# Country Profile: South Sudan

### Demographic Context

The population progressively increased from 10M to 11M between 2017 to 2022 as shown in **figure 1.** Infants aged below 12 months and those below the age of 5 years accounted for less than 7% and 18% of the entire population respectively.

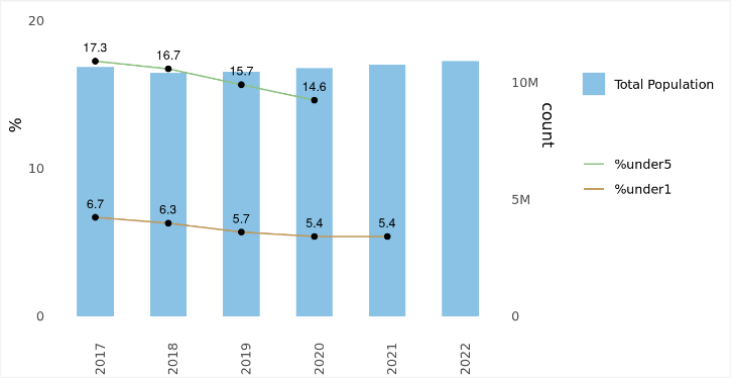


*Figure 1: Population Trends in South Sudan*

During the same period, the Human Development Index remained at 0.4, a below average performance on individual longevity, education and income capabilities **(Figure 2).** The Human Capital Index remained at 0.3, the least within the cluster. This implied that children born during the period would attain only 30% of their productivity potential. The life expectancy at birth was 55 years.

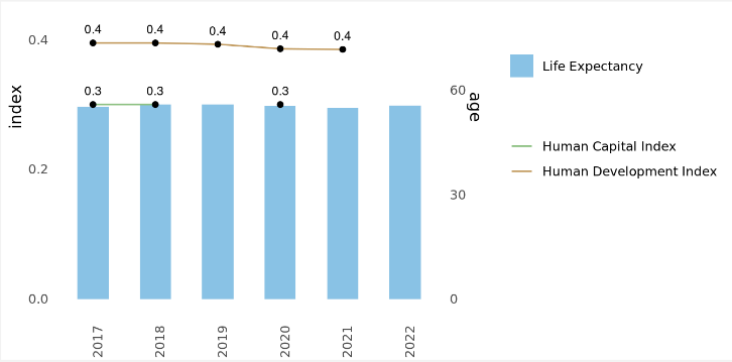


*Figure 2: Development and Productivity Potential in South Sudan*

### Economic Context

Extensive analysis of the economic context in South Sudan was limited by paucity of data. However, latest available data (2017) had the Gross National Income Per Capita at USD 748. This matched the Initial self-financing phase for GAVI eligibility(GAVI, 2022).

The Debt to GDP ratio decreased from a high of 120% in 2017 to 40% in 2022, which is well within the EAC regional threshold of 50% for debt sustainability and adequacy of financing public services beyond debt repayment. Analysis of the Tax to GDP ratio was limited by lack of data.

**Highlight**

The paucity of data on key Public Finance and Health system performance indicators e.g., economic indicators, poses a great threat to effective forecasting, planning, implementation and accountability for immunization financing. It thus necessitates strengthening of data management systems across all levels of governance (National and sub-national level).

The declining debt levels in South Sudan are commendable particularly in view of the ongoing transitions and the need for government to strengthen public debt sustainability options.

A strengthened tax administration in South Sudan would help mobilize more resources for public goods such as health and immunization.

## Health System Context

The top 3 causes of death amongst the general population were Neonatal conditions, lower respiratory tract infections and HIV/AIDS. Malaria, Pneumonia and Diarrhea were the main causes of under 5 mortalities.

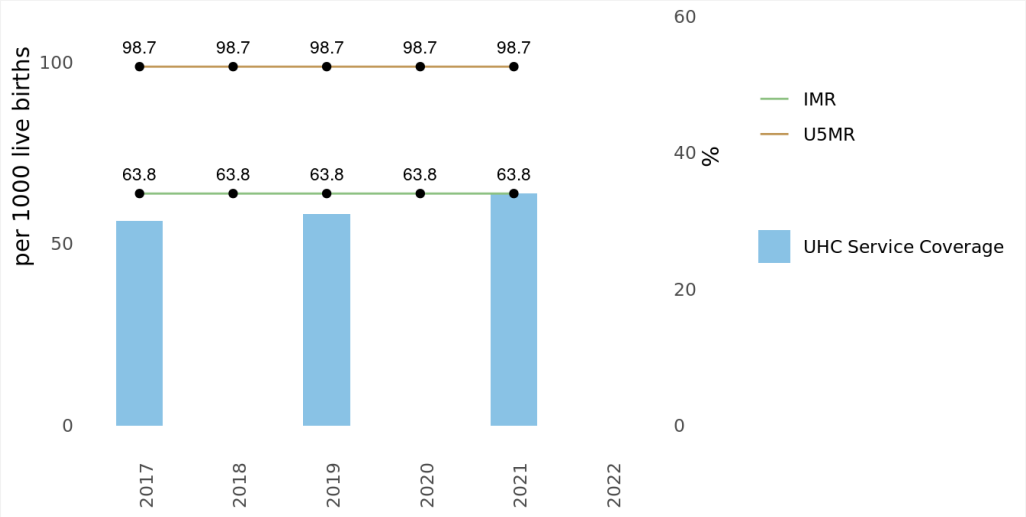


*Figure 3: Health System Performance in South Sudan*

Both the Infant and Under Five Mortality Rates remained constant over the period of analysis. The Infant Mortality Rate (IMR) stood at 64 deaths per 1000 live births, while the Under Five Mortality Rate was 99 deaths per 1000 live births as shown in **figure 3.**

The UHC Service Coverage Index in 2021 was 34%, the lowest within the cluster. This implied that only 34% of the population in South Sudan had access to quality essential services including reproductive, maternal, newborn and child health, infectious diseases, and non-communicable disease services.

### Health Financing Context

Government spending on health between 2017 and 2020 remained below 1% of the GDP which was markedly below the minimum of 5% recommended for progression towards UHC(McIntyre et al., 2017). The per capita spending on health remained between USD 20 in 2017 to USD35 in 2020 hence significantly below the recommended per capita target of USD 86(McIntyre et al., 2017). Further, the government expenditure on health relative to other sectors stood at 2%, which was substantially below the 15% Abuja target **(Figure 4).**

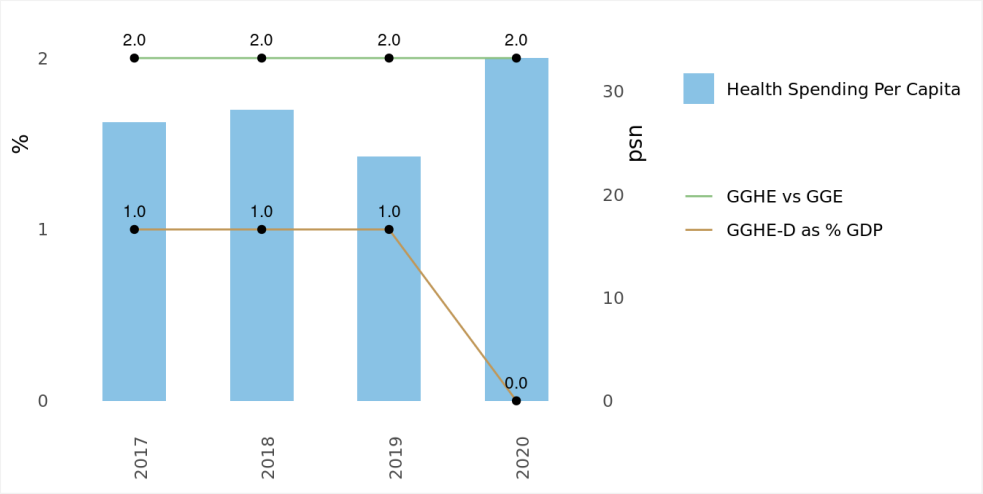


*Figure 4: Health Financing Trends in South Sudan*

Donnor funding was the most significant source of financing for health in South Sudan. This accounted for between 56% and 68% of all health financing. This was followed by Out-of-Pocket spending (19% to 21%), donor funding (16% to 23%) and Government grants (8 to 16%) during the period of analysis **(Figure 5).**

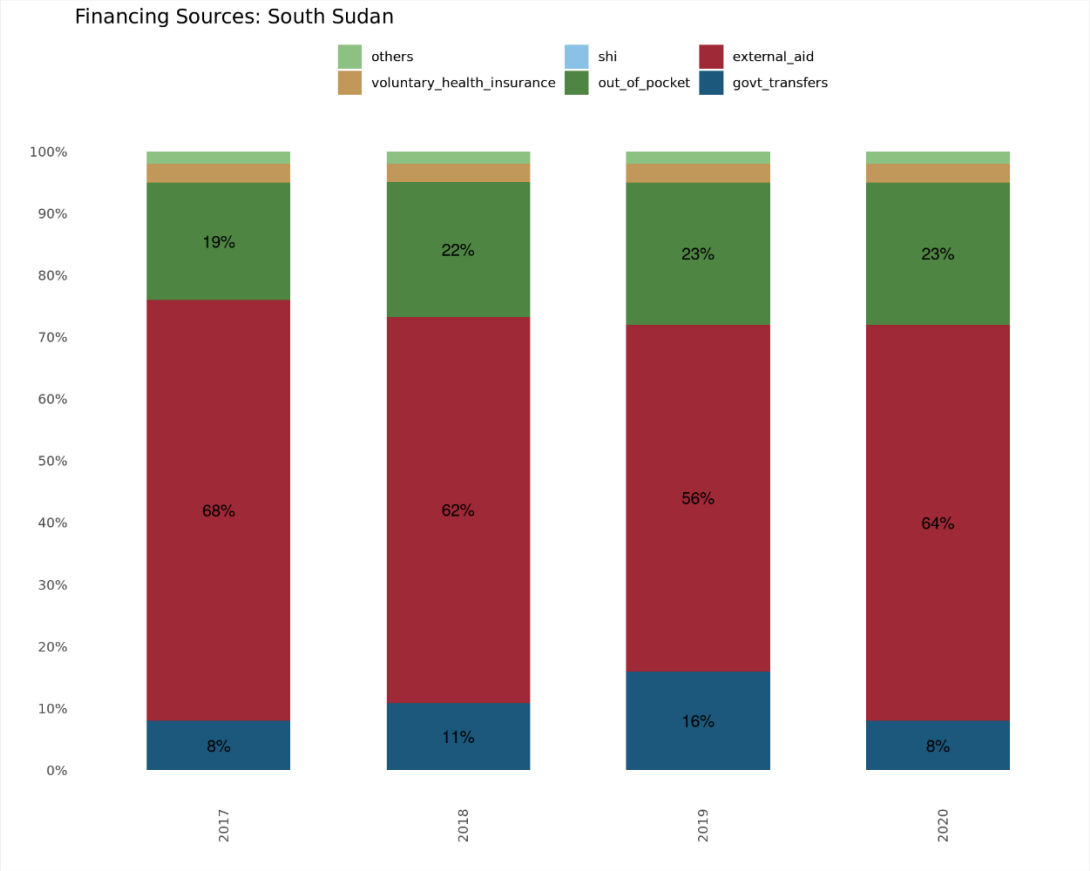


*Figure 5:Health Financing Sources in South Sudan*

**Highlight**

The low UHC service coverage index highlights the need for system wide improvements to facilitate access to quality essential healthcare in South Sudan.

The high OOP payments poses a significant risk of financial hardship among the population as they seek for care. Strengthening pooling mechanisms in South Sudan would help reduce OOPs.

The significant dependence on donor funding limits the transition to domestic financing of health and immunization, and further threatens sustainability of immunization services.

Increased government allocations are therefore essential to guarantee sustainability of health services, including immunization services.

**Immunization Coverage**

Overall, the national immunisation coverage rates show a positive trend in performance between 2017-2022. Measles 2 vaccine is yet to be introduced into the EPI schedule in South Sudan **(Figure 6).**

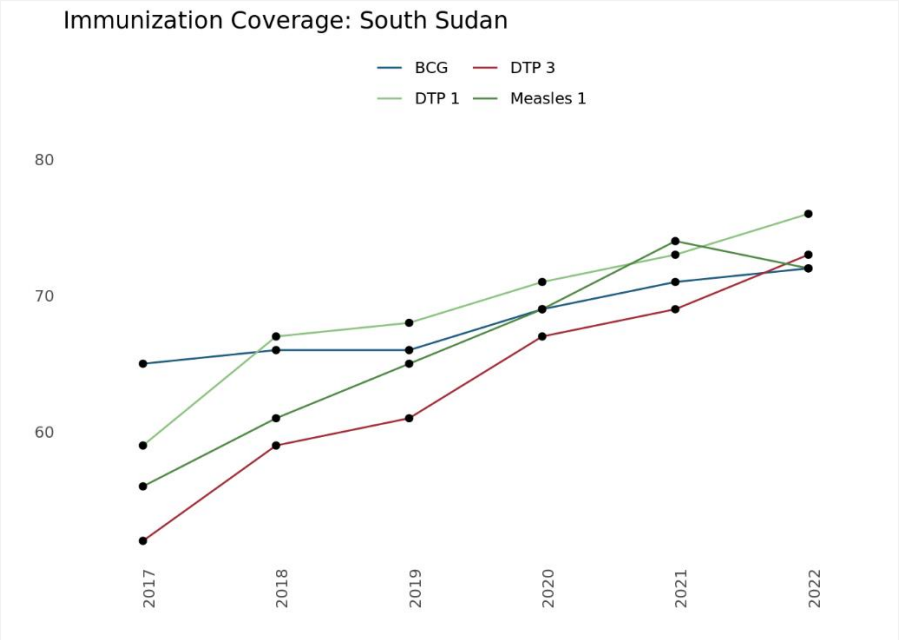


*Figure 6: Immunization Coverage trends in South Sudan*

Overall, lower income groups had higher under five mortality rates and lower immunization coverage (DTP 3 and MCV) which indicated income related inequities. The gap between the under-five mortality rates for low-income households and wealthy households was less than 10 deaths per 1000 live births across the years (2017-2021) as in **figure 7.**

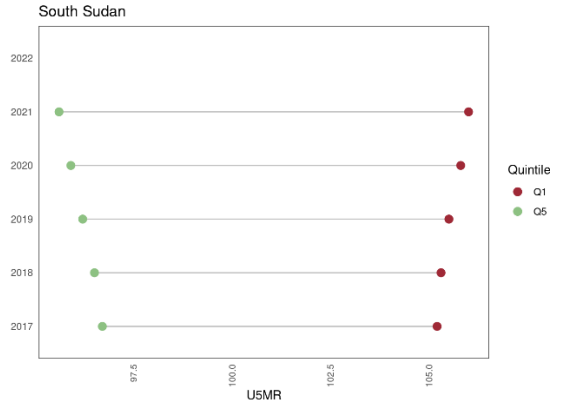


*Figure 7: Equity Analysis of U5MR in South Sudan*

Coverage of DTP3 was generally higher among the high-income groups in South Sudan. The coverage gap for DTP3 across the income groups was minimal **(Figure 8)**

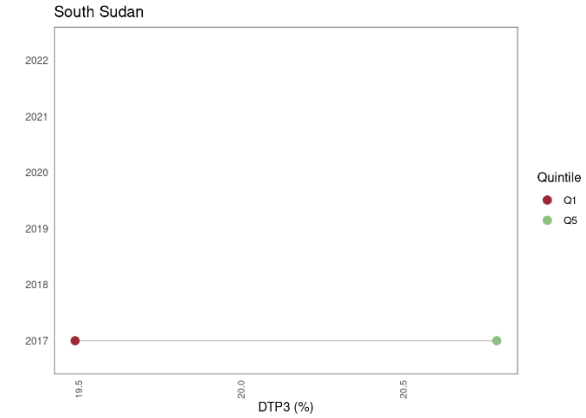


*Figure 8: Equity Analysis of DTP3 coverage in South Sudan*

**Highlight**

The widening gap in under five mortalities between the wealthiest and poorest quintiles necessitate intentional equity enhancing approaches to increase and sustain access to the essential vaccines, and health services within the first 5 years of life.

## Immunization Financing

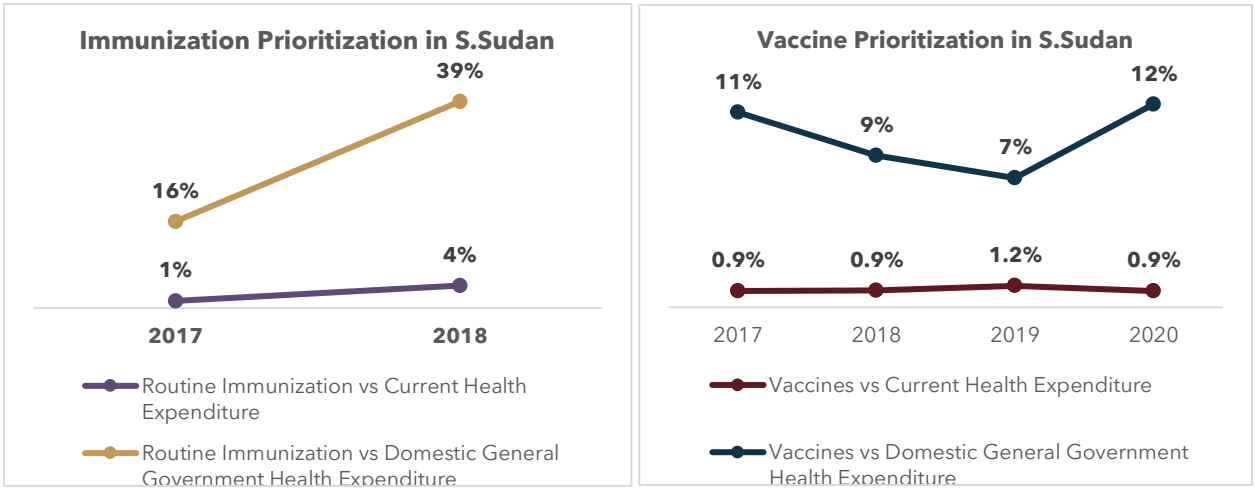


*Figure 9: Prioritization of Immunization and Vaccines in South Sudan*

Analysis of Routine Immunization Financing in South Sudan was limited by paucity of data after 2019. However, available data between 2017 and 2018 suggests that Routine Immunization accounted for between 1% and 4% of the respective Current Health Expenditures; and between 16% and 39% of the Domestic General Government Health Expenditures between 2017 and 2020 **(Figure 9).** Vaccine related expenditures accounted for less than 2% of the CHE, and between 7% to 12% of the Domestic General Government Expenditures.

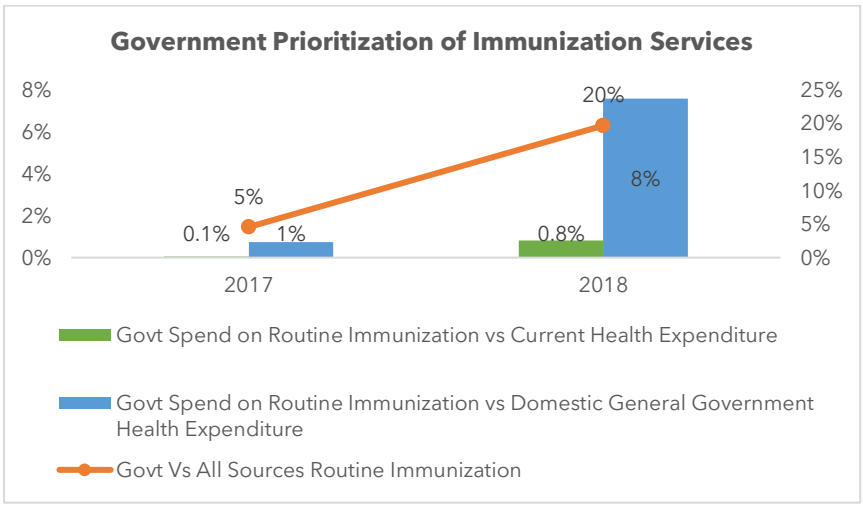


*Figure 10: Government Prioritization of Immunization in Services*

Government funding as a source of immunization financing increased from 5% in 2017 to 20% in 2018. This accounted for less than 1% of Current Health Expenditures and less than 10% of the Domestic General Government Health Expenditure **(Figure 10).**

Analysis of Government funding as a source of vaccination financing in South Sudan was limited by paucity of data during the period of analysis.

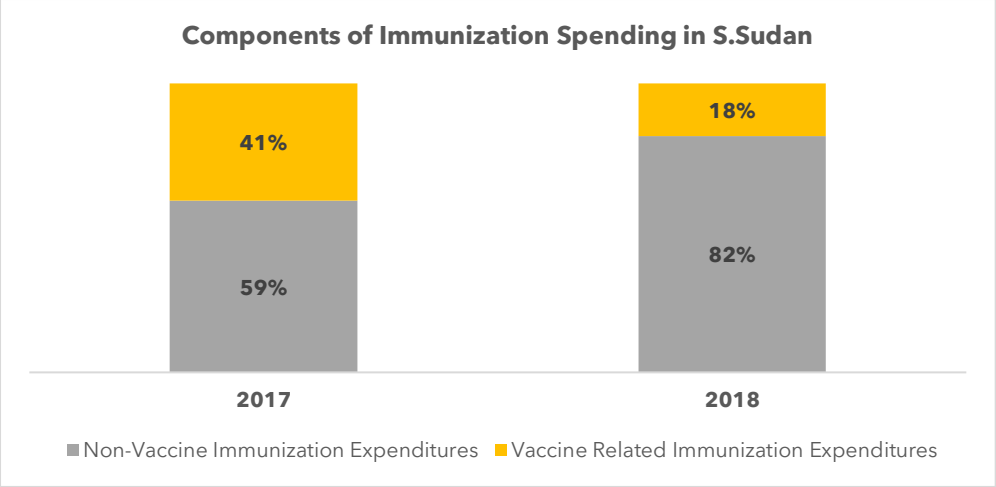


*Figure 11: Components of Immunization Spending in South Sudan*

From the available data, expenditures related to procurement of vaccine products accounted 41% and 18% of all the immunization financing in South Sudan in 2017 and 2018 respectively as in figure 11.

**Highlight**

The available data suggests significant dependence on donors for funding of the immunization in South Sudan.

Increased Government investments in immunization are necessary to ensure sustainability and continuity of care post donor transitions.

Data availability and integrity are critical for proper planning, forecasting and accountability for immunization. Strengthening data management in South Sudan should thus be a priority.

## Recommendations towards improving immunization services in South Sudan.

1. **Vaccine Supply and Cold Chain Management**: Increase vaccine production and distribution, improve cold chain infrastructure, and implement effective waste management mechanisms.
2. **Access and Geographic Barriers**: Establish mobile immunization clinics, increase the number of healthcare workers, and improve transportation infrastructure.
3. **Vaccine Hesitancy**: Increase public awareness through targeted campaigns, engage with community leaders, and provide accurate information about vaccines.
4. **Healthcare Workforce Shortages**: Increase the number of trained healthcare workers, provide adequate training and supervision, and incentivize healthcare workers to work in rural areas.
5. **Socioeconomic Factors**: Increase public awareness through targeted campaigns, provide free or subsidized vaccines, and improve access to education and healthcare.
6. **Security Challenges & Political Instability**: Increase security in conflict-prone areas, provide adequate protection for healthcare workers, and establish contingency plans for immunization services.
7. **Data Management and Monitoring**: Improve data collection and management systems, establish a centralized database for immunization data, and provide training for healthcare workers on data management.
8. **Cultural and Religious Factors**: Engage with religious and community leaders, provide accurate information about vaccines, and address cultural and religious beliefs that discourage vaccination while developing culturally appropriate immunization programs.
9. **Inadequate Government Funding**: Increase government funding for immunization programs, establish a predictable funding mechanism, and reduce dependence on external donors.
10. **Health System Weaknesses**: Improve healthcare infrastructure, establish efficient logistics and supply chain management, and strengthen health system governance.

## Recommendations towards improving immunization financing in South Sudan.

1. **Inadequate Government Funding**: Increase budget allocation for immunization programs, prioritize immunization spending, and improve budget transparency.
2. **Dependency on Donor Funding**: Diversify funding sources, establish predictable long-term partnerships with donors and private sector, and develop contingency plans for funding fluctuations.
3. **Financial Mismanagement**: Improve financial management systems, establish accountability mechanisms, and increase transparency in financial reporting.
4. **High Cost of Vaccines**: Negotiate favorable vaccine prices with manufacturers, explore alternative negotiated procurement mechanisms, prioritize vaccines based on cost-effectiveness, and incentivize domestic manufacturing of vaccines.
5. **Supply Chain Costs**: Increase budget allocation for supply chain logistics, improve cold chain infrastructure, and establish effective waste management mechanisms.
6. **Human Resource Costs**: Increase incentives for healthcare workers involved in immunization delivery, provide adequate training and supervision, and incentivize healthcare workers to work in rural areas.
7. **Healthcare Infrastructure Costs**: Increase budget allocation for healthcare infrastructure, prioritize infrastructure development in underserved areas, and establish public-private partnerships for infrastructure development.
8. **Health Insurance Coverage**: Expand health insurance programs to cover immunization costs, establish public-private partnerships for health insurance, and increase awareness of health insurance benefits.
9. **Economic Challenges**: Strengthen Public Finance Management systems, establish contingency plans for economic fluctuations, prioritize immunization spending during recessions, and increase public-private partnerships for immunization financing.
10. **Advocacy & Awareness**: Increase public and political awareness of the importance of immunization, engage with community leaders and stakeholders, and establish advocacy campaigns for immunization financing.
11. **Coordination & Accountability**: Strengthen central and decentralized immunization coordination among government agencies, donors, and implementing partners, with stronger accountability mechanisms to ensure funds are used effectively.
12. **Data and Monitoring**: Increase funding for data collection, monitoring, and evaluation of immunization programs, strengthen the centralized database for immunization data, and provide training for healthcare workers on data management.

## References


GAVI. (2022). *Gavi Alliance Eligibility and Transition Policy Version 4*. https://www.gavi.org/types-support/sustainability/eligibility

McIntyre, D., Meheus, F., & Rottingen, J. A. (2017). What level of domestic government health expenditure should we aspire to for universal health coverage? *Health Economics, Policy and Law*, *12*(2), 125–137. https://doi.org/10.1017/S1744133116000414