POLICY BRIEF

Strategic Health Purchasing as an Enabler of Health Systems Resilience in Fragile States: Evidence from South Sudan

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Abstract

South Sudan's fragile health system faces multiple challenges, including low domestic funding estimated at 2-5% of the annual budget, heavy donor dependency estimated at more than 65% of the total budget, fragmented purchasing mechanisms, and weak governance. Strategic health purchasing (SHP) offers a pathway to realign limited resources with national health priorities, enhance accountability, and ultimately build a resilient health system. This policy brief is based on a recent study that applied the SPARC Progress Tracking Framework to assess the status of SHP in South Sudan. Key findings reveal notable reforms, including the development of the Basic Package of Health and Nutrition Services (BPHNS) and the Health Sector Transformation Project (HSTP). However, progress and service delivery are constrained by barriers such as nascent Public Financial Management (PFM), uncosted BPHNS, suboptimal provider payments, and limited facility autonomy. This brief calls for strengthening governance, aligning SHP with realistic national priorities, reforming provider payment and contracting mechanisms, bolstering data systems, and mobilizing domestic resources to reduce donor dependency even as the country prioritizes making progress towards achieving Universal Health Coverage (UHC).

Background

South Sudan's has a predominantly young population with a median age of about 19 years and one of the highest dependency ratios globally, estimated at 75 dependents per 100 workers. This places significant pressure on a small working-age population to finance education, healthcare, and other social services amid chronic underinvestment in health. The health sector relies heavily on external funding, which accounts for over 60–65% of total health expenditure (1), while per capita health spending remains low at approximately USD 34 compared to the WHO-recommended USD 84 (2017) (2). Public health spending rarely exceeds 2–5% of the national budget, and out-of-pocket payments remain high at 16.5%, exacerbating inequities and undermining financial protection (3). These challenges are compounded by fragile governance and predominantly passive, donor-driven purchasing arrangements that are weakly aligned with evidence and population health needs.

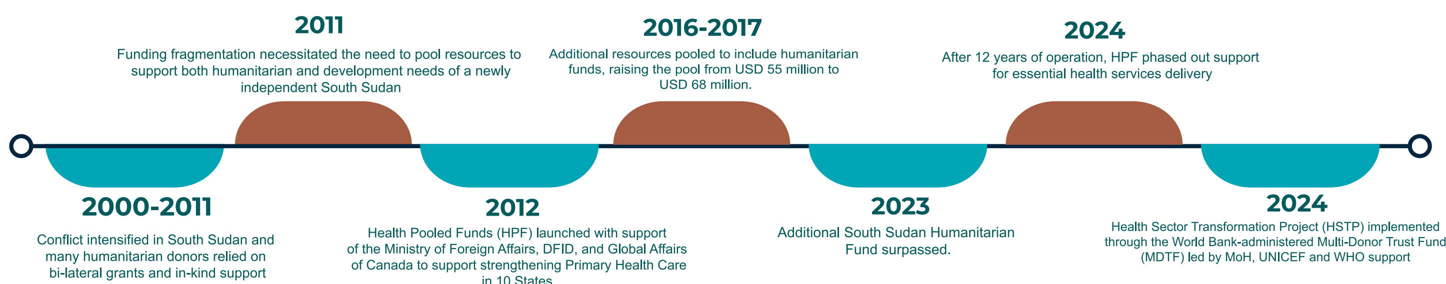
South Sudan at a glance

- Population (2023): **11.5 million**[i]
- GDP per capita (nominal, 2025 est.): **US$ 368**[ii]
- CHE as % of GDP (2021): **5.9%**[iii]
- Current Health Expenditure per capita (2022 est.): **US$ 49**[iv]
- GGHE-D as % of CHE (2022): **8.6%**[v]
- GGHE-D as % of GGE (2022): **0.5%**[vi]
- OOP as % of CHE (2023): **27.1%**[vii]
- External Health Expenditure as % of CHE (2022): **49.8%** [viii]

i https://data.who.int/countries/728
ii https://www.imf.org/external/datamapper/profile/SSD
iii https://data.who.int/countries/728
iv https://www.macrotrends.net/global-metrics/countries/ssd/south-sudan/healthcare-spending
v https://p4h.world/en/countries/south-sudan/
vi https://p4h.world/en/countries/south-sudan/
vii https://apps.who.int/nha/database/country_profile/Index/en
viii https://p4h.world/en/countries/south-sudan/

South Sudan's journey toward achieving Universal Health Coverage (UHC) is characterised by several key strategic initiatives. Since achieving independence in 2011, South Sudan has made significant strides in defining its health service priorities. The development of The Basic Package of Health and Nutrition Services (BPHNS), introduced shortly after independence and updated with a second edition in 2023, lays out the priority essential health services identified to meet the population's needs (4). Additionally, through the Health Sector Transformation Project (HSTP), launched in 2024, donors have established a pooling mechanism that allows them to reinvest available resources towards key health priorities to the benefit package and enhance stewardship in the health sector (5). The HSTP serves as a critical mechanism for channeling external resources, coordinating contracting arrangements, provider payments, and performance monitoring. This succeeds the Health Pooled Fund (HPF), initiated in the early 2010s, to consolidate donor contributions and ensure a more coordinated approach to financing health services (3,5).

Fig 1: Evolution of Pooled Health Financing and Health System Support in South Sudan (2000–2024) Source: Authors



Due to the limited financial allocations to the health sector by the government of South Sudan, the pooled funds from donors have become a key source that allocates financial resources to health facilities (both public and selected private). Strategic health purchasing, the deliberate allocation of funds based on service quality, population needs, and performance data, emerges as a critical tool for aligning health investments with national priorities and enhancing system resilience in fragile settings (6,7). It has the potential to redirect scarce resources toward high-impact, cost-effective interventions. However, without robust governance and accountability, even well-designed SHP policies risk falling short (7). This policy brief examines how strategic health purchasing can be strengthened within South Sudan's donor-dependent financing architecture to better align pooled resources with national priorities, population health needs, and progress toward Universal Health Coverage.

Methodology

Evidence was gathered through the application of the Strategic Health Purchasing Progress Tracking Framework developed by the Strategic Purchasing Africa Resource Centre (SPARC) to assess South Sudan's purchasing arrangements. Data were collected through document review of grey and published literature, and 10 Key informant interviews (KII) with the Ministry of Health (MoH) officials, implementing partners, and frontline providers. Additionally, a validation workshop brought together stakeholders to discuss findings and verify evidence hence providing consensus on findings and feasibility of policy actions. This multi-method approach enabled triangulation of evidence and a robust assessment of the current state of SHP in South Sudan.

Findings

South Sudan's health system is highly decentralized in design, with the Ministry of Health (MoH) responsible for overall policy direction. In practice, however, purchasing decisions are predominantly driven by donor-led pooled financing mechanisms, with limited government fiscal space and institutional capacity to exercise strategic purchasing. The South Sudan National Health Policy (2016–2026) outlines roles for the MoH, State, and County governments, but ambiguities, overlapping mandates, and weak coordination persist. A key pooled mechanism is the Health Sector Transformation Fund/Project (HSTF/HSTP), managed through a Project Management Unit (PMU) with government and donor representation.

Table 2: Health Purchasing Arrangements in South Sudan

SHP arrangements	Ministry of Health (MoH)	State & County Governments	HSTF/HSTP (PMU-managed pooled mechanism)
% of Current Health Expenditure (CHE)	~2–5% (public financing)	Part of overall public financing	>65% (external/donor financing through pooled arrangements)
Population covered	National policy mandate—entire population	Entire population within jurisdictions	Broad population reach via supported facilities, but service focus shaped by donor priorities
Governance arrangements	Sets national policy direction; defines BPHNS; stewardship role per National Health Policy (2016–2026). Governance constrained by weak legal/accountability clarity, limited coordination, and low fiscal space.	Implement service delivery and local planning, but operate with limited resources, weak institutional capacity, and high dependence on external programs.	PMU jointly governed (govt + donors). Exercises core purchasing functions (contracting, payments, monitoring). Operates parallel to government systems, reducing harmonization and domestic stewardship.
Public Financial Management (PFM)	Underdeveloped PFM with weak execution, incomplete classification, low credibility, and limited transparency/oversight—constraining strategic allocation and timely disbursement.	Weak sub-national PFM capability, bureaucratic delays, limited autonomy at facility level, and low flexibility in allocating resources.	Parallel fiduciary systems outside core PFM/IFMIS reduce visibility and consolidation of health resources; contributes to fragmentation and misalignment with national priorities.
Benefit specification (Health benefits package)	Defines BPHNS: comprehensive but un-costed, ambitious, and under-resourced, creating mismatch between entitlements and feasible delivery. Low public awareness of entitlements.	Expected to deliver BPHNS but constrained by HR shortages, poor infrastructure (water, electricity, equipment), and essential supplies gaps.	Supports delivery of priority interventions aligned to funded program design; may cover only parts of BPHNS depending on donor financing and implementation focus.
Provider contracting & selection arrangements	Contracting largely automatic/implicit for public providers; weak enforcement due to limited institutional capacity and weak PFM accountability structures.	Contracting generally weak or informal; limited capacity for oversight and enforcement of service agreements.	Some form of contracting exists (often via implementing partners), with potential to institutionalize performance metrics. However, modalities vary across partners, leading to heterogeneity and fragmentation. Limited provider market necessitates non-selective contracting, weakening strategic leverage.
Provider payment methods	Predominantly passive: line-item and global budgets based on historical allocations, civil service salary structures, budget ceilings; includes in-kind transfers of commodities. Limited linkage to cost, outputs, or quality.	Similar input-based financing with constrained flexibility and frequent delays; limited scope for performance-linked incentives.	Mainly input-based financing: HR support, essential supplies, and operational inputs. Limited performance-based incentives; operational cost coverage not systematically linked to BPHNS delivery costs or verified outputs. Delays in disbursement and reporting weaken effectiveness.
Performance monitoring	DHIS2 has improved data availability but data are often incomplete due to late reporting, inaccuracies, and weak private-provider reporting. Limited linkage between service outputs and expenditures; weak analytics capacity limits use for purchasing decisions.	Uses DHIS2 variably; limited capacity for data analysis and use in planning/budgeting; weak feedback loops for accountability.	Multiple parallel donor/partner systems operate alongside DHIS2. Monitoring is often donor-facing and indicator-limited, not covering full BPHNS scope. Non-uniform reporting weakens credibility and comparability of performance metrics.

Challenges to health system resilience

The health system in South Sudan faces multiple challenges that undermine its resilience. A heavy dependency on external donor funding, at more than 65% of the annual health budget , leads to a more reactive approach to service delivery and often not aligned with national health priorities. Donor commitments often focus on short-term, vertical programs such as disease-specific interventions rather than sustainable, comprehensive health system strengthening. This misalignment results in fragmented strategies and hampers long-term planning. Inadequate human resources for health, weak management systems, poor incentives, and delayed salary payments have led to high attrition rates and a brain drain of essential staff.

Infrastructure deficiencies further complicate service delivery, as many facilities lack basic services, and over 54% of the population lives more than five kilometres from functional care. Logistical barriers, including poor road networks, costly air transport, and limited storage capacity, exacerbate supply chain inefficiencies, delaying access to critical medicines and supplies. Moreover, fragile governance structures and accountability mechanisms undermine local decision-making, while chronic political instability, armed conflicts, and limited institutional capacity hinder policy reforms and emergency preparedness. Collectively, these factors create a volatile environment that compromises the system's ability to respond effectively to crises and maintain sustainable healthcare provision. Immediate action is required for sustainable reform.

Policy Implications and Recommendations

i. **Strengthen governance and institutional capacity** by revising legal and regulatory frameworks to clearly delineate roles and responsibilities for health purchasing and enhance MoH capacity through targeted training and investment in public financial management systems. This can be progressively done using the HSTP that is already the dominant purchasing arrangements in the country.

ii. **Progressive alignment of the Health Benefit Package with resource realities** by re-assessing and prioritizing interventions that the BPHNS that yield high-impact, are cost-effective and those that match with available resource envelopes. Additionally, engaging stakeholders in a transparent process to recalibrate service expectations and resource allocation.

iii. **Progressively increase domestic resource mobilization** to gradually reduce donor dependency through a variety of mechanisms to include tax-based financing, operationalizing the National Social Insurance Fund act 2023 to strengthen social health insurance schemes, gradually integrating donor-managed funds into national budgetary processes, and leveraging innovative public–private partnerships

iv. **Foster greater coordination** among government, donors, and implementing partners by strengthening the role of the PMU through transparent platforms to ensure that purchasing decisions under HSTP are driven by national health priorities. This provides opportunities of transferring skills and capacities to MoH in the long-term.

v. **Strengthen standardized, introduce performance-linked contracts** to incentivize quality improvements linking the HSTP to the broader health system goals. In addition, advocate for transition from passive, line-item payment systems to mixed payment models that include performance-based incentives as the country prioritizes UHC related priorities.

vi. **Invest in strengthening performance monitoring arrangements** building on the existing databases such as DHIS2 and complementary data systems to ensure timely and accurate reporting. Use robust performance data to guide purchasing decisions such as contracting, provider payments, reinforcing accountability.

Conclusion

Strategic health purchasing holds significant promise for reorienting South Sudan's health financing toward efficiency, equity, and health systems resilience. By implementing governance reforms, aligning the health benefit package with realistic resource availability, utilizing data for decision making, and strengthening contracting and payment mechanisms, the country can better harness its existing limited resources including HSTP to deliver essential health services and build resilience in the face of fragility. Urgent policy action that government progressively increases domestic resource mobilization and improves oversight is key to achieving a more equitable, efficient, and sustainable health system

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