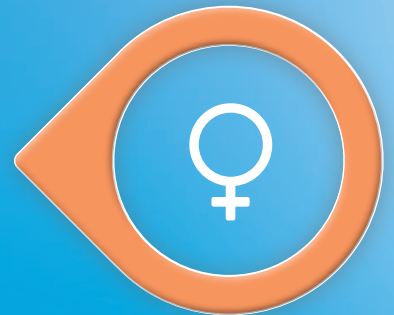




# THE SOUTH SUDAN MILLENNIUM DEVELOPMENT GOALS STATUS REPORT



## MDG REPORT 2012





The information provided in this report is from the First Sudan Household Health Survey (2006), the Southern Sudan Population and Housing Census (2008), the Poverty Survey (2009), the MICS (2010), and the administrative record of the Government of South Sudan.

**Mapping data source:** National Bureau of Statistics (NBS)

**Disclaimer:** The administrative boundaries depicted in the maps shown in this report are the boundaries used in the Sudan 5th Population and Housing Census, 2008. The boundaries are intended for census and statistical purposes only. It does not imply acceptance or recognition by the Government of the Republic of South Sudan. The Abyei boundary is based on the ruling of the Permanent Court of Arbitration in 2009.

The information shown on the maps in this publication does not imply official recognition or endorsement of any physical, political boundaries or feature names by the United Nations or its collaborative agencies.

© National Bureau of Statistics (NBS) November 2013

**Recommended citation:** South Sudan National Bureau of Statistics (NBS) South Sudan MDG Status Report 2012

# FOREWORD

As a consequence of the protracted conflict which lasted several decades up to the signing of the Comprehensive Peace Agreement (CPA) in January 2005, development issues were side-lined in the then Southern Sudan. After the signing of the CPA and the cessation of hostilities, the Government of Southern Sudan (GoSS) proceeded speedily to take necessary measures to provide for the welfare of its people and to make some progress towards the attainment of MDGs. However, the challenges faced by GoSS were numerous.

At the time of the signing of the CPA, it was anticipated that the real political litmus test would be how to meet the expectations of the people who had been deprived of basic services for decades. GoSS took the opportunity to demonstrate its readiness to commit to a shared long-term objective of eradicating poverty and providing basic services to its people.

After the referendum in 2011 and the overwhelming vote for independence, South Sudan was admitted to the United Nations (UN) in August 2011. Upon gaining membership, the new nation automatically adopted the Millennium Declaration and became a signatory to it. Subsequently, it became necessary to document progress towards the achievement of the Millennium Development Goals (MDGs) for an independent South Sudan. This report, which was approved by the Council of Ministers in May 2013, was prepared to fulfil that need and possibly reinvigorate efforts to achieve the MDGs.

The report outlines the current status and trends in providing basic services, improvement in human development outcomes and poverty reduction in South Sudan. It describes the policy and programming interventions that have been initiated by the government and our development partners, and identifies key challenges. By identifying South Sudan's progress in achieving the MDGs, this report is a useful tool for accountability, awareness raising, advocacy and policy dialogue. In a number of areas, the report portrays a worrisome state of affairs; however, there is enough optimism that South Sudan is making progress on a number of fronts, especially in the provision of primary education and water, and in the promotion of gender equality.

This report, along with other Government of the Republic of South Sudan publications, in particular the South Sudan Development Plan (SSDP) will serve an additional objective of redirecting the efforts of all stakeholders to actions that will result in an accelerated drive towards the attainment of the MDGs.

This report was prepared with active collaboration of all the stakeholders. We would like to extend our sincere thanks to the UNDP for facilitating the preparation of the report. We also thank all the UN agencies, NGOs and government counterparts who all joined us in the preparation of this report. This collaboration demonstrates the spirit of firm partnership in achieving development in South Sudan.

We hope this report will inform future debates and actions on the overall development of South Sudan.



**Hon. Aggrey Tisa Sabuni**

*Minister of Finance, Commerce, Investment and Economic Planning*

# ACKNOWLEDGEMENTS

The **South Sudan Millennium Development Goals (MDGs) Status Report** outlines the country's achievements through the calendar year 2011. It was first drafted in 2010 for the then Southern Sudan as part of the Sudan MDGs Progress Report, 2010; involving extensive consultations among stakeholders, including government and UN agencies as well as Non-Governmental Organizations (NGOs). This was done principally to ensure country ownership; and necessitated putting in place proper co-ordination mechanisms in preparing the report. For this reason, four working groups were established in accordance with the themes of the eight MDG Thematic Working Groups (TWGs). This, it was thought, would also guarantee timely availability and accuracy of information for the report as well as ensure synergy in the form of contributions from all stakeholders.

Each Thematic Working Group was headed by a chairperson from a government agency as it ought to; and was co-chaired by a representative from a development partner agency. The chairpersons were responsible for organizing and facilitating each group's work.

## THE SPECIFIC RESPONSIBILITIES OF THE THEMATIC WORKING GROUPS INCLUDED:

- ▶ Examining all available data sources and determining the adequacy or limitations of the data for deriving the indicators of their respective goals;
- ▶ Identifying data and information gaps and how they may be addressed;
- ▶ Providing the needed up-to-date data and information on their respective goals and targets ; and
- ▶ Preparing a brief analytical papers on its respective goal and associated targets and performance indicators.

The National Bureau of Statistics (NBS), on behalf of the Government of the Republic of South Sudan (GRSS), conducted a series of media engagements to raise public awareness on MDGs Report and supported the TWGs in data collection and preparing

a draft MDGs report. It also, together with other stakeholders, provided quality assurance by editing and consolidating the work of all the TWGs.

In 2012, the report was revised with data from the Sudan Household Health Survey (SHHS, 2010) and with some administrative records generated between 2010 and 2012. The revised draft was then provided to stakeholders for re-validation at a one-day workshop on 17th October 2012.

This report is a product of the additional work on the 2010 report that was undertaken between October 2010 and October 2012. It outlines the current status and trends in providing basic services, improvement in human development outcomes and poverty reduction in South Sudan. It describes the policy and programming interventions that have been made by the government and development partners alike, and identifies key challenges.

I am very grateful to all the Ministries, Commissions and other independent bodies which chaired the various TWGs and/or participated in the work of the various TWGs as well as those that provided statistical information. These included, but are not limited to, the Office of the President, the Ministry of Finance and Economic Planning, the Ministry of General Education and Instruction, the Ministry of Health, the South Sudan HIV/AIDS Commission, the Ministry of Water Resources and Irrigation, the Ministry of Gender Child and Social Welfare and the Ministry of Telecommunications and Postal Services. These agencies provided the primary raw material and supplemented



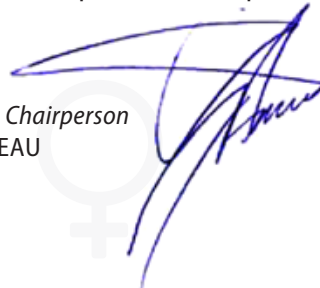
data generated by the National Bureau of Statistics with administrative records in a truly collaborative spirit.

I would also like to extend special thanks to the UN agencies, NGOs and other development partners which co-chaired the TWGs and or participated in the various TWGs including: UNDP, UNICEF, UNFPA, UNWOMEN, UNAIDS, UNOCHA, UNHCR, WFP, WHO, and the NGO Forum. These and other development partners, along with the government agencies provided the information on the policy and programming interventions, the identification of various

challenges in meeting the MDGs and made recommendations for increased progress towards the attainment of the eight goals.

Lastly, I would like to pay particular tribute and extend special appreciation and acknowledgement to UNDP for their technical and financial assistance in preparation of this report from inception to the very end.

**Isaiah Chol Aruai**, Chairperson  
NATIONAL BUREAU  
OF STATISTICS



A woman from the town of Boma, South Sudan, in traditional attire. © UN Photo/Martine Perret

# STATUS AT A GLANCE

GOAL	INDICATOR <sup>1</sup>
<b>Eradicate Extreme Poverty and Hunger</b>	
Reduce by half, between 1990 and 2015, the proportion of people living below the poverty line	Proportion of population living below the national poverty line
	Poverty gap ratio (%)
	Poorest quintile share in national consumption (%)
Reduce by half, between 1990 and 2015, the proportion of people who suffer from hunger	Prevalence of underweight children (%)
	Prevalence of severely undernourished children
	Proportion of population below minimum level of dietary energy consumption (%)
<b>Achieve Universal Primary Education</b>	
Ensure that, by 2015, all boys and girls complete a full course of primary schooling	Net enrolment in primary (%)
	Proportion of pupils starting grade 1 reaching grade 8 (%)
	Literacy rate (15-24yrs) (%)
<b>Promote Gender Equality and Empower Women</b>	
Eliminate gender disparity in primary and secondary education, preferably by 2005 and at all levels by 2015	Ratio of girls to boys in primary education
	Ratio of girls to boys in secondary education
Empower women	Literacy rate for women (15-24) years old
	Proportion of seats held by women in parliament (%)
<b>Reduce Child Mortality</b>	
Reduce by two thirds, between 1990 and 2015, the mortality rate among children under-five	Under-five mortality rate (per 1,000 live births)
	Infant mortality rate (per 1,000 live births)
	Proportion of 1 year old children immunized against measles (%)
	Proportion of (12-23) months old children fully immunized

	2006	2007	2008	2009	2010	2011	2015 GLOBAL TARGET
				50.6% (NBHS)			
				24% (NBHS)			
				4% (NBHS)			
					30% (SHHS2)		
	131/1000 (SHHS1)				122/1000 (SHHS2)		
				47% (NBHS)			
	15.8% (SHHS1)				40% (NBHS)	42.9%, (EMIS)	100%
					64.5% (SHHS2)		100%
	28% (SHHS1)			40% (NBHS)			100%
	0.8 (SHHS1)			0.7 (NBHS)			1
				0.4 (NBHS)			1
				16.0% (NBHS)	13.4% (SHHS2)		100%
				20.0 (SSLA)	34% (SSLA)		50%
	135/1,000 (SHHS1)				105/1,000 (SHHS2)		
	102/1,000 (SHHS1)				75/1,000 (SHHS2)		
	17.3% (SHHS1)				26% (SHHS2)		
					6.3% (SHHS2)		

Table continued next page...

GOAL	INDICATOR <sup>1</sup>
<b>Improve Maternal Health</b>	
Reduce by three quarters, between 1990 and 2015, the maternal mortality rate	Maternal mortality ratio (per 100,000 live births)
Achieve, by 2015, universal access to reproductive health	Proportion of births attended to by skilled health personnel (%)
	Contraceptive prevalence rate
<b>Combat HIV and AIDS, Malaria and Other Diseases</b>	
Halt by 2015 and begin to reverse the incidence of Malaria and other diseases	HIV prevalence among 15-24 year old pregnant women (%)
	Comprehensive knowledge of HIV/AIDS
	Access to anti-Malaria treatment (%)
	Proportion of household with at least one ITN (%)
	Proportion of TB cases under DOTS (%)
<b>Ensure Environmental Sustainability</b>	
Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	Proportion of land covered by forest (%)
	Proportion of population using solid fuel (%)
	Proportion of population with sustainable access to an improved water source (%)
	Proportion of population with access to improved sanitation (%)
<b>Develop a Global Partnership for Development</b>	
In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	Net ODA as a percentage of real Gross Domestic Product (%)
	Cellular subscribers per 100 people (%)



	2006	2007	2008	2009	2010	2011	2015 GLOBAL TARGET
	2054/100,000 (SHHS1)		1989 (5th SPHC, 2008)				
	10% (SHHS1)				19.4% (SHHS2)		
	3.5% (SHHS1)				4% (SHHS2)		100%
				3.04% (NBHS)	-		
					9% (SHHS2)		
	47% (SHHS1)				51% (SHHS2)		
	38.5% (SHHS1)				52.3% (SHHS2)		
		36% (HMIS)			48% (HMIS)		
					32.4% (MAF/NBS/FAO)		
				99% (NBHS)	-		
				55% (NBHS)	68.7% (SHHS2)		
				20% (NBHS)	36.9% (SHHS2)		
						3.24% (NBS Press Release)	
				19% (NBHS)			

<sup>1</sup>South Sudan became an independent sovereign country in 2011. The National Bureau of Statistics was set up in 2005, and was called the South[ern] Sudan Centre for Census, Statistics and Evaluation (SSCCSSE). Although, it has done commendable work in laying the foundations of a robust national statistical information system for South Sudan, a number of capacity gaps still exist. Since 2005, three Surveys and a Population and Housing Census have been conducted in the country. The choice of indicators, particularly around MDG 7 and 8, used in the South Sudan MDG Report 2013 have been influenced by limitations in available data.

Major sources of data utilized in the MDG report are the Surveys, the Census, and in select cases administrative records where available, specifically:

- ▶ Living Standards Measurement Study (LSMS), 2009 was used to generate single-time poverty estimates used for Goal 1;
- ▶ Multiple Indicator Cluster Surveys (2010) was used to track progress in Goals 2, 4, 5 and 6; and
- ▶ Administrative records were used notably for Goal 3.

# EXECUTIVE SUMMARY

The Government of South Sudan is committed to making advances to the achievement of the Millennium Development Goals (MDGs) through the implementation of her national development strategy, the South Sudan Development Plan (2011-2013) which is being extended to 2016.

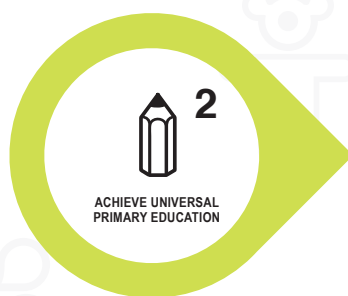


South Sudan has committed to eradicating extreme poverty and to that end envisaged that the proportion of the population that would be living under the national poverty line by the year 2013 will have gone down to 46%.

Malnutrition remains a big challenge globally and is a big contributor to child mortality in South Sudan. The prevalence of severely undernourished children (under five years) was 131 per 1,000 children in 2006 that had reduced to 122 per 1000 by 2010. The proportion of the population that was below the minimum level of dietary energy consumption stood at 47% in 2009 and the government aims to reduce it to 11% by 2015.



The government recognizes the need for women's empowerment and has enshrined the protection of women's rights in the country's Transitional Constitution and other Statutes. Affirmative action has resulted in an increase in the proportion of seats held by women in the decision making organs of government, including the National Assemblies, both at national and state levels of government. However, the number of male Parliamentarians, Governors and Undersecretaries still remains the monopoly of men, with much higher numbers than women. The government remains committed to redressing this imbalance over time.

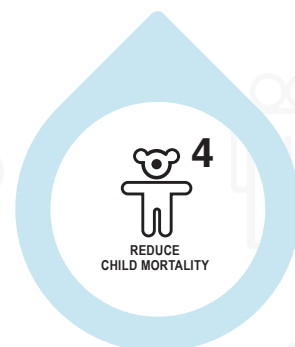


The government recognizes the importance of education in the national development and has placed the sector among the top five priority programme areas in the Social and Human Development pillar of the SSDP.

As a result of the government intervention, primary school enrolment increased from only 400,000 in 2006 to 1.3 million in 2009 and number of primary schools has increased by 20%. Likewise, the literacy rate improved from 28% in 2006 to 40% in 2009; with males registering 37% compared to women, who were at 30%, by the year 2009. Only 28% of women are literate in comparison to 55% for men, implying a ratio of literate females to males of barely above half.

Net Enrolment Rate (NER) in primary schools of South Sudan stood at 40% in 2009, and Gross Enrolment Rate (GER) was 65%. During the same year, the completion rate was 64.5%.

Under-five mortality rate (U5MR) was estimated at 135 per 1000 live births in 2006 which was brought down to 105 in 2010. Similarly, infant mortality rate (IMR) decreased from 102 per 1,000 live births to 75 per 1,000 live births during the same period. The trend shows notable improvements being made in the provision of basic health services.

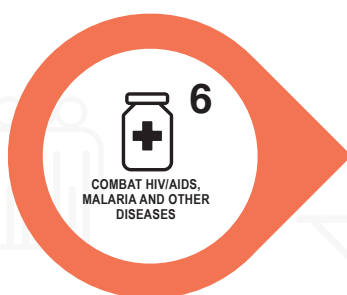




Maternal Mortality Ratio (MMR) is a serious concern in South Sudan. From 2054 deaths per 100,000 live births in 2006, it had decreased to 1,989 deaths in 2008. Only about 10% of women aged 15-49 years who had a live birth were tended by skilled birth attendants in 2006. By 2010, this had increased to 19%. The contraceptive prevalence rate (CPR) in 2006 was estimated at 3.6% which increased to 4% in 2010. The unmet need for family planning increased at a phenomenal rate from 1.2% in 2006 to 26.3 in 2010.



Lack of safe drinking water and poor sanitation is a major cause of disease. As such, the government and development partners are investing a lot of resources to improve the health of the population. Access to improved sources of drinking water was at 48.3% in 2006 and increased to 68.70% in 2010. At this rate, projection on this indicator shows that South Sudan will exceed the MDG target in 2015; while access to improved sanitary means of excreta disposal increased from 6% in 2006 to 13.8% over the same period, with most of the remainder using either a pit latrine without a slab, or even more likely the bush.



While the spread of HIV/AIDS has not reached alarming levels yet compared to Sub-Saharan African countries, nevertheless there is still a cause for serious concern. The provisional estimate of HIV prevalence for South Sudan was slightly over 3% in 2009 while comprehensive knowledge of HIV/AIDS was close to 9%. The number of people living with

HIV in 2010 was at 149,717 (135,466 adults and 14,251 children) and there were about 16,133 new infections per year. Unfortunately, knowledge about the three means of mother-to-child HIV transmission was only at 15% in the same year.

Malaria is one of the biggest causes of morbidity and mortality among children, but ownership of at least one mosquito net stood at only 52.3% in 2009. Out of this, only 34.2% owned a long lasting, treated net. Worse still, only 25% of children under-five slept under a bed net in 2009.

With respect to treatment of tuberculosis, Direct Observed Treatment Strategy (DOTS) coverage increased from 36% in 2007 to 48% in 2010, Case Detection Rate (CDR) from 19% to 35% over the same period. Treatment success rate had been maintained well above 80% (although WHO recommends at least 85%).

The benefits of new technologies are still a monopoly of a small percentage of the population. Ownership of phones was 19% in 2009; while ownership of phones by urban households was at 65%, greatly surpassing ownership of phones by the rural households at 10%. [NBHS, 2009]



# TABLE OF CONTENTS

<b>Foreword</b>	<b>3</b>
<b>Acknowledgments</b>	<b>4</b>
<b>Status at a Glance</b>	<b>6</b>
<b>Executive Summary</b>	<b>10</b>
<b>Table of Contents</b>	<b>12</b>
<b>List of Acronyms</b>	<b>13</b>
<b>List of Figures</b>	<b>14</b>
<b>List of Tables</b>	<b>15</b>
<b>1. Introduction</b>	<b>16</b>
<b>2. National Development Context</b>	<b>17</b>
<b>3. Progress Towards the MDGs</b>	<b>23</b>
<b>Goal 1: Eradicate Poverty</b>	<b>24</b>
<b>Goal 2: Achieve Universal Primary Education</b>	<b>32</b>
<b>Goal 3: Promote Gender Equality and Empower Women</b>	<b>38</b>
<b>Goal 4: Reduce Child Mortality</b>	<b>44</b>
<b>Goal 5: Improve Maternal Health</b>	<b>50</b>
<b>Goal 6: Combat HIV and AIDS, Malaria and Other Diseases</b>	<b>58</b>
<b>Goal 7: Ensure Environmental Sustainability</b>	<b>66</b>
<b>Goal 8: Develop a Global Partnership for Development</b>	<b>74</b>
<b>4. Conclusion</b>	<b>78</b>
<b>5. Bibliography</b>	<b>79</b>

# LIST OF ACRONYMS

<b>5th SPHC</b>	5th Sudan Population and Housing Census
<b>ACSI</b>	Accelerated Child Survival Initiative
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>C/GBV</b>	Combating Gender-Based Violence
<b>CGS</b>	Community Girls School
<b>DOTS</b>	Directly Observed Therapy Short Course
<b>DPT</b>	Dichloro-Diphenyl-Trichloethane
<b>EPI</b>	Expanded Immunization
<b>FGM</b>	Female Genital Mutilation
<b>GER</b>	Gross Enrolment Ratio
<b>GF</b>	Global Fund
<b>GoSS</b>	Government of Southern Sudan
<b>HIV/AIDS</b>	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
<b>HMM</b>	Home Management of Malaria
<b>HTC</b>	HIV Testing and Counseling
<b>IMR</b>	Infant Mortality Rate
<b>IPT</b>	Intermittent Preventive Treatment
<b>LLINS</b>	Long Lasting Insecticide Nets
<b>MDG</b>	Millennium Development Goal
<b>MMR</b>	Maternal Mortality Ratio
<b>MTDS</b>	Medium Term Capacity Development Strategy
<b>NBHS</b>	National Baseline Household Survey
<b>NER</b>	Net Enrolment Ratio
<b>NGO</b>	Non-Governmental Organization
<b>NMCP</b>	National Malaria Control Programme
<b>ODA</b>	Overseas Development Assistance
<b>PMTCT</b>	Prevention of Mother-To-Child Transmission
<b>SHHS</b>	Sudan Household Health Survey
<b>SHHSII</b>	Sudan Household Health Survey II
<b>SP</b>	Sulfadoxine Pyrimethamine
<b>SSCCSE</b>	Southern Sudan Centre for Census Statistics and Evaluation
<b>SSDP</b>	South Sudan Development Plan
<b>SSLA</b>	Southern Sudan Legislative Assembly
<b>TB</b>	Tuberculosis
<b>USMR</b>	Under-five Mortality Rate
<b>UNCT</b>	United Nations Country Team
<b>UNDAF</b>	United Nations Development Assistance Framework
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Fund for Population Activities
<b>UNICEF</b>	United Nations Children's Fund
<b>UNITAID</b>	Public Health Financing Mechanism for Purchase of Drugs for AIDS, Malaria, TB and other Diseases
<b>USAID</b>	United States Aid for International Development
<b>VCT</b>	Voluntary Counseling and Testing
<b>WHO</b>	World Health Organization

# LIST OF FIGURES

- Figure B.1** GDP per capita for South Sudan in regional comparison
- Figure B.2** Annual CPI inflation (%) update
- Figure B.3** Sector shares in public expenditure in South Sudan Development Plan
- Figure 1.1A** Poverty estimates by state (Mapping)
- Figure 1.1B** Poverty estimates (proportion) by state
- Figure 1.2A** Percentage of population severely food insecure by state
- Figure 1.2B** Percentage of population severely food insecure by state (Mapping)
- Figure 1.3** Percentage of children under-five who are severely undernourished by state and year
- Figure 2.1** Net Enrolment Rate (NER) in Primary education 2006, 2009, and 2011
- Figure 2.2** NER for children in primary education, 2011
- Figure 2.3** NER for boys and girls in primary education by state
- Figure 2.4** Net Enrolment Rates in primary education by state (Mapping)
- Figure 2.5** Percentage of classrooms by type of structure
- Figure 2.6** literacy rate (15-24) years of age
- Figure 3.1** Ratio of girls to boys in primary education
- Figure 3.2** Ratio of girls to boys in secondary education
- Figure 3.3** Proportion of seats held by women in decision making positions in various organs of government
- Figure 4.1A** Under-five mortality rates by state
- Figure 4.1B** Under five mortality rates by state (Mapping)
- Figure 4.2A** Infant mortality rates by state (Mapping)
- Figure 4.2B** Infant mortality rates by state
- Figure 4.3** DPT3 immunization coverage for children less than 1 year old
- Figure 4.4** Dropout rate (DPT1 - DPT3) for children less than 1 year old
- Figure 5.1A** Maternal mortality ratio by state (Mapping)
- Figure 5.1B** Maternal mortality ratio by state
- Figure 5.2** Proportion of births attended by skilled health personnel
- Figure 5.3** Percentage of women aged (15-49) with a birth assisted by skilled health personnel by state and year
- Figure 5.4A** Proportion of women aged (15-49) currently married who use any method of contraceptives by state (Mapping)
- Figure 5.4B** Proportion of women aged (15-49) currently married who use any method methods of contraception by state and by year

**Figure 5.5** Proportion of women aged 15-49 years currently married who use modern or traditional methods of contraception by state and year

**Figure 5.6A** Proportion of women aged 15-49 currently married or in union with unmet needs for contraception by state and year (Mapping).

**Figure 5.6B** Proportion of women aged 15-49 currently married or in union with unmet needs for contraception by state and year

**Figure 6.1** Percentage of population who have comprehensive knowledge of HIV/AIDS

**Figure 6.2** Proportion of population who have comprehensive knowledge of HIV/AIDS

**Figure 6.3** Proportion of population with at least one mosquito net by state and year

**Figure 6.4** TB trend and projections by year

**Figure 6.5** Percentage of children under 5 who slept under a mosquito net

**Figure 7.1** Percentage of area under reserved forest, parks and game reserves by state

**Figure 7.2** Percentage of population household using firewood and charcoal for cooking

**Figure 7.3A** Percentage of household who have access to improved source of drinking water by state and year

**Figure 7.3B** Percentage of households who have access to improved source of drinking water by state (Mapping)

**Figure 7.4A** Percentage of population with access to improved sanitation facilities in 2010 (Mapping)

**Figure 7.4B** Percentage of population with access to improved sanitation facilities by state and by year

**Figure 8.1** Net ODA as a percentage of GDP at current prices by year

**Figure 8.2** Percent of households owning a phone.

## LIST OF TABLES

**Table B.1** Some Demographic statistics (2008 Census)

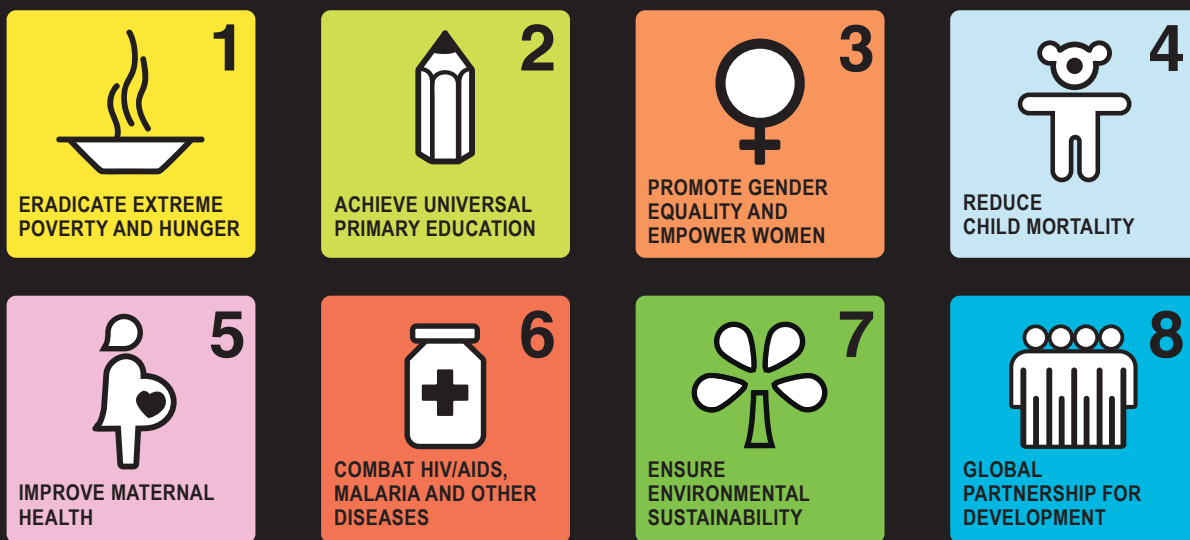
**Table B.2** Selected Economic Indicators for South Sudan



# INTRODUCTION

The Government of South Sudan is taking a keen interest in reporting its baseline indicators as it embarks upon statebuilding and its drive to achieve the eight MDGs, starting in its first year as an independent and sovereign state. This report constitutes a benchmark in reporting progress on the MDGs that were adopted by the United Nations General Assembly for Heads of State and Governments in the year 2000.

## THE EIGHT DEVELOPMENT GOALS ARE:



South Sudan has set itself ambitious targets for the achievement of MDGs, through the 2011-2013 Medium Term National Development Strategies – the South Sudan Development Plan (SSDP) and the Medium Term Capacity Development Strategy (MTCDS), given the short period of time remaining to reach the MDG target year of 2015.

These strategies are the agreed frameworks for implementing and monitoring activities for improving on the current MDGs status. The strategies have put emphasis on social and human development and sustainable economic growth. The SSDP, which is the first generation poverty reduction and economic growth strategy, developed immediately after the referendum that gave birth to South Sudan as an independent nation, provides a national framework for implementing actions required to attain the MDGs. The strategy puts emphasis on wealth creation and sustainable economic growth. Economic growth creates jobs and

increases the resources available for the government to allocate to poverty reduction, economic growth, and social and human development. To ensure that financial resources are directed to the priority areas of the SSDP, the government has set up an implementation, monitoring and evaluation framework to provide regular checks, balances and feedback on SSDP results and use the results to inform future strategies and budgets. This, it is hoped, will impact on the progress for eventual attainment of the MDGs.

This report outlines the current status and trends in providing basic services, improvements in human development outcomes and poverty reduction in South Sudan. It describes the policy and programming interventions that have been proposed by the government and implemented by the government and development partners alike, and identifies key challenges to the attainment of the Millennium Development Goals.



# NATIONAL DEVELOPMENT CONTEXT

## **HISTORY, CONFLICT, PEACE AND STATE-BUILDING<sup>2</sup>**

South Sudan has a troubled history, most of it characterized by domination by external powers, which has resulted in disfranchisement and underdevelopment, a situation that has gone on for centuries. This dark history has involved various kinds of subjugation, including Egyptian domination, slave trade and attempted forced conversion to Islam. The British colonialists then dominated the region with most of the South isolated from the North. However, there was hope that at independence the region would be integrated with the rest of British East Africa.

But the independence of Sudan in 1956 brought even further domination of the South with most administration positions in the South occupied by the northerners and the dream of joining the rest of East Africa completely lost. The South at that point thought that the only way to resist domination was some level of provincial autonomy, warning that failure to win legal concessions would drive the South to rebellion. But by 1955, the seeds of rebellion had already been sown and southern army officers anticipating marginalization by the North, mutinied and formed the Anyanya (snake venom) guerrilla movement to demand justice, recognition, and self-determination, from the North. As expected, at independence on 1 January 1956 the new constitution was silent on two crucial issues for southern leaders: the secular or Islamic character of the state, and its federal or unitary structure. This scene shadowed the country for the next half a century when the North in 1958 began instituting a policy of 'Islamization' and reneged on the implementation of a federal system that would have guaranteed autonomy for the South.

The Anyanya I war lasted until March 1972, when it ended with the signing of the Addis Ababa Peace Agreement with Sudan under General Nimeiri granting limited autonomy to the South, which ushered in a ten year period of peace for Southern Sudan. But in May 1983, continued marginalization and Islamization accompanied by the introduction of Sharia Law by President Nimeiri prompted a group of soldiers led by Colonel John Garang de-Mabior to revolt against the Sudan Army and eventually form the Sudan People's Liberation Army (SPLA). This episode of the war lasted up to 2003 when the SPLA/M and the Khartoum Government agreed to a ceasefire that led to the Comprehensive Peace Agreement (CPA) signed in Nairobi, Kenya on 9 January 2005. This brought an end to the 22-year conflict between the North and the South, culminating in the January 2011 referendum and independence on 9 July 2011. These wars brought the social situation and economy of Southern Sudan to its knees with grave consequences including gross violations of human rights, displacements, destruction of property and socio-economic systems disruption.

Even before the independence, the signing of the CPA had ushered in a period of peacebuilding and statebuilding leading to the formation of state institutions such as the South(ern) Sudan Human Rights Commission (SSHRC), the South(ern) Sudan Anti-Corruption Commission (SSACC), the Auditor-General's Chamber, the South(ern) Sudan Peace Commission (SSPC), and others. Indeed, in the lead up to the referendum, the Government had defined nineteen essential core functions required for "state take-off" in the areas of Executive Leadership, Security Sector, Rule of Law, Fiduciary Management, Public Administration and Natural Resources. And

<sup>2</sup>Most of the facts in this section are from the 2011-2013 South Sudan Development Plan

following on from that, in the lead up to independence, the government expanded on this work, by formulating a medium-term development plan, the South Sudan Development Plan (SSDP). This was developed through a consultative process involving hundreds of government officials and partners at all levels and covers the first years of statehood. It includes more than eighty development objectives of which twenty have been identified as high priorities. Building on the Core Governance framework, the SSDP includes a Medium-Term Capacity Development Strategy aimed at strengthening national capacities, building institutional and organizational structures and expanding human capital.

A Peace-building Support Plan has now been prepared aimed at fast-tracking the enabling peace-building aspects of the SSDP. Since 2012, after the oil shutdown, the government has been fast-tracking key enabling peace-building and statebuilding aspects of the SSDP aimed at: (a) ensuring continuity of core functions; (b) mitigating the impact of austerity on vulnerable populations by buttressing front-line service delivery, and (c) increasing accountability and efficiency in the use of public financial resources. The government has also now formulated the South Sudan Development Initiative (SSDI), which is aimed at making the SSDP actionable where priority projects mainly in the Enabling Environment

sectors in the plan are costed and designed for implementation for the period 2013-2020. In addition to the UN Peace-Building Support Plan (PBSP) a Second Generation Core Functions plan has also been formulated as a framework for fast-tracking statebuilding deliverables.

## DEMOGRAPHIC CONTEXT

South Sudan has a population of 8.3 million according to the Fifth Sudan Population and Housing Census (2008), of which 1.4 million live in urban areas, while 6.9 million live in rural areas. The population is therefore currently predominantly rural (83%) and dependent on subsistence agriculture. South Sudan is a young country with half (51%) the population under the age of eighteen and 72% under the age of thirty. There were rapid changes in the demographic structure of South Sudan following the signing of the CPA in 2005, with a large number of returnees and increased household formation. Since the successful completion of the referendum in January 2011, there has been a fresh wave of returnees primarily from the North. The UN Office for the Coordination of Humanitarian Affairs (UNOCHA) estimates that 290,000 people have returned in the six months prior to April 2011, and even more returned after independence in July 2011. It is crucial that special provisions are made for these most vulnerable populations.

**TABLE B.1: SOME DEMOGRAPHIC STATISTICS (2008 CENSUS)<sup>3</sup>**

Total population	8.3m (2008 census)
Rural	6.9
Urban	1.4
Male	4.3 m
Female	4.0 m
Less than 18 years old	51% of the population
Less than 30 years	72% of the population
Growth rate	2.60%
Fertility rate (2008)	3.9
Life expectancy at birth (2008)	61 years

Source: NBS, 2012

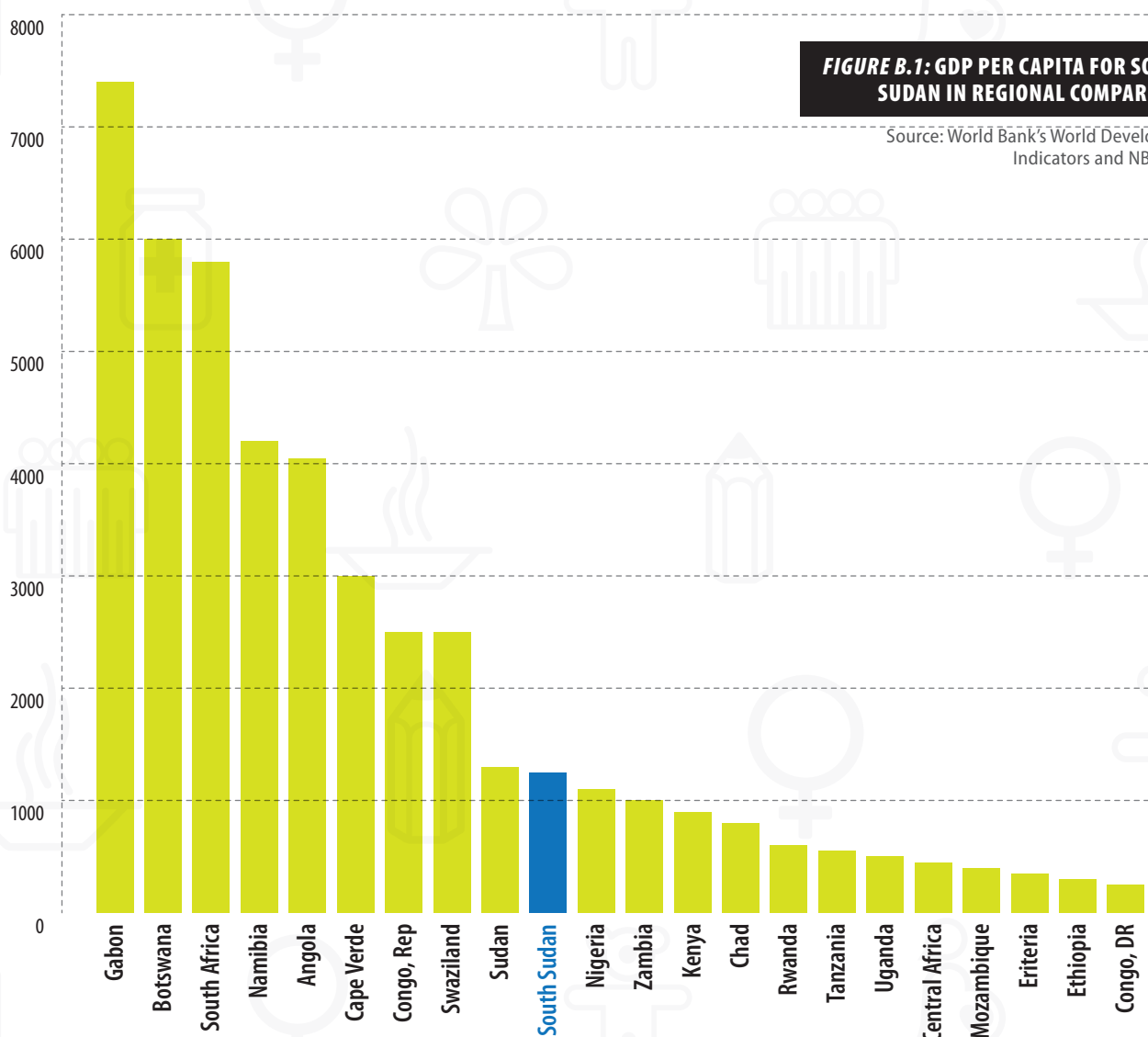
<sup>3</sup>These numbers especially, the total population is estimated to have gone up to about 10.5M but these are not yet used officially.

## THE SOUTH SUDAN ECONOMY

The South Sudan economy is still largely subsistence, consisting predominantly of small-scale agriculture, livestock-raising and oil extraction, though in monetary terms the oil sector is the largest. There is little domestic commercial production, even for agriculture products, and export markets outside of oil. Available data indicate that 78% of households depend on crop farming or animal husbandry as their primary source of livelihood. The limited trade data available indicates that about 60% of imports from Uganda and Kenya are agriculture products. Estimates by NBS indicate that before the oil shutdown in 2012, oil exports were equivalent to 60% of GDP and 98% of exports.

Before the oil shutdown, government finances were heavily dependent on oil revenues with roughly 98% of all government revenues coming from oil exports over the past six years. But even with serious attempts to diversify revenue sources triggered by the oil shutdown, it is expected that oil will continue to dominate government expenditure and exports with major implications for the welfare of the vulnerable sections of the population in case of a sudden oil shutdown as it happened in 2012 or even due to oil price volatility as it happened in 2009.

Due to the oil sector, the GDP per capita for South Sudan is relatively high compared to the regional average (figure B.1). But the 2012 oil shutdown resulted in a decline of GDP amounting to 47%.



## THE IMPACT OF THE OIL SHUTDOWN AND AUSTERITY ON THE SOUTH SUDAN ECONOMY

**TABLE B.2: SELECTED ECONOMIC INDICATORS FOR SOUTH SUDAN**

GDP per capita (2009 Constant prices)	US\$ 514 (2011)
Oil and Non-Oil GDP	% of GDP
Oil	60%
Non-Oil	40%
<b>Government finances</b>	
Government finance	% of GDP
Total revenue	9.02%
Total expenditure	8.17%
Recurrent expenditure	6.42%
Capital expenditure	1.74%
<b>External sector</b>	
Export (goods & services)	65%
Import (goods & services)	27.2%
Trade balance	37.8%
Gross official reserves (2011)	US \$ 3,707 million
In months of imports cover	3.66 months
Annual inflation (for year ended December 2011)	65.55%
Annual Average Exchange Rate	2.95

Source: National Bureau of Statistics, 2012

After a prolonged disagreement between South Sudan and the Republic of Sudan on a fee for the former to export its oil using the latter's infrastructure, and the former accusing the latter of several issues related to the export of its crude oil, South Sudan decided to shut down its oil production and export effective 28th January 2012. The associated loss of oil revenue led to the termination of the 2011/2012 budget in its final approval stages and the adoption of austerity measures.

After the oil shutdown and the adoption of austerity measures, the budget approved for the 2011-2012 fiscal year was modified into a four month February-June 2012 Austerity Budget (i.e. until the end of the fiscal year). Based on the 2011-2012 budget, the austerity budget proposed a 50% cut in operational costs and capital expenditure and a 10% cut in state block transfers, while all salaries were to continue being paid in full. The total monthly spending approved by the Cabinet for the remainder of the fiscal year was SSP 650 million per month, a close to 45% cut on the 2011 expenditure. In addition, the Ministerial Austerity Committee passed guidelines that spending agencies would follow in making their budgets, including eliminating expenditure in non-critical areas. With reserves of about SSP 4.4 billion at the time of the adoption of these measures, it was estimated that the available resources would be able to take the country to at least July 2012. However, due to the continued unfavourable fiscal situation, the government undertook even more cuts for the 2012/13 fiscal year to about SSP 6.4 billion, with monthly expenditure of SSP 530 million. Additional cuts were made in foreign travels, freezing of all vehicle purchases, cutting of housing allowance by 50% and a 25% cut in block transfers to states. These cuts in expenditure which effectively amount to about 38% reduction from the 2011 budget have serious implications for the socio-economic indicators in the country. The following sections outline the impact of the austerity measures on the different facets of the economy.

**Impact on the local currency/exchange rate:** As indicated above, almost all export earnings are generated from oil exports. In addition to export earnings, the country gets a significant amount of hard currency from external aid through different channels which amounted to \$1.2bn in 2010 (Donor Book, 2011). But these funds are not

on the budget and therefore cannot be relied on by government to run the country. On the other hand, the South Sudan economy (particularly the monetized and urban part) is heavily dependent on imports for consumption and investment, including basic food stuffs. The South Sudan Pound is heavily supported by the foreign exchange reserves from oil and, because of the shutdown of oil production, the government ran down the reserves and this has put significant pressure on the exchange rate which has resulted in significant devaluation of the SSP. Consequently, the black market exchange rate had increased from 3.3 SSP before the shutdown to about SSP 4.5 per US dollar; but had subsequently moderated to around SSP 4.00 per dollar by October 2012.

**Impact on local prices/inflation:**

The weakening of the SSP has led to a spike in inflation and erosion of the purchasing power of the population, especially the vulnerable poor. The significant reduction in government expenditure has also dampened economic activity which is putting an opposite pressure on prices. It should however, be noted that, due to low domestic production, inflation has always been a problem for South Sudan because most of the basic commodities consumed in the country are imported from East Africa. Inflation in South Sudan is driven mainly by changes in the price of food items, with the

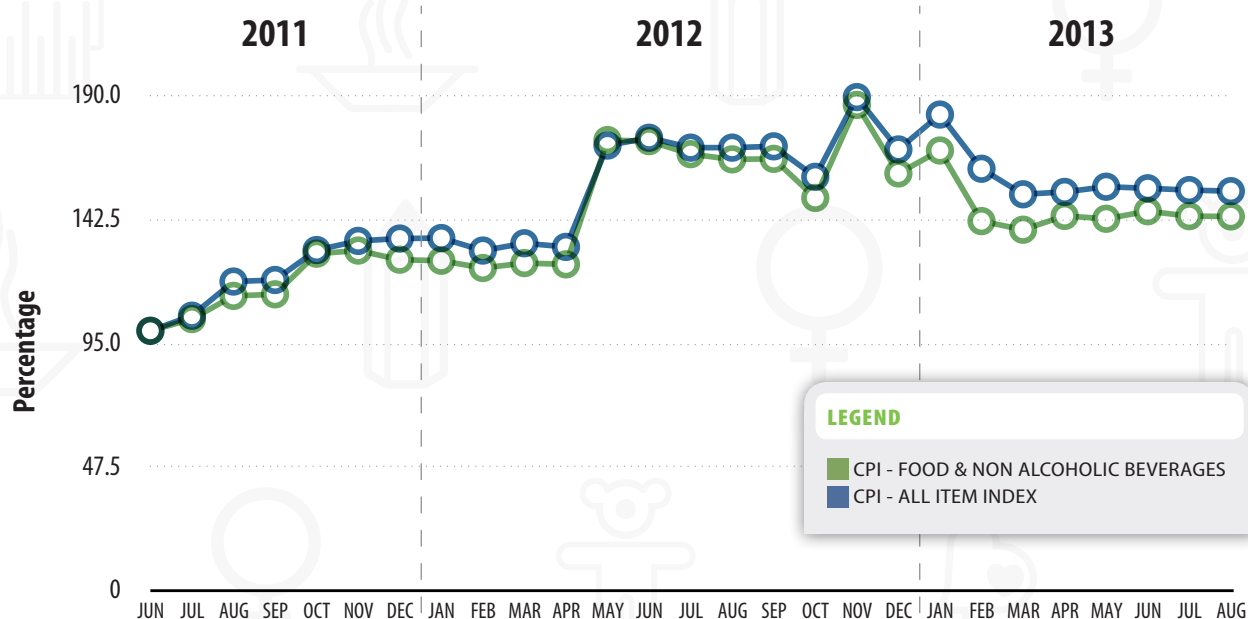
'food and non-alcoholic beverages' category comprising 71% of the overall consumption basket (Fig. B.1). It can be seen from the graph that after a long period of relatively low and stable prices, inflation increased dramatically towards the end of 2010, reaching a peak of 79% in November 2011. From the end of 2011, the annual inflation rate declined to about 29.5% in April 2012, but rose sharply to about 80% in May 2012.

**Impact on delivery of social services:**

The vast majority of the currently existing social services in the country are provided by NGOs, community-based organizations and development partners with minimal public intervention. For example, the SSDP indicates that the whole of the Social and Human Development pillar was expected to get just 9% of the national budget for 2011. Even under austerity the share is still in that range, therefore, these austerity measures have adversely impacted the welfare of the population. Reduced government expenditure, which in South Sudan made up the biggest share of total national expenditure, impacted on the livelihoods of the population that depended on it, for example members of the extended family with a public salaried worker. Moreover, with austerity budget, the probability of the government introducing social protection programmes such as the social cash transfer programme proposed in the SSDP is very slim.

**FIGURE B.2: ANNUAL CPI INFLATION (%)-UPDATE**

Source: National Bureau of Statistics, 2012



## THE SOUTH SUDAN DEVELOPMENT PLAN

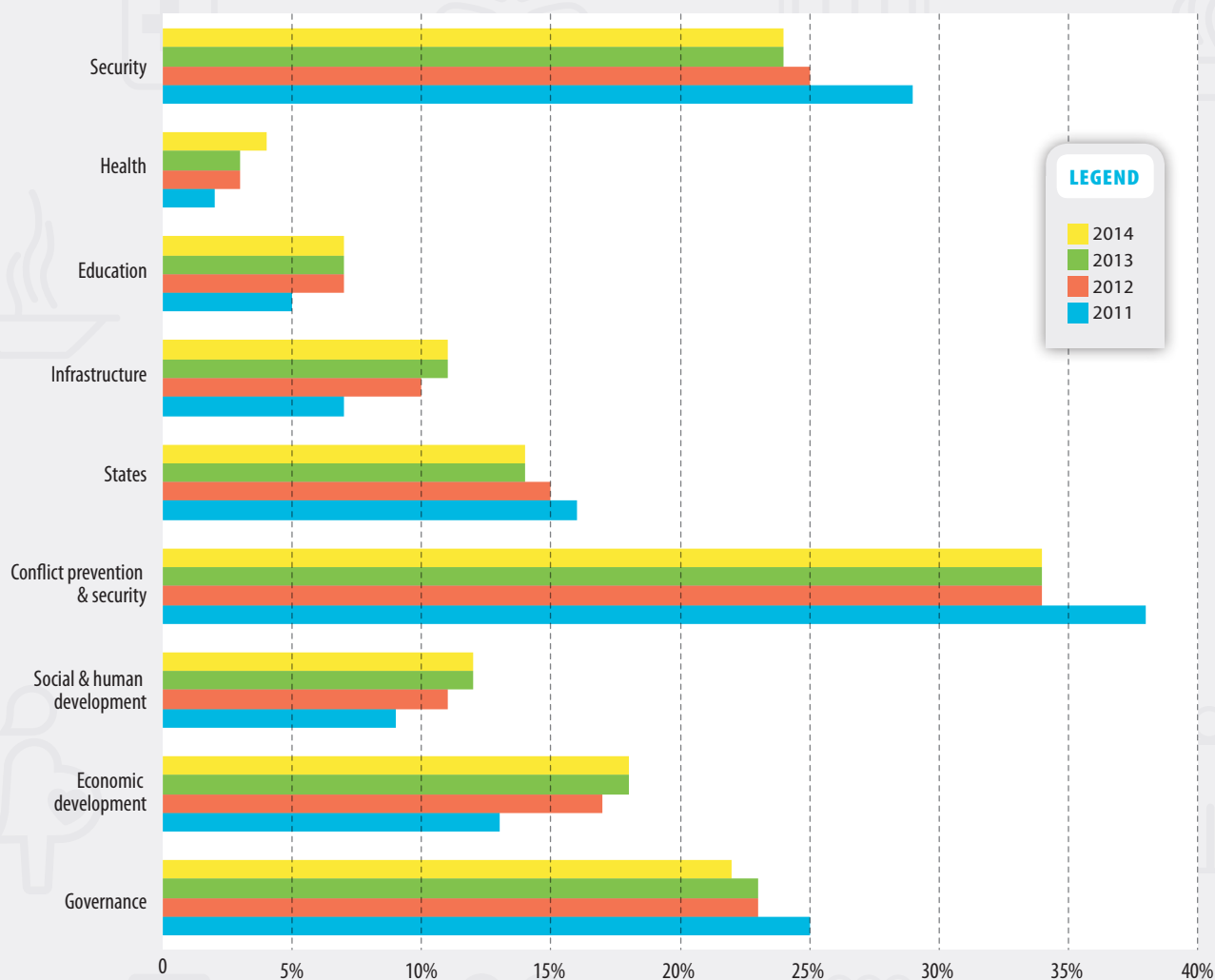
The South Sudan Development Plan (SSDP) 2011-13 is a medium-term transitional development plan drafted under the theme **'Realizing Freedom, Equality, Justice, Peace and Prosperity for All'**. It was developed following the GOSS Sectors, grouped together into four pillars, namely Governance, Economic Development, Social and Human Development, and Conflict Prevention and Security. Therefore, there were four national goals underpinning the formulation of the SSDP, namely good governance, safety and security,

increased prosperity, and enhanced quality of life. These goals were to be achieved through intervention in twenty priority programmes spread over the four pillars. Resource allocation over the planning period was targeted at all these priority programmes to ensure efficient attainment of the goals of the plan.

Considerable challenges still remaining in the security sector due to the ongoing low-level conflict between South Sudan and Sudan, necessitated maintaining the security resource

**FIGURE B.3: SECTOR SHARES OF PUBLIC EXPENDITURE IN THE SOUTH SUDAN DEVELOPMENT PLAN**

Source: South Sudan Development Plan 2011-2013



allocation high, it was envisaged that the share of the resources allocated to the social sector would marginally increase from 9% in 2011 to only about 12% by 2014. This has implications for progress in attainment of the MDGs. It means that public investment in areas that have an impact on MDGs attainment would be minimal, leaving the rest to the private sector (which itself is nascent) or to the humanitarian organizations which have traditionally taken the largest burden of social services provision. Inability to invest in MDG areas has in part been due to the lack of action plans with bankable projects in the productive and social areas of

the economy. The government under the South Sudan Development Initiative has since designed a number of projects and programmes, costed and ready for implementation, into which resources are now being channeled. Therefore, under these historical, political and economic conditions, including the history of conflict, but also renewed optimism, this report seeks to ascertain the progress the country has made in attaining the MDGs.



**Women selling locally-produced honey in the market** © UNDP/Brian Sokol



1

**ERADICATE EXTREME  
POVERTY AND HUNGER**







© UNDP / Brian Sokol

# PROGRESS TOWARDS THE ATTAINMENT OF THE MDGS

This section illustrates, goal by goal and indicator by indicator, through each of the MDGs, an update on the status and trends towards meeting the targets.

## Goal 1: Eradicating Poverty

Eradicating extreme poverty is the first of the eight Millennium Development Goals (MDGs). Extreme poverty is defined as **the inability to meet basic minimum food requirements based on the monthly cost of a food basket**. Two main targets were set accordingly to achieve the goal. The first target is to halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day. The second target is to halve, between 1990 and 2015, the proportion of people who suffer from hunger

### TARGET

1.A

Halve between 1990 and 2015 the proportion of population whose income is less than one dollar per day<sup>4</sup>

To monitor progress towards achieving the first target, three indicators are used. The first looks at the percentage of the population below the poverty line and the proportion of population living on less than one US dollar a day.

### Indicator 1.1: Proportion of population below the national poverty line

It is estimated that 50.6% (NBHS, 2009) of the population of South Sudan are below the national poverty line which was set at 72.9 SDG per person per month in 2009<sup>5</sup>. The poverty rates are 55.4% of the rural population and 24.4% of the urban population.

### Indicator 1.2: Incidence of depth of poverty as measured by the poverty gap

The second indicator looks at the extent of poverty amongst individuals below the poverty line. The poverty gap ratio measures the average distance separating the poor from the poverty line expressed as a percentage of the poverty line.

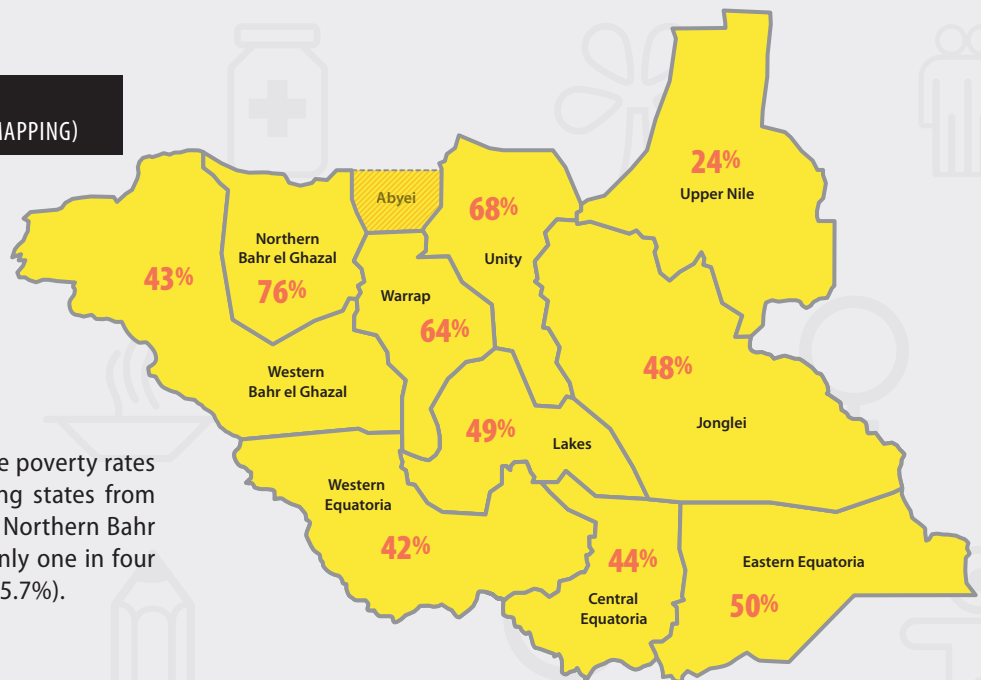
The poverty gap for the total population stands at 24% (NBHS, 2009) which implies that the average deficit in consumption of each person in the country is 24% below the poverty line, assuming the non-poor are considered to have a zero shortfall. However, poverty gap among the poor alone is 47%. No attempt has been made to forecast the target rate to be attained by 2015 for this indicator.

<sup>4</sup>The decision to use one dollar a day was taken because at the time the poverty line was changed to 1.25 dollars a day, South Sudan had already set its poverty line.

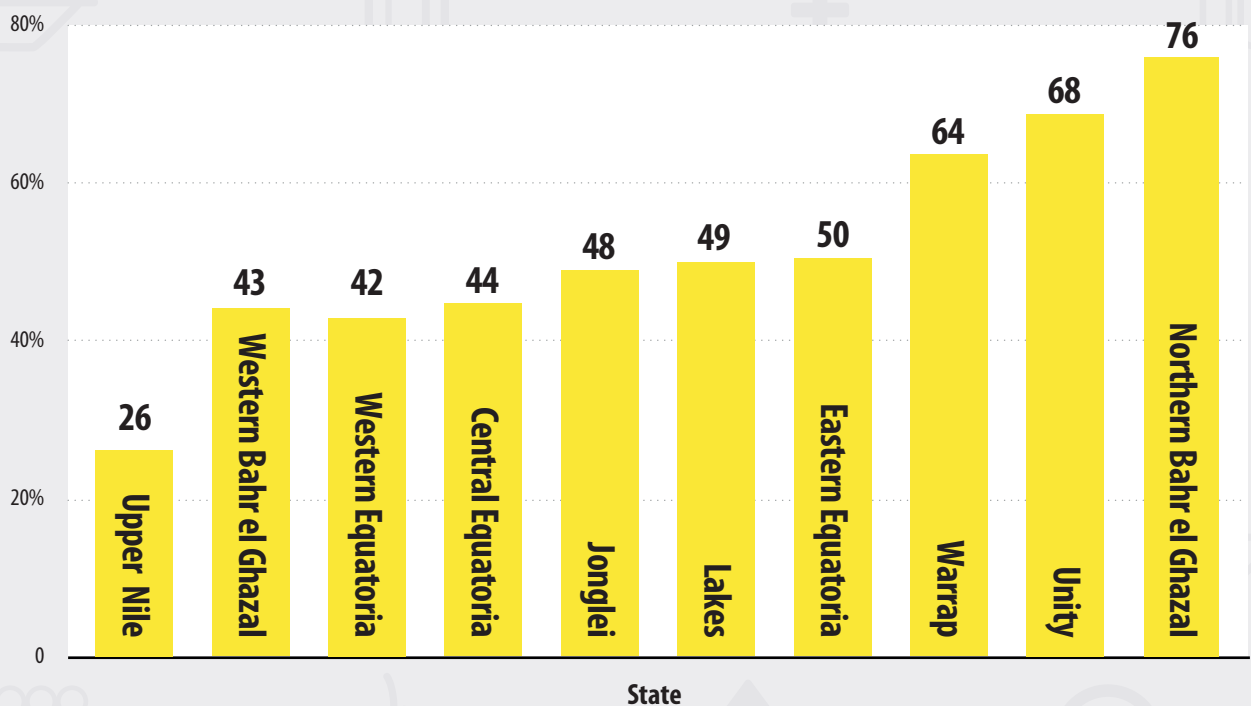
<sup>5</sup>In the 2004 MDGs Report, over 90% of the population in South Sudan was perceived to be living on one dollar a day, although no anecdotal evidence was used to support this.

**FIGURE 1.1A: POVERTY ESTIMATES BY STATE (MAPPING)**

Source: SSCSE (2010)  
Poverty in Southern Sudan - NBHS 2009



As Figure 1.1 shows, the poverty rates vary significantly among states from three in four people in Northern Bahr el Ghazal (75.6%), to only one in four people in Upper Nile (25.7%).



**Indicator 1.3: Share of poorest quintile in national consumption**

This third indicator looks at issues of income inequality through a measure of the distribution of consumption. If the distribution of consumption becomes more equal, it is expected that the share of consumption of the poorest quintile will increase.

The share of poorest quintile in national consumption in the population is 4% (NBHS, 2009), implying that the poorest 20% of the population controlled only 4% of national consumption.

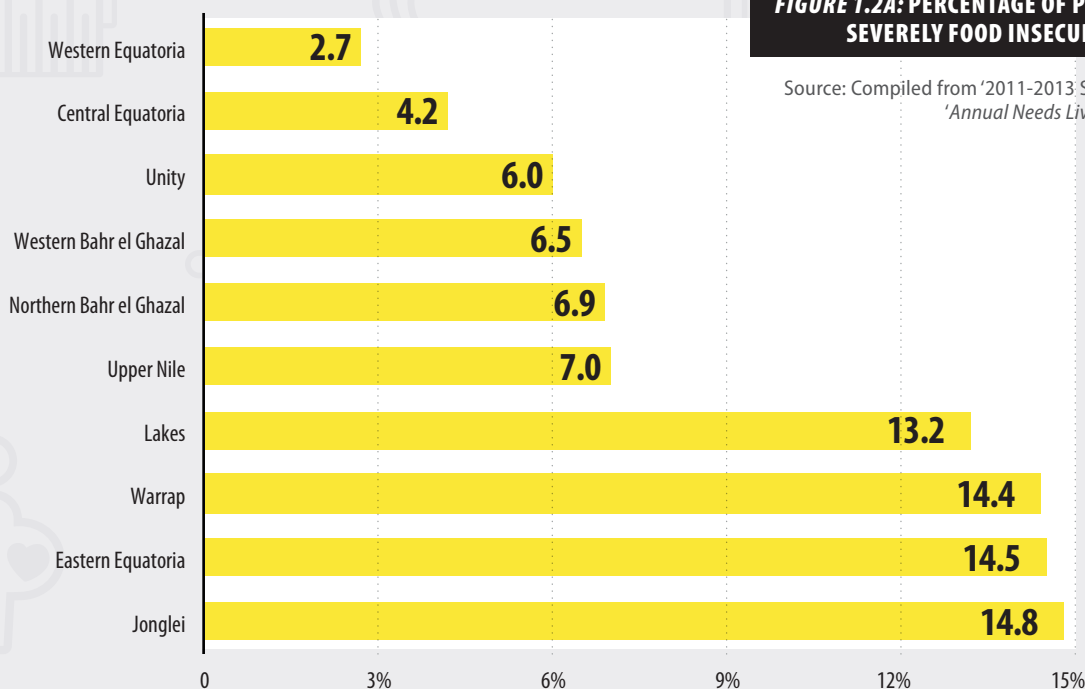
**TARGET**

1.0B

Halve, between 1990 and 2015, the proportion of people who suffer from hunger

A household's ability to acquire sufficient food is one of the most important determining factors for food security. This depends on its income. However, measures of income are not sufficient to understand fully the level of poverty. It is for this reason that levels of hunger are also measured. The two main indicators for monitoring hunger are the prevalence of underweight children under-five years and the proportion of the population living below the minimum level of dietary energy consumption.

**FIGURE 1.2A: PERCENTAGE OF POPULATION SEVERELY FOOD INSECURE BY STATE**



Source: Compiled from '2011-2013 SSDP - WFP, 2011 Annual Needs Livelihood Analysis'

**FIGURE 1.2B: PERCENTAGE OF POPULATION SEVERELY FOOD INSECURE BY STATE (MAPPING)**

Source: Compiled from '2011-2013 SSDP - WFP, 2011 Annual Needs Livelihood Analysis'

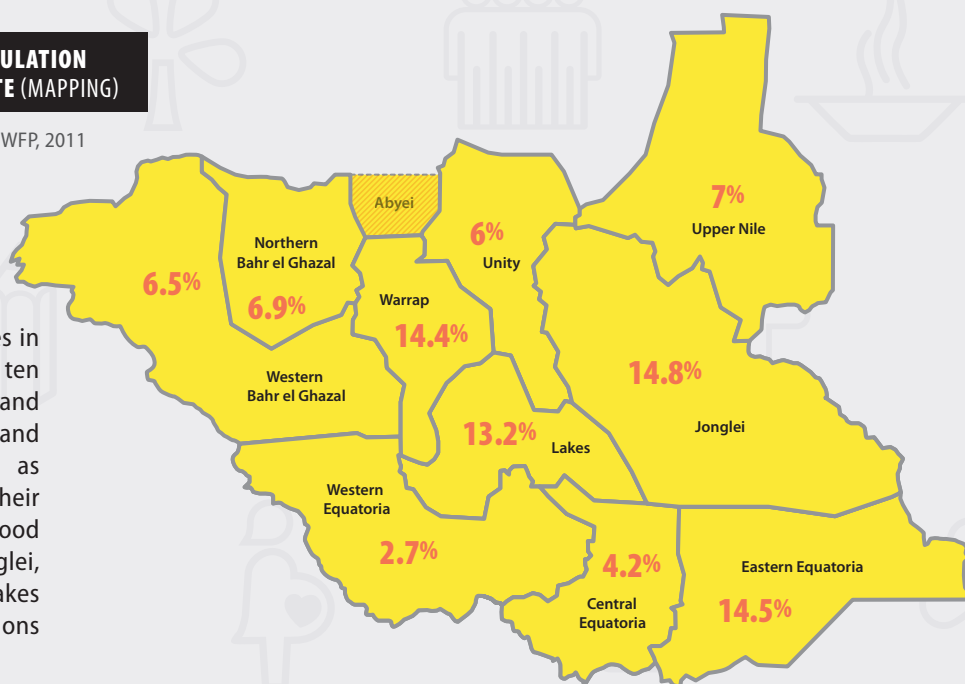


Figure 1.2 above shows disparities in food insecurity across all the ten states of South Sudan. Central and Western Equatoria, Western and Northern Bahr Ghazal as well as Upper Nile had less than 10% of their populations falling under the food insecure category, but Jonglei, Eastern, Equatoria, Warrap and Lakes had over 10% of their populations being food insecure.

**Indicator 1.8: Prevalence of underweight children (under five years)**

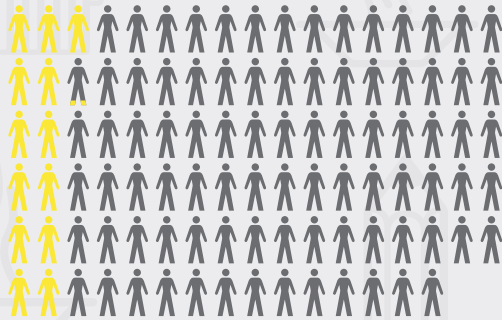
Malnutrition remains a big challenge globally and is a big contributor to child mortality. Children's nutritional status is a reflection of their overall health and development. The nutritional wellbeing of children is therefore a sign of the household, community and national investment in family health. Prevalence of underweight children is taken as a proxy indicator of the proportion of the population that is undernourished. Food

intake for undernourished population is always below minimum requirements and insufficient to meet dietary energy needs.

The prevalence of severely undernourished children (under five years) was 131 per 1,000 children (SHHS, 2006) and has since come down to 122 per 1,000, according to the 2010 Sudan Household Health Survey (SHHS, 2010). The prevalence of child malnutrition (weight/age) of under-fives is 33% (SHHS, 2006) and government plans to reduce this rate to 24% by 2015.

## SEVERELY UNDERNOURISHED CHILDREN UNDER 5

**2006**  
**131 PER 1000**



**2010**  
**122 PER 1000**

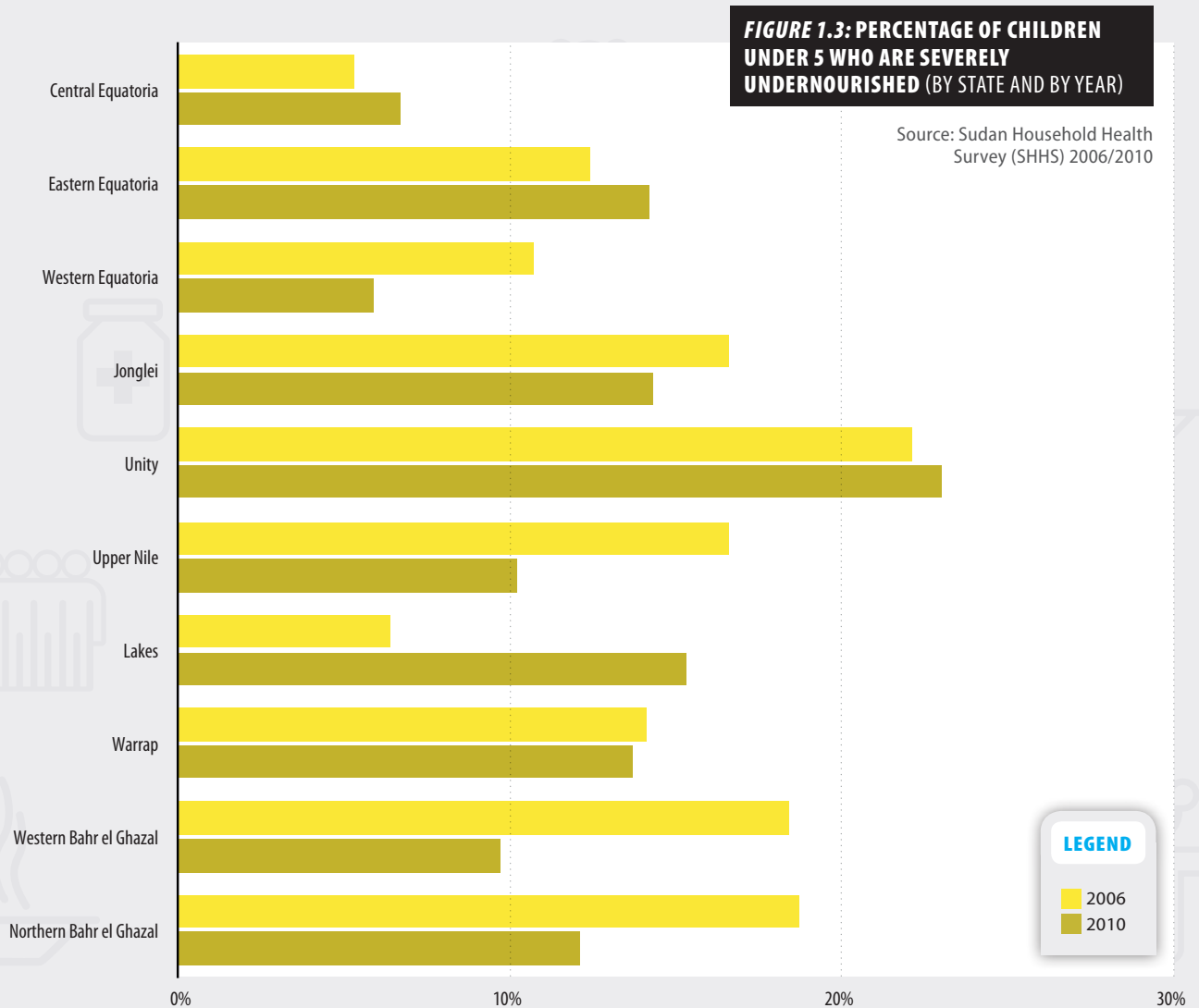
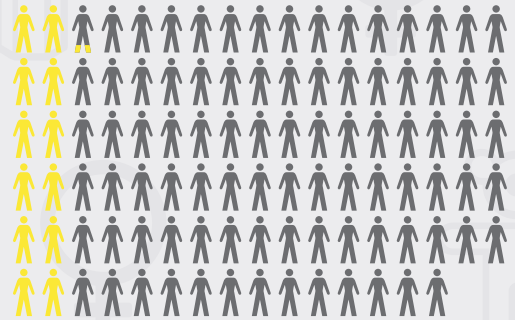


Figure 1.3 above shows the rate of undernourishment among under-five children in South Sudan by state. Unity tops the list of children who are undernourished (23%) and Western Equatoria (SHHS, 2010) with the lowest at 5.9%, according to the 2010 Sudan Household Health Survey (SHHS, 2010).

However, there has been a remarkable decline in severely undernourished children in six of the ten states from 2006 to 2010.

**Indicator 1.9:** Proportion of population below minimum level of dietary energy consumption.

The proportion of population below the minimum level of dietary energy requirement is estimated by defining a food poverty line. All persons below this line are deemed as ultra-poor. Proportion of ultra-poor in the population is used as a proxy indicator for the proportion of population below minimum level of dietary energy consumption.

The proportion of population below the minimum level of dietary energy consumption stands at 47% and the government aims at reducing this rate to 11% by 2015.

## CHALLENGES

There are several challenges that the country is facing with respect to eradicating extreme poverty and hunger, and the main ones are the following:

- › The legacy of prolonged war makes the fight against poverty more demanding and challenging;
- › Poverty and other social indicators in rural areas lag behind urban areas. Only 24% of people living in urban areas are poor, whereas more than double, 55%, of those living in rural areas fall below the poverty line, and this varies greatly by state;
- › Lack of resources to implement sound poverty eradication measures due to the oil shutdown, which was the main source of revenue for the national budget;



- › Low literacy rates that limit the adoption of new skills and methods to improve productivity;
- › Inadequate marketing infrastructure in rural communities, which discourages individuals from economic empowerment activities; and
- › While the government's preferred route to alleviating poverty is through agricultural productivity improvements, instead of relying solely on oil production, it is recognized that such endeavours may not always meet the needs of the ultra-poor who may not have access to adequate land or income.

## POLICY FRAMEWORK & STRATEGIES

The government and development partners have already taken a number of measures to address the challenges referred to by tackling poverty and agriculture sector growth in the SSDP as top priorities, namely:

- › The government is providing support to diversification of sources of income generation to reduce vulnerability;
- › The government, with support of donors, will provide a minimum safety net for the population by an eventual development of a social protection institutional framework. The introduction of a child benefit cash transfer is an example of a safety net measure being pursued by the government as articulated in the 2011-2013 SSDP. It proposes that at least 20% of households will receive cash transfers within the first three years of statehood;
- › The government, over the medium-term, intends to undertake poverty and vulnerability analysis disaggregated by population groups, and economic status, which facilitate the formulation of a poverty reduction strategy; and
- › Notable development partners have pledged support through United Nations Development Assistance Framework (UNDAF) to:
  - Provide complementary support for the introduction of child benefit cash transfers and the establishment of the civil registration system;
  - Focus on fostering inclusive and pro-poor growth and reducing food insecurity, specifically supporting initiatives that increase cereal production and improve livelihoods of smallholder farmers and conflict-affected people, including women and returnees;
  - Support the establishment of a strategic grain reserve; and
  - Help to formulate gender-sensitive policies and strategies for sustainable agricultural and rural development.



© UN Photo/Martine Perret



2

# ACHIEVE UNIVERSAL PRIMARY EDUCATION







A class session in an outdoor classroom  
© UNICEF / Giacomo Pirozzi

# Goal 2: Achieve Universal Primary Education

**Education is a vital prerequisite for combating poverty** by empowering women and protecting children from labour and sexual exploitation, among others. Education is among the top five priority programme areas for the Social and Human Development pillar of the South Sudan.

The Social and Human Development pillar objective of the Development Plan aims at promoting the wellbeing and dignity of all the people of South Sudan by progressively accelerating universal access to basic social services.

schools. This is a percentage calculated by dividing the number of official school-going children enrolled in schools with the total number of the same age in the population. Gross Enrolment Rate on the other hand, is defined as the extent to which children of any age are enrolled in schools.

## TARGET

# 2.0A

Ensure that by 2015, all boys and girls should be able to complete a full course of primary schooling

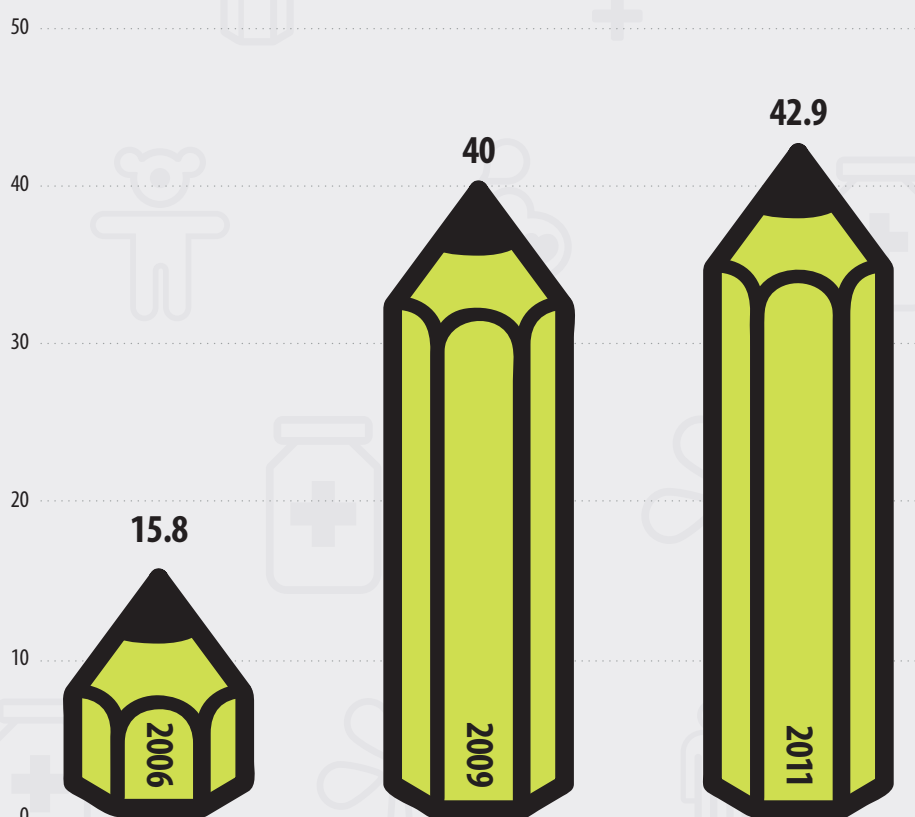
## Indicator 2.1: Net Enrolment Rate (NER) in primary education

Net Enrolment Rate in primary education is defined as the extent to which children of official school-going age are enrolled in

Under the SHHS, 2006 the Net Enrolment Rate (NER) in primary schools was 15.8%, The NBHS 2009 recorded NER as 40% and according to the EMIS report of 2011, the NER was at 42.9%. This indicates an upward trend in net enrolment.

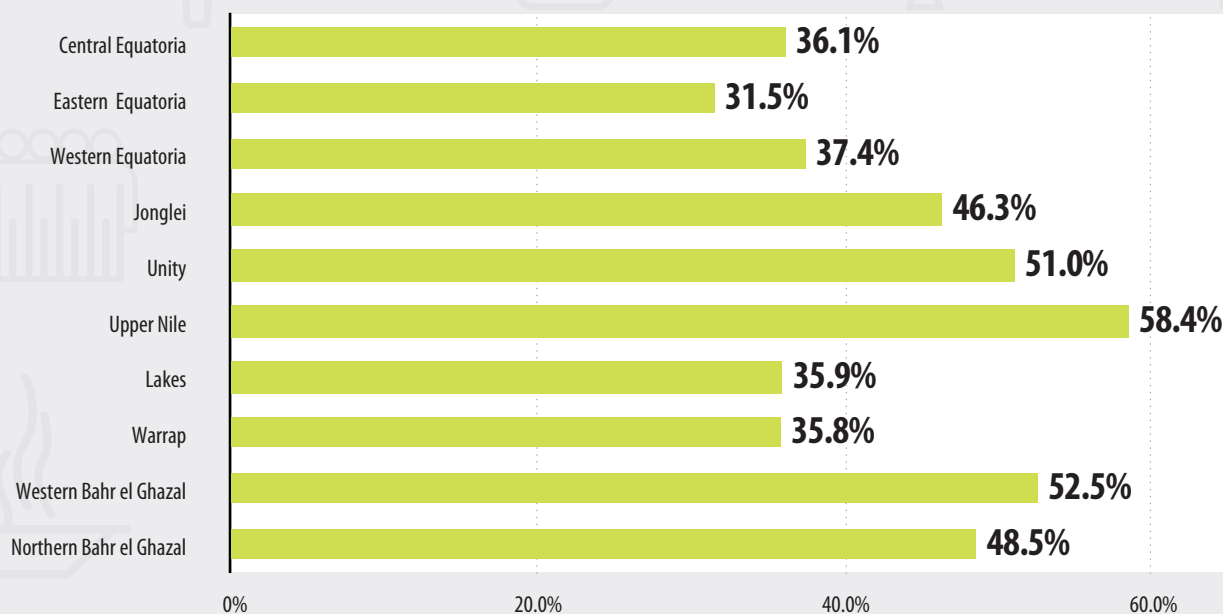
**FIGURE 2.1: NET ENROLMENT RATE (NER) IN PRIMARY EDUCATION 2006, 2009 & 2011**

Source: SHHS, 2006 and NBHS, 2009 & M.E/EMIS



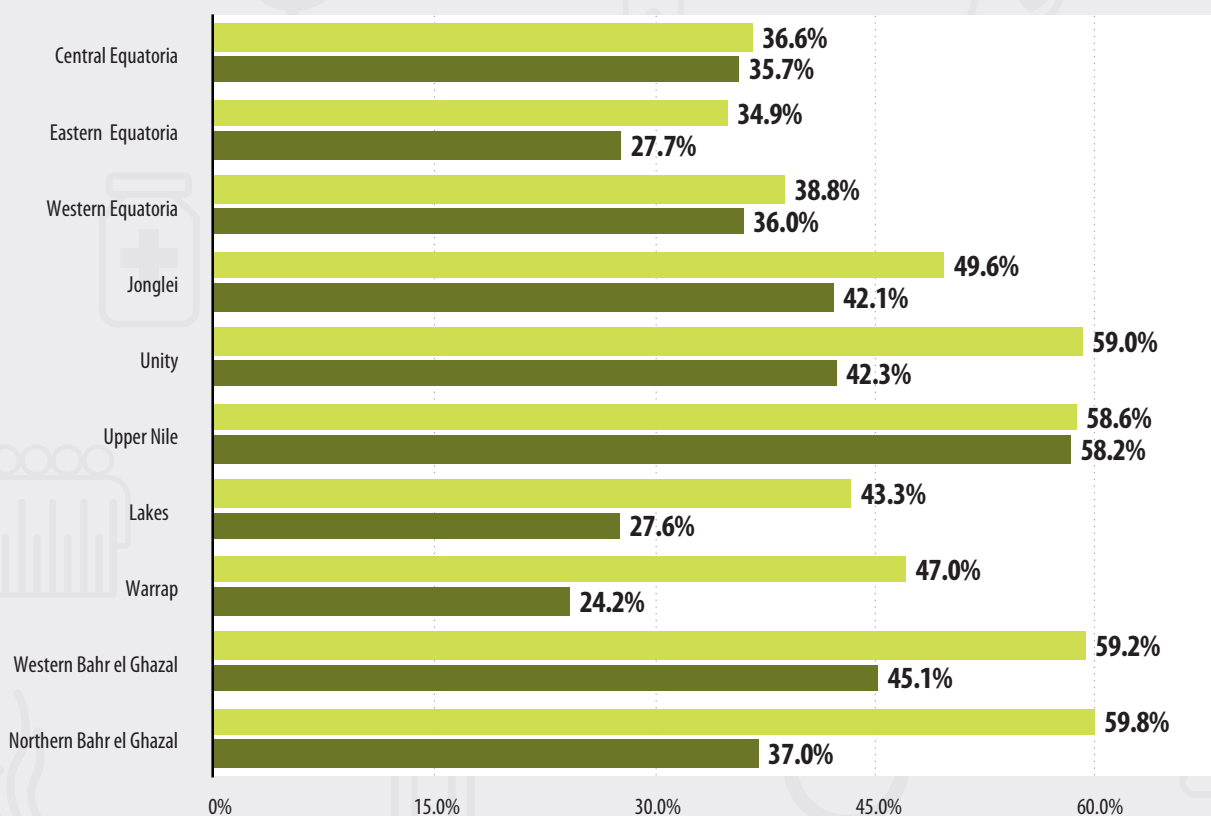
**FIGURE 2.2: NER FOR CHILDREN IN PRIMARY EDUCATION, 2011**

Source: EMIS, 2011



**FIGURE 2.3: NER FOR BOYS AND GIRLS IN PRIMARY EDUCATION BY STATE**

Source: EMIS, 2011

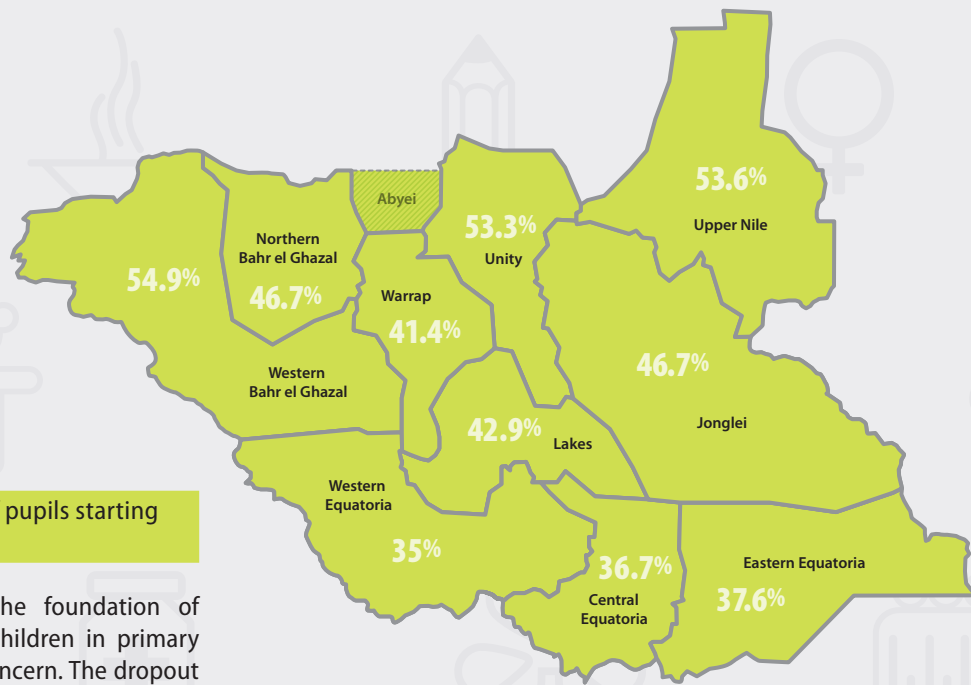


Figures 2.2, 2.3 and 2.4 above indicate that for both GER and NER, fewer girls than boys were enrolled in school in 2010 and 2011. Enrolment disparities exist across states, with the highest NERs found in Upper Nile (58.4%), Western Bahr el Ghazal (52.5%) and Unity (51.0%). The NERs

were lowest in Eastern Equatoria (31.5%), Warrap (35.8%) and Lakes (35.9%). Warrap registered the lowest NER for girls. Unity and Northern Bahr-el-Ghazal registered GERs of 130% and 113% respectively; their GERs exceeded 100% in 2011.

**FIGURE 2.4: NET ENROLMENT RATE IN PRIMARY EDUCATION BY STATE (MAPPING)**

Source: Government of South Sudan, Ministry of Education (GoSS/MoE), 2010

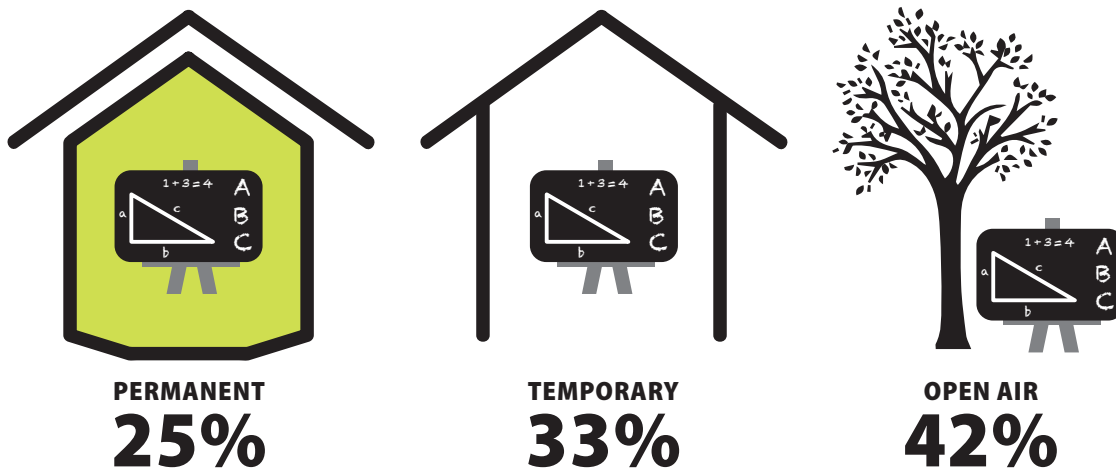


**Indicator 2.2:** Proportion of pupils starting grade 1 who reach grade 5

As primary education is the foundation of education, the dropout of children in primary school is a matter of great concern. The dropout indicator measures the extent of dropout in primary education. Data on pupils starting grade 1 who reach grade 5 is not available, but data for pupils that start grade 1 and who reach grade 8 exists and is 64.5% (SHHS, 2010) of the boys and girls who start grade 1.

75% of classrooms in South Sudan are open-air or temporary classrooms with grass thatched roofs. The open-air classrooms constitute 42% of total classrooms and outnumber other types of classrooms.

**FIGURE 2.5: PERCENTAGE OF CLASSROOMS BY TYPE OF STRUCTURE**



**Indicator 2.3:** Literacy rate of 15-24 year olds

Literacy rate among 15-24 year olds can be defined as the percentage of the people between the ages of 15 and 24 who can read and write in any language out of the total population of the same age category. In South Sudan, the literacy rate of this age category improved by 12 percentage points from 28% in 2006 (SHHS, 2006) to 40% (NBHS, 2009) in 2009; with males registering 55% compared to women (28%) by the year 2009. This is in sharp contrast to the scale in disparity observed in 2006 (SHHS, 2006) when males registered 38% compared to 18% for

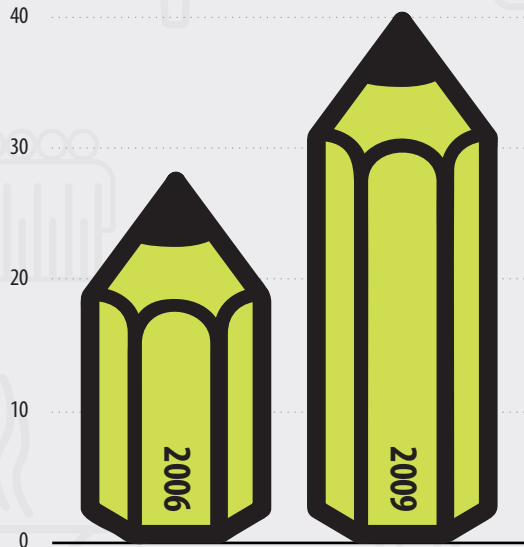
women, a 20 percentage point difference. However, the government is determined to reach 100% literacy by target year 2015.

**CHALLENGES**

Despite the positive developments in the education sector, major challenges exist that may hinder the achievement of the MDG target on education in all parts of South Sudan. Much is left to be done regarding coverage, efficiency, quality, equity and relevance. Some of the challenges include:

**FIGURE 2.6: LITERACY RATE (15-24) YEARS OF AGE**

Source: SHHS, 2006/NBHS, 2009



Years of conflict have not allowed for consistent training of teachers and many trained teachers have left South Sudan or have become internally displaced. Only 45% of the teachers working in South Sudan are considered trained<sup>6</sup> and 40% are primary school leavers. The student teacher ratio (STR) is 52.6. However, many teachers working in South Sudan are volunteers, waiting for recruitment of paid teachers. Teacher absenteeism is common and this hampers student learning<sup>7</sup>.

Localized conflicts in several counties have greatly contributed to children being displaced from their communities and moving to areas where access to schooling is not assured;

Quite a number of children had never attended a school or had to leave school due to the civil war. After the war, they re-entered school while over-age. As a result, they often drop out before completion of the primary school cycle. This is particularly true of girls;

Inadequate physical infrastructure due to many years of civil war;

Lack of resources for training and/or recruiting teachers due to oil shutdown as a result of austerity;

A large part of the South Sudan population is semi-nomadic and this prevents them from attending formal schooling.

<sup>6</sup> Defined as having a diploma in teaching, or completed in- or pre-service training.

<sup>7</sup> GoSSMoE, EMIS, 2009

## POLICY FRAMEWORK & STRATEGIES

The Government of South Sudan recognizes the importance of education to the extent that it has included education among the top five priority programme areas for the Social and Human Development pillars of the South Sudan Development Plan.

### The plan:

Proposes provision of qualified teachers and academic staff in order to reduce the pupil-teacher ratio and produce a relevant curriculum for general education; and

Intends to increase the enrolment rate in primary school to 65% within the three years of statehood; it is also proposed that each of the ten states will each have either technical or higher education facilities.

### Additionally,

The General Education Bill 2012 makes provision for private schools to enable parents to have choices between taking their children to public or private schools;

The Bill approved by the National Legislative Assembly will address issues of making primary school attendance compulsory, where parents will be held accountable for absenteeism;

The sector has been boosted by the South Sudan Teachers Education Programme (SSTEP) through the Global Partnership for education to address the issue of quality of teachers and enrolment levels in South Sudan; and

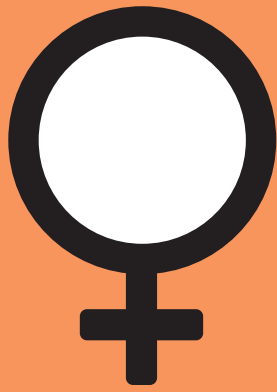
Development partners have committed themselves through the United Nations Development Assistance Framework (UNDAF) to provide specific support to:

Expand the Education Management Information System (EMIS) at both national and state levels;

Expand access and improve the quality and relevance of general education by helping to rapidly accelerate capacity development through training of teachers, head teachers and education managers;

Assist the government to review existing policies and develop a relevant curriculum for general education and vocational training; and

Accelerate the enrolment and completion of basic education for children, especially girls, through school-based food safety net programmes and expand education opportunities for youth and women literacy and numeracy campaigns.



**3**

**PROMOTE GENDER  
EQUALITY AND  
EMPOWER WOMEN**





Lilian Riziq, Chair of Board of Directors, South Sudan Women Empowerment Network (SSWEN) and Minister of Finance, Trade and Industry, Western Bhar el Ghazal, delivering speech at the National Women Constitutional conference. © UNDP / Joseph Tabani

# Goal 3: Promote Gender Equality and Empower Women

Gender inequality exists in South Sudan and it negatively affects women more than their male counterparts. Women, who constitute 49% of the population, are in most cases marginalized in social and economic spheres and, therefore, are unable to contribute effectively to social, economic and political development. The SSDP in its broad outline recognizes that there is a high correlation between poverty, social vulnerability and gender inequality.

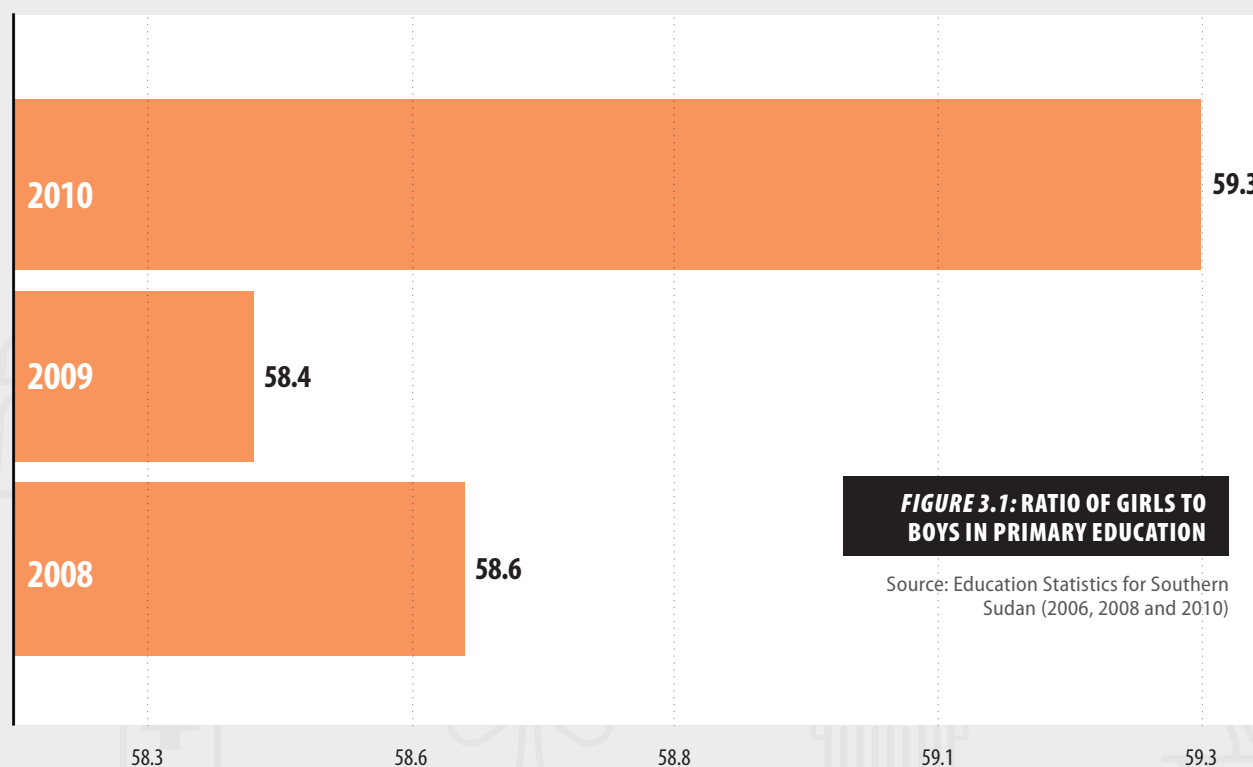
Strongly related to the poverty, social vulnerability and gender inequality is the low literacy level among women, estimated at 70% (NBHS, 2009). This state of affairs is a key determinant of gender inequality in South Sudan.

## TARGET

3.A

Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

**Indicator 3.1:** Ratio of girls to boys in primary education



**FIGURE 3.1: RATIO OF GIRLS TO BOYS IN PRIMARY EDUCATION**

Source: Education Statistics for Southern Sudan (2006, 2008 and 2010)



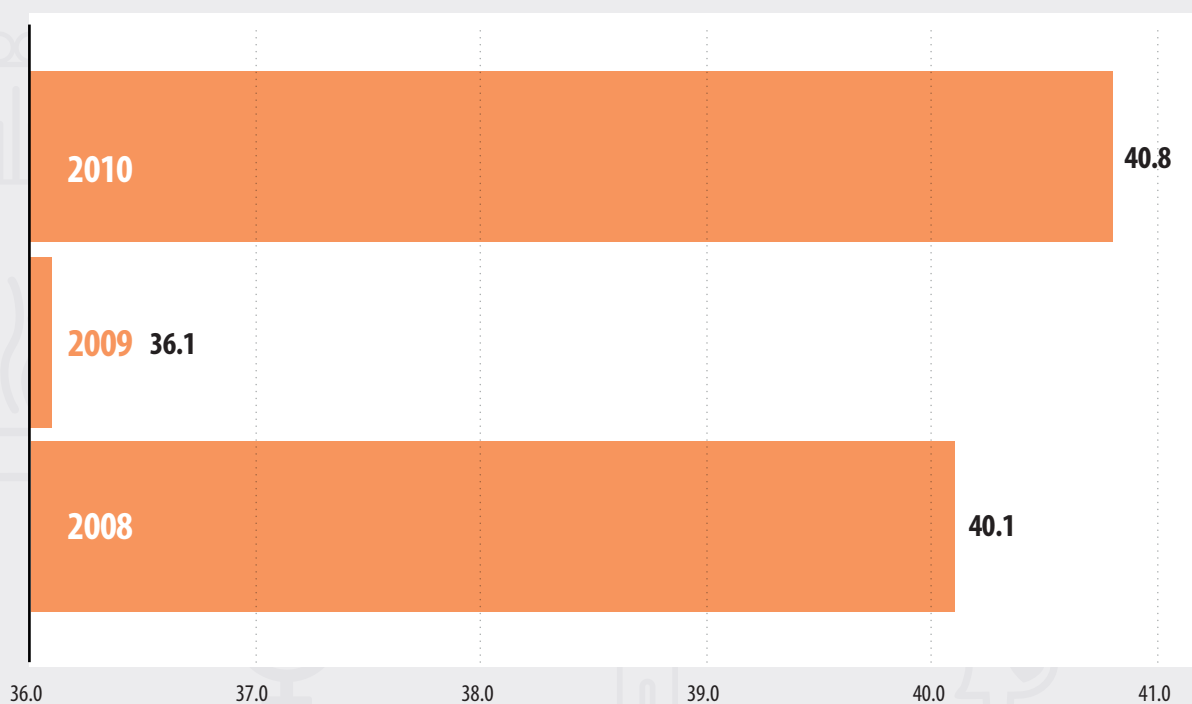
Figure 3.1 shows that the ratio of girls to boys in primary school which in 2008 was at 58.6% fell slightly to 58.40% in 2009, but increased again to 59.30 % in 2010 (EMIS, 2009 & 2010). This is evidently attributable to the Government of South Sudan's political will to promote gender equality and empower women by putting the right policies in place, enacting the relevant laws where they are required, and by designing the right strategies and programmes on the education of the girl child in particular. As a consequence, the ratio of girls to boys in primary, secondary and tertiary education has been rising.

**Indicator 3.1: Ratio of girls to boys in secondary education**

Although figure 3.2 below shows that the ratio of girls to boys in secondary education rose from year 2009 to 2010, it is still very low. Factors that force girls out of school include late starts in education, as well as family and cultural responsibilities because girls are more likely than boys to assume roles of providing home care and support for relatives that are aged or sick. This implies that the elimination of gender disparities remains a challenge at secondary school level. This might also be the case at tertiary education level. Therefore, there is a need to formulate strategies that target family and cultural tendencies with a view to eliminating them altogether.

**FIGURE 3.2: RATIO OF GIRLS TO BOYS IN SECONDARY EDUCATION**

Source: Education Statistics for Southern Sudan (2006, 2008 and 2010)



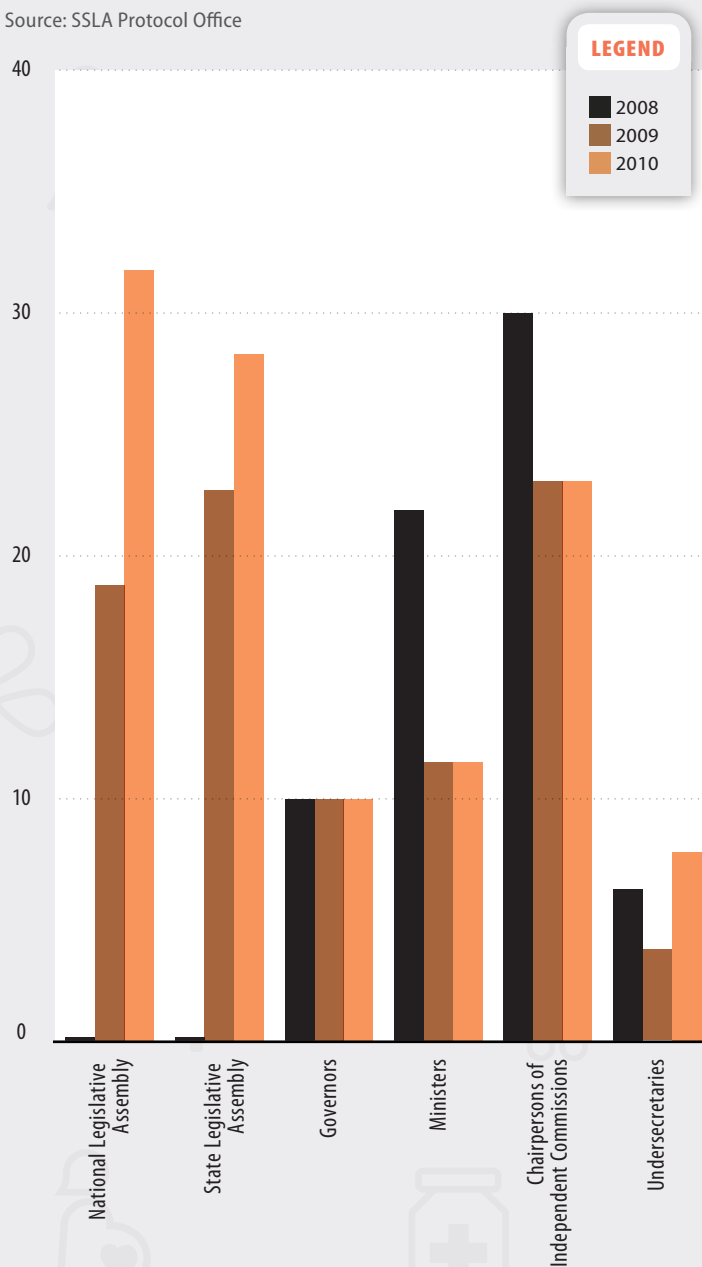
**Indicator 3.2:** Proportion of seats held by women in national parliament

The Government of the Republic of South Sudan (RSS) adopted a national plan for action on Combating Gender-Based Violence (C/GBV) because gender-based violence was commonly practiced. Following this plan of action, it adopted a national policy on women empowerment and the national policy for girl's education in 2007; as well as the national strategy on Female Genital Mutilation (FGM) in 2008. The adoption of the quota system in the general election law of 2008, which guaranteed 25% of the total number of seats for women in the legislative assemblies, in addition to earlier policies constituted the necessary evidence of the then existing political will to empower women in Southern Sudan.

Figure 3.3 shows that there was an increase in the proportion of seats held by women in the National Assemblies both at national and state levels in South Sudan for the three years within the CPA period and up to independence. However, male Parliamentarians, Governors and Undersecretaries still outnumber women. There is a need to accelerate progress on this front.

**FIGURE 3.3: PROPORTION OF SEATS HELD BY WOMEN IN DECISION-MAKING POSITIONS IN VARIOUS ORGANS OF GOVERNMENT**

Source: SSLA Protocol Office



**CHALLENGES**

The following are some of the challenges faced in promoting gender equality and women empowerment:

- › Lack of organizational structures for women empowerment;
- › Lack of gender sensitization programmes;
- › Shortage of personnel to carry out women empowerment sensitization campaigns;
- › Limited capacity in terms of human and material resources to facilitate adult literacy and continuing education;
- › Lack of encouragement on non-formal educational programmes and building campaigns of continuing distance education programmes targeting women;
- › Lack of mechanisms for monitoring the implementation of education reforms;
- › Early marriages influenced by socioeconomic factors;

- › Socio-cultural factors that make people believe that men should be leaders and women followers, and
- › Poor learning environments which affect girls in primary and secondary schools e.g. sanitary facilities, long distance to education facilities, extra burden from domestic chores especially for adolescent girls resulting into high dropout rate.
- › Adopted the national strategy on stopping Female Genital Mutilation (FGM) in 2008;
- › Adopted the quota system in the general election law of 2008, which guaranteed 25% of the total number of seats for women in the legislative assemblies, in addition to earlier policies demonstrates the existence of political will to empower women in South Sudan;
- › Adopted the policy of affirmative action to increase number of women in decision making positions in the public and private sectors;
- › Amended the 1991 criminal law in 2009 to include provisions on special protection for women during armed conflicts, and the armed forces law formulated in 2007 embraced an article on special protection for women during armed conflicts as is the situation on the borders of South Sudan; and
- › The Ministry has developed a 5-year (2012-2017) Strategic Plan which, inter-alia, has proposed to establish departments of women empowerment in various areas such as in politics. The Strategy has also proposed a gender mainstreaming desk office in each ministry.

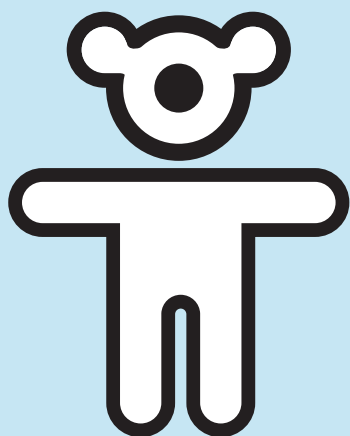
## POLICY FRAMEWORK & STRATEGIES

While recognizing important efforts that are being made in the area of gender equality and empowerment, there still is need to streamline gender concerns in all government policies and strategies. The government has, therefore, put in place a number of strategies through the SSDP and other relevant policy documents in an effort to eliminate gender disparities. To achieve this objective, the government has:

- › Adopted a national plan for action on Combating Gender Based Violence (C/GBV) because gender-based violence was commonly practiced. Following this plan of action, it adopted a national policy on women empowerment and the national policy for girl's education in 2007;



© UNWOMEN



4

**REDUCE  
CHILD MORTALITY**





© UNICEF / Giacomo Pirozzi

# Goal 4: Reduce Child Mortality

The government remains highly committed to reducing child mortality. As a manifestation of this commitment, the government with the collaboration of development partners has intensified investment in essential health care services. Special focus has been put on human resources development, through the UNV placement initiative and the IGAD initiative, increased intake in midwifery and nursing training institutions, procurement of essential basic equipment, drugs and other medical supplies, and providing infrastructure.

Young children in South Sudan face daily threats from malaria, diarrheal diseases, Acute Respiratory Infection (ARI), vaccine-preventable diseases and malnutrition. Health infrastructure is still limited and decades of conflicts have reduced national health service provisioning capacity considerably. Less than half of the population has access to appropriate health care, while more than 40% have no access to safe drinking water.

Malaria morbidity and mortality remains high due to low utilization of long-lasting insecticide nets (LLIN), estimated at 11.6%, and use of and poor access to effective recommended treatment.

DPT 3 coverage stands at 20.2%, while measles immunization stands at 27.7, and neonatal tetanus protection at birth stands at 30%. Reported immunization performance indicators (based on the DPT-3 coverage and DPT1-DPT3 dropout rate) shown in the table below indicate that the routine immunization coverage has improved while the drop-outs remain a challenge. This is mainly due to poor access to services which emanates from inadequate infrastructure and trained personnel. The infrastructure is poor in terms of communication, transportation networks, physical health facilities and cold chain equipment. As pointed out above, there are too few health units with cold chain facilities for the geographical size of South Sudan.

**TARGET**

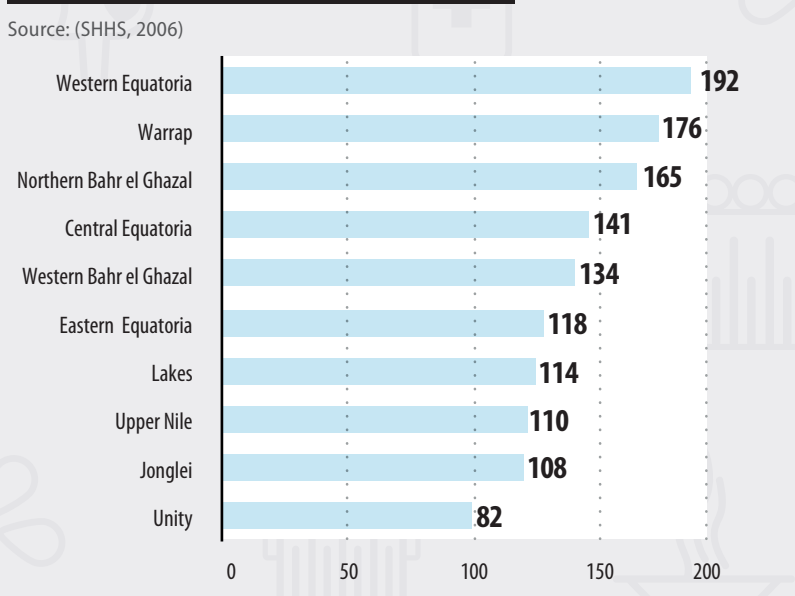
4.0.A

Reduce by two thirds, between 1990 and 2015, the mortality rate among under-five children

**Indicator 4.1: Under-Five Mortality Rate (U5MR)**

Child mortality is particularly high in South Sudan. Under-five mortality rate was 135 per 1000 in 2006 (SHHS-2006). As per the SHHS, 2010, the rate was estimated at 105 per 1,000 live births.

**FIGURE 4.1A: UNDER-FIVE MORTALITY (U5MR) RATE BY STATE**



**FIGURE 4.1B: UNDER-FIVE MORTALITY RATE (MAPPING)**

Source: (SHHS, 2006)

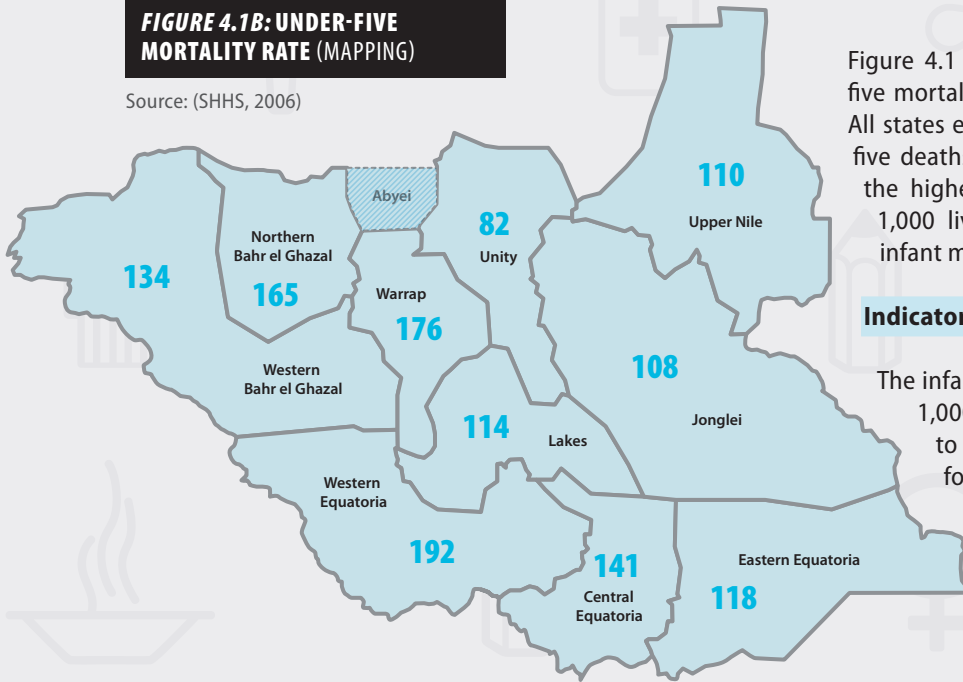


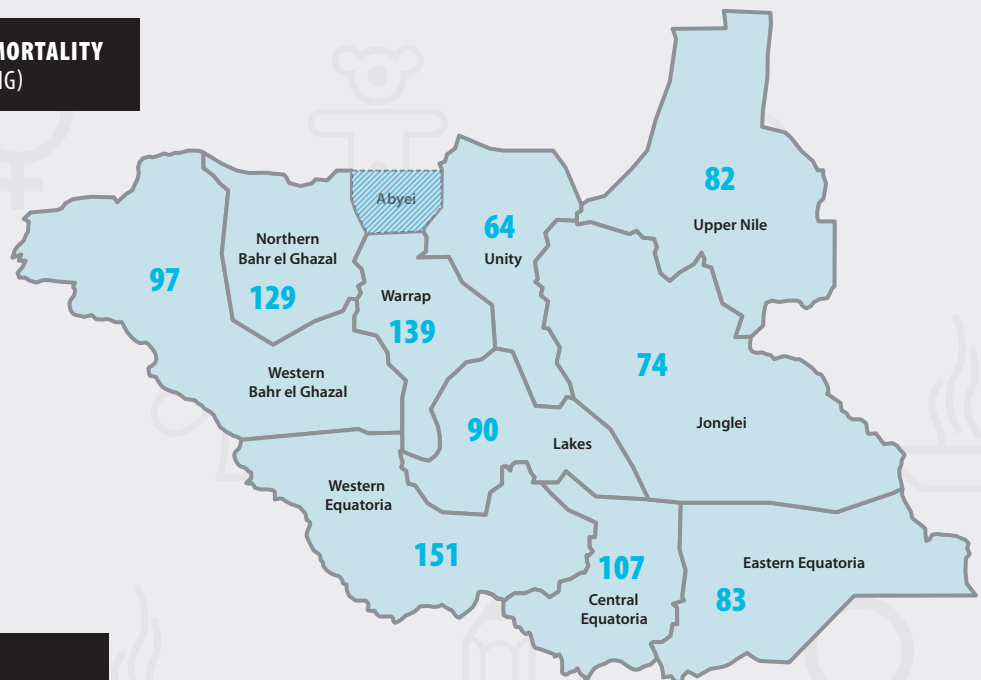
Figure 4.1 shows the distribution of the under-five mortality rates (U5MR) across the ten states. All states except Unity registered over 100 under five deaths per 1,000 live births. The state with the highest U5MR is West Equatoria (192 per 1,000 live births), that also has the highest infant mortality rate (151 per 1,000 live births).

**Indicator 4.2: Infant Mortality Rate (IMR)**

The infant mortality rate (IMR) is 75 deaths per 1,000 live births (SHHSII, 2010). According to the SHHS, 2006, the infant mortality for South Sudan was at 102 per 1,000 live births.

**FIGURE 4.2A: INFANT MORTALITY RATE BY STATE (MAPPING)**

Source: (SHHS, 2006)



**FIGURE 4.2B: INFANT MORTALITY RATE BY STATE**

Source: (SHHS, 2006)

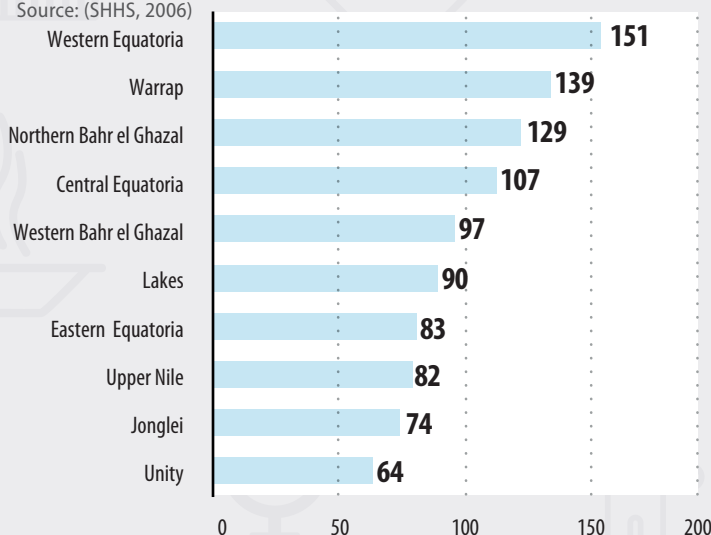


Figure 4.2 shows how infant mortality rates vary across states. Western Equatoria registered 151 deaths per 1,000 live births followed by Warrap (139 deaths per 1,000 live births), Northern Bahr el Ghazal (129 deaths per 1,000 live births) and Central Equatoria (107 deaths per 1,000 live births). Unity and Jonglei registered the lowest infant mortality rates of 64 and 74 per 1,000 live births respectively.

**Indicator 4.3: Proportion of 1-year old children immunized against measles**

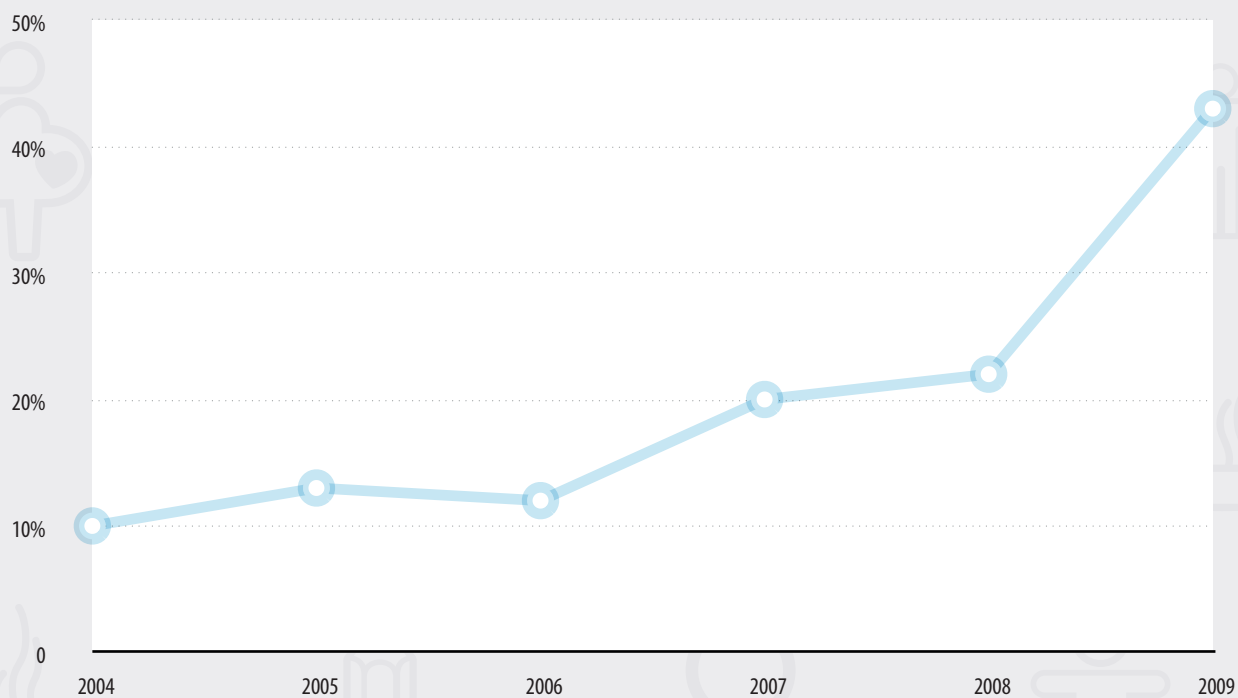
In accordance with the South Sudan immunization schedule and guidelines, developed by the World Health Organization, children are considered fully vaccinated when they have received a vaccination

against tuberculosis (BCG) at birth or first contact, three doses each of the DPT and polio vaccines (given at 6, 10 and 14 weeks) to protect against diphtheria, pertussis, tetanus and polio, and a measles vaccination given at or soon after reaching 9 months of age.

According to the SHHS, 2006, 17.3% of the children were fully immunized, that is, the percentage of children aged 12-23 months who have received BCG, DPT 1-3, OPV1-3 and measles immunizations.

**FIGURE 4.3: DPT3 IMMUNIZATION COVERAGE FOR CHILDREN LESS THAN 1 YEAR OLD**

Source: (SHHS, 2006)



**FIGURE 4.4: DROPOUT RATE (DPT1 – DPT3) FOR CHILDREN LESS THAN 1 YEAR OLD**

Source: (SHHS, 2006)

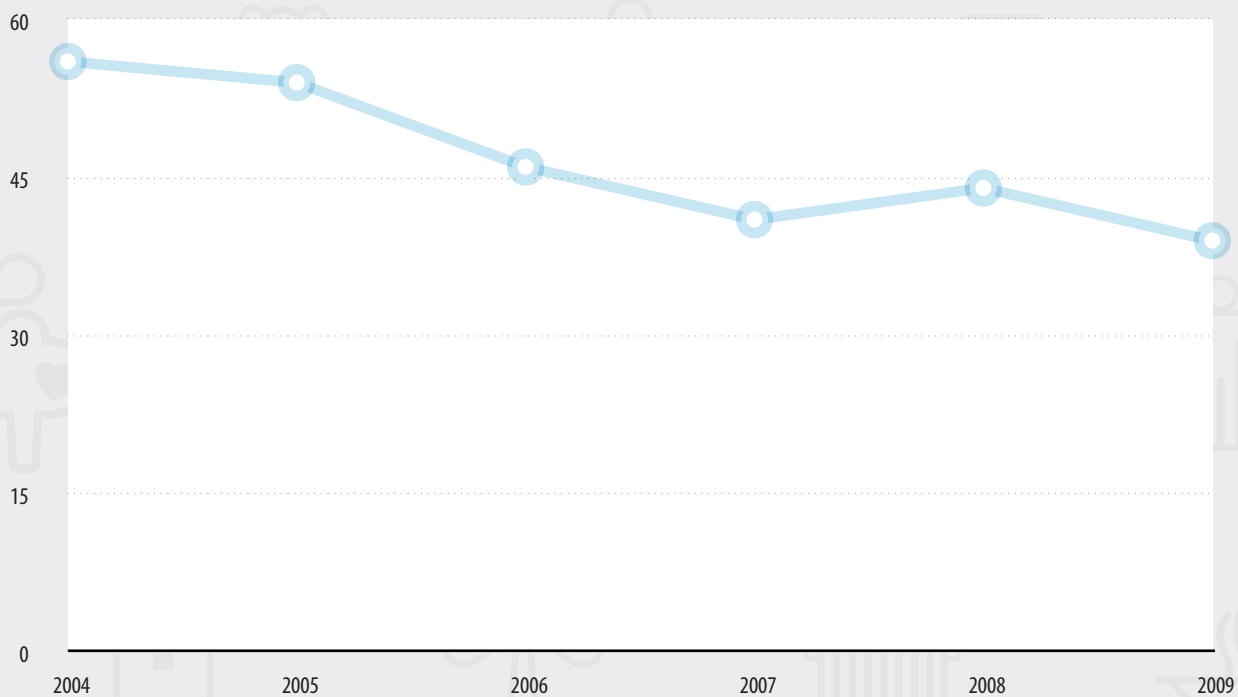




Figure 4.4 above shows the proportion of 1 year old children immunized against diphtheria, tetanus and pertussis (DPT3) taking an upward trend from 10% in 2004 to over 40% in 2009. Although Figure 4.5 shows the dropout rate of DPT1 to DPT3 as decreasing, it is still worrying due to the high levels of the initial dropout rate at 56% in 2004 and the slow pace of the decrease, from 56% in 2004 down to 39% in 2009. Dropout rates for DPT3 could also signal eminent dropout in other immunizations such as polio. At the national level, only 26.3% were immunized against measles (SHHS, 2010).

## CHALLENGES

South Sudan as a new nation faces a number of challenges in her efforts to reduce child mortality. These include:

- ▶ The slow rate of decline in drop-out rates in DPT1-DPT3;
- ▶ Inadequate infrastructure and trained personnel. The infrastructure is still too poor in terms of communication, transportation networks, physical health facilities and cold chain equipment;
- ▶ There are very few health units with cold chain facilities for the geographical size of South Sudan;
- ▶ Threat of morbidity and deaths from measles which remains for many of the children: about 30% of the children under the age of one were not immunized against the disease by routine immunization services in South Sudan in 2009, reaching as high as 60% in some of the states;
- ▶ Increased vulnerability to morbidity and mortality due to HIV and AIDS as it reduces the body's immunity; and
- ▶ Lack of resources to purchase drugs and other medical supplies due to the oil shutdown, which was the main source of revenue in the national budget.

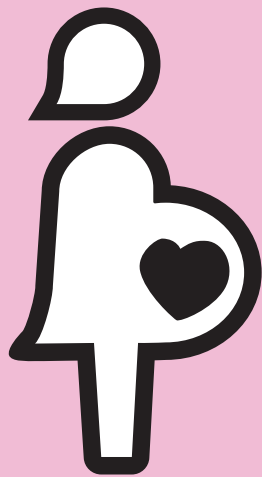
## POLICY FRAMEWORK & STRATEGIES:

As a major priority in the Social and Human Development pillar in the South Sudan Development Plan, the government has set a

target for reducing maternal mortality and under-five mortality by 20% within the first three years of her statehood. To achieve this objective, there are a number of initiatives the government ought to undertake in addition to those currently being implemented.

### These include:

- ▶ The 5-year (2011-2015) National Health Policy and Health Sector Strategic Plan addresses, among a number of issues, capacity building for nurses and other medical staff as well as construction of health infrastructure;
- ▶ Strengthening routine immunization services to ensure that more children are protected against all immunizable diseases especially in high-risk counties with large number of un-immunized children;
- ▶ Continued implementation of the Basic Package of Health, Nutrition and WASH Services (BPHN&W) which was developed and endorsed at the highest level under the Accelerated Child Survival Initiative (ACSI) in 2007 as the innovative strategy to deliver the package;
- ▶ Development of a national plan which calls for reaching all, especially the vulnerable population, with cost-effective and high-impact interventions/ services for the prevention and treatment of malaria, diarrhea, ARI, measles, neo-natal tetanus, and malnutrition;
- ▶ The continued implementation of the Jump-start Phase. The aim of the Jump-start Phase is to scale up integrated one-time delivery of services/ interventions (including Long Lasting Insecticide Nets, measles and tetanus immunization, and Vitamin A supplementation); and
- ▶ Continued promotion of de-worming, hand-washing and breast-feeding, and the screening and referral of severely malnourished children to therapeutic feeding facilities over a period of one month.



5

## IMPROVE MATERNAL HEALTH





© UNDP / Marguerite Nowak

# Goal 5: Improve Maternal Health

South Sudan is among the countries that have very high maternal mortality rates. The country, like many developing countries, records complications during pregnancy and childbirth as a leading cause of deaths and disability among women of reproductive age.

In order to achieve the targets with respect to maternal health, there is a need for continued improvement on antenatal care, basic emergency obstetric care, and postnatal care. Progress under this goal is measured by two indicators, namely, proportion of births attended by skilled health personnel, and the Maternal Mortality Ratio (MMR). Although maternal health has performed poorly, there has been a general reduction in maternal deaths over the past few years.

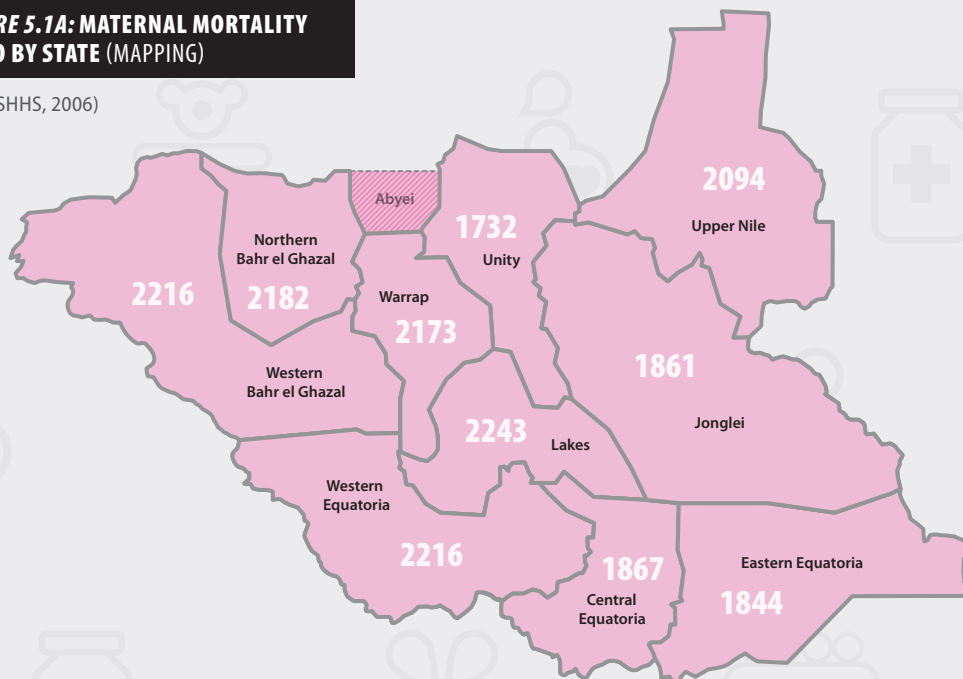
<b>TARGET</b>	Reduce by three quarters, between 1990 and 2015, the Maternal Mortality Ratio (MMR)
<b>5.A</b>	

### Indicator 5.1: Maternal Mortality Ratio

MMR is one of the indicators used for monitoring progress towards the achievement of the MDG 5. The 2006 Sudan Household Health Survey (SHHS) indicated that the MMR in South Sudan stood at 2054/100,000 live births. In 2008, the MMR is reported to have improved to 1,989 deaths out of 100,000 live births (5th SPHC, 2008).

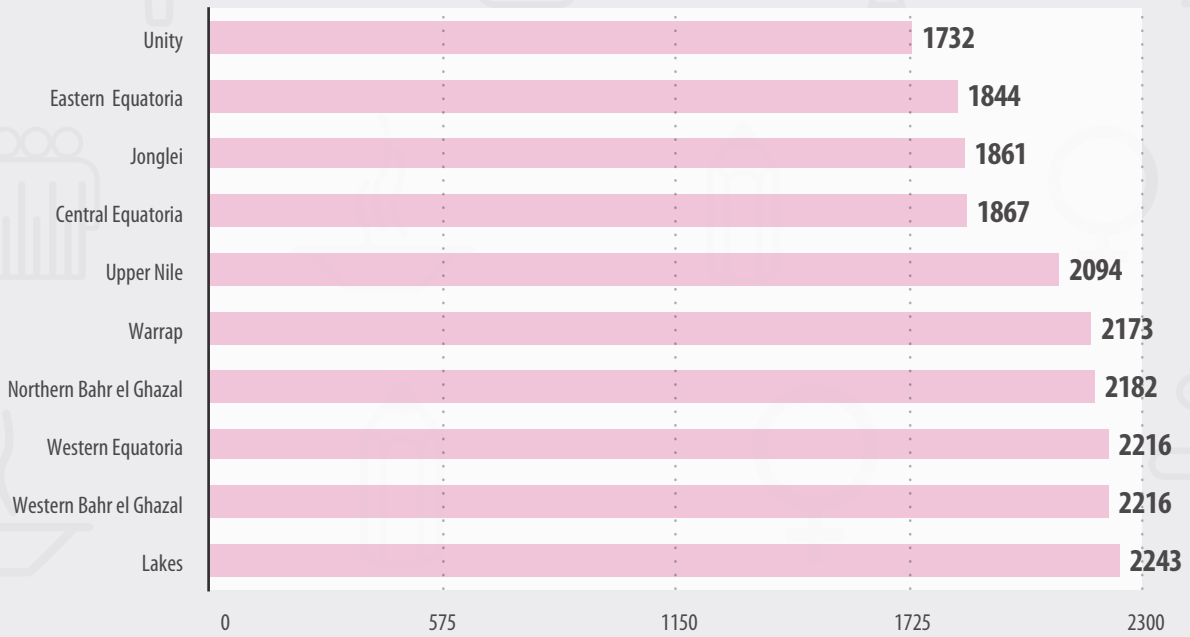
**FIGURE 5.1A: MATERNAL MORTALITY RATIO BY STATE (MAPPING)**

Source: (SHHS, 2006)



**FIGURE 5.1B: MATERNAL MORTALITY RATIO BY STATE**

Source: (SHHS, 2006)



According to the SHHS (2006) there were variations between states within South Sudan: Lakes had the highest MMR standing at 2243/100,000 per live births and Unity had the lowest at 1732.

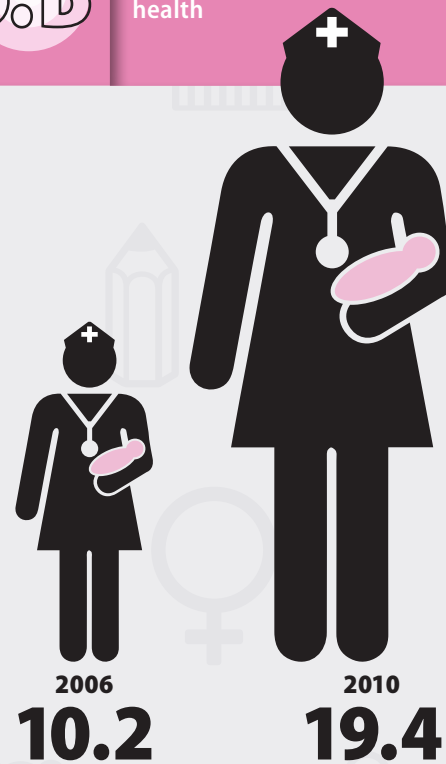
In the 2006 SHHS 2006, only 10.02% of all deliveries were attended by “skilled” health staff or Skilled Birth Attendants, increasing to 19.4% in 2010 (SHHS, 2010).

**Indicator 5.2: Proportion of births attended by skilled health personnel**

The second indicator used for assessing the MDG 5 goal is the proportion of births attended by skilled health personnel. Skilled assistance at delivery is defined as assistance provided by a doctor, nurse, midwife or auxiliary midwife. However, others argue that the level of skill needed to identify, manage and/or refer obstetric complications for higher levels of care requires more training than either a village midwife or the average nurse might offer.

**TARGET**

**5.B** Achieve, by 2015, universal access to reproductive health



**FIGURE 5.2: PROPORTION OF BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL**

Source: (SHHS, 2006 & 2010)



© UNDP / Marguerite Nowak

**FIGURE 5.3: PERCENTAGE OF WOMEN AGED (15-49) WITH A BIRTH ASSISTED BY SKILLED HEALTH PERSONNEL BY STATE AND BY YEAR**

Source: (SHHS, 2006 & 2010)

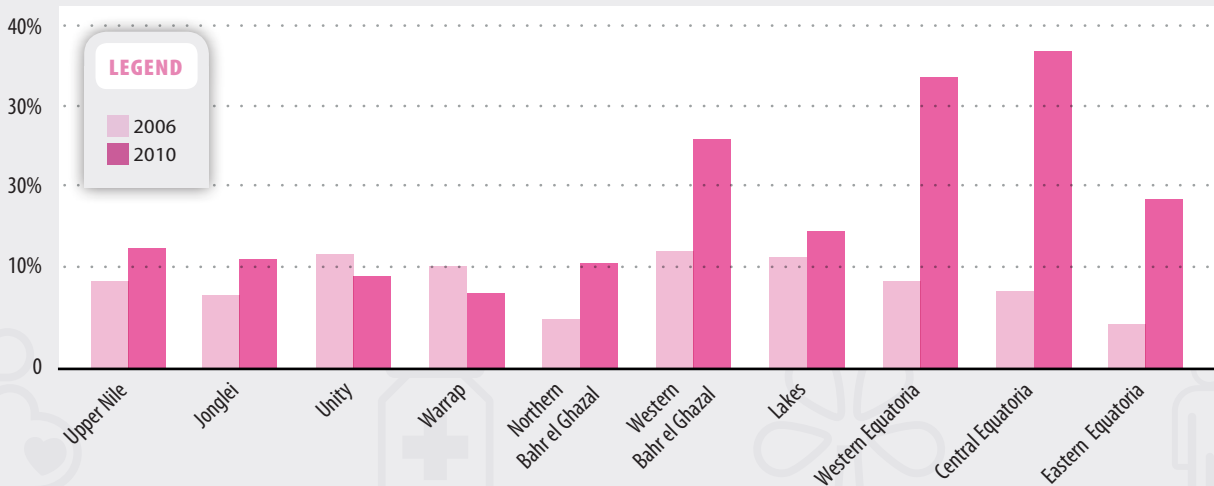


Figure 5.3 reveals the distribution of births by women aged 15-49 years that were assisted by skilled personnel. Central Equatoria had the highest percentage of births of women aged 15-49 years assisted by skilled personnel according to the (SHHS, 2010), while Warrap had the lowest.

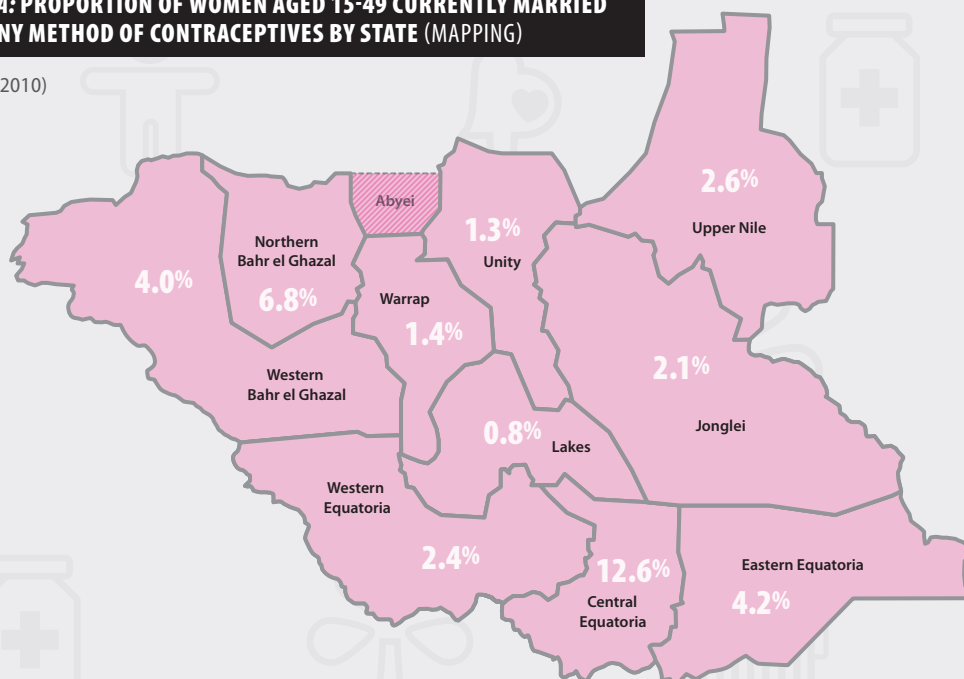
**Indicator 5.3: Contraceptive prevalence rate and unmet need for family planning**

The third indicator used for monitoring progress of MDG 5 is the Contraceptive Prevalence Rate (CPR) at 3.6% (SHHS, 2006), increasing only slightly to 4% in 2010 (SHHS, 2010). Unmet need for family planning is the number of women with unmet need for family planning expressed

as a percentage of women of reproductive age who are married or in union. Women with unmet needs are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child. Unmet need for family planning according to the 2006 SHHS was at 1.2%. The SHHS, 2010 indicated a sharp increase from the unmet need of family planning of 1.2% in 2006 to 26.3% in 2010 which is still too low to trigger off a corresponding rise in the CPR, without increased advocacy about benefits of family planning and an uninterrupted supply of contraceptives. A 1.1% difference in CPR levels separates the urban (4.9%) from rural (3.7%) rates, (SHHS, 2010).

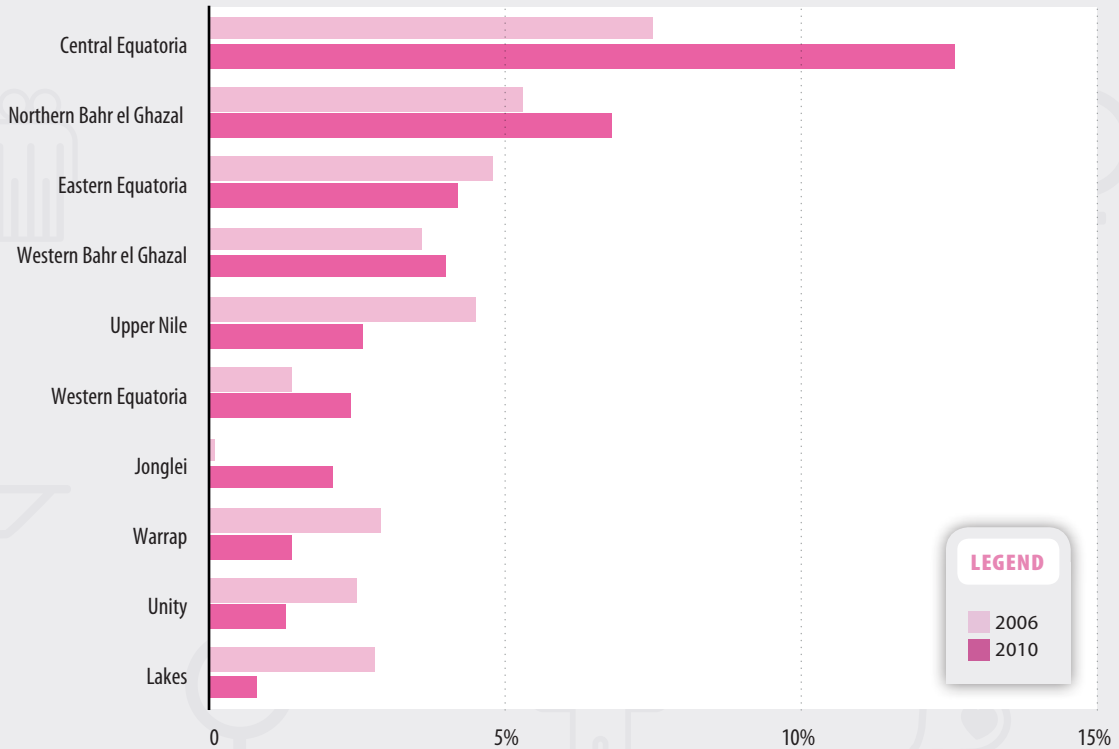
**FIGURE 5.4A: PROPORTION OF WOMEN AGED 15-49 CURRENTLY MARRIED WHO USE ANY METHOD OF CONTRACEPTIVES BY STATE (MAPPING)**

Source: (SHHS, 2010)



**FIGURE 5.4B: PROPORTION OF WOMEN AGED 15-49 CURRENTLY MARRIED WHO USE ANY METHODS OF CONTRACEPTIVES BY STATE AND BY YEAR**

Source: (SHHS, 2006, 2010)



**FIGURE 5.5: PROPORTION OF WOMEN AGED 15-49 CURRENTLY MARRIED WHO USE MODERN OR TRADITIONAL METHODS OF CONTRACEPTIVES BY STATE AND BY YEAR**

Source: (SHHS, 2010)

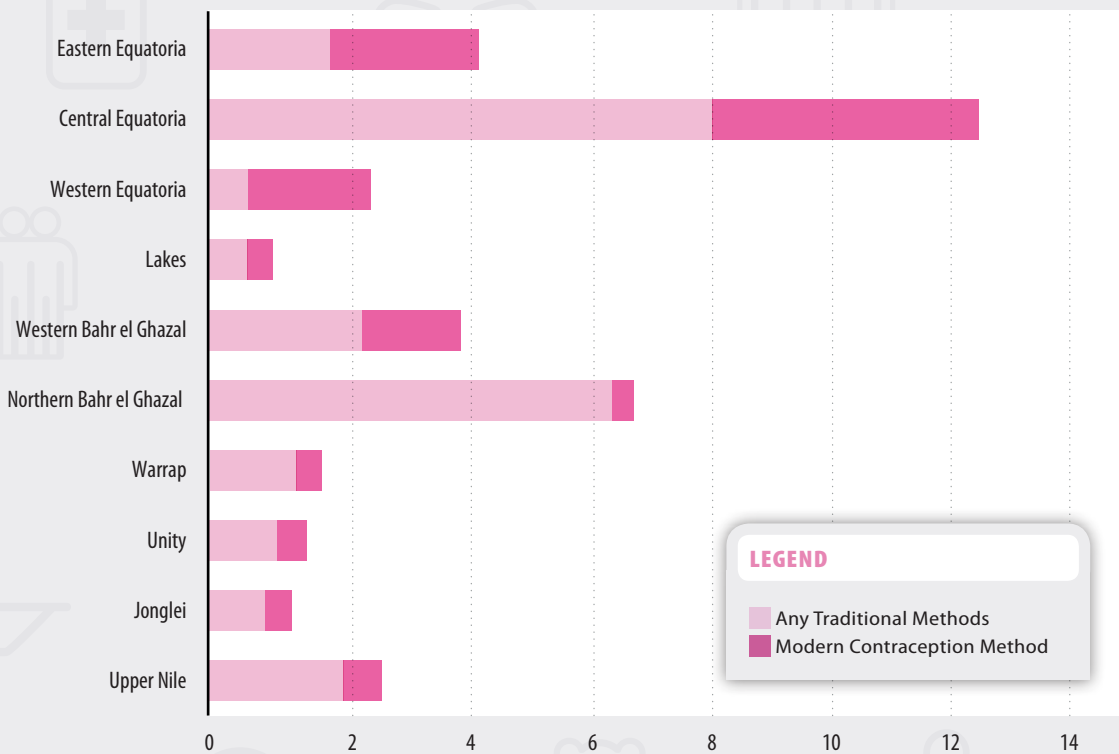


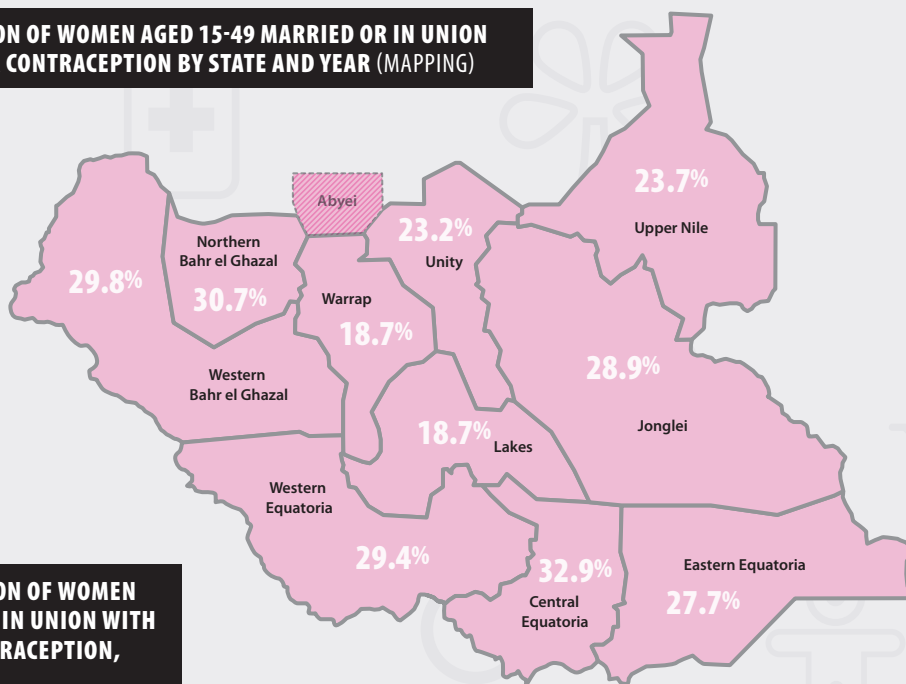
Figure 5.5 above clearly shows that the majority of women aged 15-49 use traditional methods. Approximately 2.8% out of the 4% who use any method of contraception at national level do use traditional methods, (SHHS, 2010) to prevent pregnancy. Western Equatoria uses more of modern contraceptive methods than other forms of contraception, while it is only Central Equatoria that has recorded more than 10% use of 'any contraceptive methods'.

Overall, only four out of ten states have recorded increases in the levels of contraception use from the year 2006 to year 2010.

The states have witnessed a drastic increase in the levels of unmet need for contraception, including Jonglei, which in 2006 registered a zero unmet need which rose to about 29% in the year 2010.

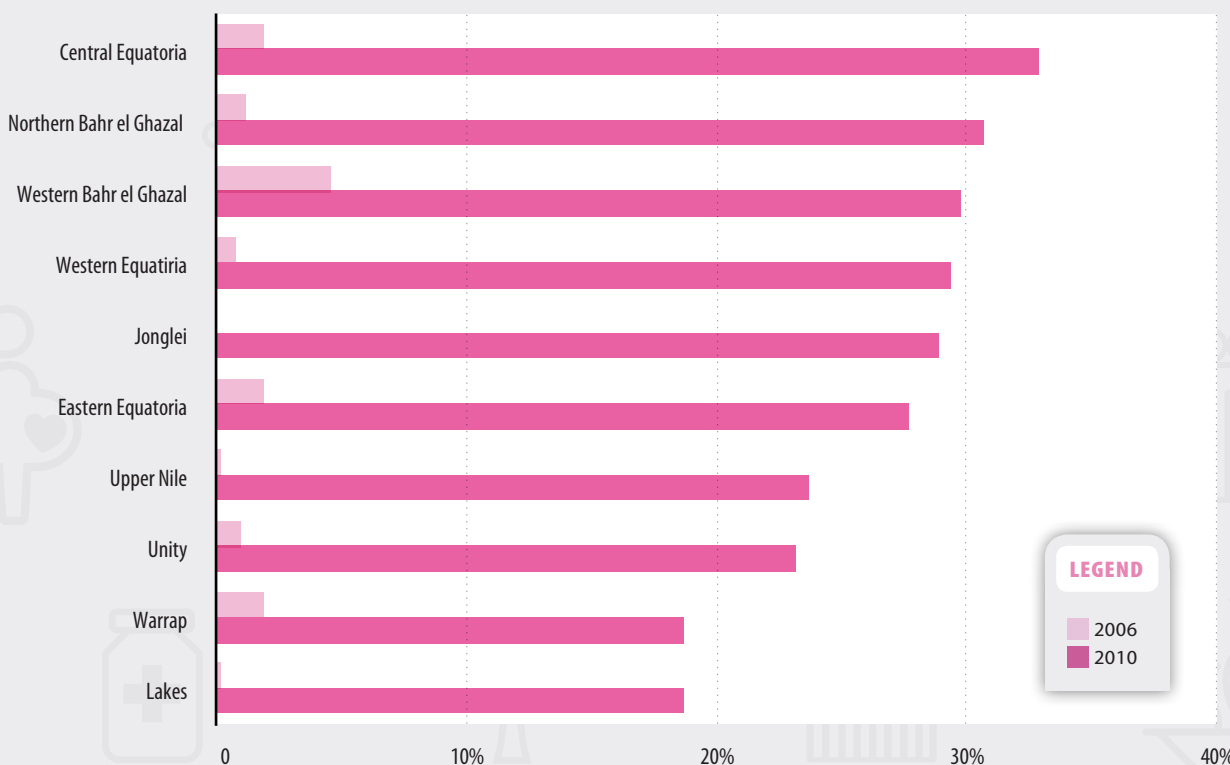
**FIGURE 5.6A: PROPORTION OF WOMEN AGED 15-49 MARRIED OR IN UNION WITH UNMET NEEDS FOR CONTRACEPTION BY STATE AND YEAR (MAPPING)**

Source: (SHHS, 2010)



**FIGURE 5.6B: PROPORTION OF WOMEN AGED 15-49 MARRIED OR IN UNION WITH UNMET NEEDS FOR CONTRACEPTION, BY STATE AND BY YEAR**

Source: (SHHS, 2006, 2010)





According to SHHS (2006), the unmet need for contraception at national level for South Sudan was at 1.2% but had risen to 26% by 2010 (SHHS, 2010).

## CHALLENGES

There are a number of challenges the health sector is facing, and these include:

- ▶ Inadequate access to essential maternity and basic health care services and low utilization of the health care services available;
  - ▶ Absence of emergency obstetric service at reasonable distances, reproductive health/family planning services including uninterrupted supplies and trained providers and human resources;
  - ▶ A critical shortage of skilled health personnel trained in midwifery;
  - ▶ Lack of infrastructure such as roads and transport in many parts of the country and lack of security in the border states;
  - ▶ Inadequate advocacy for family planning, and
  - ▶ Lack of family planning methods, reproductive health commodity supplies, knowledge of health providers, and physical infrastructures.
- ▶ Providing emergency obstetric services at a reasonable distance from villages;
  - ▶ Increasing government spending or budget allocation for reproductive health (maternal health) programmes;
  - ▶ Providing reproductive health/family planning services including uninterrupted supplies, and making trained providers available;
  - ▶ Investing in training midwifery personnel at grass root level which is key to reducing maternal mortality;
  - ▶ Investing in infrastructure development, including roads, transport, midwifery schools; and
  - ▶ Investing in social development, including women empowerment, education and gender equality issues.

The five-year (2011-2015) National Reproductive Health Policy and Strategic Plan addresses, among a number of issues, capacity building of nurses and midwives, and provision of qualified doctors as well as construction of health infrastructure to provide easy-access clinics for pregnant women.

## POLICY FRAMEWORK & STRATEGIES

The SSDP states that the government will increase equitably the utilization of quality basic health and HIV/AIDS services throughout South Sudan. As a major priority, the health sector has set a target of reducing maternal mortality by 20% within the first three years of statehood. In order to achieve this target, the government should prioritize:

- ▶ Increasing the availability and accessibility of antenatal services;
- ▶ Ensuring the utilization of skilled health personnel during pregnancy, childbirth and postnatal period at all levels of the health system;



© UNDP / Marguerite Nowak



6

**COMBAT HIV/AIDS,  
MALARIA AND OTHER  
DISEASES**





© UNDP / Marguerite Nowak

# Goal 6: Combat HIV and AIDS, Malaria and Other Diseases

South Sudan, like many other countries in Sub-Saharan Africa, has been affected by the spread of the HIV and AIDS pandemic. Its impact is increasingly being manifested through aggravation of the incidence of other diseases such as malaria, tuberculosis (TB) and other opportunistic infections.

The increasing disease burden places a big challenge to efforts to attain a healthy nation and also impedes development efforts. The high prevalence of these diseases affects human capital development, well-being and the health service delivery system. Currently, HIV/AIDS has not reached pandemic levels but containment requires a coordinated national response.

**TARGET**

**6.A** Halt by 2015, and begin to reverse the spread of HIV/AIDS

**Indicator 6.1:** Prevalence and knowledge of HIV/AIDS

The provisional estimate of HIV prevalence for South Sudan was slightly over 3% in 2009, with close to 9% (SHHS, 2010) reported to have comprehensive knowledge of HIV/AIDS. Comprehensive knowledge of HIV transmission is defined as knowing that having a monogamous relationship with an uninfected partner and that using a condom every time one has sex can reduce the chance of becoming infected.

The same data (SHHS, 2010) indicate that only 15% of people have knowledge of the three means of mother-to-child HIV transmission. The number of people living with HIV is 149,717, of which 135,466 are adults and 14,251 children. About 16,133 new infections per year were reported (SHHS, 2010).

**FIGURE 6.1: PERCENTAGE OF POPULATION WHO HAVE COMPREHENSIVE KNOWLEDGE OF HIV/AIDS**

Source: (SHHS, 2006, 2010)

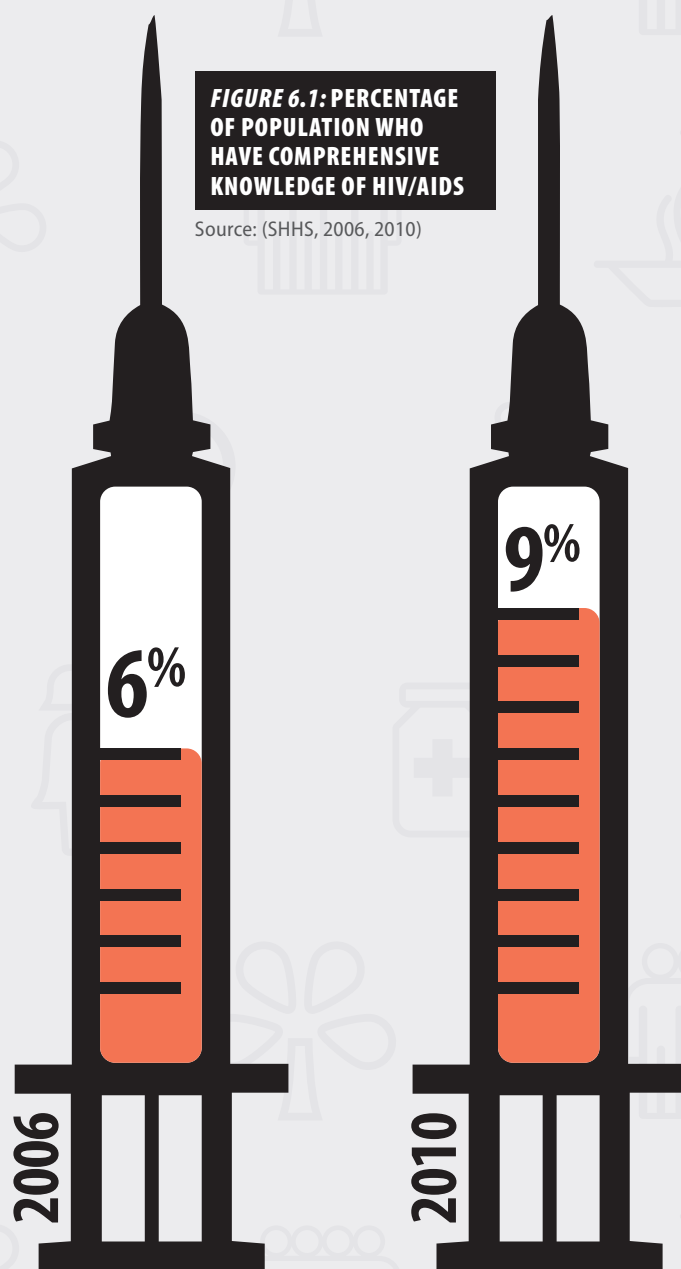
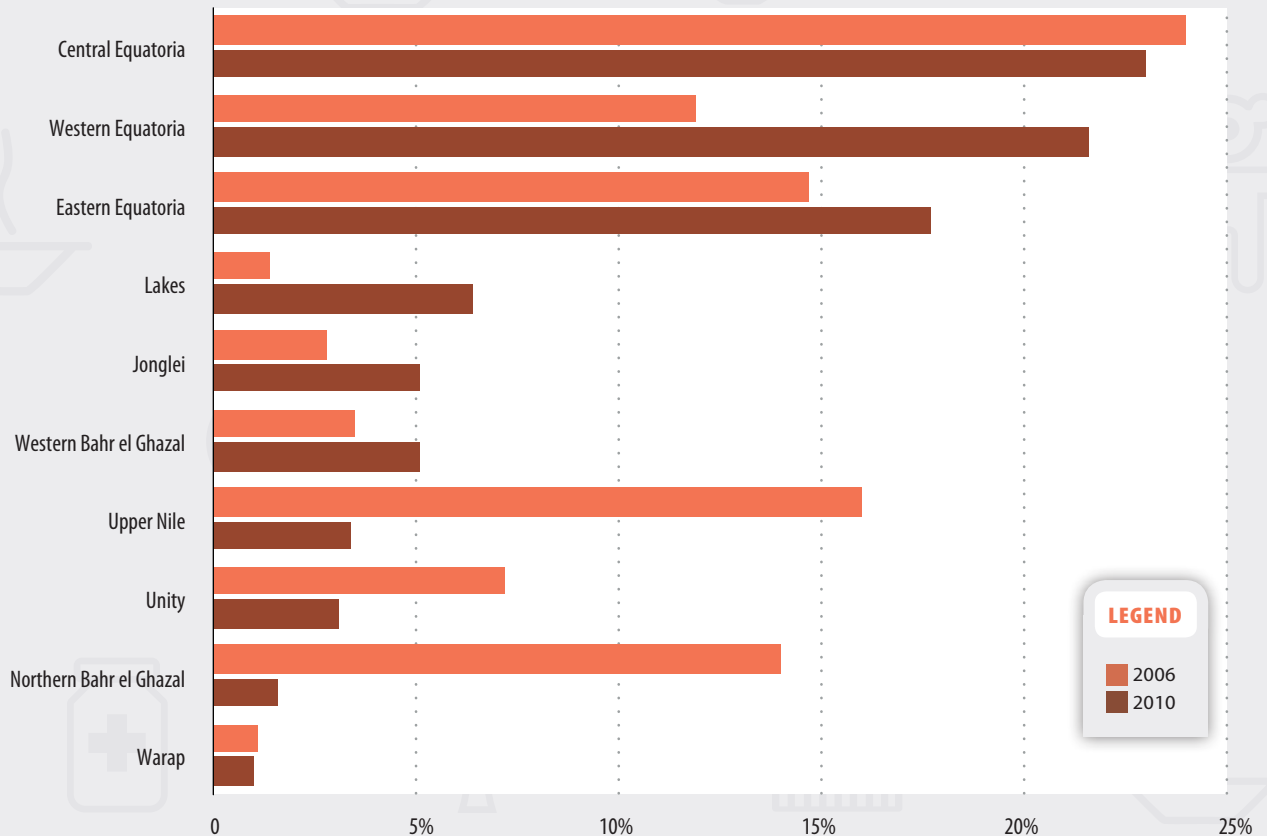


Figure 6.2 below shows the levels of comprehensive knowledge of HIV/AIDS by state for the years 2006 and 2010. The lowest performing state was Warrap for both years, registering only 1%. Central Equatoria, (23%), registered the highest level.

**FIGURE 6.2: PROPORTION OF POPULATION WHO HAVE COMPREHENSIVE KNOWLEDGE OF HIV/AIDS.**

Source: (SHHS, 2006, 2010)



**TARGET**



Halt by 2015, and begin to reverse the incidence of malaria and other major diseases.

**Indicator 6.6: Death rates associated with malaria**

Malaria remains the most common cause of illness and death among under five children and pregnant women in South Sudan. The South Sudanese climate is suitable for malaria transmission throughout the year, with endemicity varying between meso-, hyper-, and endemic. The major vectors are anopheles gambiae, arabiensis and funestus subspecies. Plasmodium falciparum is the dominant parasite species. The duration of transmission

varies across the country, longer in the southern parts (7 – 8 months) than in northern parts (5 – 6 months).

**Indicator 6.5: Access to Malaria Treatment**

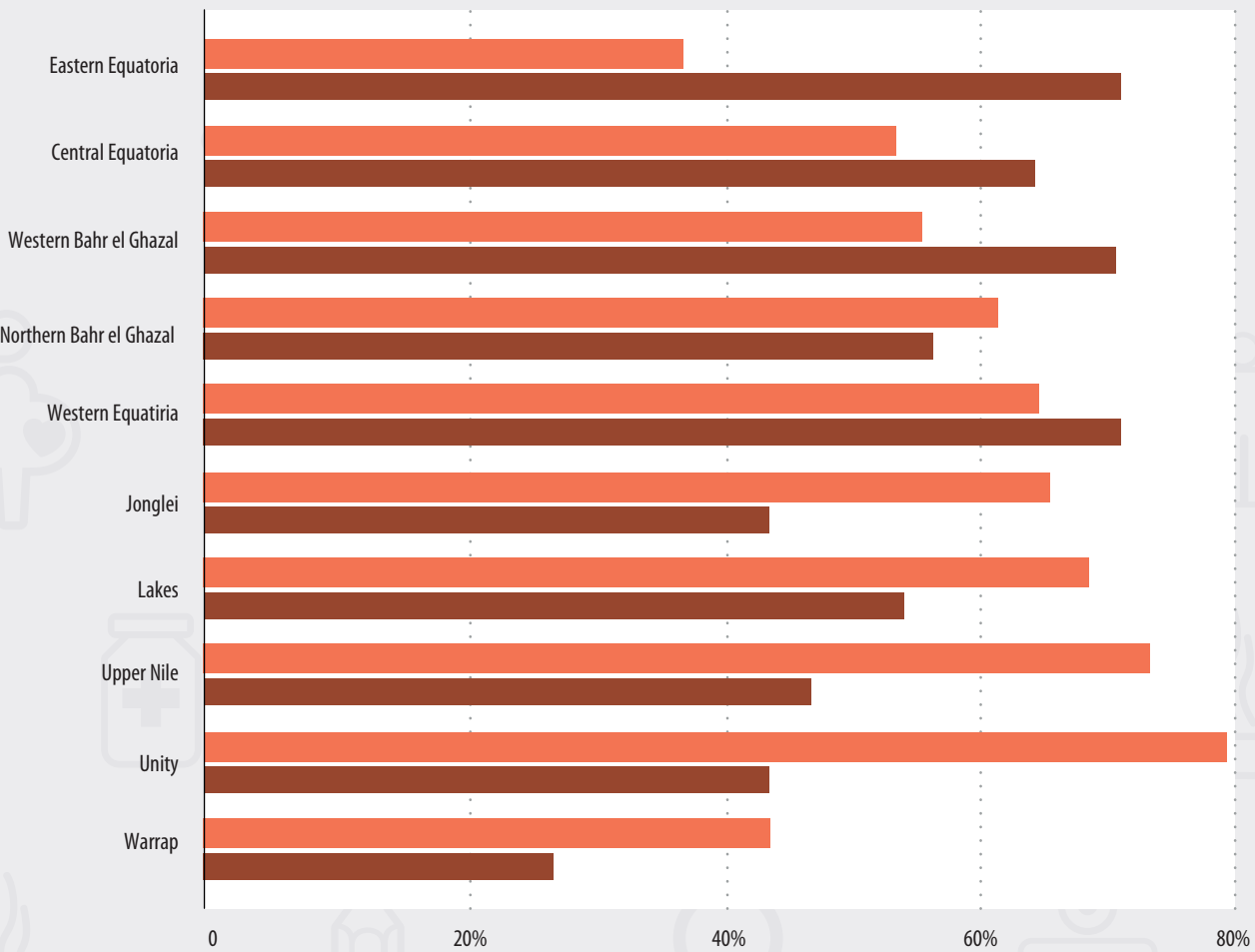
The government is committed to controlling malaria through a number of programmes, fashioned around the Global Roll Back Malaria strategy. National targets are well aligned to both international and regional targets (e.g. Abuja targets) such as the Roll Back Malaria (RBM) initiative. The objective of the initiative is to ensure that those at risk of malaria, particularly pregnant women and under five children, have access to the most suitable and affordable combination of personal and community preventive measures such as insecticide-treated mosquito nets (ITNs) and prompt effective treatment for malaria within 24 hours of onset of illness.

**FIGURE 6.3: PROPORTION OF POPULATION WITH AT LEAST ONE MOSQUITO NET BY STATE AND BY YEAR**

Source: NBHS, 2009/SHHS, 2010

**LEGEND**

2009 2010



**Indicator 6.7: Proportion of households with at least one ITN**

About half (46.8%) of children aged 0-59 months who have had fever in the last two weeks of the survey (SHHSII, 2010) had not received any anti-malarial drugs. However, of all households in South Sudan, according to the 2009 NBHS, 52.3% owned at least one mosquito net. Of these households, only 34.2% of them own a long-lasting, treated net. In 2006, ownership of at least one bed net was at 38.5% (SHHS, 2006).

According to the Management Information System of Ministry of Health (HMIS, 2009), 25% of children under five sleep under bed net.

The mosquito net ownership varies widely across states, ranging from 37% in Eastern Equatoria to 80% in Warrap.

**Indicator 6.9: Death rates associated with tuberculosis**

As in most other Sub-Saharan African countries, tuberculosis is one of the major causes of mortality and morbidity in South Sudan. Its greatest impact is on the poor who live in overcrowded environments and have poor nutrition which provide favorable conditions for the transmission and development of active diseases from latent infection. This situation may be worsened with the advent of the HIV infection which accelerates the progression from infection with the bacterium to the TB disease. Thus, unless HIV infection in the community is reduced, TB cases, as an opportunistic disease, will remain high. Although its exact burden is not known, the incidence is estimated to be 79 sputum smear positive cases per 100,000 population and 140 for all forms of tuberculosis.

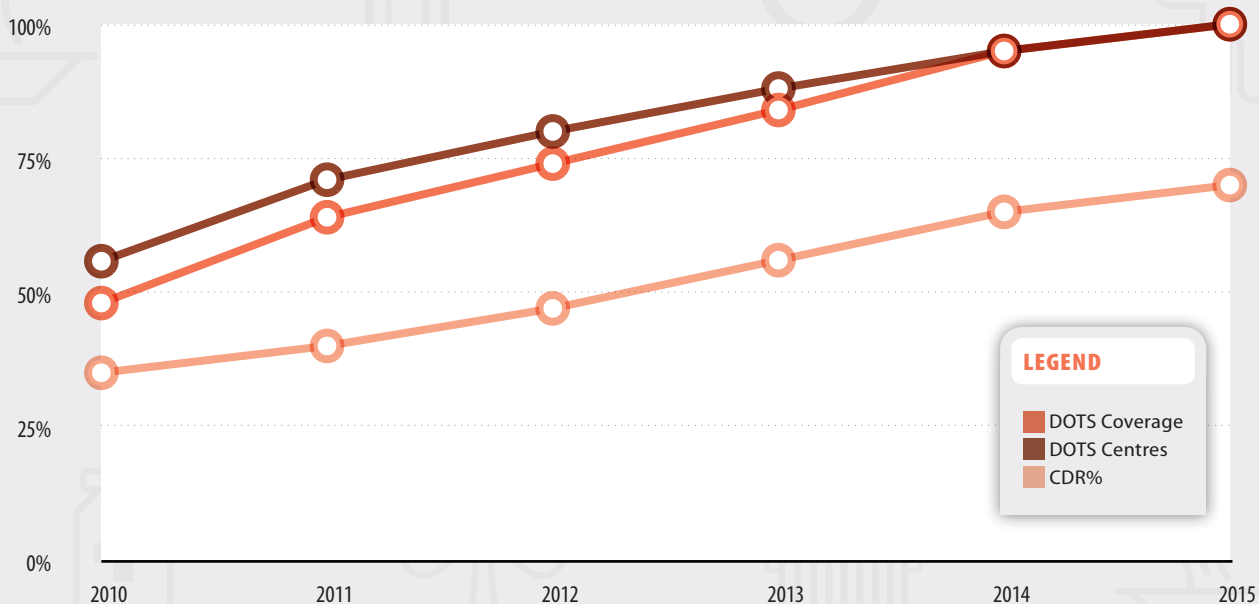
With the population of South Sudan estimated to be 8.26 million (2009 Population and Housing Census), around 12,268 TB cases occur annually in South Sudan of which 6,923 are of infectious forms. Cohorts of 2002 to 2007 indicated the number of new sputum smear positive TB cases increased from 752 to 2,513 for sputum smear positive TB cases and 1,260 to 4,978 for TB cases of all forms respectively. Among the new sputum smear positive TB cases registered in 2007, the productive age group of 15 to 45 years was

most affected and males were substantially higher than females. This gender disparity requires establishing an evidence base to explain the current trends.

The TB programme in South Sudan has an M&E framework with clear indicators used for monitoring programme performance. The key monitoring indicators are DOTS coverage, case detection rate and treatment success rate. Over the years, the programme has made significant progress in terms of these indicators.

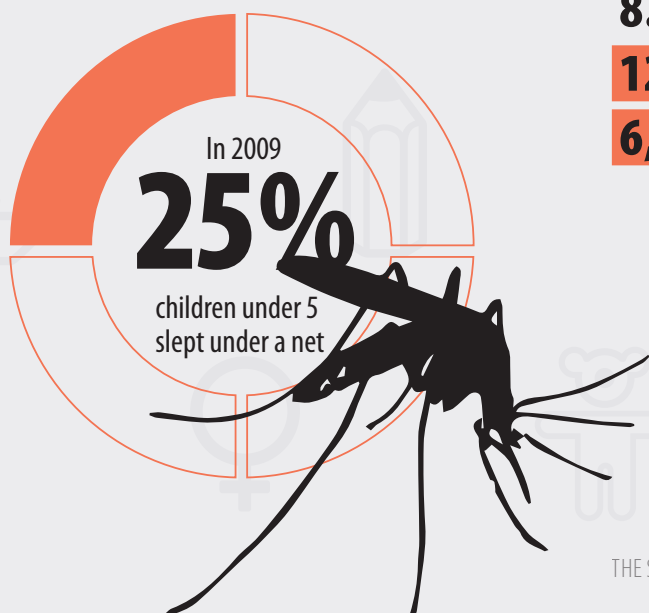
**FIGURE 6.4: TB TREND AND PROJECTIONS BY YEAR**

Source: WHO



Direct Observed Treatment Strategy (DOTS) coverage increased from 36% in 2007 to 48% in 2010 (aim for 100%); Case Detection Rate (CDR) increased from 19% in 2007 to 35% in 2010 (WHO recommended target is 70%) and treatment success rate has been maintained well above 80% (WHO recommends at least 85%).

**FIGURE 6.5: PERCENTAGE OF CHILDREN UNDER 5 WHO SLEPT UNDER A MOSQUITO NET**



**2009**

**8.26 million people**

**12,268 TB cases occur annually**

**6,923 are of infectious forms**

## CHALLENGES

There are several challenges that are being faced in attaining this goal. The main ones include:

- › Negative socio-cultural attitudes towards abstinence and safe sex, including condom use;
  - › Inadequate knowledge and skills on the relationship between nutrition and HIV and AIDS;
  - › increased demand for care due to high HIV and AIDS prevalence, and
  - › Limited coverage of formal health services, human resource constraints, weak supportive systems such as HMIS, laboratories, referral hospitals and poor supply chain management including inadequate regulatory mechanisms and shortages of essential medicines.
- › Exposed about 90,633 in and out of school youths to HIV/AIDS education across South Sudan and more than 130,659 high-risk groups have been sensitized on HIV/AIDS;
  - › Provided condoms and access to ARVs to persons with HIV/AIDS;
  - › Prepared a number of key guidelines and protocols for Prevention of Mother-to-Child Transmission (PMTCT), VCT and Sexually Transmitted Infections;

## POLICY FRAMEWORK & STRATEGIES

One of the most important prerequisites for reducing the rate of HIV infection is accurate and comprehensive knowledge of how HIV is transmitted and strategies for preventing it. Correct information is the first step towards raising awareness and giving young people the tools to protect themselves from infection; misconceptions about HIV are common and can confuse young people. Therefore, policies and strategies must, among other things, be geared towards providing correct information about HIV/AIDS and creating awareness. As such the government has:

- › Produced policy documents including the South Sudan HIV/AIDS Strategic Framework (2008-2012), the HIV/AIDS Policy for South Sudan, the HIV/AIDS Monitoring and Evaluation Framework, the Behaviour Change Communication (BCC) Strategy for South Sudan and the Condom Strategy for South Sudan;
- › Integrated HIV/AIDS teaching into school curricula through the Ministry of Education. School teachers across the ten states have undergone training in HIV/AIDS life skills;



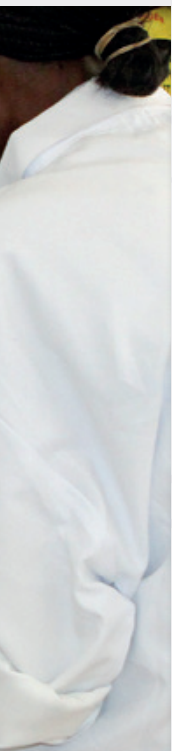
DOTS remains at the heart of the Stop TB Strategy. © UNDP / Brian Sokol



A lab technician testing a child at the new laboratory constructed with support from the Global Fund © UNDP / Marguerite Nowak



- › Set up a National Malaria Control Programme (NMCP) and a Malaria Technical Working Group. The Malaria Technical Working Group brings together all major partners to discuss and agree on malaria strategic direction and priorities. At state level, most State Ministries of Health have full-time state malaria coordinators. At county and health facility levels, delivery of malaria control and prevention services is fully integrated into the primary health care networks. At community level, volunteers are selected by community members to serve as Community Drug Distributors (CDDs) under the HMM strategy;
- › Strengthened the M&E system with tools, trainings, data collection-processing and dissemination;
- › Increased commitment of government to support coordination structures particularly at state and county level and increase funding for diagnostic and treatment supplies;
- › Strengthened collaboration between TB and HIV programmes to address the dual epidemic;
- › Formulated a TB programme for coordination, monitoring and supervision of implementation of TB activities in close collaboration with implementing partners and donors. It is structured with a central MOH unit headed by a Programme Manager, state TB office headed by a state TB coordinator, county TB office headed by a county TB coordinator and health facility headed by the facility in-charge;
- › Prepared a TB strategic plan 2009-2013, a TB specific human resource plan 2010-2014, laboratory quality assurance guidelines and laboratory standard operating procedures; and
- › Some UN agencies have also committed specific support to expand a Health Management Information System at the state level under UNDAF.



Lab technicians analyzing samples at the Juba Teaching Hospital © UNDP / Jenn Warren



**ENSURE  
ENVIRONMENTAL  
SUSTAINABILITY**





© UNDP / Joseph Tabani

# Goal 7: Ensure Environmental Sustainability

**TARGET**  
**7.A**  
 Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources

**Indicator 7.1:** Proportion of land area covered by forest

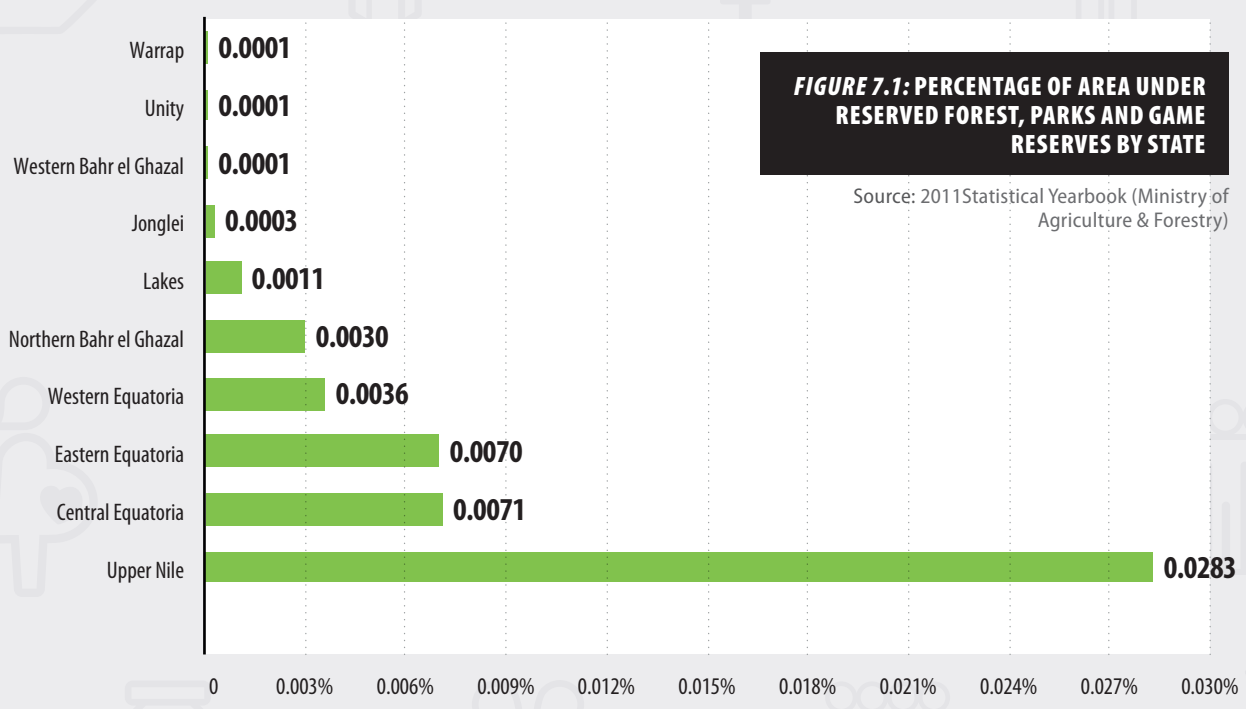
A forest<sup>8</sup> is defined by FAO as land spanning more than 0.5 hectares with trees higher than 5 meters and a canopy cover of more than 10 percent, or trees able to reach these thresholds in situ. It does not include land that is predominantly under agricultural or urban land use. So the area covered by forest is the area that is covered by trees and woody vegetation. Thus, the proportion of land area covered by forest is calculated by dividing the area under forest by the total area of the land under consideration.

The total area under reserved forest, parks and game reserves in South Sudan is 1,205,685

hectares according to the Ministry of Agriculture and Forestry. This represents only 0.01% of the total land area of South Sudan. However, the area under forest cover is estimated at 32.4% (NBS Statistical Yearbook, 2010/FAO).

## PROPORTION OF THE POPULATION USING SOLID FUELS

South Sudan is well endowed with natural resources of all sorts, ranging from oil to very fertile land for agriculture and abundant water resources for irrigation and hydro-electric power generation. However, degradation of the resources is likely to take its toll if the right policies and measures are not put in place and enforced in order to mitigate adverse effects to the environment. Environmental degradation may be a result of poverty, increasing population growth, inadequate alternative livelihoods and/or unfordable energy technologies. Forest cover is a resource that is prone to degradation as a result of the aforementioned causes of environmental degradation.



**FIGURE 7.1: PERCENTAGE OF AREA UNDER RESERVED FOREST, PARKS AND GAME RESERVES BY STATE**

Source: 2011 Statistical Yearbook (Ministry of Agriculture & Forestry)

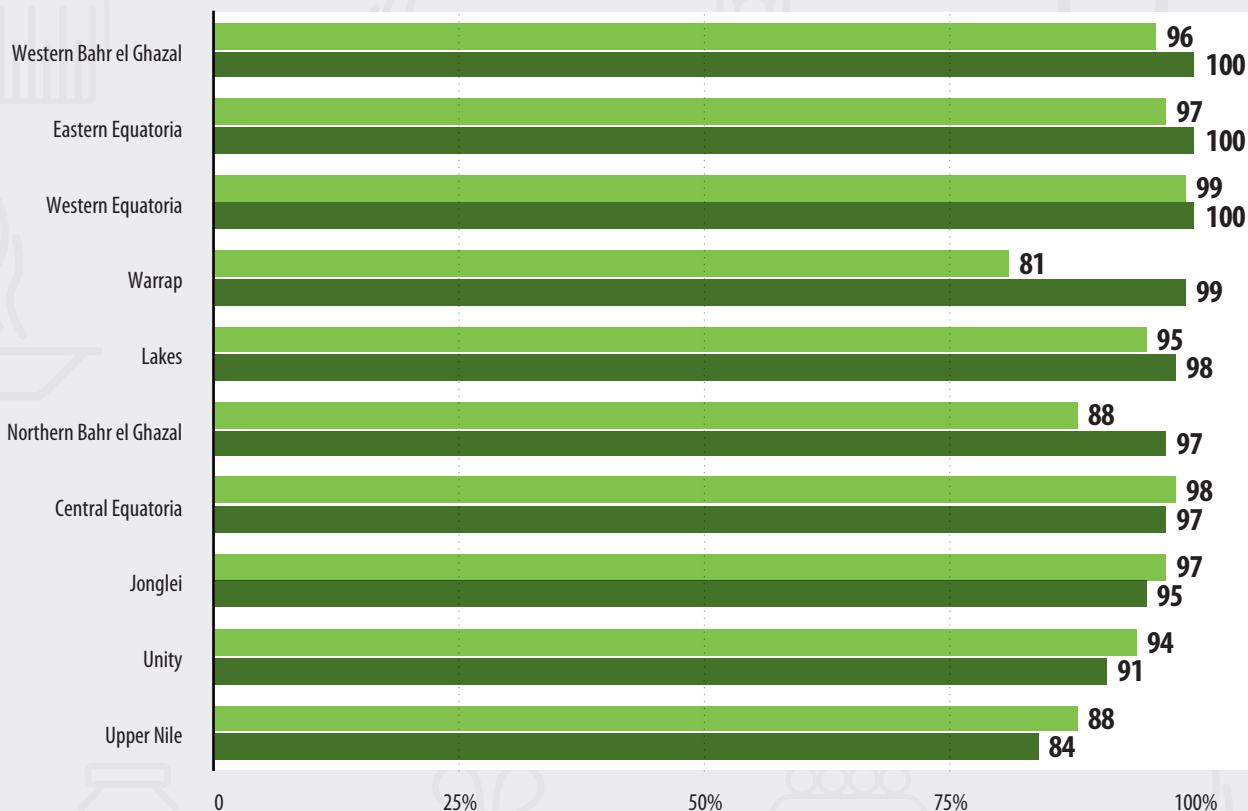
<sup>8</sup> South Sudan defines 'forest' as any land containing a vegetation association dominated by trees of any size, whether exploitable or not, capable of producing wood or other products, potentially capable of influencing climate, exercising an influence on the soil, water regime, and providing habitat for wildlife, and includes woodlands.

**FIGURE 7.2: PERCENTAGE OF HOUSEHOLD POPULATION USING FIREWOOD & CHARCOAL FOR COOKING**

Source: SHHS, 2006/NBHS, 2009

**LEGEND**

2006  
2010



86% of households in South Sudan use firewood and charcoal for cooking (NBHS, 2009). Use of firewood and charcoal varies by state. There is close to 100% usage by Western Bahr el Ghazal, Eastern Equatoria and Western Equatoria states in year 2009. Upper Nile used the least of firewood and charcoal in that year, (84%).

Water is life, and safe drinking water is a basic necessity for good health. Unsafe water can be a significant cause of diseases such as trachoma, cholera, typhoid and schistosomiasis. Drinking water can also contain hazardous physical, chemical and radiological contaminants with harmful effects on human health. In addition to its association with disease, access to drinking water may be particularly important to women and children, especially in rural areas, who bear the responsibility for fetching water, often from long distances.

**TARGET**

7.0C

Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

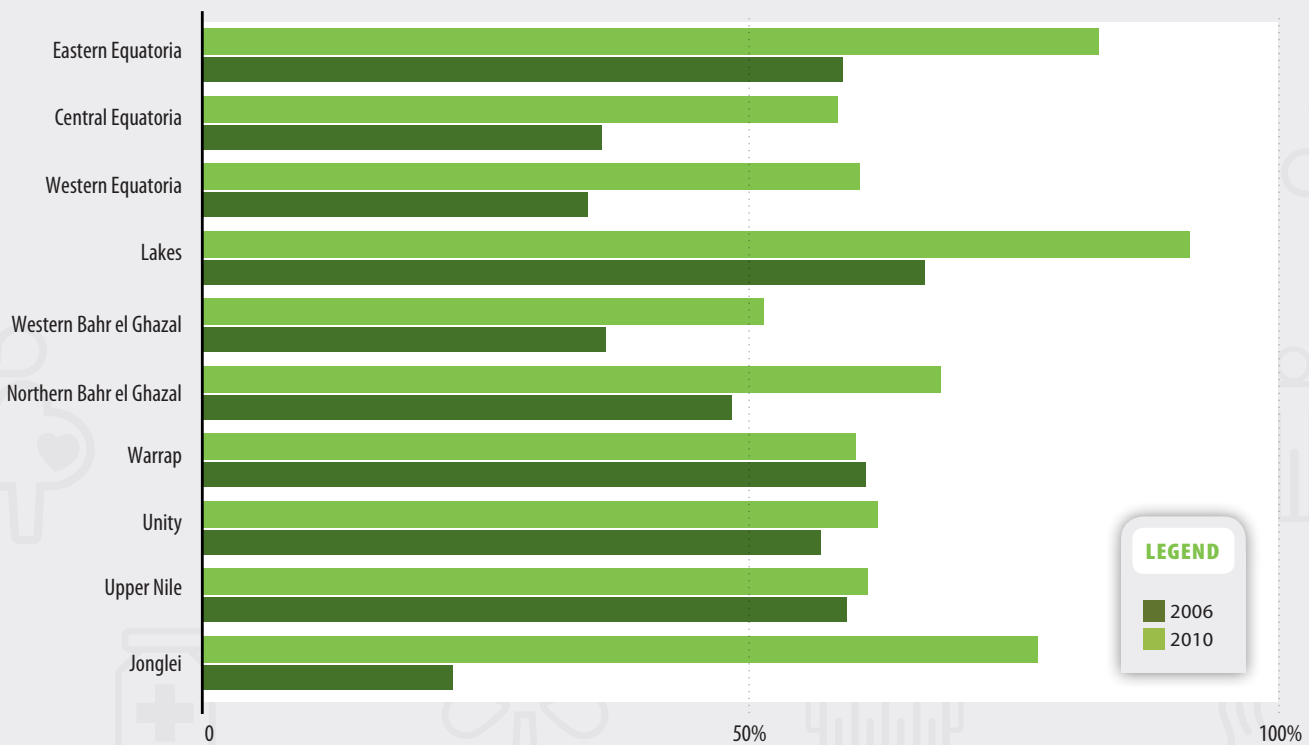
**Indicator 7.8:** Proportion of the population using an improved drinking water source

The population using improved sources of drinking water is defined as the percentage of the population using piped water, public taps/standpipes, tube well/borehole, protected well, protected spring and rainwater collection.

In South Sudan, 68.7% (SHHSII, 2010) of people have access to improved sources of drinking water. According to the SHHS 2006, just less than half (48.3%) had access to improved sources of drinking water. The 2010 SHHS survey indicated a 20% increase in access to improved sources of drinking water.

**FIGURE 7.3A: PERCENTAGE OF HOUSEHOLDS WHO HAVE ACCESS TO IMPROVED SOURCES OF DRINKING WATER BY STATE AND BY YEAR**

Source: SHHS, 2006/2010



**FIGURE 7.3B: PERCENTAGE OF HOUSEHOLDS WHO HAVE ACCESS TO IMPROVED SOURCES OF DRINKING WATER BY STATE (MAPPING)**

Source: SHHS, 2006/2010

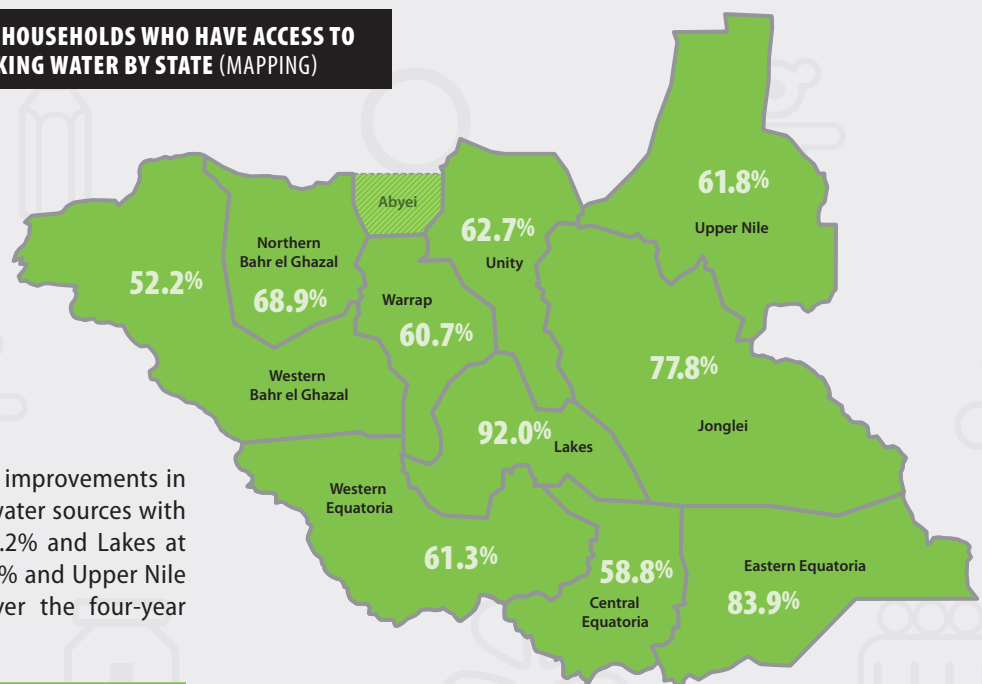


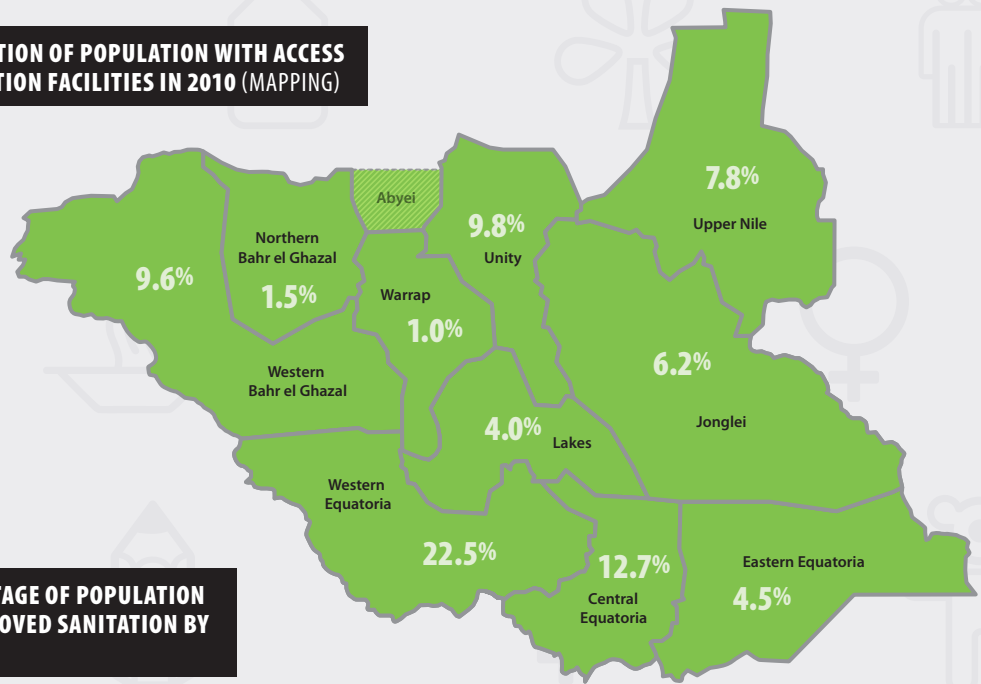
Figure 7.3A shows there were improvements in access to improved drinking water sources with Western Bahr el Ghazal at 52.2% and Lakes at 92%. However, Warrap at 61.7% and Upper Nile at 61.8% have stagnated over the four-year period from 2006 to 2010.

**Indicator 7.9:** Proportion of population using an improved sanitation facility

Inadequate disposal of human excreta and personal hygiene is associated with a range of diseases including diarrheal diseases and polio. Improved sanitation facilities for excreta disposal include flush or pour flush to a piped sewer system, septic tank, or latrine, pit latrine with slab, and composting toilet.

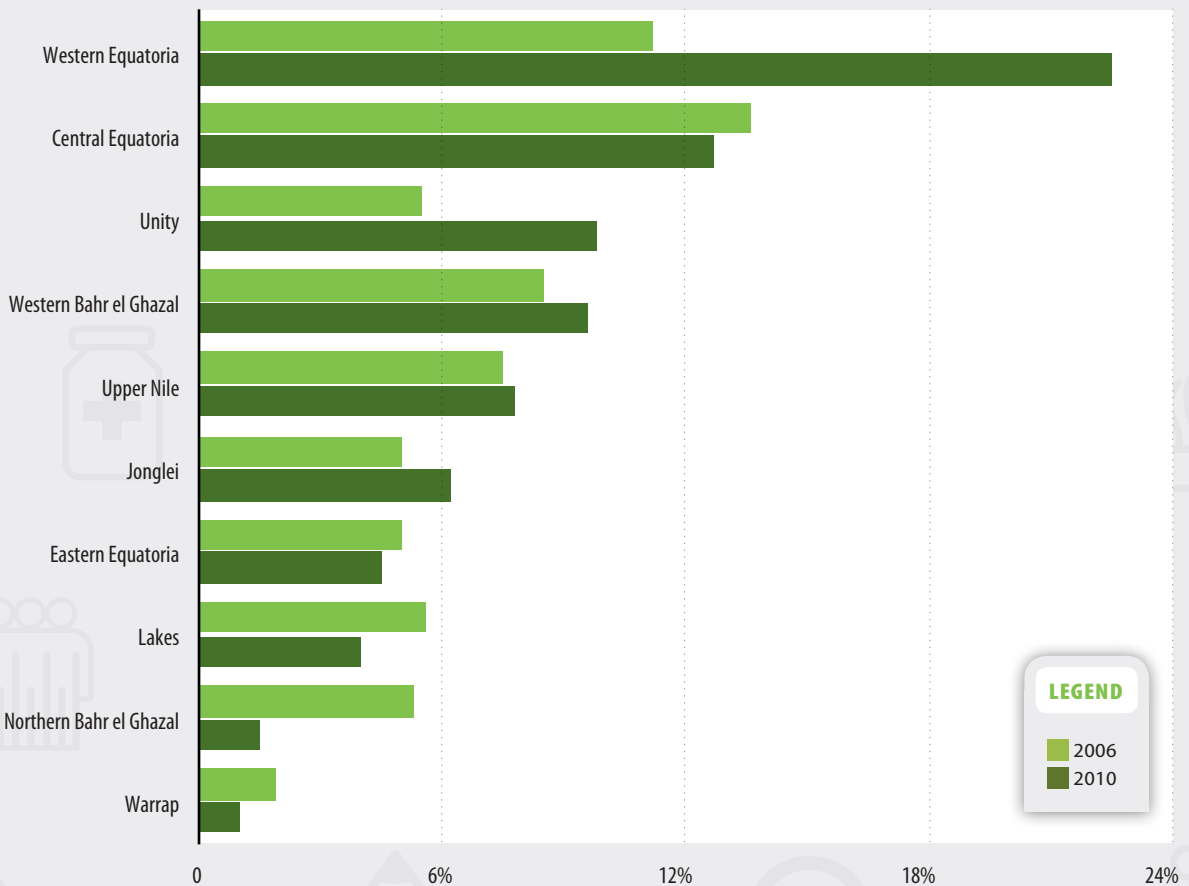
**FIGURE 7.4A: PROPORTION OF POPULATION WITH ACCESS TO IMPROVED SANITATION FACILITIES IN 2010 (MAPPING)**

Source: SHHS, 2010



**FIGURE 7.4B: PERCENTAGE OF POPULATION WITH ACCESS TO IMPROVED SANITATION BY STATE AND BY YEAR**

Source: SHHS, 2006/2010



In South Sudan, about 7.4% of households use improved sanitary means of excreta disposal (SHHS, 2010) up from 6.4% (SHHS, 2006), with most of the remainder using either a pit latrine without a slab, or even more likely, the bush. According to the 2010 SHHS, 22.5% of households in Western Equatoria were more likely to use sanitary means of excreta disposal, while it was 1.0% and 1.5% in Warrap and Northern Bahr el Ghazal states, respectively.

According to the same survey, both Warrap and Northern Bahr el Ghazal (1.3%) have the lowest improved water sources for drinking and lowest access to improved sanitation facilities among the states.

Comparing use of improved sanitation facilities across education levels shows that use of improved sanitation facilities has positive correlation with levels of education.

## CHALLENGES

While some progress has been made with respect to sustainability of the environment, there are a number of challenges that the sector is facing. These include:

- › Lack of resources to facilitate investment in conservation, water quality and monitoring. Available information indicates that problems of sustainability are often due to inappropriate choice of technology type, location or design. There is a general bias towards borehole technologies but these frequently break down because users do not have the technical or financial capacity to maintain them without financial assistance. Additionally, communities live in remote and inaccessible areas that make it difficult to maintain supply chains for spare parts;
- › Inadequate public awareness of sanitation or hygiene education. Effective integration of sanitation and hygiene education with water supply interventions will depend on co-ordination and collaboration mechanisms between water sector agencies and other agencies such as education and health;
- › Increased deforestation due to firewood and charcoal usage as there is no adequate alternative energy sources that do not use solid fuels;
- › Increased demand for arable land and failure to enforce measures to curb problems of deforestation;

- › Lack of community participation in environment and natural resources management;
- › Poor quality of surface and ground water; and
- › Inequitable promotion of improved sanitation facilities.

## POLICY FRAMEWORK & STRATEGIES

Several initiatives have been put in place in order to address the above challenges, and these include:

- › In 2007 the Government of South Sudan designed water policy to guide the implementation of water, sanitation and hygiene (WASH) programmes and provision of services. It is a comprehensive policy that aims to improve water quality, provide education to the rural communities, select appropriate technologies and then involve the communities and all other stakeholders;
- › Promotion of community participation in environmental and natural resources management; and
- › Prioritization of natural resources and environmental management.



Construction of a water hafir © UNDP







© UNEP



8

**GLOBAL  
PARTNERSHIP FOR  
DEVELOPMENT**





Illustration: David Lloyd

# Goal 8: Develop a Global Partnership for Development

## TARGET

8.A

Develop further an open, rule-based, predictable, non-discriminatory trading and financial system (includes a commitment to good governance, development and poverty reduction – both nationally and internationally)

**Indicator 8.2:** Proportion of total bilateral sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)

South Sudan is committed to good governance, development and poverty reduction as evidenced by the policies articulated in the South Sudan Development Plan (SSDP 2011-2013). It also recognizes the role external finance can play in assisting the government efforts by complementing funding for various development initiatives. To harmonize and streamline partnership

with development partners who provide resources, the government emphasizes the use of the core principles of aid strategy which are outlined in the SSDP so that development assistance is fully aligned with the Government priorities. As a consequence, the country is continuing to benefit from funding from OECD donors. Evidence from the Donor Book indicates that total donor commitments to basic social services amounted to 41% of total ODA in 2010. This rose sharply to 55% in 2011 and is set to rise further as donors agree to harmonize their development assistance with the Government priorities.

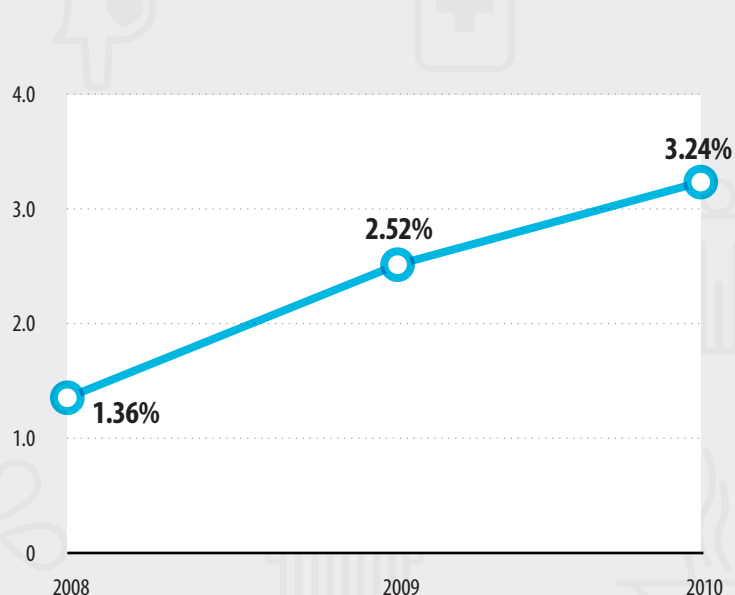
As a fraction of South Sudan's GDP, Official Development Assistance (ODA) has also been rising, which is a sign of the increased collaboration and partnership between the Republic of South Sudan and development partners.

Figure 8.1 shows that net ODA as a percentage of GDP increased from 1.36% in 2008 to 3.24% in 2010.



**FIGURE 8.1: NET ODA AS A PERCENTAGE OF GDP AT CURRENT PRICES BY YEAR**

Source: NBS, Press Release dated 11th August 2011



## TARGET

# 8.F

In Cooperation with the private sector, make available the benefits of new technologies, especially information and communications

**Indicator 8.15:** Mobile cellular subscriptions per 100 inhabitants

Telecommunications play an important role in economic development and poverty reduction. The government would like to ensure universal access to connectivity and affordable information and communications technology.

According to the NBHS, 2009, ownership of phones was 19% of households; and ownership of phones by urban households (65%) far exceeded ownership of phones by the rural households (10%).

## CHALLENGES

There are several challenges that the country is facing with respect to developing global partnerships, which include the following:

- ▶ Inadequate distribution of ICT services and infrastructure;
- ▶ High cost of ICT equipment and services; and
- ▶ Poor internet and IT support infrastructure.

These challenges are in part responsible for the fairly high levels of unemployment among 15–24 year olds, discussed above.

## POLICY FRAMEWORK & STRATEGIES

The government of the Republic of South Sudan recognizes the need for global partnerships for development; and has, since independence, engaged partners from international development agencies and NGOs with a view to enhancing the country's image and attracting external Official Development Assistance (ODA) and Foreign Direct Investment (FDI). Additionally, the government is committed to



Source: NBHS, 2009

The distribution of states owning phones varies from Jonglei (8%) to Central Equatoria and Upper Nile states (33%) according to the NBHS, 2009.

According to international treaties to meet the requirements of the new state to the community of nations. It fully understands the role external finance can play in complementing its own resources, especially in the implementation of the South Sudan Development Plan.

As such, the SSDP itself details how development partners must increasingly focus development assistance so that there is coherence between domestic resources and aid and that the aid is used primarily for strengthening systems, increasing accountability and supporting economic growth.

The government and development partners are working to include these commitments as part of the benchmarks of the New Deal Compact to be signed at the end of 2013.

It also recognizes the roles of the private sector, including but not limited to the establishment and improvement of telecommunications, postal services and information technology. The SSDP contains benchmarks relating to the processing of a country code, internet domain name and gaining full ITU membership. Some of these benchmarks have been met.

Working with telecom operators and courier service providers, the objective is to increase coverage, access, usage and literacy of ICT and postal services.

# CONCLUSION

This report highlights the array of pressing development challenges faced by the Government of South Sudan as it emerges from decades of conflict in the run up to the 2015 deadline for the achievement of the MDGs. It also brings out key elements of the policy framework, strategies and interventions instituted by the government in pursuit of the MDGs and people's welfare. While encouraging progress has been recorded on some goals, especially in view of the low baseline and initial conditions, in overall terms, the current scorecard of MDG attainment in the country paints a grim picture. About half of the population continues to live below the poverty line. There are significant shortfalls in both coverage and quality of education and health facilities and services, especially in the rural areas afflicted by woefully inadequate infrastructure. The health and nutrition indicators bring out the scale of "unfinished business" and multidimensional deprivations afflicting especially the vulnerable groups of ex-combatants, returnees, disabled, children, women and youth in the country. The MDG scorecard and assessment need to be interpreted with the caveat that the nascent statistical systems and capacities have their own limitations in data collection and production.

The protracted conflict exacerbated by an unforeseen period of 'oil shutdown' and consequent fiscal stress in a heavily oil revenue dependent economy provided a setback to national efforts in meeting the MDGs by 2015. There is clear evidence, however, of a strong government commitment to addressing these concerns and pressing ahead as brought out in the South Sudan Development Plan, 2011-2013. It is important to stress that while the availability of adequate financial resources constitutes a necessary but insufficient condition for the achievement of the MDGs. Ultimately, the harnessing of collective and concerted efforts of the South Sudan Government, development partners, private sector, and civil society including the Diaspora will be the touchstone, particularly in the critical sectors of health and education. Finally, looking ahead, while making stepped efforts to accelerate progress on the lagging MDGs in the remaining time period until 2015, the country also needs to engage in the post 2015 development framework while building on and customizing the MDGs in its the unique national context.

# BIBLIOGRAPHY

1. **Government of South Sudan:** (2011–2013) South Sudan Development Plan (SSDP)
2. **Government of Southern Sudan, Southern Sudan Centre for Census, Statistics and Evaluation (SSCCSE):** 2010 Statistical Yearbook for Southern Sudan
3. **Government of South Sudan, National Bureau of Statistics:** 2011 Statistical Yearbooks for South Sudan
4. **Government of Southern Sudan, Southern Sudan Centre for Census Statistics and Evaluation:** 2010 Sudan MDG Report
5. **United Nations Development Programme:** 2012-2013 UN Development Assistance Framework (UNDAF) for South Sudan
6. **United Nations Development Programme:** 2010 UNDP Southern Sudan Annual Report
7. **Government of South Sudan, National Bureau of Statistics:** 2011 Release of 1<sup>st</sup> GDP and GNI figures for South Sudan
8. **Government of South Sudan/Ministry of Health:** 2006 Sudan Household Health Survey
9. **Government of South Sudan/Ministry of Health:** 2010 Sudan Household Health Survey

THE SOUTH SUDAN  
MILLENNIUM DEVELOPMENT GOALS  
STATUS REPORT



*Empowered lives.  
Resilient nations.*