MoH Execution Rate	23.1%	24%	32%

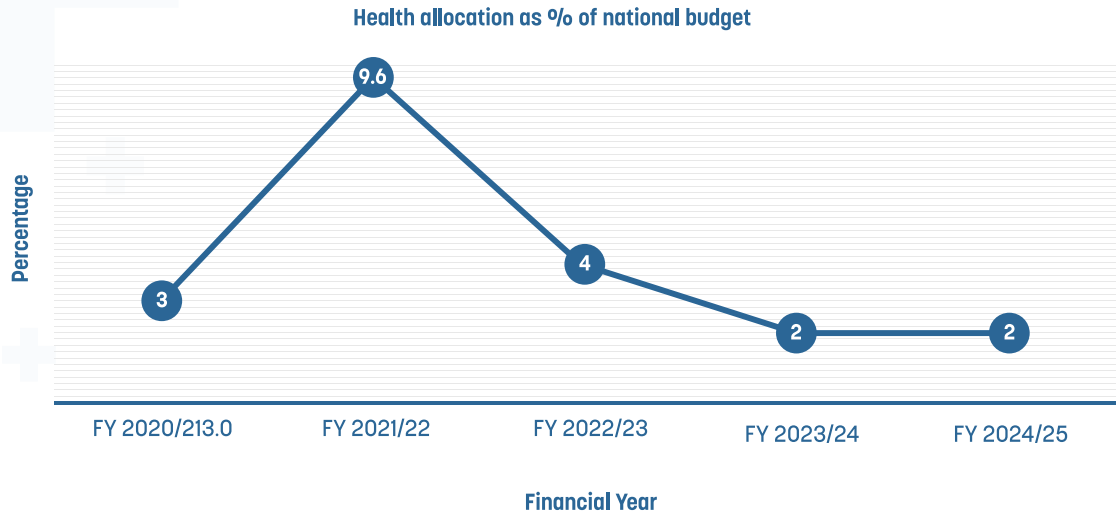

***Figure 40**: Health allocation as a % of national budget*

The budget execution rate (percentage of MOH budget implemented)

The budget execution rate declined from a high of 96% in 2021/22 to 22.8% in 2022/23, then rose modestly to 25.3% in the 2023/24 fiscal year and 41.9% in 2024/25 (Table 38). It is important to note that the baseline set in the HSSP was based on the 2021/22 execution rate. Although execution has been on a rising trend, it remains low, largely due to delayed disbursement of the already limited funds allocated to the sector, which in turn has delayed implementation, particularly payment of salaries.

Total health expenditure as a percentage of GDP

The total health expenditure as a percentage of GDP is estimated at 6.8% in 2022, up from 6.0%, according to the WHO Global Health Expenditure Database. This trend is moving in the right direction.

Externally sourced funding (percentage of current expenditure on health)

The South Sudan health sector relies heavily on external funding. Available data from Global health expenditure database shows that externally sourced funds accounted for about 50% of all current health expenditure in 2022, as shown in the figure 40 and 41. This is however a positive decline from a baseline of 63.3% an achievement that has surpassed the HSSP end term target of 50%. The decline in external funding was expected to be bridged by increased domestic resources. However, this decline, coupled with reduced government allocation to the health sector implies a potentially increasing financial burden on the individual households and as evidenced by increasing trends in OOP expenditures.

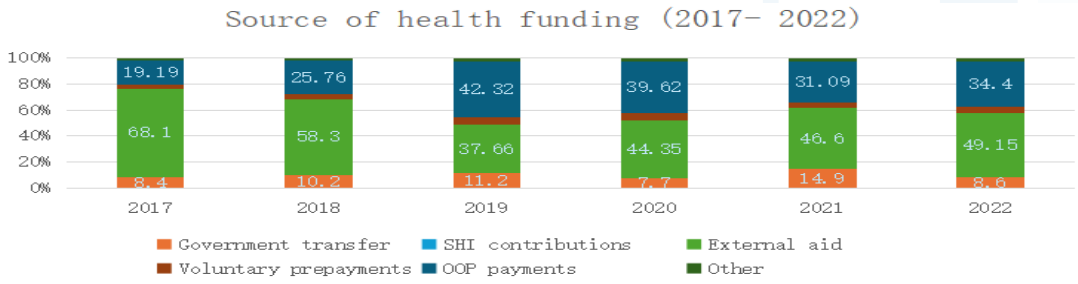

Figure 41: Source of health funding (2017-2022)

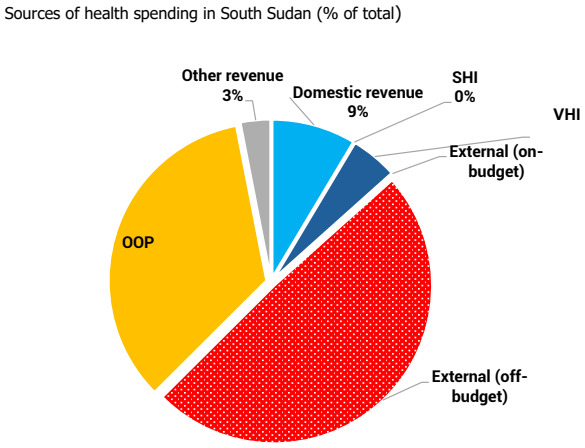

Figure 42: Source of health spending (% of total)

Out of pocket expenditure

South Sudan's health sector relies heavily on external funding. Available data from the WHO Global Health Expenditure Database show that externally sourced funds accounted for about 50% of all current health expenditure in 2022, as shown in Figures 40 and 41. This represents a decline from the baseline of 63.3%, surpassing the HSSP end-term target of 50%. The reduction in external funding was expected to be offset by increased domestic resources. However, this reduction, coupled with decreased government allocation to the health sector, implies a potentially increasing financial burden on households, as evidenced by rising trends in out-of-pocket expenditures.

Progress on implementation of targeted interventions

Towards strengthening the health financing system in the country, the sector outlined several strategies and interventions in the HSSP as outlined below.

Towards strengthening the health financing governance, leadership and policy frameworks, the Ministry of Health established a Health Financing Unit at the national level with the main objective of coordinating health financing priorities. In addition, a multi-stakeholder Health Financing Technical Working Group, comprising the Ministry of Health, the Ministry of Finance, and partners, is in place and meets on a quarterly basis to coordinate and provide oversight of health financing programs. However, as originally planned, the establishment of health financing departments/units at the state level and the review and updating of the health financing strategy are yet to be accomplished.

On the strategy on increasing sustainable funding for health, the Ministry of Health has continued to hold quarterly advocacy meetings with the health committee of parliament, although this has not resulted in additional budget allocation due to limited fiscal space. Innovative financing mechanisms–including taxes on alcohol, sugar, and tobacco–and the generation of evidence to inform the establishment of a health insurance scheme have not been implemented as planned.

Towards strengthening public financial management systems, the Ministry of health has actively been participating in the budgeting process through the sector working group. Further and towards strengthening the health expenditure tracking mechanisms, a national transfer monitoring committee (HTMC) and county transfer monitoring committee (CTMC) are in place.

The health sector also planned to generate regular health financing information for decision making by conducting National Health Accounts every 2-3 years and carrying out regular health expenditure tracking surveys and expenditure reviews for public and partner resources. However, these activities were not accomplished in the period under review, although plans are underway to conduct the NHA in 2026.

3.4 HEALTH INFORMATION SYSTEMS

Health Information Systems (HIS) provide the foundation for evidence-based decision-making and accountability in the health sector. Their role is to collect, process, and disseminate timely, accurate data on service delivery, health outcomes, and system performance. By integrating DHIS2, program-specific databases, and survey data, HIS enables monitoring of progress against strategic objectives, identification of gaps, and informed resource allocation. A strong HIS also supports transparency, enhances planning and budgeting processes, and strengthens emergency preparedness through real-time surveillance and reporting.

Achievement against HSSP (2023-2027) targets

- **Red**: limited or no progress (<50% of 2025 target);
- **Orange**: some progress, but not enough to achieve the target (50 to 99% of 2025 target);
- **Green**: good progress, target (2025) achieved or even surpassed

__Table 39__: Achievement against targets: Health information systems

Objective	Indicator	Baseline	Achievement 2025	Target (HSSP)		Progress (performance) - and colour	Data source	Comment
				Target 2025	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	40.40%	52.15%	70%	90%	74.5%	DHIS2	
	Completeness of reporting by facilities/ Reporting rate	49.50%	62.96%	70%	90%	89.9%	DHIS2	
	IDSR completeness	54%	14.50%	76%	90%	19.1%	DHIS2	EWARS remained a main platform for IDSR compared to DHIS2 hence low coverage
	Proportion of health facilities reporting directly through DHIS 2	N/A	30%	55%	90%	54.5%		HFs providing TB and HIV services were provided with tablets and bundles to directly report in DHIS2
	Percentage of states that conducted data quality assessments (DQA)	N/A	100%	60%	80%	166.7%	Activity Report	The indicator geared toward states rather than sampled HFs of <580 countrywide
	Birth Notification coverage	35%	2%	48%	55%	4.2%	DHIS2	Still at pilot stage
	Death notification coverage	N/A	ND	45%	55%			CRVS is in pilot phase at HFs
Strengthen monitoring and evaluation systems at all levels	% of programs conducting annual performance reviews	N/A	62.50%	48%	80%	130.2%	Activity Report	5 programs out of 8 conducted performance reviews
Performance index						63.2%		

Health Information System achievements against targets

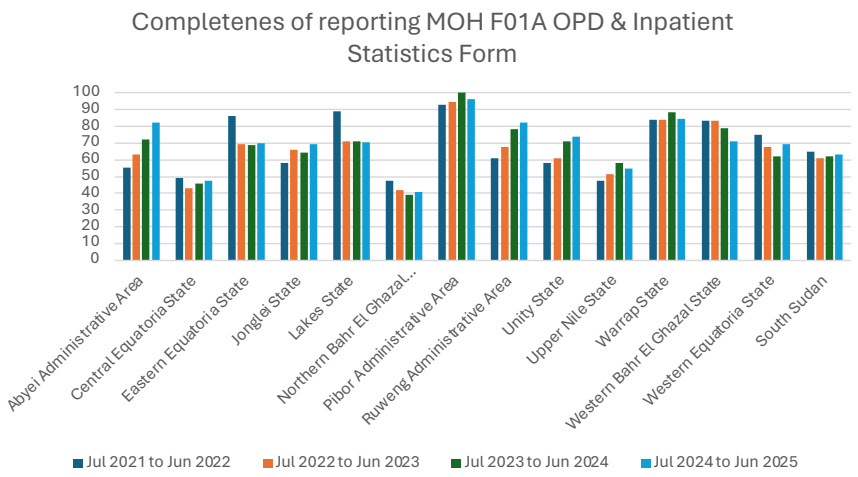

***Figure 43**: Completeness of reporting MOH F01A OPD & Inpatient Statistics Form (DHIS2)*

Figures 43 and 44 illustrate trends in completeness and timeliness of reporting for MOH F01A outpatient and inpatient statistics forms across South Sudan's states and administrative areas from July 2021 to June 2025. At the national level, completeness declined slightly from 59.38% in 2021/22 to 52.15% in 2024/25, while timeliness remained relatively stable, moving from 64.62% to 62.98% over the same period–both indicators falling short of the 2025 target of 70%.

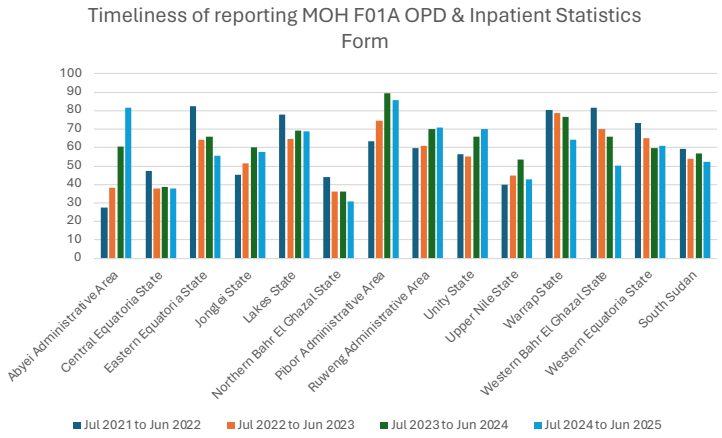

***Figure 44**: Timeliness of reporting MOH F01A OPD & Inpatient Statistics Form (DHIS2)*

States such as Greater Pibor Administrative Area and Warrap State consistently achieved high performance in both measures, whereas Central Equatoria and Northern Bahr el Ghazal remained below 50%, reflecting persistent challenges in infrastructure, connectivity, and capacity. These patterns underscore systemic issues, including parallel reporting systems and incomplete submissions, and highlight the urgent need for accelerated interventions in ICT infrastructure, direct DHIS2 reporting, and capacity building to strengthen data quality and achieve Health Sector Strategic Plan targets.

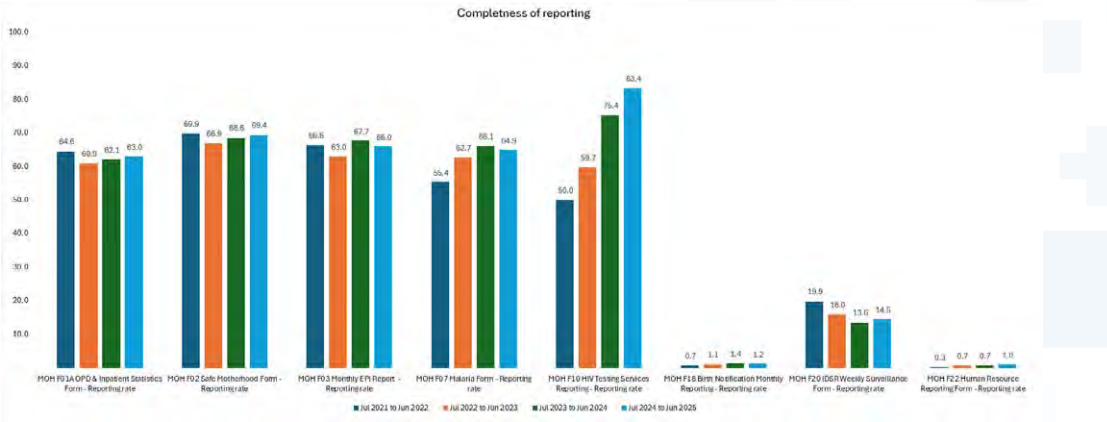

***Figure 45**: Completeness of reporting for selected forms (DHIS2)*

Figures 45 and 46 illustrate trends in completeness and timeliness of reporting across key MOH forms from July 2021 to June 2025. At the national level, completeness for core service delivery forms such as OPD/Inpatient (MOH F01A), Safe Motherhood (MOH F02), and Monthly EPI (MOH F03) remained relatively stable, averaging between 60% and 65%, while HIV Testing Services (MOH F10) showed significant improvement, rising from 50.8% to 83.4%. By contrast, completeness for Birth Notification (MOH F1B), IDSR Weekly Surveillance (MOH F20), and Human Resource (MOH F22) forms remained very low, below 15%. The IDSR form is currently reported through the EWARS platform, and the Ministry is working to ensure interoperability between EWARS and DHIS2. Once integration is complete, the reporting rate for the IDSR form will be accurately reflected within DHIS2.

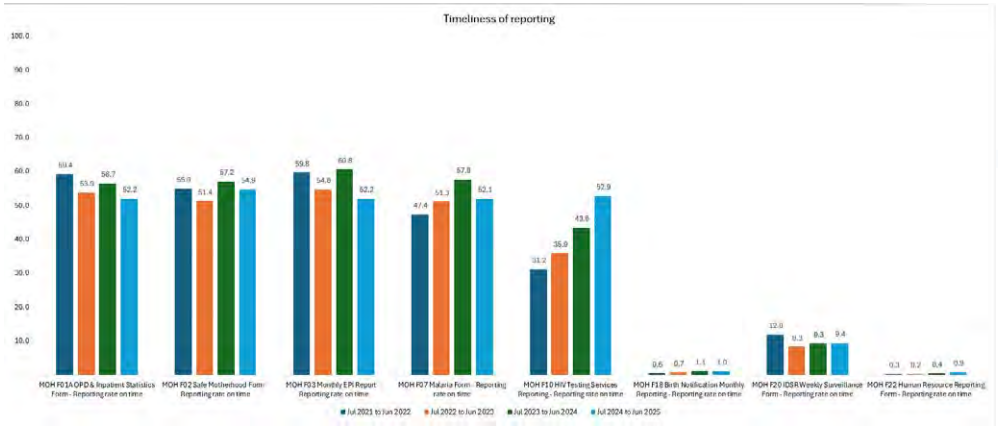

***Figure 46**: Timeliness of reporting for selected forms (DHIS2)*

Timeliness followed a similar pattern, with OPD/Inpatient and maternal health forms averaging 50–60%, while HIV Testing Services improved from 31.2% to 52.9%. However, timeliness for birth and death notifications and IDSR reporting remained below 10%, reflecting systemic challenges in data flow and integration. These trends highlight progress in high-priority programme areas but underscore persistent weaknesses in mortality reporting, surveillance, and HR data, calling for targeted investments in interoperability, ICT infrastructure, and capacity building to strengthen routine reporting and achieve Health Sector Strategic Plan targets.

The proportion of health facilities reporting directly through DHIS2 stands at 30%, compared to the 2025 target of 55%. This represents facilities equipped with tablets and computers for direct DHIS2 reporting. All states successfully conducted Data Quality Assessments (DQAs), surpassing the target of 80%. However, birth notification coverage remains very low at 2% of all live births in both community and facility settings, primarily because the initiative is still in its pilot phase and has not yet been fully rolled out.

In efforts to strengthen monitoring and evaluation systems at all levels, the programme supported program-specific annual performance reviews. Overall, 5 out of the targeted 8 reviews were conducted.

Key interventions

Governance and Coordination

During the 2024/25 financial year, the Ministry of Health strengthened health information system governance by operationalizing the Monitoring and Evaluation (M&E) Technical Working Group, which meets monthly to review progress, address bottlenecks, and provide oversight for data management and reporting at national and state levels. These meetings improved coordination among programs and partners, ensuring alignment with national priorities. In addition, a Data Governance Framework was developed, defining access roles and accountability measures, and was integrated into updated HMIS SOPs to enhance data security and governance.

Infrastructure and Connectivity

To address persistent challenges in connectivity and power supply, ICT infrastructure and hardware were deployed to selected health facilities, complemented by solar power solutions and internet connectivity via Starlink. These investments aimed to reduce delays in data submission and improve the reliability of reporting systems.

System Maturity and Strategic Planning

A Health Information System (HIS) Maturity Assessment, conducted using the WHO HIS Barometer and SCORE tools, revealed an overall maturity score of 40.5%, classified as minimal. Strengths were noted in population denominator data (67%) and data analysis (63%), while critical gaps were identified in HIS financing (7%), strategic planning (13%), and birth and death data systems (25%). These findings informed the development of a roadmap for HIS strengthening and prioritized actions for capacity building and resource mobilization.

Capacity Building and Data Use

Training sessions were conducted for key stakeholders on data analysis and interpretation to enhance evidence-based planning and resource allocation. Quarterly data review meetings were institutionalized at national and subnational levels to monitor reporting performance and provide feedback to facilities. Further, technical lab sessions were held to strengthen DHIS2 configuration skills, and an e-learning platform was identified to support ongoing training needs, reducing costs and mitigating staff attrition at subnational levels.

Data Quality and Mortality Reporting

Data Quality Assessments (DQAs) and Data Quality Reviews (DQRs) were conducted to assess completeness, timeliness, and internal consistency of reported data across key programs. The reviews highlighted gaps in timeliness and logical consistency, which informed corrective actions such as targeted training and system enhancements.

The Ministry launched ICD-11 in 10 hospital states to standardize cause-of-death reporting and improve mortality data quality. Work began on integrating Medical Certification of Cause of Death (MCCoD) data into DHIS2 to enable routine reporting of mortality statistics in line with global standards. Efforts to improve death notification and cause-of-death reporting are ongoing, with ICD-11 implementation expected to enhance data availability in subsequent years.

A Trends in Deaths by Cause (2019–2024) analysis was developed to provide insights into major causes of mortality across South Sudan and support evidence-based planning.

The Health Statistical Report (2024) was produced to consolidate health sector data and provide stakeholders with a comprehensive overview of performance indicators. This product aims to strengthen evidence-based decision-making and improve accountability.

Data Architecture Strengthening

Significant progress was made in strengthening health information system (HIS) architecture and interoperability. A comprehensive HIS assessment and data flow documentation were completed, mapping data capture processes for selected programs from facility level to DHIS2, which was confirmed as the master facility list to support interoperability. Facility data cleanup validated approximately 70% of health facilities, addressing duplicates and "ghost" facilities and categorizing them by functionality, type, and ownership to improve service delivery tracking.

Alignment of datasets was undertaken by assigning data elements based on actual services provided, enhancing accuracy and relevance. Interoperability advances included facility matching between DHIS2 and EWARS for over 500 facilities, establishment of ETL principles, and initiation of automation steps to enable seamless data exchange.

Challenges

The health information system faces several operational and structural challenges. Multiple platforms currently operate in parallel, creating duplication of effort and inconsistencies in data. This lack of integration limits the ability to produce a unified view of health service delivery and outcomes. In addition, many health facilities experience difficulties in completing and submitting reporting forms on time, resulting in gaps in routine data and undermining the reliability of indicators used for planning and decision-making.

Infrastructure limitations further compound these issues. Hospitals and Primary Health Care Centers (PHCCs) often lack essential resources such as computers, stable internet connectivity, and adequately trained personnel to enter data directly into DHIS2. As a result, data entry is frequently centralized or delayed, introducing errors and reducing the timeliness of information available for decision-making.

3.5 LEADERSHIP, GOVERNANCE AND PARTNERSHIPS

The role of leadership, governance, and partnerships is central to driving health system performance and achieving sustainable health outcomes in South Sudan. Leadership provides strategic direction, formulates policies, and ensures accountability across all levels of the health sector. Governance structures establish oversight mechanisms, clarify roles and responsibilities, and promote transparency in decision-making, while partnerships mobilize technical, financial, and operational resources through collaboration with development partners, civil society, and the private sector.

Together, these elements underpin effective coordination, resource alignment, and evidence-based planning, enabling the health system to respond to challenges and advance toward Universal Health Coverage and national priorities. This section reviews progress in strengthening leadership and governance structures, enhancing coordination mechanisms, and fostering partnerships that support policy implementation, resource mobilization, and accountability across the health sector.

Achievement against HSSP (2023-2027) targets

- **Red**: limited or no progress (<50% of 2025 target); - **Orange**: some progress, but not enough to achieve the target (50 to 99% of 2025 target); - **Green**: good progress, target (2025) achieved or even surpassed

***Table 40**: Achievement against targets: Leadership, governance and partnerships*

Objective	Indicator	Baseline	Achievement 2025	Target (HSSP)		Progress (performance) -and colour	Data source	Comment
				2025	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 organogram reviewed and implemented	0	0	1	1	0.0%	Programme report	2013 version being reviewed
	State ministry of health organograms reviewed and implemented	0	0	13	13	0.0%	Programme report	2021 version being reviewed
	Ministry of health costed annual operational plan developed and implemented	0	1	1	1	100.0%	Programme report	Achieved, AOP developed for the national level
	Percentage of state Ministries of health with annual operational plans developed and implemented	0%	77%	100%	100%	77.0%	Meeting minutes	First time the different levels develop AOPs hence the change from 0% to 77%
	Percentage of health sector steering committee meetings held at the national level	50%	25%	100%	100%	25.0%	Meeting minutes	Coordination challenges
	Percentage of state ministries of health conducting regular coordination meetings	58.30%	100%	80%	100%	125.0%	Meeting minutes	Regular coordination meetings are conducted at the sub-national level
Strengthen partnership for health service delivery and health systems development	Percentage of inter-ministerial/inter-sectoral coordination forum meetings held at national level	No data	80%	80%	100%	100.0%	Meeting minutes	The scheduled meetings were all held
	Percentage of Health Ministerial Advisory Board meetings	50%	75%	100%	100%	75.0%	Meeting minutes	Senior Management Board acts as Advisory Board
	Public Private Partnership for Health Policy in Place	0	0	1	1	0.0%	Programme report	PPP policy development is in initial stages
Performance index						53.0%		

The Ministry of Health made significant progress in institutionalizing annual operational planning through the development of an AOP manual, guidelines, and standardized templates for all levels of the health system. Using these tools and a coordinated planning process, all states–except the three Administrative Areas–developed their AOPs for the first time, a major milestone for sector-wide planning. Additionally, 17 national and subnational officials were trained to produce AOPs aligned with the Health Sector Strategic Plan (HSSP).

For the first time, a fully costed national AOP was also developed and implemented, marking a major advancement from a baseline of zero. These achievements strengthened planning capacity, standardized practices across the country, and improved the translation of strategic priorities into actionable, costed plans, laying a stronger foundation for coordinated service delivery and better health outcomes in South Sudan.

OBJECTIVE 1:

Strengthen leadership and governance within the Ministry of Health

Progress against this objective has been mixed across key indicators:

- **Organogram review and implementation**

  Both the national and state-level organograms are outdated and have not been reviewed or implemented by 2025. The national organogram dates to 2013, while the state-level version is from 2021.

- **Costed Annual Operational Plan (AOP)**

  The Ministry successfully developed and implemented a cost AOP at the national level, meeting the 2025 target.

- **State-level AOPs**

  A significant milestone was reached, with 77% of state Ministries of Health (except Abyei, Pibor, and Ruweng) developing and implementing AOPs for the first time, marking the first time such plans have been available across both previous and current HSSP cycles.

OBJECTIVE 2:

of the HSSP 2023-2027, to strengthen partnerships for health service delivery and systems development, has shown varied progress across coordination and policy indicators

- **National Health Sector Steering Committee meetings**

Only 25% of planned meetings were held by 2025, a decline from the 50% baseline and far below the 100% target. This indicates a significant gap in national-level coordination.

- **State-level coordination meetings**

Coverage reached 100% by 2025, up from 58.3% and surpassing the 2025 target of 80%. This reflects strong engagement and improved coordination at the subnational level.

- **Inter-ministerial/inter-sectoral forums**

With no baseline data, the achievement of 80% by 2025 meets the target, suggesting that all scheduled meetings were successfully conducted.

- **Health Ministerial Advisory Board meetings**

The achievement of 75% by 2025 is below the target of 100%. In place of a formal Health Ministerial Advisory Board, the Ministry currently utilizes a Senior Management Board, which effectively fulfills the advisory and oversight function on its behalf.

- **Public-Private Partnership (PPP) policy**

Slight progress has been made toward development of a PPP policy for health, with the baseline and target both at zero. The PPP for health policy is currently in its initial stages of development. Stakeholder engagement has already been undertaken, and a series of meetings is being held to provide technical support and guide formulation of the policy.

Challenges

Several systemic and operational challenges have affected progress across key areas. Delays in reviewing and finalizing organograms at both national and subnational levels have affected clarity of roles and responsibilities. Resource limitations have constrained the development and operationalization of Annual Operational Plans (AOPs) at all levels, reducing the effectiveness of planned interventions.

Priority alignment also remains a challenge, with gaps further exacerbated by partner-driven agendas. National-level coordination has weakened, as reflected in the decline in National Steering Committee meetings. In addition, progress on Public-Private Partnership (PPP) policy development has been slow, primarily due to financial constraints.

CHAPTER 4.
SPECIAL FOCUS AREAS

Special focus areas are selected thematic priorities that require deeper analysis because of their critical role in achieving health outcomes and strengthening system resilience. These areas go beyond routine performance tracking to provide a detailed assessment of interventions that have high impact on service delivery and health system transformation.

The purpose of this focus is to highlight progress in these areas while emphasizing their importance toward achieving the objectives of the Health Sector Strategic Plan (HSSP) 2023-2027. The thematic areas include: Health Sector Transformation Project (HSTP), a flagship initiative supporting delivery of essential health and nutrition services and health systems strengthening; Status of Hospital Services, evaluating infrastructure, readiness, and specialized service provision; Malaria, with intensified interventions for prevention and treatment toward pre-elimination targets; and BHI, which scales up integrated community-based health services to improve equity and access.


World Health Organization
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4.1 THE HEALTH SECTOR TRANSFORMATION PROJECT

Background

The health sector in South Sudan has long been supported by a wide range of development partners and humanitarian actors. However, this support has often been delivered in a fragmented and uncoordinated manner, leading to duplication of efforts, inefficient use of resources, and misalignment with national priorities. Recognizing the urgent need for a more harmonized and strategic approach, and under the leadership of the Ministry of Health, the HSTP was launched.

The HSTP is a three-year (1 July 2024 to 30 June 2027) multi-donor trust fund project implemented in South Sudan. Its interventions were jointly developed with partners and the different directorates of the Ministry of Health. The project is fully aligned with the South Sudan Health Sector Strategic Plan (HSSP 2023-2027), which aims to improve the health status of the population through effective delivery of the BPHNS and highlights partnership with donors to support key health sector programs as one of its strategic objectives. The Project Development Objective is to expand access to a basic package of health and nutrition services, improve health sector stewardship, and strengthen the health system. The project comprises four components: Provision of Basic Health and Nutrition Services, Health System Strengthening, Monitoring, Evaluation, and Project Management, and Contingent Emergency Response.

Scope of the Project

The Health Sector Transformation Project currently covers 10 states and 3 administrative areas. The initial aim at inception was to reach 1,158 facilities in three phases: Phase 1 (816 facilities), Phase 2 (1,000 facilities), and Phase 3 (1,158 facilities). As of now, the project covers 816 health facilities across South Sudan.

Table 41: Number of HSTP supported Bomas by state

HSTP Phase I Boma by State	
State	**# of Boma**
Central Equatoria	89
Eastern Equatoria	118
Jonglei	90
Lakes	102
Northern Bahr El Ghazal	75
Greater Pibor Administrative Area	12
Ruweng Administrative Area	33
Unity	79
Upper Nile	83
Warrap	108
Western Bahr El Ghazal	22
Western Equatoria	120
Grand Total	931

Implementation arrangements

The implementation of the HSTP is guided by a multi-tiered governance and operational structure to ensure strategic oversight and effective delivery. At the highest level, the High-Level Steering Committee provides policy direction and strategic guidance, while the Operational Steering Committee focuses on technical review and operational oversight. The Ministry of Health senior management provides technical leadership, complemented by portfolio review meetings that assess overall performance. The World Bank supports implementation through regular Implementation Support Missions, providing supervision and operational guidance. Day-to-day management of the project, including grant and contract administration, is undertaken by the Project Management Unit (PMU). At the subnational level, State Ministries of Health and County Health Departments oversee service delivery by implementing partners in collaboration with NGOs.

The implementation structure relies on managing organizations contracted by the PMU. UNICEF is responsible for service delivery and has subcontracted 28 implementing partners operating across 80 counties organized into 28 lots. WHO leads health systems strengthening interventions, ensuring alignment with national priorities.

To enhance accountability and data integrity, the PMU engages third-party monitoring agencies to verify reported data, conduct surveys and assessments, and monitor implementation progress.

The HSTP is structured around four components designed to improve access to essential health services and strengthen the health system.

Component 1:

Provision of Basic Health Services Nationwide

This component focuses on delivering prioritized services from the BPHNS across the country. It includes facility-based delivery of high-impact health and nutrition interventions, expansion of the Boma Health Initiative for community-based care, last-mile delivery of pharmaceuticals and supplies, and integration of climate-resilient approaches to ensure continuity of services in fragile and disaster-prone settings.

Component 2:

Health System Strengthening

Aligned with the Health Sector Strategic Plan, this component aims to build the capacity of the health system to improve access and quality of care. Activities include strengthening emergency preparedness and response; enhancing laboratory systems and disease control; improving blood banking and transfusion services; institutionalizing quality-of-care standards; upgrading health management information systems; and reinforcing stewardship and financing mechanisms at national and subnational levels.

Component 3:

Monitoring and Evaluation, and Project Management

This component supports robust monitoring and evaluation to generate credible data on service delivery and commodity availability. It ensures that data are analyzed and used for decision-making by the Government, the World Bank, and partners. Key activities include development of data analysis and visualization platforms, capacity building for contract and programme management, and overall project coordination to maintain accountability and minimize risks.

Component 4:

Contingent Emergency Response (CERC)

The CERC provides flexibility to reallocate funds during emergencies such as disease outbreaks or food insecurity. It enables rapid response and recovery by allowing contracted agencies, through the Project Management Unit (PMU), to access resources for eligible emergency interventions. Disbursements under this component require an official emergency declaration and an operational manual agreed upon with the World Bank.

During the reporting period, significant progress was made in expanding access to essential health services and strengthening health systems under the Health Sector Transformation Project. Malaria case management improved markedly, with over 2.17 million patients–representing 88% of confirmed cases–receiving first-line antimalarial treatment in line with national guidelines, and a treatment compliance rate of 97% across suspected cases. Safe motherhood services reached 164,695 pregnant women, contributing to improved maternal health outcomes. Routine immunization coverage was enhanced through supported outreach activities, achieving 92% for Penta 1 and 76% for Penta 3.

Supply chain performance was strengthened through three cycles of last-mile distribution of pharmaceuticals and medical supplies to 816 health facilities, while C1/C2 kits were delivered to 1,158 facilities.

Waste management systems were improved through the development of an e-waste management plan and assessments in 28 high-volume facilities, and infrastructure risk management was enhanced through site-specific Environmental and Social Management Plans for warehouses and assessments for minor rehabilitation of regional warehouses. Renovation of health facilities under the project further supported service readiness.

Challenges

The implementation of the HSTP has faced multiple challenges that have slowed progress and constrained expansion. Budget and funding limitations remain a major obstacle, with non-payment of the government's co-financing share stalling the rollout of Phases 2 and 3. Delays in fund disbursement to managing organizations have created operational bottlenecks, affecting activity implementation and postponing health worker incentive payments, which continues to undermine staff motivation, retention, and service continuity.

The shrinking presence of partners has further increased pressure on HSTP-supported facilities, as withdrawals from high-burden areas have created service gaps that remaining partners must absorb. Insecurity in several counties–including looting of medical supplies and destruction of ambulances in Morobo, Akobo, and Ulang–has disrupted operations and limited population access to essential services. Seasonal flooding and poor road conditions compound these challenges, making last-mile delivery difficult and often necessitating costly air transport to maintain supply chains.

Persistent delays in the delivery of essential health commodities, including laboratory reagents, continue to strain service delivery. Procurement delays, long shipment lead times, fragmented distribution systems, and limited storage capacity restrict the ability to pre-position supplies ahead of the rainy season and respond efficiently to service needs.

Moving forward

Closing existing financing gaps remains a critical priority for sustaining and expanding the Health Sector Transformation Project. This will require robust resource mobilization, including honoring the government's co-financing commitments, revisiting overhead costs for managing organizations, financial service providers, and implementing partners, and transitioning to regional procurement of supplies to reduce in-country logistics costs. Protecting health facilities, supplies, and health workers must remain integral to planning and operational decisions, particularly in conflict-affected areas where security risks remain high.

The continued involvement and leadership of relevant Ministry of Health directorates, supported by regular joint reviews, will be essential for tracking progress and addressing implementation bottlenecks. These processes will reinforce accountability and ensure evidence-based decision-making. Clear and consistent communication on the scope and limitations of the HSTP is also necessary to avoid misinterpretation. Key clarifications include that the project focuses on basic health and nutrition services, provides temporary incentive allowances rather than salaries, and emphasizes government-led coordination over fragmented NGO-driven delivery.

4.2 MALARIA MANAGEMENT

South Sudan made significant strides in strengthening malaria prevention, diagnosis, and treatment through a series of high-impact activities implemented by the National Malaria Control Program (NMCP) with technical and operational support from WHO, UNICEF, and partners. These achievements demonstrate the country's commitment to accelerating progress toward malaria elimination and improving population health outcomes.

Malaria vaccine introduction and scale up

The introduction of the WHO-endorsed R21 malaria vaccine (MV) in July 2024 marked a pivotal step in combating malaria transmission in high-incidence areas. The initial phase of the rollout, however, revealed significant challenges. While the first dose (MV1) reached 148,878 children by May 2025, this represented only 56% of the Phase One target. More critically, the program experienced severe dropout rates, with 43.8% of children not returning for the second dose (MV2) and a 65.7% dropout between the second and third doses (MV3). This indicates major gaps in retaining children in the multi-dose schedule, severely affecting progress toward the objective of achieving 50% coverage for all four doses.

Learning from these difficulties, Phase Two aims to scale up the program to 52 new counties, targeting over 324,571 people across 535 health facilities starting in the third quarter of 2025. Its objectives are rightly focused on correcting Phase One shortcomings by enhancing vaccine uptake, reducing the MV1-MV2 dropout rate to below 30% and the MV1-MV3 dropout rate to below 50%, and ensuring sustained community demand.

The MoH led the malaria vaccine rollout through intensive coordination with support from WHO. A national task force, steered by the EPI manager with input from the NMCP and the Immunization TWG, met weekly. Participants were drawn from various entities, including the MoH, WHO, UNICEF, World Vision (core group), SSWIM, among others.

The scale-up of MV in 52 counties was integrated with the introduction of the second dose of measles-containing vaccine (MCV2), which was being introduced in all 80 counties in South Sudan. This integration created an opportunity to strengthen implementation of MV in the 28 counties where it was initially introduced in July 2024, since training was conducted across all 80 counties. It also supported implementation of other new vaccines (PCV and Rota). In total, 26 national facilitators were oriented and deployed to state and county training sites to facilitate subnational training. A total of 476 state Trainers of Trainers (TOTs) and 2,241 vaccinators were trained and deployed across states and administrative areas. Among the TOTs, 264 (56%) are male and 212 (45%) female; among vaccinators, 1,344 are male and 849 female.

Training was completed in 71 of the 80 targeted counties, with five counties pending due to insecurity and four due to access challenges. Forty-seven (90%) of the 52 counties targeted for MV scale-up launched vaccination, whereas 75 (94%) of the 80 counties targeted for MCV2 launched.

Completion of the 2023-2024 Therapeutic Efficacy Study (TES)

The NMCP conducted a Therapeutic Efficacy Study (TES) to assess the effectiveness of artesunate-amodiaquine (ASAQ) and artemether-lumefantrine (AL), the first- and second-line treatments for uncomplicated Plasmodium falciparum malaria, respectively. Conducted across sentinel sites in Wau, Bor, Yambio, and Juba, the study confirmed sustained efficacy of both regimens, with no treatment failures detected. WHO facilitated advanced molecular analysis of dried blood spot samples in Australia to test for K13 mutations and HRP2 deletions, which are markers of antimalarial resistance and false-negative rapid diagnostic test results, respectively. The findings informed the development of a national policy brief supporting the introduction of Multiple First-Line Therapies (MFT) to preserve treatment efficacy.

Advancement of Subnational Malaria Stratification (SNT)

South Sudan achieved major milestones in subnational stratification (SNT), a core pillar of the Global Technical Strategy for Malaria 2016-2030. With WHO support, the country completed epidemiological stratification, analysis of determinants of malaria transmission, intervention tailoring, and prioritization. The SNT categorized counties into four transmission levels–high, moderate, low, and very low–enabling more precise deployment of interventions based on local epidemiological data. Findings from the epidemiological stratification show malaria incidence rising from 95 per 1,000 population in 2021 to 185 per 1,000 in 2024, and to an estimated 403 per 1,000 after adjustment for reporting gaps, underscoring the urgent need for tailored, data-driven action.

Malaria Programme Review (MPR)

The NMCP, with support from WHO, UNICEF, and partners, is in the final stages of completing an inclusive Malaria Program Review (MPR) to guide the transition to the next National Malaria Strategic Plan (2026-2030). The review includes an in-depth analysis of malaria program performance and subnational field assessments in Warrap, Lakes, Unity, Eastern and Western Equatoria, Abyei, and Pibor. It has identified priority gaps and generated evidence-based recommendations that will shape future policies and ensure alignment with global standards.

Launch of the High Burden High Impact (HBHI) Initiative

The WHO Global Malaria Programme (GMP) selected South Sudan for inclusion in the second tier of High Burden High Impact (HBHI) countries because the country contributes about 1% of the global malaria burden. HBHI, launched by WHO and the Roll Back Malaria (RBM) Partnership, is a targeted response to reignite progress in countries with the highest malaria burden. The initiative emphasizes country-led approaches, political commitment, strategic use of data, and coordinated multisectoral efforts to reduce malaria cases and deaths. South Sudan's inclusion in HBHI is critical to accelerating progress toward the Global Technical Strategy for Malaria 2016-2030 targets and the Sustainable Development Goals.

Political will and leadership

The assessment revealed that while the Minister of Health and the Director General for Primary Health Care frequently emphasize malaria as a leading cause of morbidity and mortality in official communications, higher levels of government rarely mention it in national addresses or budget speeches. Parliamentary engagement on malaria remains ad hoc, typically triggered by emergencies, and there is no regular agenda item on malaria within specialized health committees. Coordination between the NMCP and Parliament is weak, with limited invitations for parliamentarians to technical working groups and a lack of tailored briefs or constituency-level data. Strengthening political will require systematic engagement with Parliament and targeted advocacy to secure malaria-specific attention in national policy dialogues and budget discussions.

Awareness and communication

The assessment found that although an updated Social and Behavior Change (SBC) strategy exists, its implementation has been inconsistent, largely due to funding constraints. Communication targeting political leaders and community chiefs is not systematic, and the "Zero Malaria Starts with Me" campaign launched in 2023 has not been sustained across media channels. Intermittent malaria communication activities have occurred through radio and IEC materials, often integrated into broader health initiatives. To improve awareness, a structured communication plan with regular briefs, dashboards, and infographics should be developed and sustained across multiple platforms, ensuring integration with other health campaigns such as the Boma Health Initiative and the Expanded Programme on Immunization.

Financing

The national health budget allocation in South Sudan ranges between 1.5% and 2%, far below the Abuja target of 15%. Within this limited allocation, malaria-specific funding is not clearly defined, and most malaria-related expenditures are covered by external partners. While the government supports salaries and some operational costs, direct funding for malaria interventions remains minimal. To address this gap, the HBHI approach recommends establishing multisectoral resource mobilization mechanisms, including an End Malaria Fund, to complement government and partner resources and catalyze increased domestic funding for malaria control.

Strategic information

Effective malaria control requires robust surveillance and data systems. The assessment identified the absence of an integrated national malaria data repository linked to DHIS2 as a major operational gap. In addition, private health facilities are not systematically reporting data into the national health information system. Addressing these gaps will require creating a centralized malaria data repository integrated with DHIS2, supported by data-sharing agreements with partners, and developing policies and standard operating procedures to ensure private-sector reporting. These measures will enable timely access to strategic information for evidence-based planning and intervention tailoring.

Analysis and subnational tailoring (SNT)

Subnational stratification and tailoring of interventions are ongoing with technical support from the WHO. However, the assessment highlighted significant gaps in national human resource capacity to conduct SNT and other analytical tasks, and data quality for stratification also needs improvement. Strengthening local technical capacity and reviving the SNT technical team are critical steps to ensure efficient targeting of resources and effective implementation of malaria interventions.

Ongoing planning for the distribution of LLINs

Planning for the distribution of 9.5 million insecticide-treated nets donated by the Against Malaria Foundation is ongoing. The country will distribute both piperonyl butoxide (PBO) and dual long-lasting insecticidal nets (LLINs) based on insecticide-resistance studies conducted in several states, which show resistance to standard insecticides. There is a need to conduct additional resistance studies to better understand the magnitude of insecticide resistance and guide the choice of insecticide-treated nets across all states.

Malaria treatment guideline review

To strengthen malaria case management nationwide, the NMCP, supported by WHO, UNICEF, and partners, completed the review and validation of the updated national malaria treatment guidelines, which were formally endorsed by the Ministry of Health for leadership. Building on this milestone, the programme trained 56 state malaria focal persons and implementing partners through a training-of-trainers approach. These trainers subsequently cascaded malaria case-management training to 2,757 frontline health workers in 76 of the 80 counties, significantly improving the consistency and quality of malaria diagnosis and treatment across the country.

4.3 MATERNAL AND NEWBORN HEALTH

Despite several years of multiple humanitarian crises, South Sudan has made some good progress in improving the health of women and children. The recent UN Inter Agency report shows a 59% reduction of maternal mortality ratio between 2000 and 2023 to now 692 deaths per 100,000 live births [8]. Neonatal mortality rate dropped from 56 to 40 per 1,000 live births in the same period of time, still the birth rate dropped from 39 to 28 per 1,000 total births while the under-five mortality rate decreased from 183 to 99 per 1,000 live births. Mortality rates among adolescents aged 10-14 years also decreased from 19 to 8 per 1,000 live births while, among 15-19-year-olds, it dropped from 29 to 15 per 1000 live births [9].

8 Trends in maternal mortality 2000 to 2023: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2023.

9 Levels & Trends in Child Mortality. Report 2023. Estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation.

Challenges

The disproportionately high burden of deaths is primarily driven by complications during pregnancy and childbirth–particularly bleeding, abortion complications, hypertension, and infections–combined with poor quality of care, all of which result in preventable deaths. Threats to the health and well-being of communities are largely due to the under-prioritization of sexual and reproductive health and rights services in planning, policies, and legal frameworks. This is further compounded by the high prevalence of communicable diseases, the growing burden of noncommunicable diseases, and widespread malnutrition. Adolescent health is a major concern, influenced by factors such as persistently high adolescent birth rates, a high burden of mental health disorders, and anemia. In addition, inequalities in child development outcomes remain a particular concern.

Limited access to and utilization of quality RMNCAH services continues to be a challenge. Only 19 out of every 100 births take place under the care of a trained health professional, meaning that most mothers give birth without skilled assistance. As a result, many newborns do not survive, with nearly 40 out of every 1,000 babies dying within the first month of life and 26 stillbirths occurring for every 1,000 births. In addition, only 3 out of every 100 health facilities are equipped to provide CEmONC, making it difficult for women to obtain life-saving care when complications arise during pregnancy and childbirth.

Cesarean sections account for 3% of deliveries in health facilities (DHIS2, 2024), representing only 1% of the total expected births occurring both inside and outside health facilities. This means that some women who need to deliver by cesarean section do not receive this service.

The influence of cultural norms also affects the health of women, children, and adolescents. This is typified by child marriage, which is a major driver of adolescent pregnancy and maternal mortality and is prevalent in South Sudan. Despite the enactment of legislation against sexual intercourse with children, enforcement is weak, and traditional practices often obstruct its application.

workers remain a critical challenge for achieving Universal Health Coverage. Shortfalls in the resource envelope limit the employment of all trained health workers. Suboptimal working conditions are fueling excessive out-migration, further weakening service delivery capacity. Diagnostic and treatment accuracy among health workers is low in some facilities, and health worker absenteeism is also widespread. These challenges call for reforms in professionalism, curricula, training, education, and health systems to align health worker skills with the evolving needs of the population.

The call for action

Stimulating investments in MNH as a socioeconomic development priority

Strengthening health governance and coordination is fundamental to creating an enabling environment for MNH investments. Leadership and governance for MNH should be enhanced through the implementation of intersectoral national health policies and strategies, complemented by regular national dialogues and accountability summits to track progress and align stakeholder actions.

Appropriate health sector reforms, including legislation guaranteeing the right to health, are essential to institutionalize accountability and equity. Engaging civil society, youth groups, and other stakeholders will ensure representation of individuals, families, and communities in prioritizing, planning, delivering, and monitoring health services at both national and subnational levels. Optimizing private sector contributions and incentivizing sustainable investments will strengthen health systems.

Political commitment must be reinforced by improving management skills through pre-service curricula, ensuring leadership autonomy, and promoting accountability for the health of women, children, and adolescents. Advancing a health-in-all-policies approach and fostering multisectoral coordination for policy development, planning, implementation, and monitoring will ensure inclusive and integrated action across sectors.

Stimulating and aligning health investments for mothers and newborns

Stimulating and aligning health investments for mothers and newborns requires positioning health as a top priority on the national strategic agenda. Regular high-level policy dialogues on health financing for Universal Health Coverage should be convened to drive commitment and resource allocation. Integration of health investment plans and the implementation of strategies to increase domestic resource mobilization, while leveraging external investment opportunities, will be critical for sustainability. Tracking resource use and assessing value for money will inform investment decisions and enhance accountability, ensuring that resources are directed toward interventions with the greatest impact on maternal and newborn health outcomes.

4.4 BOMA HEALTH INITIATIVE

In South Sudan, only 56% of the population lives within a 5 km radius of a health facility, creating a major coverage gap in access to services. In response to these inequities and in line with the government's commitment to strengthening the national health system and improving access to the Basic Package of Health and Nutrition Services (BPHNS), the government established a community health system called the Boma Health Initiative (BHI).

This flagship community health programme was officially launched in March 2017 and rolled out in 2018 to institutionalize community-level health services. It forms part of the formal structure of the health system at the boma level and is dedicated to delivering an integrated package of health promotion, disease prevention, and selected treatment services to individuals, families, and communities, using trained, equipped, and salaried community resource persons. The overall aim is to reduce morbidity and mortality due to preventable health conditions.

The BHI is not a project but an integral structure of the health system. It is governed by Boma Health Committees, staffed and managed by salaried Boma Health Workers (BHWs), technically supervised by Payam Health Supervisors, with referrals made to health facilities and routine reports submitted to the Payam Health Office.

Goal

A strengthened health system that efficiently delivers components of the BPHNS at community level to contribute to the achievement of universal health coverage.

Objectives

1. **Develop community health structures as a formal component of the national health system at the Boma level.**
2. **Increase access to quality health promotion, disease prevention, and selected curative services through community engagement.**
3. **Provide leadership for the implementation of the BHI through intersectoral collaboration and community participation.**

Progress

Currently, the BHI reaches 52% of bomas, with about 10,560 trained BHWs delivering integrated service packages at the community level across the country since its inception. In October, a BHI review was conducted to examine implementation progress, assess the effectiveness of Boma Health Workers, evaluate coverage across bomas, and gather recommendations for strengthening community health services. In addition, the Ministry of Health carried out a maturity assessment of community health/BHI to gauge the maturity of the community health system (health system building blocks) within the BHI and identify areas for improvement.

Table 42: Interventions delivered by BHWs

S/no	Intervention	Reached
1	ANC referrals	59,524
2	Mid-Upper Arm Circumference (MUAC) Screened U5	1,090,866
3	Immunization zero dose identified and re-ferred	30,458
4	Household reached with HEP	895,000

Source: programme report

Innovation

Geocoding and mapping of BHWs has been completed, enabling precise identification of coverage gaps and assessment of distances to linked health facilities. This has informed deployment strategies and improved resource allocation for community health services. In addition, biometric systems have been introduced to verify identities, reduce fraud, and streamline the disbursement of incentives and operational support, resulting in greater accountability and efficiency within the program.

Lessons learned

Fragmented and duplicative vertical approaches have resulted in resource inefficiencies, underscoring the need for integrated strategies and coordinated implementation. There is no allocation of domestic resources for operations, training, and supervision of community health workers, which limits sustainability and programme effectiveness. Furthermore, facility staff with high clinical workloads and limited technical skills have little or no time to provide community health services, highlighting the importance of dedicated community health cadres and capacity-building initiatives.

Table 43: BHWs supported partners

Partner	BHWs	BHWS	Bomas	Comments
HSTP	7,494	540	931	supported
AMREF /GF	1,000	47	24	supported
CORDAID/GF	1,472	64	209	supported
Momentum	217	9		no support / handed over to states
SSRC	247	0	15	missing data
MSF	130	17	24	supported
	10,560	668	1203	

Source: programme report

Challenges

Persistent stock-outs of essential medicines, including AS/AQ, amoxicillin, ORS, and zinc, continue to limit treatment effectiveness and increase reliance on clinical diagnosis in the absence of confirmed test results. Weak supply chain and logistics systems further exacerbate these shortages, undermining service delivery at both facility and community levels. High turnover and attrition of BHWs remain a significant concern, driven by irregular incentive payments and the absence of a defined career pathway or certification system. In addition, delays in completing subsequent phases of the BHI from Phase 3 onward have slowed progress toward full implementation and scale-up.

Way forward

Investing in systems and people is critical to strengthening community health delivery. Priority should be given to funding training for both existing and new BHWs on integrated service packages, including Social and Behavior Change Communication (SBCC). A cost-effective, phased supportive supervision plan should be implemented to ensure quality and accountability. In addition, integrating existing networks into the BHI program through a structured, phased approach will enhance efficiency and harmonization.

Empowerment for sustainability requires securing dedicated funding for Boma Health Committee activities to foster local ownership and accountability. Efforts should focus on integrating and scaling services through a trained and motivated community health workforce, ensuring continuity and resilience of primary health care delivery at the community level.

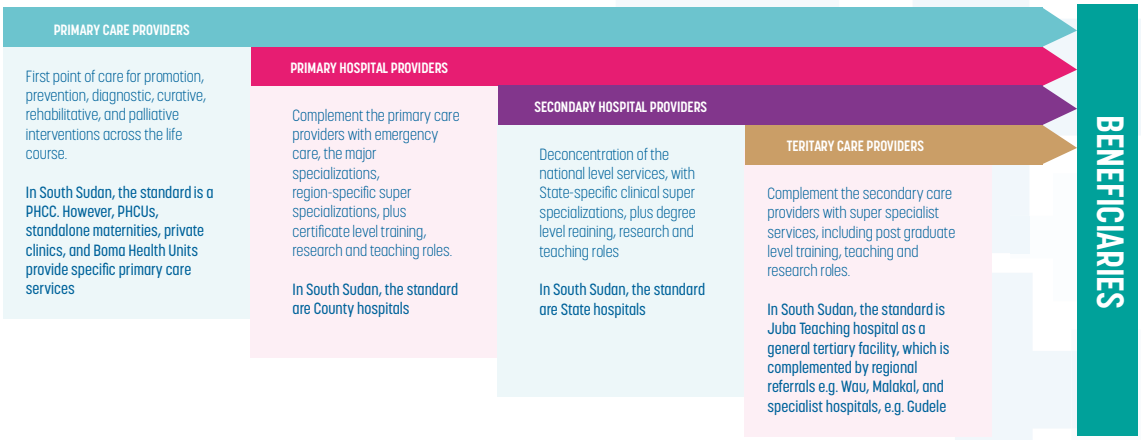
4.5 STATE OF HEALTH SERVICES PROVISION INSTITUTIONS

Context

The classification of health facilities is a critical part of the organization and management of health services, ensuring that care is efficiently and effectively made available to specific populations.

Health facilities are commonly classified into four levels, based on the range of services provided and their existing capacity, as shown in the figure below.

Categories of health service provision institutions [10]



The classification of a health facility therefore aims to map (1) which health provider category it best belongs to, and (2) what capacities it needs to invest in, for it to meet the standards of its given category.

Methodology

The assessment was conducted by designated focal points, including Hospital Directors, Medical Directors, and facility in-charges, with support from a WHO technical team. The team applied the WHO Facility Classification Tool to ensure a standardised and consistent review. The tool assesses both the range of services provided across the continuum of care and the facility's capacity to deliver those services, based on key health system investment areas.

Assessment outcomes

In total, four submissions were received from referral and teaching hospitals in Upper Nile, Western Bahr el Ghazal, Central Equatoria and Lakes State. Additionally, all State hospitals submitted their assessments. As part of the methodology, all tertiary hospitals were additionally assessed against the state hospital standards, reflecting their dual mandate and ensuring comparability across levels of care.

10 Source: The state of health in the WHO African Region: an analysis of the status of health, health services and health systems in the context of the Sustainable Development Goals. Brazzaville: WHO Regional Office for Africa; 2018 https://www.afro.who.int/publications/state-health-who-african-region

The following sections present the key assessment findings, structured around service availability, service readiness, and capacity gaps. They also highlight priority areas requiring improvement to align facilities with national standards.

National referral and teaching hospitals

Classification of the health facilities

A detailed, facility-level consolidation of this assessment is available in Annex 1.

Table 44: *Status of health service in health facilities: classification of health facilities*

Services areas	Expectations at the Tertiary level	Status*	Description	Required improvements
Promotion	Interventions that target health behaviors and appropriate health seeking actions.		Activities are available in all hospitals, but packages are not standardized and remain weakly integrated into disease-specific and life-course services, including NCDs, maternal and newborn health, pediatrics and adolescent care.	Standardize health promotion packages and fully integrate them across all age cohorts.
Prevention	Specialized preventive programs such as cancer screening (e.g., cervical, breast), genetic counseling, and advanced infectious disease prevention strategies.		Basic and intermediate prevention services exist across hospitals, but advanced tertiary-level interventions such as breast and cervical cancer screening and prostate assessments are not well established. Infection prevention for TB, HIV and hepatitis also remains limited.	Introduce standardized cancer screening protocols and strengthen advanced infection prevention and control services.
Diagnostic	Full diagnostic departments capable of molecular diagnostics, CT scans, MRIs, pathology and histology, enabling the identification of complex and rare conditions and serving as referral laboratories for the country.		Hospitals demonstrate diagnostic functions, but capacities fall below tertiary expectations. Advanced imaging (CT, MRI), molecular diagnostics, pathology, histology and radiology capacity are inadequate or absent. Some essential lab tests are missing.	Invest in advanced imaging, lab and pathology infrastructure, biomedical engineering and strengthen sample referral systems.
Curative	Highly specialized clinical interventions such as advanced surgery, oncology, cardiology, neurology, intensive care, and multi-disciplinary case management.		General curative care is available, but specialization is limited. ICUs and oncology services are scarce, chronic disease management is inconsistent and intensive care capacity is missing in several facilities.	Establish functional ICUs, expand specialized NCD and oncology care, improve advanced surgical capacity and formalize multidisciplinary case management.
Rehabilitative	Specialized rehabilitation units to serve patients with long-term conditions or post-surgical recovery needs covering occupational therapy, physical therapy, speech therapy and cognitive and behavioral rehabilitation		Rehabilitation services are inconsistent and incomplete. Two hospitals offer none at all, and where available, key components like speech or occupational therapy are missing. No hospital meets requirements for a full multidisciplinary rehab unit.	Establish dedicated rehab departments, train and recruit specialized staff and integrate rehab across key clinical pathways.
Palliative	Standalone palliative care unit providing pain, spiritual and psychosocial support for all the needs of beneficiary individuals.		Some hospitals offer basic pain management or limited psychosocial support, but none meet tertiary-level expectations. Two hospitals provide no palliative care services.	Establish integrated palliative care units with multidisciplinary teams, trained staff and strong linkage with oncology, HIV and chronic disease services.
Pre-service Training	Pre-service training for graduate & post-graduate health worker courses.		Most hospitals provide pre-service training, but the scope and depth vary widely; one facility only trains at the undergraduate level. Supervision structures are often informal or inconsistent.	Formalize supervision systems, expand postgraduate training programs and strengthen partnerships with academic institutions.
Internship	Internship orientation for graduate & post graduate HWs (for area of specialization).		Internship programs exist in most hospitals but vary in structure; two hospitals offer none. In places where internships exist, rotations and supervision are not always well defined.	Develop standardized internship frameworks, ensure specialist supervision and align programs with national training requirements.
Research	Initiate critical research for addressing health issues in the Country Participate in national and internationally commissioned health research.		Research activity varies greatly. Some hospitals conduct minimal studies, and two conduct none. Only one hospital shows strong research engagement, including national and international studies.	Establish research units, define institutional priorities, strengthen data and analytics capacity and build partnerships with universities and research networks.

*__Red__ - Not present; __Orange__- basic unit; __Yellow__- close to standard but missing some elements; __Green__ - all elements in line with standard

Overall, tertiary hospitals in South Sudan fulfil the expected functional domains in structure, but the level of specialization, comprehensiveness and readiness across these domains remains below the standards required for tertiary-level classification. Targeted investments in advanced diagnostics, specialized curative services, rehabilitation, palliative care, structured training programs and institutional research capacity are essential for enabling these hospitals to fully perform their role as national and state-level referral centers.

Capacity for patient-facing investment areas

A detailed, facility-level consolidation of this assessment is available in Annex 1.

Table 45: *Status of health service in health facilities: capacity for patient-facing investment areas*

Capacity area	Expectations at the Tertiary level	Status*	Description	Required improvements
Health infrastructure	Physical infrastructure - Hospitals must have outpatient units for general, specialized and super-specialist care, a fully equipped emergency unit with an emergency theatre and comprehensive imaging services including MRI, CT and PET scans. Laboratories should provide bacteriology, basic tests, culture and sensitivity, molecular diagnostics, pathology and histology. Operative capacity must include general, maternity and super-specialist theatres, supported by inpatient wards for medical, surgical, gynecology, pediatrics, maternity and specialist care. Critical care requires HDU, PICU, NICU and ICU services. Facilities must also include a functional pharmacy, a dedicated medical products store and a mortuary with adequate cooling capacity.		Physical infrastructure - Basic infrastructure for outpatient care, emergency services, inpatient wards, pharmacy and medical stores is largely available. However, major tertiary-level components are consistently underdeveloped. No hospital has advanced imaging (CT, MRI, PET), pathology or histology. ICU, PICU and NICU capacity is limited or absent. Operative units function but do not meet super-specialist theatre standards, and mortuary capacity is uneven.	Invest in advanced diagnostic infrastructure, critical care readiness, super-specialist operative capacity and standardized mortuary services.
	Medical Equipment - Hospitals ust have medical equipment must support comprehensive specialized and super-specialist care. This includes equipment for general and specialized outpatient units, fully equipped emergency units, and a complete imaging suite covering basic (X-ray, ultrasound), advanced (MRI) and specialized (PET scan) modalities. Laboratory units require equipment for basic tests, bacteriology, culture and sensitivity. Operative units must support maternity theatres, procedure rooms and general operating theatres. In-patient wards require equipment for surgical, maternity, pediatric and super-specialist care. Critical care units must be equipped for HDU, PICU and NICU services. Medical product stores require proper temperature-controlled storage, and mortuary units must have reliable cooling systems.		Medical Equipment - Basic infrastructure for outpatient care, emergency services, inpatient wards, pharmacy and medical stores is largely available. However, major tertiary-level components are consistently underdeveloped. No hospital has advanced imaging (CT, MRI, PET), pathology or histology. ICU, PICU and NICU capacity is limited or absent. Operative units function but do not meet super-specialist theatre standards, and mortuary capacity is uneven.	Procure advanced diagnostic and operative equipment, expand critical care device availability and strengthen biomedical engineering and maintenance systems.
	Referral transport - Hospitals must have reliable, fully equipped ambulances and transport vehicles to support referrals, emergencies, outreach and supervision..		Referral transport - Ambulances are available in some hospitals but vary in functionality and equipment levels. Utility vehicles are not consistently available, limiting referrals, outreach and supervision.	Ensure reliable, fully equipped ambulances and strengthen transport systems to support referrals, emergencies and supervision.
	Infrastructure readiness - Hospitals must have reliable dual-source power, a continuous 24-hour water supply and fully functional waste-handling systems that ensure safe segregation, treatment and disposal.		Infrastructure readiness - Power supply is unstable and often dependent on a single generator. Water supply is inconsistent in several hospitals. Waste management systems exist but do not fully meet tertiary-level standards for safe segregation and disposal.	Establish multiple power sources including renewable options, strengthen water supply systems and upgrade waste management facilities.
Health workforce	Tertiary hospitals must have County Hospital cadres plus general specialists, dentists and super-specialists, supported by professional and specialized nurses and midwives for theatres, anesthesia, emergency and inpatient care. Allied staff must include pharmacists, physiotherapists and technical assistants for medical, laboratory, pharmacy, x-ray, physiotherapy and anesthesia services. Management and administration must include senior leadership, departmental heads, health information staff, HR, procurement and finance teams, security, maintenance and biomedical engineering support..		Core medical, nursing and managerial teams are in place, enabling routine and intermediate services. However, availability of super specialists (oncologists, cardiologists, etc.) is limited. Specialized nurses for ICU, emergency, theatre and neonatal care are present but the expansion is still needed. Allied health cadres (physiotherapists, radiographers, lab technologists, anesthesia technologists, biomedical engineers) are inconsistently available. Some hospitals lack full specialization in HR, procurement, finance or health information roles.	Deploy super specialists, expand specialized nursing roles, ensure consistent availability of allied health cadres and strengthen managerial and support teams.
Health products	Hospitals must have essential medicines that cover all age groups and priority health conditions, including high-risk and specialized needs, with adequate supplies. This also includes all required vaccines for major public-health concerns such as malaria, yellow fever, BCG, DPT, measles, polio, pneumococcal, rotavirus, tetanus toxoid, diphtheria, meningococcal disease, hepatitis B and other epidemic-prone diseases, along with antirabies, antivenom and anthrax vaccines. Medical products of human origin mustbe available, including whole blood and breastmilk storage, fresh frozen plasma, platelets, red blood cells and tissues and organs for transplant. Where nationally approved, traditional products such as herbal remedies, medicinal teas, therapeutic oils, acupuncture, cupping, yoga and massage therapy should also be available.		Essential medicines are available with some variability. Routine vaccines are present, but specialized vaccines (antivenom, antirabies, anthrax) are inconsistent. Availability of blood and products of human origin (FFP, platelets, RBCs) is limited. Traditional and complementary products are absent.	Strengthen supply chains for specialized vaccines and biologicals, expand availability of blood and human-origin products and increase storage and cold chain capacity.

*__Red__ - Not present; __Orange__- basic unit; __Yellow__- close to standard but missing some elements; __Green__ - all elements in line with standard

Overall, tertiary hospitals have the foundational inputs required to function, but the level of specialization, readiness, and comprehensiveness of these investments remains below tertiary-level standards. Upgrading advanced diagnostics, operative capacity, critical care services, specialized workforce, availability of blood and products of human origin, and specialized vaccines and biological products is essential for tertiary hospitals to perform their role as national and state referral centres capable of delivering complex and high-acuity care. As state referral centres, tertiary facilities also require dedicated investments in physical infrastructure to effectively fulfil this mandate.

State Hospitals

Classification of the State hospitals

A detailed, facility-level consolidation of this assessment is available in Annex 1.

***Table 46:** Status of health service in health facilities: classification of state hospitals*

Services areas	Expectations at the State level	Status*	Description	Required improvements
Promotion	Interventions that target health behaviors and appropriate health seeking actions.		Several hospitals offer health-promotion activities aligned with expectations, but interventions are inconsistent. Some facilities provide only limited activities such as nutrition or physical-activity counselling, and a few offer none at all.	Establish structured, continuous health-promotion programs covering nutrition, hygiene, reproductive health and NCD prevention.
Prevention	Provides interventions offered at lower levels, including routine vaccinations, non-invasive screening, and early detection and management of high-risk conditions, and further expands the package through specialized maternal and neonatal screening, strengthened facility-based outbreak preparedness, and robust infection prevention and control.		Routine immunization and maternal health interventions are generally available. However, newborn screening for congenital anomalies is absent in several hospitals. Preventive capacity is uneven and lacks a dedicated unit to deliver comprehensive screening and preparedness.	Establish a dedicated disease-prevention unit that delivers newborn screening, antenatal care, chronic disease detection and strong outbreak preparedness.
Diagnostic	Capacity for advanced diagnostics for the top 5 causes of morbidity, mortality and/or condition of public health importance according for communicable and non-communicable at each age cohort		Diagnostic readiness varies. Most hospitals provide basic tests (e.g GeneXpert, stool tests), but several lack essential blood tests, and imaging is often limited to ultrasound. Only a few facilities approach expected diagnostic capacity.	Invest in essential lab panels, imaging equipment, trained diagnostic personnel and supporting infrastructure for reliable service availability.
Curative	Complements the primary hospital by providing emergency and specialized interventions responding to high-risk conditions for the area.		Capacity differs widely. Some hospitals lack specialist outpatient clinics and specialist theatre services, limiting management of complex or high-risk cases. Others offer broader specialist care but still have gaps in chronic disease management and emergency surgical readiness.	Strengthen human resources, equipment and service delivery infrastructure to ensure reliable specialist outpatient, inpatient and surgical services.
Rehabilitative	Specialized rehabilitation units to serve patients with long-term conditions or post-surgical recovery needs covering physical therapy, occupational therapy and speech therapy.		One of the weakest areas. Many hospitals provide no rehabilitation services, and where available, they are limited to basic physiotherapy without occupational or speech therapy.	Establish dedicated rehabilitation units offering physical, occupational and speech therapy for trauma, surgical recovery and chronic conditions.
Palliative	Multidisciplinary palliative care teams capable of managing complex pain, coordinating home-based care.		Services range from comprehensive symptom management in a few hospitals to minimal spiritual support or complete absence in others.	Set up structured palliative care units with multidisciplinary teams addressing pain, symptoms, psychosocial needs and spiritual care.
Pre-service Training	Pre-service training for graduate health worker courses.		Available only in a small number of hospitals. Others provide limited field exposure or none at all.	Establish structured pre-service training programs with clear supervision and defined learning objectives.
Internship	Internship orientation for graduate HWs & postgraduate (for area of specialization).		Largely limited to certificate-level trainees. Only one hospital offers full graduate-level internship orientation.	Develop full internship programs with supervised rotations and alignment with national training requirements.
Research	Initiate critical research for addressing health issues in the State. Participate in health research within the State.		The least developed domain. Only a few hospitals engage in health research; most do not conduct any research activities.	Establish research units, define institutional priorities and build partnerships with academic and research organizations.

*__Red__ - Not present; __Orange__- basic unit; __Yellow__- close to standard but missing some elements; __Green__ - all elements in line with standard

Overall, while State Hospitals demonstrate the presence of core functional areas, the scope, specialization and readiness of these functions are not yet at the level required for full State Hospital classification. Targeted investments in diagnostics, specialist curative services, rehabilitation, palliative care, training and research will be essential to strengthening State Hospitals as reliable referral hubs within the health system.

Capacity for patient-facing investment areas

A detailed, facility-level consolidation of this assessment is available in Annex 1.

Table 47: Status of health service in health facilities: capacity for patient-facing investment areas

Capacity area	Expectations at the State level	Status*	Description	Required improvements
Health infrastructure	Hospitals must have general and specialized outpatient clinics, emergency services, basic imaging and essential laboratory capacity, operating theatres, core inpatient wards, HDU and neonatal/pediatric critical care, plus a functional pharmacy, medical store and mortuary.		Physical infrastructure - General outpatient and emergency units are functional. Specialized outpatient services are inconsistent and incomplete. Imaging is limited to basic X-ray and ultrasound. Laboratory capacity is partial, with gaps in bacteriology, culture and sensitivity. Operative units exist but remain basic. In-patient wards are functional, but critical care capacity (HDU, NICU, PICU) is largely absent. Pharmacy and medical store systems exist but need better storage conditions. Mortuary services vary in adequacy.	Expand specialized outpatient services. Strengthen imaging and laboratory capacity with essential and intermediate-level diagnostics. Upgrade operative units. Establish HDU, NICU and PICU where feasible. Improve pharmacy and medical store infrastructure. Upgrade mortuary space and refrigeration.
	Hospitals must have essential equipment for outpatient, emergency, inpatient and operative care, along with basic imaging, laboratory and critical-care equipment needed for intermediate-level services.		Medical equipment - Essential equipment for outpatient, emergency, inpatient and operative care is available. Advanced diagnostic tools, critical care devices and full laboratory equipment are lacking.	Procure intermediate-level diagnostic tools, essential critical care devices and complete laboratory equipment sets. Strengthen biomedical maintenance capacity.
	Hospitals must have reliable, fully equipped ambulances and transport vehicles to support referrals, emergencies, outreach and supervision.		Referral Transport - Ambulances and administrative vehicles exist in some hospitals but are inconsistently available and unevenly equipped.	Ensure reliable availability of fully equipped ambulances and adequate transport for referrals, outreach and supervision.
	Infrastructure readiness - reliable dual-source power, a continuous 24-hour water supply and fully functional waste-handling systems that ensure safe segregation, treatment and disposal.		Readiness - Power supply is unreliable and often single-source. Water availability is inconsistent. Waste management systems are present but below required standards.	Ensure two reliable power sources, improve water supply continuity and upgrade waste handling and disposal systems.
Health workforce	Hospitals must have general specialists and dentists, nursing and midwifery staff, key allied professionals including pharmacists and technical assistants and a full managerial team for administration, HR, finance, procurement and facility support.		Nursing and midwifery are strong. Specialist doctors are limited, with most hospitals dependent on general practitioners. Allied health cadres (physiotherapists, radiographers, lab technologists, anesthesia technologists, biomedical engineers) are unevenly present. Managerial teams exist but lack specialized HR, finance, procurement and health information roles.	Deploy intermediate-level specialists. Increase availability of physiotherapists, radiographers, anesthesia and laboratory technologists and biomedical engineers. Strengthen managerial teams with specialized HR, finance, procurement and HIS roles.
Health products	Hospitals must have essential medicines for priority conditions, required vaccines for major public-health concerns, basic capacity for whole blood, plasma, platelets and red cells and traditional products where permitted.		Essential medicines are mostly available but vary in completeness. Routine vaccines are mostly available. Specialized vaccines and biologicals (antivenom, antirabies, anthrax) are limited. Blood and products of human origin are largely unavailable. Traditional products not offered.	Strengthen supply chains for essential medicines, specialized vaccines and biologicals. Expand availability of blood, plasma and platelets. Explore traditional products if aligned with national policy.

*__Red__ - Not present; __Orange__- basic unit; __Yellow__- close to standard but missing some elements; __Green__ - all elements in line with standard

Overall, State Hospitals have basic structures and systems in place and can deliver essential services, but many components remain below the standard required for this level of care. Targeted investments in diagnostics, critical care, specialist staffing, allied health roles, transport, supply management and advanced essential medicines will be necessary for State Hospitals to fully play their role as intermediate referral facilities within the national health system.

Capacities for required managerial processes

A detailed, facility-level consolidation of this assessment is available in Annex 1.

This section reviews the extent to which hospitals have established and maintained core management systems for service delivery, health information, and governance. The assessment focuses on whether key structures and processes are functional, documented, and aligned with national standards for State hospitals.

Table 48: Status of health service in health facilities: capacity for required managerial processes

Process area	Expectations for States and Tertiary facilities	Status*	Description	Required improvements
Service delivery	Functional therapeutic committee, patient rights and obligations charter, routine supervision and mentorship, comprehensive mortality audits, clear departmental roles and coordination, structured referral system		Therapeutic committees exist in some hospitals but function irregularly. Patient entitlement and service charters are available only in a few facilities. Supervision and mentorship occur but are episodic and limited to certain units. Mortality audits are conducted mainly for maternal deaths. Departmental coordination is uneven with unclear role definitions. Referral systems lack structure, documentation and feedback mechanisms.	Institutionalize and strengthen therapeutic committees. Develop and implement patient service charters. Establish routine, facility-wide supervision and mentorship. Expand mortality audits to all departments and align with national guidelines. Update organograms and clarify departmental roles. Strengthen referral pathways, documentation and feedback and introduce innovations such as specimen referral and rotating specialists.
Health information	Integrated DHIS2 reporting, routine monthly utilization reports, regular data verification, adherence to IDSR guidelines, systematic data analysis and use for decision making.		DHIS2 reporting is common, but integration with internal systems is incomplete. Routine monthly reports and verification are inconsistent.	Fully integrate hospital data systems, align with IDSR guidelines and institutionalize routine reporting, verification and data use in decision-making.
Governance	Annual and quarterly planning, routine performance reporting, functional coordination mechanisms, structured public engagement, regular management meetings		Operational planning and performance reporting vary widely. Public engagement and coordination mechanisms are limited. Management meetings are inconsistant.	Institutionalize annual and quarterly planning and reporting, strengthen coordination and public engagement and ensure regular leadership and management meetings.

*__Red__ - Not present; __Orange__- basic unit; __Yellow__- close to standard but missing some elements; __Green__ - all elements in line with standard

Findings highlight areas of compliance, operational gaps, and opportunities to strengthen accountability and performance oversight.

Selected county hospitals and primary health care facilities

A total of 56 primary care facilities (PHCCs and PHCUs) from Lakes and Western Equatoria submitted data for this assessment, with additional facilities expected to report as the tool is rolled out more widely. Likewise, seven County Hospitals (Western Equatoria, Greater Pibor Administrative Area , Ruweng Administrative Area) submitted data in this round, and more will be assessed as data collection expands. The summary tables below present the performance of these facilities across service delivery, capacities, health infrastructure, health workforce and health products.

County hospital overview

***Table 49:** County hospital overview*

Capacity	Expectation	Score	Description	Required improvements
Promotion	Community-based activities that target health behaviors and appropriate health seeking actions.		Most interventions are available, although half of the facilities still have gaps in interventions targeting unhealthy diets and physical activity.	Implement structured, continuous health-promotion activities, so communities are empowered to adopt healthier behaviors and appropriate health seeking actions. The hospital requires a health promotion unit/department that focuses on individuals and community and education on key issues that promote their health, including nutrition, hygiene, reproductive health, and the prevention of noncommunicable diseases
Prevention	Provision of primary preventions interventions, e.g vaccinations and non-invasive screening for common communicable and non-communicable conditions at the household and the facility.		A full range of primary prevention interventions, including routine vaccinations and non-invasive screening for common communicable and non-communicable conditions, are available.	Preventive services are a core function of a county hospital, encompassing routine immunization, antenatal care, screening for chronic and infectious diseases, and infection-prevention measures. The hospital should establish a disease prevention department, covering vaccination, screening for hypertension, diabetes, and malnutrition, and antenatal care amongst other services.
Diagnostic	Capacity for comprehensive diagnostics for the top 5 causes of morbidity, mortality and/or condition of public health importance according to the HMIS,		None of the basic diagnostic services are available.	Establish basic diagnostic capacity by ensuring the availability of essential tests for the top five causes of morbidity identified in the HMIS, including microscopy and other core facility-based diagnostics.
Curative	Complements the first point of care interventions by providing additional interventions to cover the top 10 causes of morbidity , mortality and/or conditions of public health importance according to the HMIS (e.g. complicated deliveries).		All County Hospitals report providing general outpatient and inpatient services, maternity and maternity theatre care, HIV and hepatitis B treatment, TB and malaria services, SRHR, blood transfusion services, IMCI and some management of diabetes and chronic lung conditions.	Build on the existing curative services by strengthening care for all major causes of morbidity and mortality and ensuring they fully complement primary-level interventions as required at this level of service.
Rehabilitative	Provision of physical therapy and occupational therapy for recovering individuals.		None of the facilities are providing expected services for the level of care.	The hospital requires a rehabilitation unit, providing especially physical and occupational therapy services.
Palliative	Follow up supportive care, pain relief, spiritual and psychosocial support for individuals and caregivers with terminal illnesses.		Symptom management and spiritual support were generally available with gaps in emotional and psychosocial support in half of the facilities assessed.	The hospital should have a palliative care unit, focusing on pain management, social, and spiritual care for the beneficiaries of its services.
Training	Pre-service training for certificate heath worker courses.		Training capacity is mixed across facilities. Two out of seven provide field experience; three offer no training activities; one delivers pre-service training for certificate-level health workers, and one provides pre-service training for graduate-level trainees.	Provide pre-service training for community health workers and certificate level support staff.
Internship	Internship orientation for certificate trainees		Less than half of the facilities reported providing internship orientation for certificate trainees, while the others indicated that no internship activities were offered.	Provide an internship for certificate courses in nursing, midwifery, allied health professionals.
Research	Initiate critical research for addressing health issues in the County Participate in health research within the county.		No research activity was carried out.	Build basic research capacity to initiate studies on priority county health issues and participate in ongoing research to support evidence-based decision making.

Capacity	Expectation	Score	Description	Required improvements
Health infrastructure	County Hospitals must have general and ANC consultation rooms, triage and emergency units, basic laboratory tests and imaging (2D and ultrasound), emergency and general operating theatres including maternity, male, female, pediatric and neonatal inpatient wards, along with reliable power and water, waste management, pharmacy and storage areas, mortuary services and transport capacity for referrals and administration		County Hospitals have basic OPD and emergency services, though many lack proper reception, records areas and full triage space. ANC units and OPD procedure rooms are common but often incomplete. Diagnostic capacity is weak, with limited imaging and almost no bacteriology infrastructure. Operative services and basic inpatient wards are mostly available but remain at a basic level, and PICU/NICU capacity is largely absent. Most facilities, however, have functional pharmacies and designated storage areas.	Strengthen reception, OPD and emergency areas, ensure complete procedure rooms, expand imaging and laboratory capacity including bacteriology, enhance emergency units, upgrade operative and inpatient wards and establish PICU/NICU infrastructure, while sustaining strong pharmacy and storage systems.
Health workforce	County Hospitals must have all PHCC cadres plus generalist medical practitioners, pharmaceutical technicians, dental assistants, physiotherapy and imaging technicians. Management must include a hospital director, nursing director, administrator, and health information staff. Support functions must include procurement, finance, HR and clerical staff, storekeeping, maintenance, waste management, laundry, kitchen services, drivers, guards, porters and mortuary attendants.		Medical assistants, nursing professionals, pharmaceutical assistants, laboratory technicians, midwifery staff, and pharmacists are mostly available. However, major gaps persist in blood bank technicians and mortuary staff, with these capacities largely absent across most facilities.	Prioritize strengthening critical support functions by recruiting and training blood bank technicians and mortuary staff to ensure safe transfusion services and appropriate management of deceased patients.
Health products	County Hospitals must have PHCC-level tools plus basic surgical, imaging and lab equipment, essential medicines for priority conditions, PHCC vaccines plus antirabies, antivenom and anthrax, whole-blood collection and storage capacity, basic breastmilk storage and selected traditional remedies.		Most facilities lack equipment for basic laboratory testing, imaging, PICU/NICU care, OPD emergency services, and operating theatres. However, many facilities do have equipment for ANC specialized outpatient units, general consultation rooms, maternity wards, and OPD procedure rooms. The availability of essential medicines is mixed, with some hospitals meeting most requirements and others reporting gaps. Vaccine availability for priority public-health conditions is generally adequate, though several facilities lack specific vaccines such as antirabies, antivenom and anthrax. Whole-blood capacity is limited in about half of the hospitals, and none provide breastmilk storage.	Strengthen its medical equipment and health product capacity by equipping basic laboratory and imaging units, upgrading emergency and operative equipment, ensuring full availability of essential medicines and priority vaccines and expanding capacity for whole-blood services and breastmilk storage.
Service delivery	Functional therapeutic committee, patient rights and obligations charter, routine supervision and mentorship, comprehensive mortality audits, clear departmental roles and coordination, structured referral system		Performance is mixed. While all facilities provide supervision and mentorship and have clearly defined departmental roles, only a few have functional therapeutic committees or conduct comprehensive death audits. Publicly displayed service charters are available in most, but not all facilities and referral systems are reported being largely in place.	Establish a formal emergency referral network with regional hospitals, set up a functional therapeutic committee for continuous clinical review, and fully adopt the SSD mortality audit guidelines.
Health information	Integrated DHIS2 reporting, routine monthly utilization reports, regular data verification, adherence to IDSR guidelines, systematic data analysis, and use for decision making.		Consistently met all health information standards, with timely monthly DHIS2 reporting, complete data submissions, regular monthly analysis for decision-making, weekly reporting of notifiable conditions and routine discussion of utilization data during management meetings.	Continue to strengthen its health information system by ensuring full linkage of in-house data tools to DHIS2, maintaining adherence to IDSR guidelines for weekly reporting of notifiable conditions and using monthly utilization reports to guide management decisions.
Governance	Annual and quarterly planning, routine performance reporting, functional coordination mechanisms, structured public engagement, regular management meetings		Facilities generally reported satisfactory practices, including the development of annual operational plans aligned with SSD guidelines, the presence of oversight boards with community, authority and CSO representation, and regular management team meetings.	Institutionalize the annual planning process Produce quarterly and annual performance reports in line with national requirements.

*__Red__ - Not present; __Orange__- basic unit; __Yellow__- close to standard but missing some elements; __Green__ - all elements in line with standard

County Hospitals offer a broader service package than primary care facilities but show major gaps that limit their effectiveness as referral centers. Diagnostic capacity is almost entirely absent, highlighting a critical system weakness. Rehabilitation services are not provided, palliative care is partial and training, internship and research functions remain limited. Infrastructure is uneven, with gaps in emergency, triage, imaging and laboratory space, and no PICU/NICU capacity, though basic OPD, ANC and operative areas exist.

Workforce availability is stronger for core clinical roles but lacks key support staff such as blood bank and mortuary personnel. Health products and equipment are incomplete, with shortages in essential medicines, vaccines, blood services and basic diagnostic tools. Overall, substantial investments are needed across diagnostics, infrastructure, workforce and health products to enable County Hospitals to meet expected standards and effectively support primary care.

Primary health care facilities overviews

Table 50: *Primary health care facilities overview*

Capacity	Expectation	Score	Description	Required improvements
Promotion	Community-based activities that target health behaviors and appropriate health seeking actions.		Most interventions are available, particularly those related to nutrition, school health education, and health-seeking behaviour.	Strengthen community-based activities that promote healthy behaviours, including guidance on social risk factors, encourage appropriate health-seeking actions, and integrate physical activity into routine health-promotion efforts.
Prevention	Provision of primary preventions interventions, e.g. vaccinations and non-invasive screening for common communicable and non-communicable conditions at the household and the facility.		Most interventions are available, particularly those for nutrition, malaria, and routine immunization.	Extend prevention interventions to include non-communicable and neglected tropical disease interventions through routine non-invasive screening (e.g. blood pressure screening, blood sugar screening) at both household and facility level.
Diagnostic	Capacity for basic diagnostics for the top 5 causes of morbidity according to the HMIS.		Nonexistent capacity for basic laboratory diagnostics for 80% of the facilities assessed.	Primary care facilities should strengthen their basic diagnostic capacity by ensuring routine malaria testing and other essential point-of-care tests for the top five causes of morbidity identified in the HMIS.
Curative	First point of care treatment for the top 5 causes of morbidity, mortality and/or conditions of public health importance according to the HMIS uncomplicated illnesses (e.g., malaria, diarrhea, respiratory infections, normal/ assisted delivery).		Curative services are mostly available for maternity care, malaria, SRH, and IMCI, while services such as HIV care or TB are not provided.	Primary care facilities should broaden their curative service package by adding other essential interventions needed at this level to ensure comprehensive and integrated care for the community.
Rehabilitative	Follow up and support to physical therapy, occupation therapy and speech therapy needs.		Rehabilitation services are not available in any of the facilities, with no provision for physical, occupational or speech therapy support.	Introduce basic rehabilitation services by establishing follow-up and support for physical, occupational and speech therapy needs at primary care level.
Palliative	Follow up of supportive care, pain relief, spiritual and psychosocial support for individuals and caregivers with terminal illnesses.		Palliative care is inconsistently available, with only about half of the facilities offering supportive care, pain relief, and spiritual or psychosocial support for individuals with terminal illnesses.	Ensure all facilities provide basic palliative care services, including pain relief, psychosocial and spiritual support and follow-up for individuals and caregivers facing terminal conditions.
Training	Field experiences centres.		Limited capacity for training.	Primary care facilities should be developed as field experience centers to support hands-on training, mentorship, and practical learning for health trainees and community health workers.
Research	Participate in biomedical and public health research		No research activity carried out.	Participate in basic biomedical and public health research to generate local evidence that informs service delivery and operations at the facility level as well as community health interventions.
Health infrastructure	Facilities must have consultation and procedure rooms, reception and records space, basic laboratory capacity, observation beds, drug storage and dispensing areas, reliable power, clean water, waste management systems, storage space and functional transport for administration and support.		Most facilities have a single general consultation room, but major gaps exist in observation and stabilization beds, procedure rooms, basic laboratory space and OPD procedure capacity. These critical elements are missing in nearly all facilities.	Investments in infrastructure by establishing observation and stabilization areas, functional procedure rooms, OPD procedure capacity, and basic laboratory space to meet the expected service standards for delivery of quality health services to the population that these facilities serve.
Health workforce	Facilities must have medical assistants, nursing and midwifery professionals, community health workers, pharmaceutical and laboratory assistants, dieticians and nutritionists, a facility in-charge, as well as cleaners and security guards to ensure safe and continuous service delivery.		Most facilities reported lacking medical assistants, laboratory technicians and having generally limited workforce capacity. More than half do not have nursing professionals, pharmaceutical assistants, midwifery staff, dieticians or a designated facility in-charge.	Invest in essential clinical and support staff to strengthen service delivery and ensure reliable patient care.
Health products	Facilities must have basic diagnostic tools, essential medicines for priority conditions, required vaccines for major public-health risks, basic whole-blood collection and storage capacity and traditional remedies such as herbal preparations where appropriate.		Major gaps in health products. None have whole blood. Essential medicines are incomplete, with 23 percent reporting nonavailability and half only partially meeting the standard. Vaccine availability for priority public-health conditions is partial, and all facilities lack basic laboratory capacity such as microscopy.	Must ensure full availability of essential medicines and vaccines for priority conditions, establish basic laboratory capacity including microscopy and develop the capacity to provide whole-blood services as required at this level.

*__Red__ - Not present; __Orange__- basic unit; __Yellow__- close to standard but missing some elements; __Green__ - all elements in line with standard

Primary health care facilities provide basic promotion, prevention and some curative services, but major gaps remain across diagnostics, rehabilitation, palliative care, training and research. Infrastructure is limited, with most facilities lacking procedure rooms, observation beds, laboratory space, and adequate OPD capacity. Workforce shortages are widespread, particularly among nursing, midwifery, pharmaceutical, and laboratory staff. Health products are incomplete, with gaps in essential medicines, vaccines, whole-blood capacity and basic laboratory tools. Overall, substantial investment is needed across service delivery, infrastructure, staffing and health products for facilities to meet expected primary care standards and deliver comprehensive, safe care.

Way forward

The assessment highlights important progress across hospitals and primary care facilities, while also identifying priority areas that must be strengthened for facilities to meet national standards. The recommendations outlined in this report provide a practical, phased path for improving service delivery, building critical capacities, and reinforcing the systems that support hospital performance.

Moving forward, facilities will need to work closely with the Ministry of Health to plan and implement these actions in a realistic and coordinated manner. Regular progress reviews should be conducted to track implementation, address emerging gaps and ensure steady movement toward full alignment with national expectations.

CHAPTER 5.
MOVING FORWARD AND PRIORITIES FOR 2026-27

5.1 SYNTHESIS OF HEALTH SECTOR PERFORMANCE

The sections below present a synthesis of South Sudan's health sector performance, structured around three core domains: programme areas, health systems, and access, quality and safety. The analysis is anchored in the country's own Health Sector Strategic Plan (HSSP) targets, meaning that the scores reflect progress against nationally defined objectives rather than international norms or standards of care. The composite index provides a high-level view of how well the sector is advancing toward its stated priorities, highlighting both areas of notable achievement and systemic constraints that continue to limit overall performance.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Programme area performance

The composite index reveals a health sector in South Sudan with highly uneven performance. The overall picture is one of a system that excels in specific, often community-based initiatives but struggles significantly with the foundational, continuous healthcare services required for a healthy population. The exceptional performance in Health Promotion (96.95%) skews the average upwards, masking serious challenges in core clinical service delivery, particularly for Reproductive, Maternal, and Child Health (63.24%) and especially for Non-Communicable Diseases (41.8%).

It is critical to remember that these scores measure progress against the government's own Health Sector Strategic Plan (HSSP) targets, not against international standards of care. A high score indicates target achievement, not necessarily that the health outcome is at an acceptable level.

The composite index is shaped by several striking performances: in Health Promotion, the exceptional 126.7% achievement in training health promotion cadres dramatically elevated the index for that area, showcasing a clear success in capacity building. Conversely, the RMNCAH index was severely dragged down by the catastrophic -111.4% performance on reducing unmet need for family planning, indicating a critical failure in a foundational service that cascades across all maternal and child health outcomes.

For Communicable Diseases, the index was pulled in opposite directions by the -113.3% performance on the TB incidence rate, revealing a worsening epidemic that undermines strong programmatic results in treatment. The abysmal performance of NCDs is epitomized by the 6.7% coverage of services for severe mental health disorders, highlighting a near-total system neglect for this entire health domain. Finally, the Emergencies index was constrained not by response efforts but by a foundational gap, where having only one functional public health laboratory (33.3% performance) fundamentally limited the capacity for timely detection and confirmation of outbreaks.

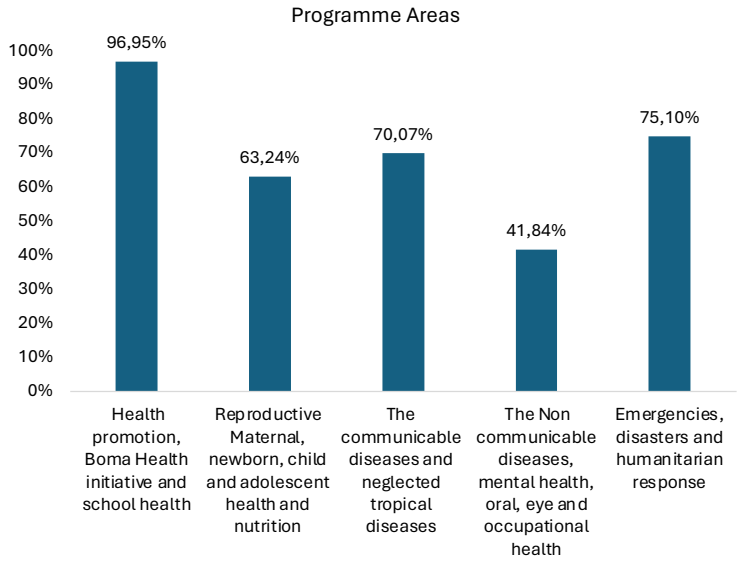


***Figure 47**: The performance of programme areas compared to the set targets*

Health systems performance

The overall performance of South Sudan's health systems is constrained and uneven, with a composite score of 58.3%. The system demonstrates operational capabilities in specific service delivery areas but is fundamentally undermined by critical deficits in strategic governance and sustainable domestic financing. The performance across the main health system pillars is as follows: Health Financing (42.9%), Leadership and Governance (53.0%), Human Resources for Health (60.9%), Health Information Systems (63.2%), and Essential Medicines & Laboratory Systems (71.5%).

Health Financing (42.9%) demonstrates the most critical weakest link in the health system, driven primarily by insufficient government prioritization of the health sector, as reflected in a severe under-execution of the allocated health budget. This is compounded by a high and increasing reliance on out-of-pocket expenditures by citizens, which creates a significant financial barrier to accessing care and undermines the sustainability of all other health system functions.

Leadership and Governance (53.0%) is severely hampered by a fundamental failure to establish core administrative structures, evidenced by the non-review and implementation of national and state-level ministry organograms. While operational planning shows moderate progress, this foundational governance deficit stymies strategic direction, accountability, and effective coordination across the health sector.

Human Resources for Health (60.9%) exhibits a critical imbalance; while the system has maintained a baseline level of frontline health workers, its progress is capped by the lack of a comprehensive strategic framework for workforce management. The absence of a fully developed and implemented HRH policy, strategy, and manual prevents the systematic expansion, regulation, and quality assurance of the health workforce.

Health Information Systems (63.2%) reveals a significant disparity between data collection and its strategic utility. The system performs adequately in the routine reporting of service statistics but fails catastrophically in its core public health function of integrated disease surveillance. This indicates a capability to monitor general activities but an inability to effectively track and respond to epidemics in a timely manner.

The 50% score for Essential Medicines & Laboratory Systems reflects a system at odds with itself. While exceptional progress in launching critical blood bank services demonstrates high potential, it is critically undermined by systemic failures in the core supply chain. Persistent stockouts of essential medicines and a complete inability to enforce laboratory quality standards create a dangerous paradox, where advanced services are built atop an unstable and unsafe foundation for daily clinical care.

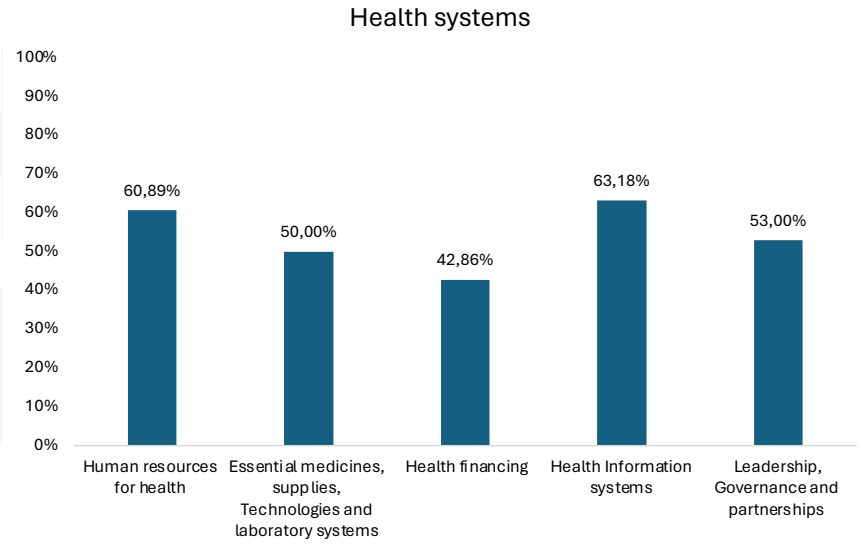


***Figure 48**: The performance of the health system building blocks*

Overall health sector performance index

The health sector's overall performance is assessed at 61.6%, indicating a moderate level of achievement. While the system demonstrates notable strengths in service delivery, its progress is constrained by persistent weaknesses in access and foundational system enablers. The composite index is derived from three domain areas, each weighted according to its relative contribution.

Programme Areas: 69.44% performance, 37% contribution: This domain represents the strongest area of performance and serves as the primary driver of the overall index. With a substantial weighting of 37%, successes in health promotion, disease control, and emergency response exert the most significant positive influence, elevating the sector's overall standing.

Access, Quality and Safety: 57.7% performance, 31% contribution and Health Systems: 58.3% performance, 31% contribution: These two domains, together accounting for 62% of the index weighting, act as the principal constraints. Their comparatively lower performance undermines gains achieved in programme areas. Weaknesses in equitable access, quality of care, and system foundations; including financing, governance, and supply chain management; create a substantial drag on overall sector performance.

Despite commendable achievements in programme implementation, the sector's overall progress remains limited by systemic challenges. Addressing deficiencies in access, quality, and system enablers will be critical to translating programme successes into sustained improvements in health outcomes and sector resilience.

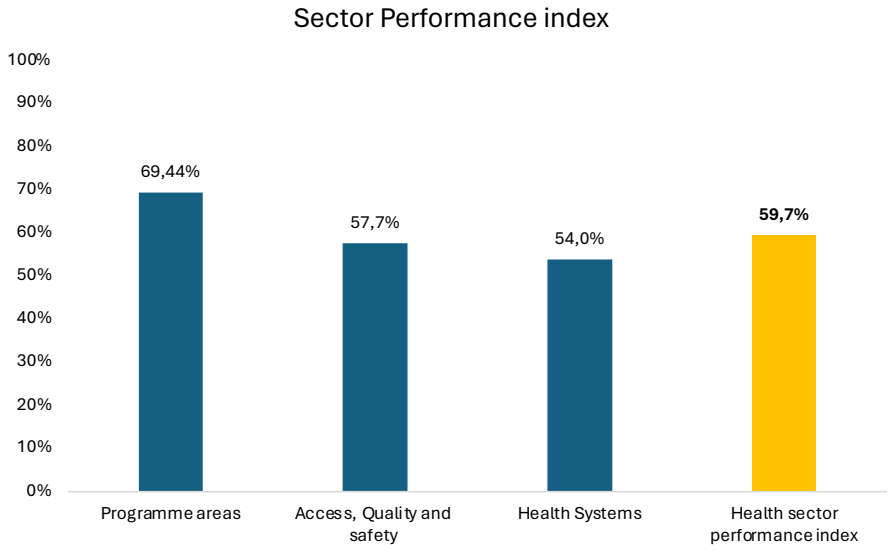


***Figure 49**: The overall performance of the heath sector against the set target*

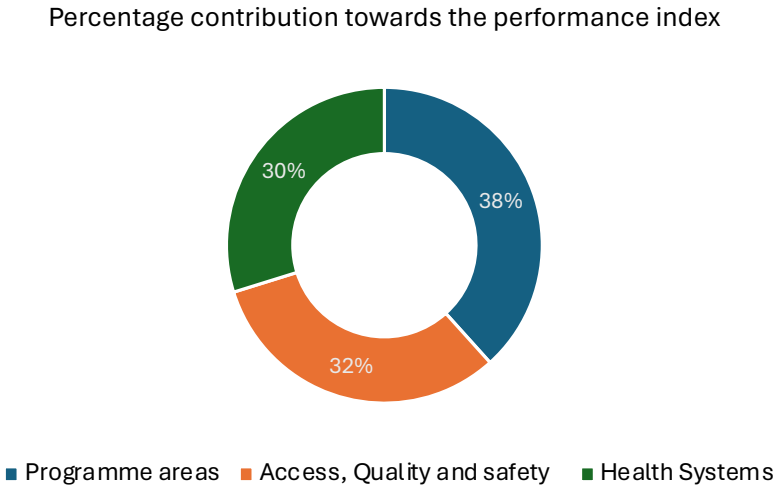


***Figure 50**: Percentage contribution to the overall health system performance*

5.2 COMPARISON OF SOUTH SUDAN'S HEALTH PERFORMANCE WITH SDG TARGETS

This section maps the available performance data from South Sudan's Health Sector Strategic Plan (HSSP) against the closest corresponding Sustainable Development Goal (SDG) indicators and targets. It is important to note that the "Performance" column reflects progress against national HSSP 2025 targets, not the SDGs themselves. This analysis shows how current national progress translates into the global SDG context.

Table 51: *South Sudan's Health Performance vs. SDG Targets*

SDG Indicator & Target	South Sudan Achievement (2025)	SDG Target (2030)	Performance vs. SDG Target & Likelihood of Achievement
SDG 3.1: Reduce maternal mortality to <70 per 100,000 live births	692	70	Drastically off-track (Approx 10 times the target). At current trajectory, it is highly unlikely to achieve the target by 2030 without transformative investment in maternal health services.
SDG 3.2: End preventable deaths of newborns & under-5s (U5MR ≤ 25 per 1,000)	98.7	25	Drastically off-track (Approx four times the target). Progress is too slow; unlikely to meet the target by 2030.
SDG 3.2: Neonatal mortality (≤ 12 per 1,000)	39.4	12	Drastically off-track (Approx 3 times the target). Current pace of reduction is insufficient; unlikely to achieve by 2030.
SDG 3.3: End epidemics of AIDS, TB, and malaria	HIV new infections: 8,700; TB incidence: 320/100k; Malaria incidence: 348/1,000	Substantial reduction	All epidemics remain high burden. Off-track and unlikely to achieve epidemic control by 2030 without major scale-up of prevention and treatment.
SDG 3.7: Universal access to sexual & reproductive healthcare (incl. family planning)	Unmet need for FP: 29.6%; Contraceptive prevalence: 6.4%	100% access, 0% unmet need	Critically off-track. Family planning coverage is extremely low; highly unlikely to achieve by 2030.
SDG 3.8: Achieve universal health coverage (UHC)	Proxy: Out-of-pocket spending at 34.4% (high & rising)	Financial risk protection & access to essential services	Severely off-track. Rising OOP spending undermines equity; unlikely to achieve UHC by 2030.
SDG 3.b: Support R&D for vaccines and medicines (Proxy: Immunization Coverage)	Fully immunized: No data	High coverage	Lack of data prevents assessment, but gaps in immunization services suggest unlikely to achieve full coverage by 2030.
SDG 2.2: End all forms of malnutrition	Stunting: 15.5%; Wasting: 17.4%	0%	Off-track. Wasting rates indicate a critical emergency; unlikely to achieve by 2030.
SDG 3.a: Strengthen implementation of WHO FCTC (Proxy: NCD Risk Factor)	Raised blood pressure: 29.5%	Reduction	Off-track. NCD risk factors are rising; unlikely to meet reduction targets by 2030.
SDG 3.c: Substantially increase health financing & recruitment (Health Workforce Density)	7.9 per 10,000	WHO benchmark: 44.5	Critically off-track. Workforce density is far below benchmark; highly unlikely to achieve by 2030.

South Sudan's 2025 achievements reveal that the country is drastically off track across nearly all SDG health indicators, with maternal mortality, child survival, family planning, epidemic control, and workforce density showing the most severe gaps. The scale of underperformance; often several times higher than the 2030 targets; indicates that current trajectories make achievement by 2030 highly unlikely.

Regular reviews are therefore critical to recalibrate strategies, identify bottlenecks, and mobilize resources toward the most urgent priorities. Without accelerated investment in maternal and child health, epidemic control, nutrition, and health system strengthening, South Sudan risks missing nearly all health related SDGs. The findings underscore the need for transformative reforms, sustained financing, and stronger governance to shift the trajectory toward even partial attainment of the 2030 goals.

5.3 RECOMMENDATIONS/UNFINISHED BUSINESS

This section presents the key actions required to address gaps identified during the reporting period and to consolidate progress toward health sector objectives. It focuses on areas where implementation remains incomplete or where performance has fallen short of targets, highlighting interventions that need to be accelerated or scaled up. The recommendations aim to strengthen governance, improve service delivery, and enhance system resilience, providing a roadmap for stakeholders to guide planning and resource allocation in the next phase of the Health Sector Strategic Plan.

Programme area 1: Health promotion, Boma Health initiative and school health

The next phase of implementation for health promotion and the Boma Health Initiative should focus on strengthening workforce systems, expanding coverage, and improving integration. Establishing a clear career pathway and certification framework for Boma Health Workers and their supervisors is essential to enhance motivation, professional recognition, and retention. Expansion of BHI beyond the current 56% coverage should be undertaken to reach underserved and urban poor populations, ensuring equitable access to community-based health services. Integration of additional service delivery packages, including TB, HIV, and neglected tropical diseases, into the BHI platform will promote comprehensive care at the community level. To maintain quality, supportive supervision, provision of essential supplies, and refresher training for BHWs to be prioritized. Furthermore, geo-mapping of BHWs should be undertaken to optimize selection and allocation based on population distribution, improving efficiency and service reach.

Programme area 2: Reproductive Maternal, newborn, child and adolescent health and nutrition

RMNCAH

Capacity building for healthcare workers in contraceptive counseling and service provision is essential to improve the quality and accessibility of family planning services. Distributing contraceptives through community health workers and mobile clinics will expand coverage, particularly in hard-to-reach areas, and ensure continuity of care for underserved populations.

Raising awareness through media campaigns and community dialogues is recommended to dispel myths and encourage positive attitudes toward family planning. Integrating family planning services with maternal and child health programs will further increase reach and efficiency, promoting comprehensive care for women and children.

Significant and sustained investment, coupled with peace and targeted interventions, is required to reverse negative trends and ensure safer motherhood for women and their newborns. Key initiatives include training more midwives, improving emergency obstetric care, and expanding community outreach programs to strengthen maternal health services.

The persistently high neonatal mortality rate underscores the urgency for enhanced healthcare infrastructure, improved maternal and neonatal care, and increased access to skilled health personnel. These measures are critical to reducing neonatal deaths and improving child survival rates across the country.

Nutrition

Prioritizing malnutrition prevention through multi-sectoral action is essential to address underlying determinants and reduce vulnerability. Investments in climate-resilient agriculture and local food production should be scaled up to reduce dependency on imports and humanitarian aid, ensuring sustainable food security. Infant and Young Child Feeding practices must be promoted, emphasizing exclusive breastfeeding for the first six months and appropriate complementary feeding thereafter. Scaling up micronutrient supplementation, including Vitamin A, iron-folic acid, and therapeutic food distribution, will help prevent and treat deficiencies. Additionally, improving access to clean water and sanitation through WASH interventions is critical to reducing diarrheal diseases that exacerbate malnutrition. Capacity building of the Health Sector Transformation Plan (HSTP) workforce will strengthen service delivery and programme implementation.

Implementation of the national nutrition policy, integration of nutrition services into health systems, and adoption of initiatives such as the Baby-Friendly Hospital Initiative will reinforce programme effectiveness. Legislative measures should be enacted to regulate market exposure of nutrition commodities, while pre-service nutrition curricula should be institutionalized to build future workforce capacity. Finally, reviewing and updating nutrition indicators in the Health Sector Strategic Plan (HSSP) will improve monitoring and accountability for nutrition outcomes.

Preventive Chemotherapy (PC-NTDs)

Mass Drug Administration (MDA) campaigns should continue to sustain progress in reducing the burden of neglected tropical diseases. Regular assessments, including Transmission Assessment Surveys (TIS), Epidemiological Monitoring Surveys (EMS), and OV-16/Pre-Stop evaluations, are necessary to monitor programme effectiveness and readiness for elimination. Mapping of remaining endemic areas is essential to identify gaps and ensure targeted interventions. Cross-border collaboration needs to be strengthened to address transmission risks in border communities and improve coordination of interventions.

Adoption and implementation of the Lymphatic Filariasis Morbidity Management and Disability Prevention (LF-MMDP) strategy should continue to improve care for affected individuals. Full implementation of the integrated NTD monitoring and evaluation framework will enhance data-driven decision-making and accountability across all programme components.

Case Management (CM-NTDs)

Early case detection and diagnosis for Human African Trypanosomiasis (HAT) and Visceral Leishmaniasis (VL) must be strengthened to reduce morbidity and mortality. Mapping of VL in priority states, including Upper Nile, Eastern Equatoria, Jonglei, Unity, Greater Pibor Administrative Area , and Ruweng Administrative Area, should be completed to guide resource allocation and intervention planning.

Vector control measures targeting tsetse flies and sandflies are essential to interrupt transmission and should be scaled up. Digitalization of reporting tools into DHIS2 will improve timeliness, accuracy, and integration of NTD data within the national health information system. Capacity building for health workers on NTD case management should be prioritized to ensure quality diagnosis and treatment. Review and validation of VL treatment guidelines is necessary to align clinical practices with current evidence and international standards.

Leprosy

Mapping of remaining counties should be completed to establish the full geographic distribution of leprosy and inform targeted interventions. Capacity building for health workers must be prioritized to strengthen skills in diagnosis, treatment, and management of complications. Integration of leprosy services into primary health care will improve accessibility and sustainability of care.

Scaling up leprosy services, including active case finding and contact tracing, is essential to reduce transmission and prevent disability. Introducing prophylactic chemotherapy with single-dose rifampicin for contacts of leprosy patients will help interrupt transmission and accelerate progress toward elimination.

Malaria

Completion of the HBHI assessment sets the stage for launching a multisectoral response led by an End Malaria Council with strong private-sector participation. Establishing an End Malaria Fund will complement domestic and external resources, support implementation of the new National Malaria Strategic Plan, and accelerate progress toward malaria reduction targets.

Lessons from first-tier HBHI countries underscore the importance of robust stakeholder engagement and resource mobilization to translate political will into tangible action.

Integration of community management of malaria into primary health care will expand access to diagnosis and treatment, particularly in underserved areas. Entomological monitoring should be scaled up to track vector dynamics and inform targeted interventions. Social and behavior change activities must be reinforced to promote consistent use of preventive measures and adherence to treatment protocols.

TB/HIV/STI/HBV

To strengthen TB, HIV, STI, and HBV services, it is recommended to optimize service delivery to hard-to-reach areas to ensure equitable access to prevention, diagnosis, and treatment. Weather-resistant diagnostic tools, such as Truenat machines, should be secured in accordance with national guidelines to enable reliable testing in remote and climate-challenged settings.

Additionally, investment in Human Resources for Health (HRH) capacity building through targeted training and mentorship is necessary to improve technical competencies and support integrated service delivery.

Programme area 4: Non communicable diseases, mental health, oral, eye and occupational health

Community-based screening for hypertension and cancer should be expanded to improve early detection and reduce complications associated with late diagnosis. Training for mental health and dental professionals needs to be increased to address workforce gaps and enhance service delivery in these critical areas. Strengthening supply chains for essential medicines and equipment is necessary to ensure consistent availability and functionality of services. Public awareness campaigns targeting prevention should be intensified to promote healthy behaviors and reduce risk factors for noncommunicable diseases. Policy enforcement and data systems for occupational health require improvement to ensure compliance, monitor workplace health risks, and support evidence-based interventions.

Diversifying funding sources through public-private partnerships and humanitarian-development nexus approaches will enhance resilience and sustainability. Establishing a contingency emergency fund within the Health Sector Transformation Plan (HSTP) is critical to enable rapid response during crises.

Strengthening governance and leadership is essential for effective emergency management. Leadership transitions should be managed to maintain continuity in decision-making and coordination. Health Cluster and One Health coordination platforms must be reinforced to support joint planning, resource sharing, and integrated response across sectors.

Improving service delivery and access requires expanding mobile clinics and outreach services to hard-to-reach and underserved areas. Integration of refugee and returnee health needs into HSTP planning will ensure inclusive service provision. Additionally, cross-border coordination for surveillance and outbreak response should be strengthened to mitigate regional health risks.
Emergency preparedness and response capacity should be scaled up through the deployment of Rapid Response Teams (RRTs) and provision of incentives for surveillance officers. Pre-positioning emergency supplies and establishing rapid activation protocols will improve timeliness and efficiency during emergencies. Conducting regular simulation exercises is recommended to enhance readiness and operational effectiveness.

Investments in health infrastructure and systems are necessary to support emergency response. Establishing state or regional public health laboratories and strengthening quality assurance systems will improve diagnostic capacity. Accelerating the rollout of EOCs at state level and integrating them into incident management systems will enhance coordination and decision-making during crises.

Finally, strengthening health information and indicators is critical for monitoring and evaluation. Gaps identified in eSPAR and Joint External Evaluation (JEE) assessments should be prioritized through targeted investments. Revising indicators in the next Health Sector Strategic Plan (HSSP) to include context-appropriate metrics, such as outbreak response timeliness and functional capacity scores, will improve accountability and guide performance improvements.

Equitable Access, Quality and safety

To improve equitable access and service quality, priority should be given to rehabilitating existing health facilities, ensuring adequate staffing, and providing essential equipment and maintenance to achieve full operational status rather than expanding new sites. This approach will maximize the functionality of current infrastructure and optimize resource utilization.

Establishing national and state-level Quality-of-Care units is critical for institutionalizing quality improvement. Fast-tracking administrative approvals and allocating dedicated budgets will enable these units to lead systematic efforts to enhance service standards and patient safety across all levels of care.

Building trust and promoting awareness among communities is necessary to increase service utilization. These initiatives should be coupled with tangible improvements in perceived service quality to strengthen confidence in the health system and encourage timely care-seeking behavior.

Investment in ambulance fleets, including procurement, staffing, and maintenance, is essential to meet or exceed planned referral capacity. Reliable emergency transport systems will improve access to higher-level care and reduce delays in critical interventions.

Implementation of the Quality-of-Care strategy beginning in 2026 should proceed as scheduled, with clear milestones and robust monitoring mechanisms to track progress and ensure accountability. This will provide a structured pathway for continuous improvement in service delivery.

Finally, developing a comprehensive assessment tool for infrastructure readiness is recommended. The tool should reflect all BPHNS areas beyond maternal health to provide a holistic view of facility preparedness and guide targeted investments.

Human resources for health

Accelerating the consolidation of national HRH data and rolling out the HRH information system is essential to improve workforce planning, deployment, and monitoring. A functional system will enable evidence-based decision-making and strengthen accountability for human resource management.

Engagement with Ministry of Health leadership is critical to finalize and approve the HRH policy and expedite the endorsement of the HRH strategy. These foundational documents will provide a clear framework for workforce development, regulation, and sustainability.

Close collaboration with the Ministry of Justice, parliamentary committees, and professional associations is recommended to fast-track pending bills related to health workforce governance. Legislative progress will ensure regulatory compliance and professional standards across the sector.

Allocating resources for comprehensive assessments, institutional upgrades, and technical assistance is necessary to accelerate accreditation processes for training institutions. Strengthening accreditation will improve the quality of health workforce education and align competencies with service delivery needs.

To address financing gaps, opportunities for cost-sharing, technical support, and investment from development partners should be explored. Concurrently, advocacy for increased government budget allocation for HRH development is essential to support.

Essential medicines, supplies, technologies and laboratory systems

Establishing and institutionalizing an autonomous Central Medical Supplies Agency through legislative support, dedicated budget allocation, and a clear operational model is a priority to strengthen supply chain governance. Securing consistent and sustainable government funding for essential health products, coupled with effective disbursement and accountability systems, will ensure uninterrupted availability of medicines and supplies. Updating and disseminating the National Medicines Donations Guidelines, introducing drug disposal protocols, and launching public awareness campaigns on proper disposal practices are critical for compliance and safety.

Strengthening pharmaceutical governance requires developing and adapting Drugs and Therapeutics Committee (DTC) manuals and guidelines, ensuring functionality of DTCs at all hospitals, and rolling out public education campaigns to promote rational medicine use.

Advocacy for increased investment from government, development partners, and the private sector should be complemented by building a business case for pharmaceutical investment and establishing a sector-specific infrastructure development fund. Comprehensive market and private sector assessments, including economic impact and manufacturing capacity analysis, will inform strategic planning.

For laboratory systems, priorities include developing a national research agenda, integrating antimicrobial resistance surveillance into the IDSR system, and reviewing laboratory workforce policies. Creating a national HR development plan with updated pre-service curricula and continuous professional development programs will improve service quality. Additionally, enforcing a national policy for equipment maintenance and disposal, implementing emergency procurement policies for health technologies, and supporting operational research initiatives will enhance resilience and efficiency across the health system.

Health financing

Improving health financing governance remains a critical priority. This requires a comprehensive review and update of the national health financing strategy to provide clear guidance on resource mobilization, revenue raising, pooling, and purchasing mechanisms. Strengthening existing coordination structures, such as the health financing unit, and establishing corresponding structures at subnational levels is essential to ensure effective oversight, harmonization of efforts, and accountability across all tiers of the health system.

Sustainable health financing is an urgent need given that funds mobilized during the review period were inadequate and showed a declining trend. Moving forward, the health sector must progressively focus on sustainability to address priorities that will exert increasing demand for resources. These priorities include sustaining gains achieved over the past three years, responding to demographic transitions characterized by a youthful population with unique health needs, and addressing the high burden of communicable diseases alongside the rising prevalence of NCDs. Additional pressures stem from injuries, social risk factors such as alcohol and drug abuse, and health security threats including disease outbreaks and natural disasters such as floods and droughts. These challenges are compounded by dwindling donor funding and limited domestic fiscal space.

To navigate this scenario, several measures are recommended. First, increasing efficiency gains from existing resources is critical. This entails embracing efficiencies across public and external resources through enhanced coordination in planning, budgeting, monitoring, and review with partners to ensure predictability and accountability. Service delivery, including expansion of the public health system, must be cost-effective to remain within available budgets. Generating evidence to inform implementation of low-cost, high-impact interventions and targeting investments in such interventions across all programs will maximize outputs and outcomes. Second, mobilization of additional domestic resources is necessary, given that government expenditure on health remains low at 2%. Progressive increases in domestic allocations will help meet growing health needs. Third, innovative financing mechanisms should be embraced, including public-private partnerships to enhance private sector engagement in service delivery and health system investments, as well as earmarked taxes dedicated to health.

Enhancing the health financing information system is equally important to generate evidence for decision-making. Comprehensive data collection methods, including surveys, should be adopted to fill existing gaps. Conducting a National Health Account (NHA) will enable tracking of health spending and inform policies and investments to make the health system more responsive to population needs. Additionally, systematic tracking of public and partner resource expenditures will promote efficiency, strengthen accountability, and support evidence-based planning within the sector.

Health Information systems

To strengthen health information systems, it is recommended to develop and implement an integration framework that links DHIS2, EWARS, and other health information platforms to ensure interoperability and streamline data flow across programs. Reminder systems using SMS, email, or mobile app notifications should be introduced to prompt timely submission of reports and improve data completeness. Facilities that consistently miss reporting deadlines require targeted support through mentorship and structured follow-up mechanisms to address capacity gaps and enhance compliance.

Equipping hospitals and PHCCs with computers, reliable internet connectivity, and appropriate software is essential to facilitate direct data entry and reduce delays in reporting. Regular training sessions on DHIS2, EWARS, and other reporting tools should be conducted for both facility-level staff and data managers to strengthen technical skills and promote accurate, timely data submission.

Leadership, Governance and partnerships

To strengthen governance and operational planning, it is recommended that the Ministry of Health fast-track the review, approval, and finalization of the health sector organogram to clarify roles and responsibilities across all levels. Building sustainable operational planning capacity is critical and should include establishing a cadre of trainers to monitor progress and provide real-time support to states and counties that are lagging behind.

Peer learning platforms should be promoted to facilitate the exchange of best practices, with high-performing states serving as models through cross-learning workshops focused on annual operational planning and governance reforms. Additionally, mobilizing resources to support the development and implementation of annual operational plans at national and subnational levels will ensure consistency, improve accountability, and enhance the effectiveness of health sector interventions.

Revitalizing national-level coordination mechanisms is essential to improve oversight and accountability. This includes reassessing the structure, frequency, and follow-up processes for convening meetings, dedicating a coordination secretariat to track schedules, attendance, and action points, and integrating digital platforms to facilitate regular engagement and information sharing.

Accelerating the development of a PPP for Health Policy requires establishing a multisectoral task force to lead the drafting process and ensure inclusivity. Continuous engagement with private sector stakeholders is critical to secure buy-in and maintain policy relevance for health system strengthening.

Leveraging sub-national success offers an opportunity to enhance national strategies. Effective coordination models at the state level should be documented and used to inform national approaches. Facilitating cross-learning between national and sub-national entities will promote harmonization and improve overall governance and partnership effectiveness.

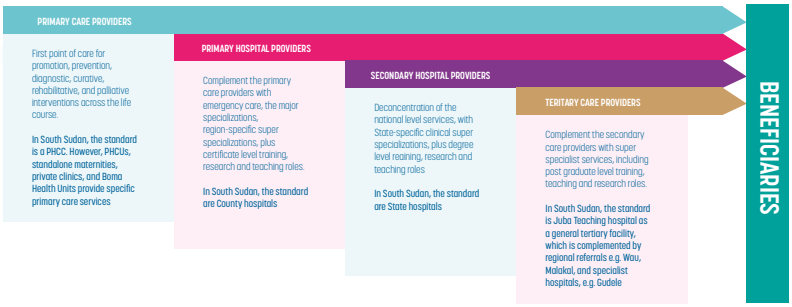
World Health Organization
SSHF South Sudan Humanitarian Fund
United Nations CERF
Gavi The Vaccine Alliance
WORLD BANK GROUP
European Union Civil Protection and Humanitarian Aid
Foreign, Commonwealth & Development Office
European Union
KING SALMAN
Sida SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
GILEAD
THE GLOBAL FUND
GF
Mectizan Donation Program
Federal Ministry for Economic Cooperation and Development
sanofi
THE END FUND
SASAKAWA Health Foundation
DAHW
unicef for every child
European Investment Bank
MEDECINS SANS FRONTIERES
REACHING the LAST MILE
malaria NO MORE
AFRICAN LEADERS MALARIA ALLIANCE ALMA
Gouvernement Princier PRINCIPAUTÉ DE MONACO
THE CARTER CENTER
ROLL BACK MALARIA
AGAINST MALARIA FOUNDATION
THE GOVERNMENT OF THE GRAND DUCHY OF LUXEMBOURG
UNDP
ICRC
UNFPA
IOM UN MIGRATION
UNHCR The UN Refugee Agency
UNAIDS

ANNEX 1: THE STATE OF HEALTH SERVICES PROVISIONS INSTITUTIONS – FULL REPORT

1. CONTEXT

The classification of health facilities is a critical part of organization and management of health services. This ensures health services are efficiently and effectively made available for a specific population. There are four common levels at which a health facility can be classified, based on the range of services and its existing capacity, as shown in the figure below.

Categories of health service provision institutions [11]



The classification of a health facility therefore aims to map (1) which health provider category it best belongs to, and (2) what capacities it needs to invest in, for it to meet the standards of its given category.

11 Source: The state of health in the WHO African Region: an analysis of the status of health, health services and health systems in the context of the Sustainable Development Goals. Brazzaville: WHO Regional Office for Africa; 2018 https://www.afro.who.int/publications/state-health-who-african-region


for every
ntegrated Community
(ICMM)
Gavi

2. METHODOLOGY

The assessment was conducted by designated focal points, including Hospital Directors, Medical Directors, and facility in-charges, with support from a WHO technical team. The team applied the WHO Facility Classification Tool to ensure a standardized and consistent review. This tool assesses both the range of services provided across the continuum of care and the facility's capacity to deliver those services, based on key health system investment areas.

3. ASSESSMENT OUTCOMES

In total, four submissions were received for referral and teaching hospitals. These included Malakal Teaching Hospital in Upper Nile, Wau Teaching Hospital in Western Bahr el Ghazal, Juba Teaching Hospital in Central Equatoria and Kiir Mayardit Women's Hospital in Lakes.

For State Hospitals, nine submissions were received from Bor State Hospital in Jonglei, Yambio State Hospital in Western Equatoria, Kuajok State Hospital in Warrap, Bentiu State Hospital in Unity, Rumbek State Hospital in Lakes, Aweil Civil Hospital in Northern Bahr el Ghazal, and Torit State Hospital in Eastern Equatoria. As part of the methodology, all tertiary hospitals were additionally assessed against the State Hospital standards, reflecting their dual mandate and ensuring comparability across levels of care. The following sections present the key assessment findings, structured around service availability, service readiness, and capacity gaps. It also highlights priority areas requiring improvement to align facilities with national standards.

3.1 NATIONAL REFERRAL AND TEACHING HOSPITALS

The assessment examined the extent to which tertiary hospitals in South Sudan fulfil the functional expectations defined for this level of care. The facility provides the required functional areas, although the level of specialization remains below tertiary standards. Variation remains in the depth, readiness, and specialization of services across the assessed hospitals.

3.1.1 CLASSIFICATION OF THE HEALTH FACILITIES

Health promotion interventions are consistently available in all hospitals, reflecting adherence to the expected functional area. Strengthening this domain will require standardizing health promotion packages and fully integrating them into disease-specific services, including NCDs, and services specific to different life course-maternal and neonatal health, pediatrics and adolescent care.
Disease prevention interventions are also present across facilities but remain limited to basic and intermediate preventive services. Specialized tertiary-level interventions such as cervical and breast cancer screening or prostate assessment are not fully established. Advancing this area requires the introduction of standardized cancer screening protocols and strengthening advanced infection prevention services for TB, HIV, and viral hepatitis.

All tertiary hospitals demonstrate the diagnostic function, but their diagnostic capacity falls short of tertiary-level expectations. Advanced diagnostic modalities, including CT and MRI imaging, molecular diagnostics, pathology and histology are either unavailable or partially functional. Radiology capacity remains limited in most hospitals, and essential laboratory services such as specialized blood tests are missing in some facilities. To improve diagnostic capability, significant investment is needed in advanced imaging equipment, laboratory infrastructure, pathology services, biomedical engineering, and strengthened sample referral systems.

Curative services are available in all tertiary hospitals, but the level of specialization remains insufficient for full tertiary-level classification. While general curative services are functional, advanced services such as intensive care or oncology are limited or absent. Some hospitals do not treat chronic conditions such as diabetes or cardiovascular diseases, and intensive care capacity is unavailable in several facilities. Strengthening curative services will require establishing fully functional ICUs, expanding specialized NCD and oncology services, enhancing advanced surgical capacity, and formalizing multidisciplinary case management systems.

Rehabilitative interventions are present in some

hospitals but remain incomplete and inconsistent. Two hospitals do not provide rehabilitation services at all. Where available, essential components such as speech therapy and occupational therapy are often missing, and no hospital meets the expectation of a comprehensive multidisciplinary rehabilitation unit. Improvements should prioritize establishing dedicated rehabilitation departments, training and recruiting rehabilitation professionals, and integrating rehabilitation into post-surgical, trauma, pediatric and chronic disease pathways.

Palliative care services exist in several hospitals but fall below the standard of a standalone tertiary-level palliative care unit. Two hospitals lack palliative services altogether, while others offer only basic pain management or limited psychosocial support. Strengthening palliative care requires establishing integrated palliative care units with dedicated multidisciplinary teams, training staff, and linking palliative care to oncology, HIV and chronic disease programs.

Pre-service training is offered across most tertiary hospitals, but the scope and depth vary significantly. While many hospitals provide training for graduate and postgraduate students, one facility offers training only at the graduate level. Strengthening this area requires formalized supervision systems, expanded postgraduate training programs and enhanced collaboration with academic institutions.

Internship services are available in most hospitals but remain inconsistent. Two hospitals do not offer internship programs, and where they exist, structured rotations and supervisory mechanisms are not always clearly defined. Improvements should focus on developing standardized internship frameworks, ensuring specialist supervision, and aligning programs with national training requirements.

Research functions vary widely across tertiary hospitals. While some facilities conduct limited public health or biomedical studies, only one demonstrates a more advanced research role, initiating research on national health issues and participating in national and international studies. Other hospitals engage minimally, and two report no research activity. Improving research functions will require establishing research units, developing institutional research priorities, building data management and analytical capacity and strengthening partnerships with universities, regional and international research organizations.

Rating of the status of health services and support capacities - tertiary level

Functions	Expectation at the Tertiary level	Western Bahr el Ghazal Wau Teaching Hospital	Upper Nile Malakal Teaching Hospital	Central Equatoria Juba Teaching Hospital	Lakes Kiir Mayardit Women Hospital
Health promotion interventions	Interventions that target health behaviors and appropriate health-saving actions.	Range of health promotion interventions available.	Range of health promotion interventions available.	Range of health promotion interventions available.	Range of health promotion interventions available
Disease prevention interventions	Specialized preventive programs such as cancer screening (e.g., cervical, breast), genetic counseling, and advanced infectious disease prevention strategies.	Range of disease prevention interventions available	Range of disease prevention interventions available.	Range of disease prevention interventions available.	Screening ofr cancers not available.
Diagnostic interventions	Full diagnostic departments capable of molecular diagnostics, CT scans, MRIs, pathology and histology, enabling the identification of complex and rare conditions and serving as referral laboratories for the country.	Limited radiology capacity.	Limited radiology capacity.	MRI scan and coagulation panel test are not available.	Blood tests, complex and specialized imaging, except for ultrasounds and XRay, are not available.
Curative interventions	Highly specialized clinical interventions such as advanced surgery, oncology, cardiology, neurology, intensive care, and multi-disciplinary case management.	No intensive care services	Conditions (e.g diabetes or cardiovascular diseases) not treated.	IMCI and Oncology services not available	Specialist OPD and inpatients available but not super specialist (e.g oncology) are not available.
Rehabilitative interventions	Specialized rehabilitation units to serve patients with long-term conditions or post-surgical recovery needs covering occupational therapy, physical therapy, speech therapy and cognitive and behavioral rehabilitation	Range of rehabilitative interventions available	No rehabilitative interventions provided.	Follow-up rehabilitation services and rehabilitation for recovering individuals not available	Speech therapy and occupational therapy not available.
Palliative interventions	Standalone palliative care unit providing pain, spiritual and psychosocial support for all the needs of beneficiary individuals.	Range of palliative interventions available	No palliative services.	Range of palliative interventions available.	Range of palliative interventions available.
Pre-service training	Pre-service training for graduate & post-graduate health worker courses.	Pre-service training for graduate & post-graduate health worker courses.	Field experiences centers.	Pre-service training for graduate and post-graduate health worker courses.	Pre-service training for graduate health worker courses.
Internship services	Internship orientation for graduate & post graduate HWs (for area of specialization).	Internship orientation for graduate HWs & postgraduate (for area of specialization)	Not provided.	Internship orientation for graduate HWs & post-graduates (for area of specialization).	Internship orientation for graduate HWs & postgraduate (for area of specialization).
Health research	Initiate critical research for addressing health issues in the Country Participate in national and internationally commissioned health research.	Initiate critical research for addressing health issues in the country. Participate in national and internationally commissioned health research.	No research activity carried out.	Participate in biomedical and public health research.	Initiate critical research for addressing health issues in the State. Participate in health research within the State.

Overall, tertiary hospitals in South Sudan fulfil the expected functional domains in structure, but the level of specialization, comprehensiveness and readiness across these domains remains below the standards required for tertiary-level classification. Targeted investments in advanced diagnostics, specialized curative services, rehabilitation, palliative care, structured training programs and institutional research capacity are essential for enabling these hospitals to fully perform their role as national and state-level referral centers.

3.1.2 CAPACITY FOR PATIENT-FACING INVESTMENT AREAS

The assessment of patient-facing health investments shows that tertiary hospitals have many of the foundational inputs required for service delivery, although the depth, completeness and level of specialization remain below the standards expected at tertiary level. Availability and functionality of infrastructure, equipment, transport, readiness systems, health workforce and health products vary substantially across facilities, with gaps that limit the delivery of complex care.

The physical infrastructure for general outpatient care, emergency services, inpatient wards, pharmacy and medical stores is largely present. However, several critical components expected at tertiary level are consistently underdeveloped. Advanced imaging capacity such as CT, MRI and PET scans is absent across all hospitals. Laboratories do not provide pathology or histology services. Critical care units including ICU, PICU and NICU are available only in limited form or not at all. Operative units function but do not meet the requirements for super specialist theatres, and mortuary capacity remains uneven. Strengthening these areas requires major investment in advanced diagnostic infrastructure, critical care readiness, and expanded operative capacity.

Medical equipment reflects similar patterns. Basic equipment for outpatient and emergency care is available, but advanced imaging equipment and molecular diagnostic technologies are lacking. Operative areas do not have equipment required for super specialist procedures. Critical care areas lack monitors, ventilators, incubators and other essential devices. Investing in advanced diagnostic and operative equipment, as well as strengthening biomedical maintenance systems, is essential.

Transport capacity is present but inconsistent. Ambulances exist in some hospitals but vary in functionality and level of equipment. Utility vehicles are not always available. Ensuring reliable, fully equipped ambulances and strengthening operational transport is necessary to support referrals and supervision.

Infrastructure readiness also presents challenges. Power supply is not consistently stable and often relies on a single source such as a generator. Water supply is not reliable throughout the day in several hospitals. Waste management systems exist but are not fully aligned with tertiary level requirements. Addressing these gaps will require ensuring multiple power sources including renewable options, strengthening water supply systems and upgrading waste management facilities for safe segregation and disposal.

The health workforce is generally strong, with core medical, nursing and managerial teams in place across the tertiary hospitals. Overall staffing levels allow facilities to deliver routine and intermediate services effectively. The main gap relates to the limited availability of super specialists such as oncologists and cardiologists, which restricts the depth of specialized service delivery expected

at the tertiary level. Although specialized nurses for intensive care, emergency care, theatres and neonatal services are available in several hospitals, their distribution remains insufficient to support fully functional critical and high-acuity units. Allied health professionals including physiotherapists, radiographers, anesthesia technologists, laboratory technologists and biomedical engineers are present in some hospitals but not consistently across all facilities, limiting the functionality and maintenance of advanced equipment. Managerial and support teams are generally established, though a few hospitals still operate without full specialization in human resources management, procurement, finance or health information. Continued strengthening of the workforce will therefore require targeted deployment of super specialists, expansion of specialized nursing roles and consistent availability of key allied health cadres.

Health products demonstrate partial alignment with expectations. Essential medicines are generally available, though with variability across facilities. Routine vaccines are present, but several specialized vaccines and biological products including antivenom, antirabies and anthrax vaccines are not consistently available. Availability of blood and products of human origin such as fresh frozen plasma, platelets and red blood cells remains limited. Traditional and complementary products are not available but could be considered in future service expansion depending on national policy direction. Improving this area requires strengthening supply chains for specialized vaccines and biologicals, expanding availability of blood and products of human origin and increasing storage and cold chain capacity.

Rating of the status of capacities - tertiary level

	Capacity area	Expectation at the State level	Jonglei Bor State Hospital	Western Equatoria Yambio State Hospital	Warrap Kuajok State Hospital	Unity Bentiu State Hospital	Lakes Rumbek State Hospital	Nothern Bahr el Ghazal Aweil Civil Hospital	Eastern Equatoria Torit State Hospital
HEALTH INFRASTRUCTURE	Physical infrastructure								
	General outpatient unit	Outpatient unit with general consultation rooms, triage area, accident and emergency unit.							
	Emergency unit	Emergency medical unit with outpatient emergency theatre.							
	Specialized outpatient unit	Specialized outpatient units for medicine, surgery, gynecology, and pediatrics.							
	Imaging unit	Basic imaging (X-ray and ultrasound), and access to complex imaging such as MRI.							
	Laboratory unit	Bacteriology, basic laboratory tests, culture and sensitivity testing.							
	Operative unit	General operating theatre and maternity theatre.							
	In-patient units	Medical wards (M/F), surgical wards, gynecologist ward, pediatric ward, maternity ward							
	Critical care unit	High Dependency Unit and Pediatric and Neonatal Intensive Care Unit.							
	Pharmacy unit	Pharmacy that ensures continuous availability, safe storage, and proper dispensing of essential medicines and medical supplies.							
	Medical products store	Designated place for storage of medicines and supplies.							
	Mortuary unit	Mortuary with adequate body storage capacity and proper cooling.							
	Medical equipment								
	General outpatient unit	Equipment to support general OPD							
	Emergency unit	Equipment to support: emergency unit							
	Specialized outpatient unit	Equipment to support specialized OPD							
	Imaging unit	Basic imaging (X-ray and ultrasound) and complex imaging (e.g. MRI)							
	Laboratory unit	Equipment to for basic lavatory services, bacteriology and culture and sensitivity							
	Operative unit	Equipment to support maternity theatre, procedure room and general operating theatre.							
	In-patient units	Equipment to support surgical ward (M/F), maternity ward, pediatric ward,							
	Critical care unit	HDU services, PICU and NICU							
	Medical products store	Medicine storage equipment, e.g fridge and temperature control equipment							
	Mortuary unit	Cooling equipment							
	Referral transport								
	Administrative transport	Utility vehicles							
	Referral transport	Ambulances							
	Infrastructure readiness								
	Power	Reliable power from two sources.							
	Water supply	Continuous 24-hour water supply							
	Waste management	Waste handling and disposal systems							
HEALTH WORKFORCE	Technical workforce								
	Medical staff	All cadres from a county hospital, plus general specialist medical practitioners and dentists							
	Nursing staff	Nursing professionals							
	Midwifery staff	Midwifery professionals							
	Allied professional staff	All cadres from a county hospital, pharmacists, physiotherapists, technical assistants in medical, laboratory, pharmacy, x-ray, physiotherapy, and anesthesia							
	Managerial workforce								
	Overall facility managers	Hospital Director, nursing director, administrator							
	Department/programme heads	Head of programme for each department.							
	Information team	Medical Records and Health Information Technician.							
	Administrative staff								
	Human resources team	Administrative staff for HR/HR officer							
	Procurement team	Administrative staff for procurement/lead procurement officers							
	Financial management team	Administrative staff for finance and accounting.							
	Security team	Security guards							
	Cleaning & maintenance team	Cleaners and maintenance workers							
	Biomedical engineering team	Waste management and grounds staff							
HEALTH PRODUCTS	Essential medicines								
	All essential medicines available Supplies are appropriate	Advanced essential medicine for the top 10 morbidity, mortality and/or conditions of public health importance according to the HMIS and for specialized interventions responding to high-risk conditions for the area.							
	Vaccines								
	All required vaccines available Supplies are appropriate	Provision of applicable vaccines for conditions of public health importance in the area including malaria, yellow fever, BCG, DPT, measles, polio, pneumococcal, rotavirus, tetanus toxoid, diphtheria, meningococcal, hepatitis B and conditions of epidemic concern as well as antirabies, antivenom as anthrax.							
	Medical products of human origin								
	Blood and products available Supplies are appropriate	Whole blood collection and storage, breastmilk collection and storage, fresh frozen plasma, platelets, and red blood cells							
	Traditional products								
	Traditional products available Supplies are appropriate	Herbal remedies, medicinal teas, therapeutic oils, acupuncture, and cupping therapy.							

Overall, tertiary hospitals have the foundational inputs required to function but the level of specialization, readiness and comprehensiveness of these investments remains below tertiary level standards. Upgrading advanced diagnostics, operative capacity, critical care services, specialized workforce, availability of blood and products of human origin and specialized vaccines and biological products is essential for tertiary hospitals to perform their role as national and state referral centres capable of delivering complex and high acuity care. As state referral centers, the tertiary facilities require to invest in designated physical infrastructure to effectively serve this purpose.

3.2 STATE HOSPITALS

The assessment examined how State Hospitals in South Sudan perform across the functional areas expected at this level of care. Overall, the functional domains are present, though the depth, specialization and readiness of services remain uneven, with substantial variation across facilities.

3.2.1 CLASSIFICATION OF THE HEALTH FACILITIES

Health promotion interventions are available in several hospitals and include a range of activities that align with State Hospital expectations. However, some facilities offer only limited interventions (e.g nutrition or physical activity), and a few provide none. Strengthening this area will require establishing structured, continuous health-promotion programs capable of addressing nutrition, hygiene, reproductive health, and the prevention of noncommunicable diseases.

Disease prevention services are generally available, including routine immunization and maternal health interventions. Nonetheless, important gaps remain, particularly the absence of newborn screening for congenital anomalies in several hospitals. A few facilities demonstrate broader preventive capacity, but overall, this function requires the establishment of a dedicated prevention unit that consistently delivers screening, antenatal care, chronic disease detection and robust outbreak preparedness.

Diagnostic capacity varies significantly. While most hospitals provide basic diagnostic services such as GeneXpert and stool testing, several have limited or no blood tests, and many lack imaging capacity beyond ultrasound. Only a small number approaches the expected level of diagnostic readiness. Improving this area will require investment in essential laboratory panels, imaging equipment, trained personnel, and the infrastructure necessary for consistent diagnostic availability.

Curative services also show considerable variation. Some State Hospitals lack specialist outpatient clinics and specialist theatre capacity, limiting their ability to manage high-risk or complex conditions. Others provide broader specialist services but still have gaps in chronic disease management and emergency surgical readiness. Strengthening curative care will require investment in human resources, equipment and service delivery infrastructure so that hospitals can reliably provide specialist outpatient, inpatient and surgical services.

Rehabilitative interventions remain one of the weakest service areas. Many State Hospitals do not provide any rehabilitation services, and where they exist, they are limited to basic physiotherapy. To meet State Hospital expectations, facilities will need dedicated rehabilitation units capable of delivering physical, occupational and speech therapy to support recovery from trauma, surgery, and chronic disease.

Palliative care services range from comprehensive symptom management in some hospitals to spiritual support only or complete absence in others. Strengthening this function requires the establishment of structured palliative care units with multidisciplinary teams that can address pain, symptoms, psychosocial needs, and spiritual care.

Support functions also show uneven capacity. Pre-service training is available in a limited number of hospitals, while others offer field experience only or no training at all. Internship services are largely restricted to certificate-level trainees, with only one hospital providing full graduate-level internship orientation. To meet expectations, hospitals should establish structured pre-service training and internship programs with clear supervision and rotation arrangements.

Research capacity is the least developed functional domain. Only a few hospitals participate in or initiate health research, and most do not conduct any research activities. Strengthening this area will require the establishment of research units, institutional priorities, and partnerships with academic organizations.

Rating of the status of health services and support capacities - State level

Functions	Expectation at the State level	Jonglei Bor State Hospital	Western Equatoria Yambio State Hospital	Warrap Kuajok State Hospital	Unity Bentiu State Hospital	Lakes Rumbek State Hospital	Nothern Bahr el Ghazal Aweil Civil Hospital	Eastern Equatoria Torit State Hospital
Health promotion interventions	Interventions that target health behaviors and appropriate health seeking actions.	Range of health promotion interventions available.	Physical activity and school health education interventions not available	Range of health promotion interventions available.	Range of health promotion interventions available.	Promotion interventions limited to nutrition education and school health education.	None of the health promotion intervention provided.	School education interventions not provided.
Disease prevention interventions	Provides all primary and secondary prevention interventions offered at lower levels, including routine vaccinations, non-invasive screening, and early detection and management of high-risk conditions, and further expands the package through specialized maternal and neonatal screening, strengthened facility-based outbreak preparedness, and robust infection prevention and control.	Screening newborns for congenital anomalies/birth defects not available.	Screening newborns for congenital anomalies/birth defects not available.	Screening newborns for congenital anomalies/birth defects not available.	Screening newborns for congenital anomalies/birth defects not available.	Range of disease prevention interventions available.	Range of disease prevention interventions available.	Range of disease prevention interventions available.
Diagnostic interventions	Capacity for advanced diagnostics for the top 5 causes of morbidity, mortality and/or condition of public health importance according for communicable and non-communicable at each age cohort	Limited capacity with Gen Xpert and and stool tests available only.	Limited capacity with Gen Xpert and and stool tests available only.	None of the blood tests available but capacity for Gen Xpert, radiology and stool tests.	Few blood tests not available but capacity for for Gen Xpert, ultrasound and stool tests.	None of the blood tests available but capacity for Gen Xpert, radiology and stool tests.	CBC,stool test, Gen Xpert and ultrasound available.	Most of the blood tests available with limited radiology services.
Curative interventions	Complements the primary hospital by providing emergency and specialized interventions responding to high-risk conditions for the area.	Specialist OPD clinics and specialist theaters not available.	None of the specialist services provided.	Specialist OPD clinics and theaters not available.	Specialist OPD, inpatients and specialized theatre services available.	Range of specialist services available, expect for the specialized theatre services.	Range of curative interventions available	Range of curative interventions available.
Rehabilitative interventions	Specialized rehabilitation units to serve patients with long-term conditions or post-surgical recovery needs covering physical therapy, occupational therapy and speech therapy.	No rehabilitative interventions provided.	No rehabilitative interventions provided.	No rehabilitative interventions provided.	No rehabilitative interventions provided.	Physical rehabilitation and physiotherapy available.	No rehabilitative interventions provided.	Physical rehabilitation available.
Palliative interventions	Multidisciplinary palliative care teams capable of managing complex pain, coordinating home-based care.	Symptom management, emotional and psychosocial and spiritual support provided.	Spiritual support only.	Symptom management, emotional and psychosocial, and spiritual support provided.	Symptom management, emotional and psychosocial and spiritual support provided.	Symptom management and emotional and psychosocial support provided.	Symptom management, emotional and psychosocial and spiritual support provided.	Range of palliative interventions available.
Pre-service training	Pre-service training for graduate health worker courses.	Pre-service training for graduate & post-graduate health worker courses.	No training provided	Field experiences centers.	Pre-service training for certificate heath worker courses.	No training provided.	Field experiences centers.	Pre-service training for graduate & post-graduate health worker courses.
Internship services	Internship orientation for graduate HWs & postgraduate (for area of specialization).	Internship orientation for certificate trainees.	Internship orientation for certificate trainees.	Internship orientation for certificate trainees	Internship orientation for certificate trainees	Internship orientation for certificate trainees	Internship orientation for certificate trainees.	Internship orientation for graduate HWs & postgraduate (for area of specialization)
Health research	Initiate critical research for addressing health issues in the State. Participate in health research within the State.	No research activity carried out.	No research activity carried out.	Participate and initiate health research within the county.	No research activity carried out.	No research activity carried out.	Participation in biomedical and public health research.	No research activity carried out.

Overall, while State Hospitals demonstrate the presence of core functional areas, the scope, specialization, and readiness of these functions are not yet at the level required for full State Hospital classification. Targeted investments in diagnostics, specialist curative services, rehabilitation, palliative care, training and research will be essential to strengthening State Hospitals as reliable referral hubs within the health system.

3.2.2 CAPACITY FOR PATIENT-FACING INVESTMENT AREAS

The assessment of patient-facing health investments in State Hospitals shows that facilities have several foundational components in place, yet many remain at a basic or incomplete stage relative to the expectations for this level of care. Overall, State Hospitals function with the essential structures required to provide routine and intermediate services, but significant improvements are needed in diagnostic capacity, critical care, specialist availability and readiness systems to ensure they can effectively serve as referral centers for primary care facilities.

In terms of **health infrastructure**, general outpatient and emergency units are established and functional, providing an entry point for patient care. However, specialized outpatient services are not consistently available, with several hospitals lacking the range of consultations expected at State level. Diagnostic capacity is particularly limited. Imaging services are generally restricted to basic X-ray and ultrasound, with no access to advanced imaging. Laboratory services support some essential tests, but key components such as bacteriology, culture, and sensitivity remain incomplete in many facilities.

Operative units exist in all hospitals, though most operate at a basic level and require additional equipment and staffing to meet the full standard. In-patient wards are generally functional, but critical care capacity is extremely limited. High dependency, neonatal intensive care, and pediatric intensive care units are mostly absent, restricting the ability to manage severe or high-risk cases and limiting internal referral capacity. Pharmacy and medical store systems are present, though several hospitals require improvements in storage conditions and overall supply management. Mortuary services are available but with varied levels of adequacy, with some requiring upgrades in space and refrigeration.

Medical equipment across facilities reflects similar patterns. Outpatient, emergency, inpatient and operative areas have essential equipment, but advanced diagnostic tools, critical care devices and comprehensive laboratory equipment are lacking. Transport systems, including ambulances and administrative vehicles, are inconsistently available, affecting emergency referrals and routine supervision. Readiness systems also face challenges: reliable power from two sources is not guaranteed, water availability is inconsistent, and waste management systems often operate

below the standards required for safe handling and disposal.

The health workforce shows strengths in nursing and midwifery, which form a solid foundation for inpatient, outpatient and maternity care. However, there is a notable shortage of clinical specialists, with many hospitals relying primarily on general practitioners. This limits the ability of State Hospitals to provide intermediate-level specialist care and manage complex cases. Allied health professionals are present in some facilities but inconsistently across the system. Physiotherapists, radiographers, anesthesia technologists, laboratory technologists and biomedical engineers are limited, with gaps that directly affect diagnostic services, operative readiness and equipment maintenance. Managerial teams are generally established, although specialized roles in human resources, procurement, finance and health information are not consistently staffed, affecting coordination and operational efficiency.

The availability of **health products** varies across hospitals. Essential medicines are generally accessible, although completeness differs from one facility to another. Vaccines for routine and priority public health conditions are mostly available, but specialized biologicals such as antivenom, anti-rabies and anthrax remain limited, reducing preparedness for certain emergencies. Blood and products of human origin, including fresh frozen plasma, platelets and red blood cells, are largely unavailable, with only minimal or basic capacity in some hospitals. This limits the ability of State Hospitals to manage emergencies requiring transfusions or advanced resuscitation. Traditional products are not currently offered but could be considered if aligned with future policy directions.

	Capacity area	Expectation at the State level	Jonglei Bor State Hospital	Western Equatoria Yambio State Hospital	Warrap Kuajok State Hospital	Unity Bentiu State Hospital	Lakes Rumbek State Hospital	Northern Bahr el Ghazal Aweil Civil Hospital	Eastern Equatoria Torit State Hospital
HEALTH INFRASTRUCTURE	Physical Infrastructure								
	General outpatient unit	Outpatient unit with general consultation rooms, triage area, accident and emergency unit.							
	Emergency unit	Emergency medical unit with outpatient emergency theatre.							
	Specialized outpatient unit	Specialized outpatient units for medicine, surgery, gynecology, and pediatrics.							
	Imaging unit	Basic imaging (X-ray and ultrasound), and access to complex imaging such as MRI.							
	Laboratory unit	Bacteriology, basic laboratory tests, culture and sensitivity testing.							
	Operative unit	General operating theatre and maternity theatre.							
	In-patient units	Medical wards (M/F), surgical wards, gynecologist ward, pediatric ward, maternity ward.							
	Critical care unit	High Dependency Unit and Pediatric and Neonatal Intensive Care Unit.							
	Pharmacy unit	Pharmacy that ensures continuous availability, safe storage, and proper dispensing of essential medicines and medical supplies.							
	Medical products store	Designated place for storage of medicines and supplies.							
	Mortuary unit	Mortuary with adequate body storage capacity and proper cooling.							
	Medical equipment								
	General outpatient unit	Equipment to support general OPD							
	Emergency unit	Equipment to support: emergency unit							
	Specialized outpatient unit	Equipment to support specialized OPD							
	Imaging unit	Basic imaging (X-ray and ultrasound) and complex imaging (e.g. MRI)							
	Laboratory unit	Equipment to for basic lavatory services, bacteriology and culture and sensitivity							
	Operative unit	Equipment to support maternity theatre, procedure room and general operating theatre.							
	In-patient units	Equipment to support surgical ward (M/F), maternity ward, pediatric ward,							
	Critical care unit	HDU services, PICU and NICU							
	Medical products store	Medicine storage equipment, e.g fridge and temperature control equipment							
	Mortuary unit	Cooling equipment							
	Referral transport								
	Administrative transport	Utility vehicles							
	Referral transport	Ambulances							
	Infrastructure readiness								
	Power	Reliable power from two sources							
	Water supply	Continuous 24-hour water supply							
	Waste management	Waste handling and disposal systems							
HEALTH WORKFORCE	Technical workforce								
	Medical staff	All cadres from a county hospital, plus general specialist medical practitioners and dentists							
	Nursing staff	Nursing professionals							
	Midwifery staff	Midwifery professionals							
	Allied professional staff	All cadres from a county hospital, pharmacists, physiotherapists, technical assistants in medical, laboratory, pharmacy, x-ray, physiotherapy, and anesthesia							
	Managerial workforce								
	Overall facility managers	Hospital Director, nursing director, administrator							
	Department/programme heads	Head of programme for each department							
	Information team	Medical Records and Health Information Technician.							
	Administrative staff								
	Human resources team	Administrative staff for HR/HR officer							
	Procurement team	Administrative staff for procurement/lead procurement officers							
	Financial management team	Administrative staff for finance and accounting							
	Security team	Security guards							
	Cleaning & maintenance team	Cleaners and maintenance workers							
	Biomedical engineering team	Waste management and grounds staff							
HEALTH PRODUCTS	Essential medicines								
	All essential medicines available	Advanced essential medicine for the top 10 morbidity, mortality and/or conditions of public health importance according to the HMIS and for specialized interventions responding to high-risk conditions for the area.							
	Supplies are appropriate								
	Vaccines								
	All required vaccines available	Provision of applicable vaccines for conditions of public health importance in the area: including malaria, yellow fever, BCG, DPT, measles, polio, pneumococcal, rotavirus, tetanus toxoid, diphtheria, meningococcal, hepatitis B and conditions of epidemic concern as well as antirabies, antivenom as anthrax.							
	Supplies are appropriate								
	Medical products of human origin								
	Blood and products available								
	Supplies are appropriate	Whole blood collection and storage, breastmilk collection and storage, fresh frozen plasma, platelets, and red blood cells							
	Traditional products								
	Traditional products available	Herbal remedies, medicinal teas, therapeutic oils, acupuncture, and cupping therapy.							
	Supplies are appropriate								

Overall, State Hospitals have basic structures and systems in place and can deliver essential services, but many components remain below the standard required for this level of care. Targeted investments in diagnostics, critical care, specialist staffing, allied health roles, transport, supply management and advanced essential medicines will be necessary for State Hospitals to fully play their role as intermediate referral facilities within the national health system.

3.2.3 CAPACITIES FOR REQUIRED MANAGERIAL PROCESSES

This section reviews the extent to which hospitals have established and maintained core management systems for service delivery, health information, and governance. The assessment focuses on whether key structures and processes are functional, documented, and aligned with national standards for State hospitals. Findings highlight areas of compliance, operational gaps, and opportunities to strengthen accountability and performance oversight.

In terms of **service delivery,** the assessment shows that hospitals have established several core managerial processes, although many remain irregular, limited in scope or not fully institutionalized. Therapeutic committees exist in some facilities but do not function consistently, underscoring the need to strengthen these structures so they can regularly review clinical quality and guide rational use of medicines. Patient entitlement and obligation charters are available in a few hospitals, yet most facilities still need to develop and implement these service charters to ensure that patients are fully informed of their rights and the standards of care they should expect.

Supervision and mentorship arrangements are in place in several hospitals but tend to be episodic and concentrated in specific units. Strengthening these processes so that supervision is conducted routinely across all departments would contribute to more consistent clinical support and performance management. Mortality audits are conducted in some hospitals, though mainly for maternal deaths. Expanding these audits across all departments and aligning them with the national mortality audit guidelines and ICD-11 classification standards would strengthen the quality and completeness of clinical review processes.

Coordination between departments remains uneven, with some hospitals lacking clear role definitions and functional interlinkages. Developing or updating hospital organograms and ensuring that departmental roles and coordination mechanisms are well defined would enhance internal communication and service integration. Referral systems also require strengthening, as several facilities lack structured processes or do not routinely document referral pathways or provide feedback. Improving referral management, including through the use of innovative approaches such as specimen referral and rotating specialist support, would enhance continuity of care and strengthen linkages with lower levels of the health system.

Health information processes are relatively stronger, although improvements are still needed. Many hospitals submit DHIS2 reports regularly, but some have not yet linked their internal data systems to the national platform. Ensuring full integration and adherence to national IDSR reporting guidelines would strengthen surveillance and early warning systems. In addition, several hospitals still need to institutionalize the generation of routine monthly utilization reports and improve the frequency and depth of data verification and analysis. Establishing a stronger culture of data use, including applying information during management

meetings, oversight discussions and community engagement forums, would significantly improve decision-making and accountability.

Governance practices vary across hospitals. Some facilities undertake annual operational planning and produce performance reports, while others still require support to institutionalize these processes in accordance with Ministry of Health guidance. Many hospitals also need to establish a routine system for preparing quarterly and annual performance reports, ensuring these documents are produced consistently and aligned with national SSD MoH guidelines. Opportunities for public engagement and participation in State or County coordination platforms remain limited in several hospitals, highlighting the need for more structured mechanisms to involve communities and local authorities. Regular management team meetings take place in some facilities but remain irregular in others, reducing leadership oversight. Strengthening these governance mechanisms, including institutionalizing planning, reporting, coordination and public engagement, will be essential to enhance transparency, accountability and performance management across hospitals.

	Process area	Jonglei Bor State Hospital	Western Equatoria Yambio State Hospital	Warrap Kuajok State Hospital	Unity Bentiu State Hospital	Lakes Rumbek State Hospital	Nothern Bahr el Ghazal Aweil Civil Hospital	Eastern Equatoria Torit State Hospital	Western Bahr el Ghazal Wau Teaching Hospital*	Upper Nile Malakal Teaching Hospital*	Central Equatoria Juba Teaching Hospital*	Lakes Kiir Mayardit Women Hospital
DELIVERY PROCESSES	Therapeutic committee	Not functional.	Not regular.	Quality of care committee.								
	Patient entitlement and obligation charter											
	Supervision/mentorship	Not regular.										
	Deaths audits	Only for obstetrics and gynecology.	Only maternal deaths.	Quarterly for maternal deaths.		Only maternal deaths.						
	Roles and interlinkages of all departments	No organogram but roles stipulated within departments.					Not in all the departments.					
	Referral systems	No feedback received or given on referrals.										
HEALTH INFORMATION	DHIS2 reporting											
	Completeness of data											
	Analysis of data			Maternal and child health data.								
	Disease surveillance		Not regular.	Maternal death.								
	Data use		Not frequent.	MPDSR or maternal death.								
GOVERNANCE	Operational planning		Draft under review.									
	Annual performance report publicly available											
	Management team monthly meeting											
	Oversight board with representation from the community, local authorities and the civil society											

Overall, while managerial structures exist across hospitals, several processes require further development to operate consistently and effectively. Reinforcing routine supervision, expanding mortality audits beyond maternal mortality audits, clarifying departmental roles, strengthening referral systems, improving data integration and use, and institutionalizing planning and reporting processes will be essential to improve accountability, governance and performance across the health system.

3.3 SELECTED COUNTY HOSPITALS AND PRIMARY HEALTH CARE FACILITIES

A total of 56 primary care facilities (PHCCs and PHCUs) from Lakes and Western Equatoria submitted data for this assessment, with additional facilities expected to report as the tool is rolled out more widely. Likewise, seven County Hospitals (Western Equatoria, Pibor Administrative Area, Ruweng Administrative Area) submitted data in this round, and more will be assessed as data collection expands. The summary tables below present the performance of these facilities across service delivery, capacities, health infrastructure, health workforce, and health products.

3.3.1 COUNTY HOSPITAL OVERVIEW

County Hospitals offer a broader service package than primary care facilities but show major gaps that limit their effectiveness as referral centers. Diagnostic capacity is almost entirely absent, highlighting a critical system of weakness. Rehabilitation services are not provided, palliative care is partial, and training, internship and research functions remain limited. Infrastructure is uneven, with gaps in emergency, triage, imaging and laboratory space, and no PICU/NICU capacity, though basic OPD, ANC, and operative areas exist.

Workforce availability is stronger for core clinical roles but lacks key support staff such as blood banks and mortuary personnel. Health products and equipment are incomplete, with shortages in essential medicines, vaccines, blood services and basic diagnostic tools. Overall, substantial investments are needed across diagnostics, infrastructure, workforce and health products to enable County Hospitals to meet expected standards and effectively support primary care.

Capacity	Expectation	Score	Description	Required improvements
Promotion	Community-based activities that target health behaviors and appropriate health seeking actions.		Most interventions are available, although half of the facilities still have gaps in interventions targeting unhealthy diets and physical activity.	Implement structured, continuous health-promotion activities, so communities are empowered to adopt healthier behaviors and appropriate health seeking actions. The hospital requires a health promotion unit/department that focuses on individuals and community and education on key issues that promote their health, including nutrition, hygiene, reproductive health, and the prevention of noncommunicable diseases
Prevention	Provision of primary preventions interventions, e.g vaccinations and non-invasive screening for common communicable and non-communicable conditions at the household and the facility.		A full range of primary prevention interventions, including routine vaccinations and non-invasive screening for common communicable and non-communicable conditions, are available.	Preventive services are a core function of a county hospital, encompassing routine immunization, antenatal care, screening for chronic and infectious diseases, and infection-prevention measures. The hospital should establish a disease prevention department, covering vaccination, screening for hypertension, diabetes, and malnutrition, and antenatal care amongst other services.
Diagnostic	Capacity for comprehensive diagnostics for the top 5 causes of morbidity, mortality and/or condition of public health importance according to the HMIS,		None of the basic diagnostic services are available.	Establish basic diagnostic capacity by ensuring the availability of essential tests for the top five causes of morbidity identified in the HMIS, including microscopy and other core facility-based diagnostics.
Curative	Complements the first point of care interventions by providing additional interventions to cover the top 10 causes of morbidity , mortality and/or conditions of public health importance according to the HMIS (e.g. complicated deliveries).		All County Hospitals report providing general outpatient and inpatient services, maternity and maternity theatre care, HIV and hepatitis B treatment, TB and malaria services, SRHR, blood transfusion services, IMCI and some management of diabetes and chronic lung conditions.	Build on the existing curative services by strengthening care for all major causes of morbidity and mortality and ensuring they fully complement primary-level interventions as required at this level of service.
Rehabilitative	Provision of physical therapy and occupational therapy for recovering individuals.		None of the facilities are providing expected services for the level of care.	The hospital requires a rehabilitation unit, providing especially physical and occupational therapy services.
Palliative	Follow up supportive care, pain relief, spiritual and psychosocial support for individuals and caregivers with terminal illnesses.		Symptom management and spiritual support were generally available with gaps in emotional and psychosocial support in half of the facilities assessed.	The hospital should have a palliative care unit, focusing on pain management, social, and spiritual care for the beneficiaries of its services.
Training	Pre-service training for certificate heath worker courses.		Training capacity is mixed across facilities. Two out of seven provide field experience; three offer no training activities; one delivers pre-service training for certificate-level health workers, and one provides pre-service training for graduate-level trainees.	Provide pre-service training for community health workers and certificate level support staff.
Internship	Internship orientation for certificate trainees		Less than half of the facilities reported providing internship orientation for certificate trainees, while the others indicated that no internship activities were offered.	Provide an internship for certificate courses in nursing, midwifery, allied health professionals.
Research	Initiate critical research for addressing health issues in the County Participate in health research within the county.		No research activity was carried out.	Build basic research capacity to initiate studies on priority county health issues and participate in ongoing research to support evidence-based decision making.
Health infrastructure	County Hospitals must have general and ANC consultation rooms, triage and emergency units, basic laboratory tests and imaging (2D and ultrasound), emergency and general operating theatres including maternity, male, female, pediatric and neonatal inpatient wards, along with reliable power and water, waste management, pharmacy and storage areas, mortuary services and transport capacity for referrals and administration		County Hospitals have basic OPD and emergency services, though many lack proper reception, records areas and full triage space. ANC units and OPD procedure rooms are common but often incomplete. Diagnostic capacity is weak, with limited imaging and almost no bacteriology infrastructure. Operative services and basic inpatient wards are mostly available but remain at a basic level, and PICU/NICU capacity is largely absent. Most facilities, however, have functional pharmacies and designated storage areas.	Strengthen reception, OPD and emergency areas, ensure complete procedure rooms, expand imaging and laboratory capacity including bacteriology, enhance emergency units, upgrade operative and inpatient wards and establish PICU/NICU infrastructure, while sustaining strong pharmacy and storage systems.
Health workforce	County Hospitals must have all PHCC cadres plus generalist medical practitioners, pharmaceutical technicians, dental assistants, physiotherapy and imaging technicians. Management must include a hospital director, nursing director, administrator, and health information staff. Support functions must include procurement, finance, HR and clerical staff, storekeeping, maintenance, waste management, laundry, kitchen services, drivers, guards, porters and mortuary attendants.		Medical assistants, nursing professionals, pharmaceutical assistants, laboratory technicians, midwifery staff, and pharmacists are mostly available. However, major gaps persist in blood bank technicians and mortuary staff, with these capacities largely absent across most facilities.	Prioritize strengthening critical support functions by recruiting and training blood bank technicians and mortuary staff to ensure safe transfusion services and appropriate management of deceased patients.
Health products	County Hospitals must have PHCC-level tools plus basic surgical, imaging and lab equipment, essential medicines for priority conditions, PHCC vaccines plus antirabies, antivenom and anthrax, whole-blood collection and storage capacity, basic breastmilk storage and selected traditional remedies.		Most facilities lack equipment for basic laboratory testing, imaging, PICU/NICU care, OPD emergency services, and operating theatres. However, many facilities do have equipment for ANC specialized outpatient units, general consultation rooms, maternity wards, and OPD procedure rooms. The availability of essential medicines is mixed, with some hospitals meeting most requirements and others reporting gaps. Vaccine availability for priority public-health conditions is generally adequate, though several facilities lack specific vaccines such as antirabies, antivenom and anthrax. Whole-blood capacity is limited in about half of the hospitals, and none provide breastmilk storage.	Strengthen its medical equipment and health product capacity by equipping basic laboratory and imaging units, upgrading emergency and operative equipment, ensuring full availability of essential medicines and priority vaccines and expanding capacity for whole-blood services and breastmilk storage.
Service delivery	Functional therapeutic committee, patient rights and obligations charter, routine supervision and mentorship, comprehensive mortality audits, clear departmental roles and coordination, structured referral system		Performance is mixed. While all facilities provide supervision and mentorship and have clearly defined departmental roles, only a few have functional therapeutic committees or conduct comprehensive death audits. Publicly displayed service charters are available in most, but not all facilities and referral systems are reported being largely in place.	Establish a formal emergency referral network with regional hospitals, set up a functional therapeutic committee for continuous clinical review, and fully adopt the SSD mortality audit guidelines.
Health information	Integrated DHIS2 reporting, routine monthly utilization reports, regular data verification, adherence to IDSR guidelines, systematic data analysis, and use for decision making.		Consistently met all health information standards, with timely monthly DHIS2 reporting, complete data submissions, regular monthly analysis for decision-making, weekly reporting of notifiable conditions and routine discussion of utilization data during management meetings.	Continue to strengthen its health information system by ensuring full linkage of in-house data tools to DHIS2, maintaining adherence to IDSR guidelines for weekly reporting of notifiable conditions and using monthly utilization reports to guide management decisions.
Governance	Annual and quarterly planning, routine performance reporting, functional coordination mechanisms, structured public engagement, regular management meetings		Facilities generally reported satisfactory practices, including the development of annual operational plans aligned with SSD guidelines, the presence of oversight boards with community, authority and CSO representation, and regular management team meetings.	Institutionalize the annual planning process Produce quarterly and annual performance reports in line with national requirements.

3.3.2 PRIMARY HEALTH CARE FACILITIES OVERVIEW

Primary health care facilities provide basic promotion, prevention and some curative services, but major gaps remain across diagnostics, rehabilitation, palliative care, training and research. Infrastructure is limited, with most facilities lacking procedure rooms, observation beds, laboratory space, and adequate OPD capacity. Workforce shortages are widespread, particularly among nursing, midwifery, pharmaceutical, and laboratory staff. Health products are incomplete, with gaps in essential medicines, vaccines, whole-blood capacity and basic laboratory tools. Overall, substantial investment is needed across service delivery, infrastructure, staffing and health products for facilities to meet expected primary care standards and deliver comprehensive, safe care.

Capacity	Expectation	Score	Description	Required improvements
Promotion	Community-based activities that target health behaviors and appropriate health seeking actions.		Most interventions are available, particularly those related to nutrition, school health education, and health-seeking behaviour.	Strengthen community-based activities that promote healthy behaviours, including guidance on social risk factors, encourage appropriate health-seeking actions, and integrate physical activity into routine health-promotion efforts.
Prevention	Provision of primary preventions interventions, e.g. vaccinations and non-invasive screening for common communicable and non-communicable conditions at the household and the facility.		Most interventions are available, particularly those for nutrition, malaria, and routine immunization.	Extend prevention interventions to include non-communicable and neglected tropical disease interventions through routine non-invasive screening (e.g. blood pressure screening, blood sugar screening) at both household and facility level.
Diagnostic	Capacity for basic diagnostics for the top 5 causes of morbidity according to the HMIS.		Nonexistent capacity for basic laboratory diagnostics for 80% of the facilities assessed.	Primary care facilities should strengthen their basic diagnostic capacity by ensuring routine malaria testing and other essential point-of-care tests for the top five causes of morbidity identified in the HMIS.
Curative	First point of care treatment for the top 5 causes of morbidity, mortality and/or conditions of public health importance according to the HMIS uncomplicated illnesses (e.g., malaria, diarrhea, respiratory infections, normal/ assisted delivery).		Curative services are mostly available for maternity care, malaria, SRH, and IMCI, while services such as HIV care or TB are not provided.	Primary care facilities should broaden their curative service package by adding other essential interventions needed at this level to ensure comprehensive and integrated care for the community.
Rehabilitative	Follow up and support to physical therapy, occupation therapy and speech therapy needs.		Rehabilitation services are not available in any of the facilities, with no provision for physical, occupational or speech therapy support.	Introduce basic rehabilitation services by establishing follow-up and support for physical, occupational and speech therapy needs at primary care level.
Palliative	Follow up of supportive care, pain relief, spiritual and psychosocial support for individuals and caregivers with terminal illnesses.		Palliative care is inconsistently available, with only about half of the facilities offering supportive care, pain relief, and spiritual or psychosocial support for individuals with terminal illnesses.	Ensure all facilities provide basic palliative care services, including pain relief, psychosocial and spiritual support and follow-up for individuals and caregivers facing terminal conditions.
Training	Field experiences centres.		Limited capacity for training.	Primary care facilities should be developed as field experience centers to support hands-on training, mentorship, and practical learning for health trainees and community health workers.
Research	Participate in biomedical and public health research		No research activity carried out.	Participate in basic biomedical and public health research to generate local evidence that informs service delivery and operations at the facility level as well as community health interventions.
Health infrastructure	Facilities must have consultation and procedure rooms, reception and records space, basic laboratory capacity, observation beds, drug storage and dispensing areas, reliable power, clean water, waste management systems, storage space and functional transport for administration and support.		Most facilities have a single general consultation room, but major gaps exist in observation and stabilization beds, procedure rooms, basic laboratory space and OPD procedure capacity. These critical elements are missing in nearly all facilities.	Investments in infrastructure by establishing observation and stabilization areas, functional procedure rooms, OPD procedure capacity, and basic laboratory space to meet the expected service standards for delivery of quality health services to the population that these facilities serve.
Health workforce	Facilities must have medical assistants, nursing and midwifery professionals, community health workers, pharmaceutical and laboratory assistants, dieticians and nutritionists, a facility in-charge, as well as cleaners and security guards to ensure safe and continuous service delivery.		Most facilities reported lacking medical assistants, laboratory technicians and having generally limited workforce capacity. More than half do not have nursing professionals, pharmaceutical assistants, midwifery staff, dieticians or a designated facility in-charge.	Invest in essential clinical and support staff to strengthen service delivery and ensure reliable patient care.
Health products	Facilities must have basic diagnostic tools, essential medicines for priority conditions, required vaccines for major public-health risks, basic whole-blood collection and storage capacity and traditional remedies such as herbal preparations where appropriate.		Major gaps in health products. None have whole blood. Essential medicines are incomplete, with 23 percent reporting nonavailability and half only partially meeting the standard. Vaccine availability for priority public-health conditions is partial, and all facilities lack basic laboratory capacity such as microscopy.	Must ensure full availability of essential medicines and vaccines for priority conditions, establish basic laboratory capacity including microscopy and develop the capacity to provide whole-blood services as required at this level.

Way forward

The assessment highlights important progress across hospitals and primary care facilities, while also identifying priority areas that must be strengthened for facilities to meet national standards. The recommendations outlined in this report provide a practical, phased path for improving service delivery, building critical capacities, and reinforcing the systems that support hospital performance.

Moving forward, facilities will need to work closely with the Ministry of Health to plan and implement these actions in a realistic and coordinated manner. Regular progress reviews should be conducted to track implementation, address emerging gaps, and ensure steady movement toward full alignment with national expectations.

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