

Institutionalising Social and Behaviour Change Systems for Universal Health Coverage in Fragile and Humanitarian Settings: Evidence from the South Sudan Social and Behaviour Change Strategic Framework (2026–2030)

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Abstract *Social and Behaviour Change (SBC) is increasingly recognised as an important health systems function for strengthening Primary Health Care (PHC), health security, community resilience, and progress toward Universal Health Coverage (UHC), particularly in fragile and humanitarian settings. However, SBC implementation in many settings remains fragmented across disease-specific programmes, limiting coordination, institutional learning, sustainability, and national ownership. This study examines the South Sudan Social and Behaviour Change Strategic Framework (2026–2030) as a national health systems reform for institutionalising SBC. This study used a qualitative Health Policy and Systems Research approach, drawing on a documentary review and thematic analysis of national policies, strategic frameworks, programme documents, stakeholder consultation reports, international guidance, and peer-reviewed literature. The analysis identified governance and leadership; behavioural and social insights; community engagement and service experience; strategic communication and digital innovation; monitoring, evaluation, and adaptive learning; and sustainable financing and multisectoral coordination as interrelated institutional functions. Building on these findings, the study proposes the Integrated Social and Behaviour Change Systems Institutionalisation Framework (ISBCS-IF), illustrating how institutionalised SBC can strengthen health system performance, service utilisation, community trust, emergency preparedness, and progress toward UHC. South Sudan's experience provides an adaptable systems model for governments and development partners seeking to institutionalise SBC within routine health systems in fragile and resource-constrained settings.*

Keywords *Behavioural Science, Fragile Settings, Health Systems Strengthening, Health Policy and Systems Research, Primary Health Care, Social and Behaviour Change, Universal Health Coverage.*

Introduction

Universal Health Coverage (UHC) remains a global health priority under Sustainable Development Goal 3, requiring health systems that provide equitable, accessible, and quality services while responding effectively to population needs [1-5]. Although investments in infrastructure, workforce, medicines, and technologies are essential, health outcomes are also influenced by individual behaviours, social norms, community participation, trust, service experience and enabling environments [3, 6-12]. These behavioural and social determinants influence service utilisation, prevention practices, treatment adherence, and public responses during health emergencies.

The Declaration of Astana reaffirmed Primary Health Care (PHC) as the foundation for achieving UHC and emphasised community empowerment, multisectoral action, and people-centred care [1, 3]. Within this context, Social and Behaviour Change (SBC) has evolved beyond conventional health education and communication to incorporate behavioural and social insights, community engagement, strategic communication, policy advocacy, implementation research and systems strengthening [7, 10-16]. Evidence across immunisation, maternal and child health, infectious diseases, and emergency response further demonstrates the importance of integrating behavioural and community-centred approaches into health programming [17-25].

However, SBC remains fragmented in many low- and middle-income and humanitarian settings, where disease-specific programmes frequently operate through separate governance, financing, coordination, and monitoring arrangements [10, 12, 20-22, 26]. Such fragmentation can constrain institutional learning, government ownership, resource efficiency, and long-term sustainability.

South Sudan illustrates these challenges. Recurrent humanitarian emergencies,

population displacement, disease outbreaks, climate-related shocks, and limited health-system capacity have increased reliance on community-centred approaches and external support [27-31]. Over time, multiple government institutions and partners have implemented SBC interventions across immunisation, nutrition, maternal and child health, HIV, tuberculosis, malaria, and emergency preparedness, but often through programme-specific approaches and parallel coordination mechanisms [29, 32-34].

In response, the Ministry of Health, with technical support from UNICEF and partners, developed the South Sudan Social and Behaviour Change Strategic Framework (2026–2030) and its Operational Framework [35, 36]. These frameworks reposition SBC as a cross-cutting health systems function by integrating governance, behavioural and social insights, community engagement, strategic communication, workforce capacity, digital innovation, monitoring and evaluation, adaptive learning, and sustainable financing within routine health-sector structures [35, 36].

Despite increasing international recognition of behavioural and social sciences within health systems [3, 7, 10, 11, 37], relatively limited literature examines the institutionalisation of SBC as a national health systems function, particularly in fragile and humanitarian contexts. This study addresses this gap by analysing South Sudan's SBC Strategic Framework from a Health Policy and Systems Research (HPSR) perspective and developing the Integrated Social and Behaviour Change Systems Institutionalisation Framework (ISBCS-IF) as a systems model for strengthening PHC, health-system resilience, and progress towards UHC.

Background and Policy Context

Evolution of Social and Behaviour Change within Health Systems

Social and Behaviour Change (SBC) has evolved from traditional health education and

information dissemination into a multidisciplinary, evidence-informed approach that incorporates behavioural and social sciences, strategic communication, community engagement, policy advocacy, implementation research and systems thinking [7, 10-16]. This evolution reflects growing recognition that knowledge alone does not necessarily produce sustained behaviour change because health decisions are shaped by interactions among individual capability and motivation, social norms, family and community influences, service experiences, institutional arrangements, and broader enabling environments [13-16].

Contemporary SBC therefore draws on complementary behavioural frameworks, including the COM-B Model and Behaviour Change Wheel, the Socio-Ecological Model, and Diffusion of Innovations, to understand how capability, opportunity, motivation, interpersonal relationships, social norms, and environmental conditions influence behaviour [13-16]. Behavioural and Social Insights (BSI), human-centred design, social listening, implementation research, and digital technologies have further strengthened health systems' capacity to identify behavioural barriers and adapt interventions to community needs [7, 11, 12].

Within Primary Health Care (PHC), SBC provides an important mechanism for linking communities with services by strengthening health literacy, trust, demand, community participation, and service responsiveness. The Declaration of Astana and WHO PHC guidance emphasise people-centred care, community empowerment, multisectoral collaboration, and integrated service delivery as foundations for Universal Health Coverage (UHC) [1, 3, 9, 37]. Community Health Workers and community-based structures are particularly important in extending these functions to underserved populations [17, 20-22].

SBC, Community Engagement and Health Emergency Preparedness

Risk Communication and Community Engagement (RCCE) represents one of the most visible applications of SBC during public health emergencies. Experience from Ebola, COVID-19, and other outbreaks demonstrates that effective response depends not only on biomedical interventions but also on public trust, credible communication, community participation, social listening, and rapid response to misinformation [18, 19, 23, 26].

Institutionalising these functions within routine health systems can strengthen preparedness between emergencies rather than activating communication structures only during crises. WHO, Africa CDC, and UNICEF guidance increasingly emphasise sustained community engagement, behavioural evidence, and accountability as integral components of emergency preparedness and health-system resilience [18, 19, 23, 26].

Similar principles apply beyond emergency response. Evidence from immunisation and community health programmes indicates that behavioural interventions are more sustainable when combined with strong community systems, supportive service environments, appropriate health-worker capacity, and coordinated implementation [17, 20-22, 24, 25]. Accordingly, SBC should be understood as a health-system function that influences both demand for services and the quality of interaction between people, communities, and health institutions.

Institutionalisation and the South Sudan Policy Context

Despite increasing recognition of SBC, implementation in many low- and middle-income and humanitarian settings remains fragmented across disease-specific programmes. Separate governance, financing, monitoring, and reporting arrangements can reduce efficiency, weaken institutional

learning, constrain government ownership, and undermine sustainability [10, 12, 20-22, 26].

South Sudan faces these challenges within a health system affected by recurrent humanitarian crises, displacement, disease outbreaks, climate-related shocks, limited infrastructure and constrained financing [27, 28, 30, 31]. National health policies and strategies have progressively emphasised PHC, community health and community participation, including the National Health Policy, Health Sector Strategic Plan II, National Health Promotion Strategy, National RCCE Strategy and Revised Boma Health Initiative [27-29, 32, 33].

Building on these reforms, the Ministry of Health developed the South Sudan Social and Behaviour Change Strategic Framework (2026–2030) and associated Operational Framework [35, 36]. The Strategic Framework establishes a national approach for integrating governance, behavioural and social insights, community engagement, service experience, strategic communication, digital innovation, workforce capacity, monitoring and evaluation, adaptive learning, multisectoral coordination and sustainable financing within routine health-sector planning and implementation [35, 36].

The framework also complements South Sudan's Community-Based Networks Integration Strategy, which seeks to harmonise community structures within national community-health governance and service-delivery arrangements [29, 34]. Together, these reforms provide an institutional foundation for shifting SBC from fragmented, programme-specific communication activities toward a coordinated national health-systems function.

Knowledge Gap and Study Contribution

Although substantial literature examines behavioural interventions and programme-specific outcomes, fewer studies analyse the institutional arrangements required to sustain

SBC within national health systems, particularly in fragile and humanitarian contexts. Existing evidence is stronger on individual behaviour change, community health-worker performance and emergency communication than on the governance, financing, coordination and organisational reforms required to institutionalise SBC [12-16, 20-22, 38, 39].

Health Policy and Systems Research (HPSR) provides an appropriate perspective for addressing this gap because it examines interactions among institutions, governance, actors, policies, implementation processes and health-system performance [38, 39]. From this perspective, South Sudan's SBC Strategic Framework can be examined not merely as a communication strategy but as a national institutional reform.

This study therefore analyses the South Sudan SBC Strategic Framework (2026–2030) and develops the Integrated Social and Behaviour Change Systems Institutionalisation Framework (ISBCS-IF) to explain how SBC functions can be embedded within routine health systems to strengthen PHC, community trust, health security, resilience and progress towards UHC.

Materials and Methods

Study Design and Setting

This study employed a qualitative Health Policy and Systems Research (HPSR) approach to examine the institutionalisation of Social and Behaviour Change (SBC) within South Sudan's national health system. HPSR was selected because it enables analysis of interactions among policies, institutions, governance arrangements, health-system actors, and implementation processes within complex health systems [38, 39].

The analysis focused on South Sudan, a fragile and humanitarian setting characterised by recurrent emergencies, population displacement, disease outbreaks, resource constraints, and substantial dependence on

external health-sector support [27, 28, 30, 31]. Particular attention was given to the South Sudan Social and Behaviour Change Strategic Framework (2026–2030) and its associated Operational Framework as national instruments for integrating SBC within routine health-system functions [35, 36].

Analytical and Conceptual Orientation

The analysis drew on complementary health systems and behavioural perspectives. The WHO health systems framework and PHC operational guidance provided the systems lens for examining governance, workforce, information, financing, service delivery, and community participation [3, 6, 8, 9]. Behavioural and social science perspectives were informed by WHO and UNICEF SBC guidance and established behaviour-change theories, including the Behaviour Change Wheel/COM-B, Diffusion of Innovations, and socio-ecological approaches [7, 10, 11, 13–16].

HPSR principles were applied to examine how institutional arrangements, actors, policies, implementation processes, and contextual factors influence the integration and sustainability of SBC within the national health system [38, 39].

Data Sources and Document Selection

The study drew on national policy and strategy documents, programme and technical reports, stakeholder consultation outputs, international normative guidance, and peer-reviewed literature relevant to SBC, PHC, community health, health-system strengthening, behavioural science, and institutionalisation.

Key national documents included the National Health Policy 2016–2026 [27], Health Sector Strategic Plan II 2023–2027 [28], National Health Promotion Strategy [32], National Risk Communication and Community Engagement Strategy [33], South Sudan Social and Behaviour Change Strategic Framework 2026–2030 [35], South Sudan

Social and Behaviour Change Operational Framework 2026–2030 [36], Revised Community Health Strategy: Boma Health Initiative 2024–2028 [29], and Community-Based Networks Integration Strategy [34].

International sources included WHO and UNICEF guidance on PHC, health systems, behavioural and social sciences, SBC, RCCE, and community health [1, 3, 6–11, 17–19, 23, 26, 37], together with peer-reviewed literature on behavioural change, community health systems and HPSR [13–16, 20–22, 38, 39].

Documents were purposively selected according to their relevance to SBC institutionalisation, health-system governance, behavioural and social insights, community engagement, strategic communication, workforce capacity, monitoring and evaluation, financing, PHC, and UHC. Documents without substantive relevance to these analytical areas were excluded.

Data Extraction and Analysis

Relevant information was extracted from the selected documents and organised around recurrent institutional and health-system themes. The analysis examined: (1) governance and leadership; (2) behavioural and social insights; (3) community engagement and service experience; (4) strategic communication and digital innovation; (5) monitoring, evaluation, learning, and adaptive management; and (6) sustainable financing and multisectoral coordination.

Thematic content analysis identified recurring patterns, institutional gaps, enabling factors, and relationships across the reviewed sources, informed by established HPSR methodological approaches [38, 39]. We compared findings from national documents with international guidance and peer-reviewed evidence to identify areas of convergence, contextual adaptation, and potential systems-level contribution.

The resulting themes informed development of the Integrated Social and Behaviour Change

Systems Institutionalisation Framework (ISBCS-IF), which synthesises the institutional functions and pathways through which SBC may contribute to PHC, health-system resilience and UHC.

Rigour and Trustworthiness

Credibility was strengthened through triangulation across multiple categories of evidence, including national policy and strategy documents, technical guidance, stakeholder consultation outputs and peer-reviewed literature. The study compared sources to assess the consistency of emerging themes and reduce reliance on any single document. The analysis maintained an audit trail linking the principal analytical themes to their supporting documentary sources.

Ethical Considerations

The study involved analysis of publicly available policies, strategic frameworks, technical documents and published literature and did not involve direct interaction with human participants or collection of identifiable personal information. Formal ethical approval and informed consent were therefore not required. The analysis followed principles of scientific integrity, appropriate attribution and accurate representation of documentary evidence.

Results

Overview of Findings

The documentary analysis identified six interrelated institutional themes underpinning the institutionalisation of Social and Behaviour Change (SBC) in South Sudan: (1) governance

and leadership; (2) behavioural and social insights; (3) community engagement and service experience; (4) strategic communication and digital innovation; (5) monitoring, evaluation, learning, and adaptive management; and (6) sustainable financing and multisectoral coordination. Together, these functions reposition SBC from fragmented, programme-based communication activities towards an integrated national health-systems function embedded within routine planning, implementation, monitoring, and accountability structures [35, 36].

Institutionalising SBC within the Health System

A key finding is that the South Sudan SBC Strategic Framework establishes an institutional architecture to integrate SBC within national health-sector governance, rather than maintaining it primarily as a disease-specific communication function [35, 36]. The framework promotes coordinated leadership, planning, supervision, behavioural evidence generation, monitoring, partner alignment, and accountability across national and subnational levels. This approach is consistent with national reforms promoting PHC, community health, and integrated community-based systems [27-29, 32-36].

The analysis further indicates that institutionalisation requires interaction among governance, behavioural evidence, community participation, workforce capacity, financing, partnerships, research and digital systems rather than isolated communication interventions. These relationships are summarised in Figure 1.



Figure 1. Analytical Framework for Institutionalising Social and Behaviour Change as a Health Systems Strengthening Function

Source: Developed by the author based on the findings of this study and informed by the South Sudan Social and Behaviour Change Strategic Framework (2026–2030) [35], WHO Primary Health Care guidance [3], the WHO Health Systems Framework [6,8], UNICEF Social and Behaviour Change Strategy (2022–2030) [10], and HPSR literature [38, 39].

Interpretation: Figure 1 illustrates how institutional functions interact to embed SBC within the health system. Together, they can strengthen health behaviours, service utilisation, community trust, emergency preparedness, and progress towards UHC.

Behavioural and Social Insights

The Strategic Framework institutionalises Behavioural and Social Insights (BSI) as a foundation for evidence-informed planning and implementation [35, 36]. Rather than relying primarily on assumptions or message dissemination, it promotes behavioural research, Knowledge, Attitudes and Practices surveys, social listening, human-centred design, behavioural barrier analysis, implementation research and community feedback. This approach is consistent with contemporary behavioural science guidance emphasising systematic diagnosis of behavioural determinants before intervention design [7, 11–14].

BSI therefore provides a mechanism to shift SBC from message-driven communication to evidence-informed, adaptive programming responsive to behavioural, social, and contextual determinants.

Community Engagement, Service Experience and Institutional Architecture

The analysis indicates that service utilisation is influenced by both community demand and people's experiences of health services. The Strategic Framework consequently links interpersonal communication, respectful and people-centred care, community participation, supportive supervision, and accountability mechanisms [35, 36]. Community structures, including Boma Health Workers, community leaders, faith-based organisations, civil society organisations, women's and youth groups, schools, and local media, provide platforms for

community engagement, mobilisation and feedback [29, 34, 35].

These arrangements are reinforced through community dialogue, participatory planning, social listening, and Accountability to affected

populations, consistent with international guidance on community engagement and people-centred health systems [18, 19, 26, 37]. Figure 2 illustrates the multi-level institutional architecture supporting these functions.



Figure 2. Institutional Architecture for Institutionalising Social and Behaviour Change Systems within the South Sudan Health System

Source: Developed by the author based on the findings of this study and informed by the South Sudan Social and Behaviour Change Strategic Framework (2026–2030) [35], South Sudan Social and Behaviour Change Operational Framework (2026–2030) [36], WHO Primary Health Care guidance [3], the WHO Health Systems Framework [6, 8], and WHO community health-worker guidance [17].

Interpretation: Figure 2 illustrates how SBC functions are coordinated across national, state, county, Payam, health-facility, and community levels. Vertical coordination and community feedback connect governance, behavioural evidence, communication, and accountability within one institutional system.

Strategic Communication, Digital Innovation, Monitoring, and Sustainable Financing

The Strategic Framework expands communication beyond conventional mass media by incorporating digital platforms for social listening, community feedback,

emergency communication, and programme monitoring [35, 36]. These include RapidPro, U-Report, Interactive Voice Response, social media, digital dashboards, and mobile messaging platforms.

Monitoring, Evaluation, Learning, and Adaptation (MELA) are integrated through standardised indicators, behavioural monitoring, implementation research, performance review, and continuous learning

[35, 36]. Sustainable implementation is linked to government stewardship, partner harmonisation, domestic resource mobilisation and integration of SBC into routine health-sector planning and financing. These elements collectively support institutional continuity beyond short-term campaigns and externally financed programmes. Figure 3 summarizes the implementation relationships.

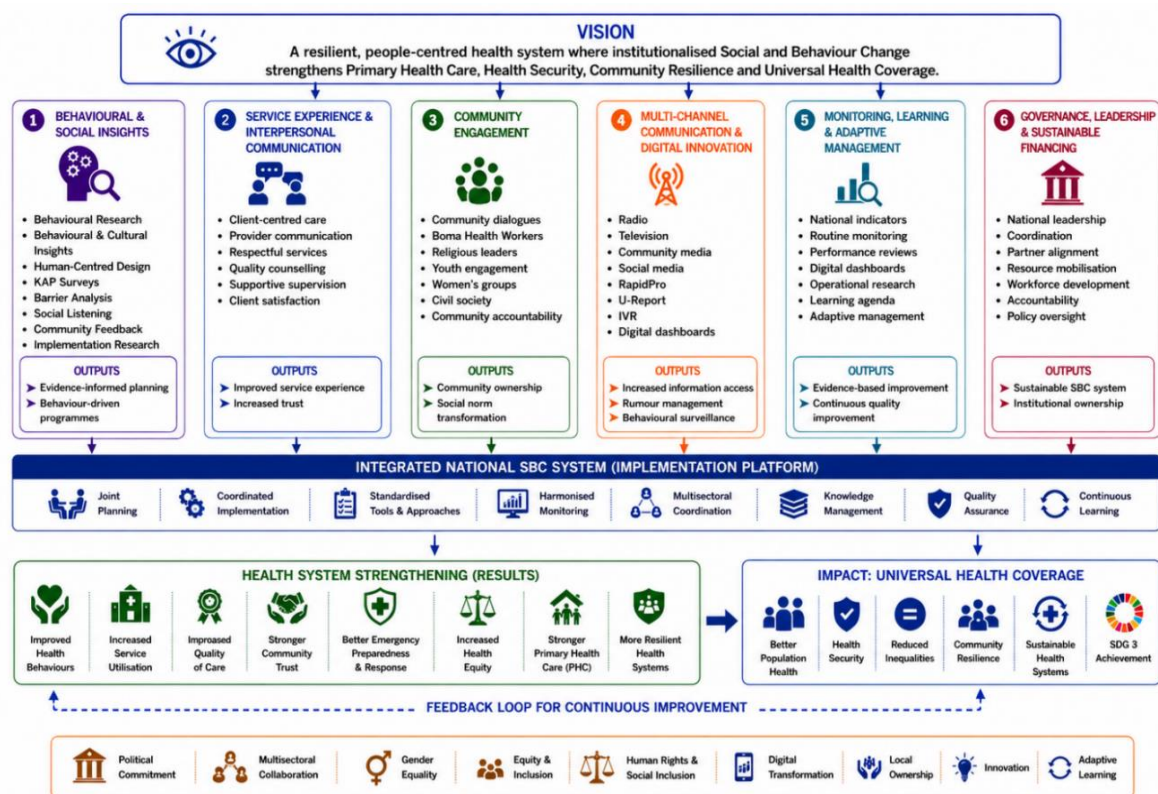


Figure 3. Strategic Implementation Framework for the South Sudan Social and Behaviour Change Strategic Framework (2026–2030).

Source: Developed by the author based on the findings of this study and informed by the South Sudan Social and Behaviour Change Strategic Framework (2026–2030) [35], WHO Primary Health Care guidance [3], WHO Health Systems Framework [6, 8], UNICEF Social and Behaviour Change Strategy (2022–2030) [10], and WHO behavioural and social sciences guidance [7, 11].

Interpretation: Figure 3 shows how governance, evidence, community engagement, communication, workforce capacity, monitoring, and financing interact during implementation. Continuous learning provides feedback for adapting interventions and strengthening institutional performance.

Theory of Change for Institutionalising Social and Behaviour Change

The analysis indicates that sustainable SBC institutionalisation requires progression from enabling inputs and institutional arrangements to coordinated implementation, measurable outputs, and health-system outcomes. The resulting Theory of Change links government

leadership, financing, workforce capacity, behavioural evidence, community structures, partnerships, and digital systems with

coordinated SBC interventions and improved behavioural and health-system outcomes [3, 10, 35, 36, 38, 39].



Figure 4. Theory of Change for Institutionalising Social and Behaviour Change Systems in South Sudan

Source: Developed by the author based on the findings of this study and informed by the South Sudan Social and Behaviour Change Strategic Framework (2026–2030) [35], South Sudan Social and Behaviour Change Operational Framework (2026–2030) [36], WHO PHC and Health Systems Strengthening guidance [3, 6, 8], UNICEF Social and Behaviour Change Strategy (2022–2030) [10], and HPSR literature [38, 39].

Interpretation: Figure 4 demonstrates the pathway through which institutional inputs and coordinated SBC interventions are expected to generate outputs, behavioural and health-system outcomes, and longer-term contributions to resilient PHC and UHC.

Integrated Social and Behaviour Change Systems Institutionalisation Framework

Synthesising the six themes, this study proposes the Integrated Social and Behaviour Change Systems Institutionalisation

Framework (ISBCS-IF) as its principal conceptual contribution. The framework integrates governance and leadership, behavioural and social insights, community engagement, strategic communication and digital innovation, workforce capacity, monitoring and adaptive learning, partnerships, and sustainable financing within a unified systems model.

The ISBCS-IF conceptualises institutionalisation as a dynamic process in which these functions interact rather than operate as independent programme

components. It proposes that embedding them within routine health-system structures can strengthen PHC, community trust, service

utilisation, emergency preparedness, institutional resilience, and progress towards UHC [3, 6, 7, 10, 35, 36, 38, 39].



Figure 5. Integrated Social and Behaviour Change Systems Institutionalisation Framework (ISBCS-IF)

Source: Developed by the author based on the findings of this study and informed by the South Sudan Social and Behaviour Change Strategic Framework (2026–2030) [35], the WHO Primary Health Care Operational Framework [3], the WHO Health Systems Framework [6, 8], the UNICEF Social and Behaviour Change Strategy (2022–2030) [10], the WHO behavioural and social sciences guidance [7, 11], and HPSR literature [38, 39].

Interpretation: Figure 5 presents the ISBCS-IF as an integrated systems model linking institutional SBC functions with strengthened PHC, community trust, health-system resilience, and UHC. The framework emphasises continuous interaction among governance, behavioural evidence, communities, workforce, financing, partnerships, communication, and learning rather than a linear communication model.

Discussion

Institutionalising SBC as a Health Systems Function

This study demonstrates that the South Sudan Social and Behaviour Change Strategic Framework (2026–2030) represents an important shift from fragmented, programme-specific communication towards institutionalising SBC as a routine health-systems function. This transition is consistent with international approaches that increasingly recognise behavioural and social determinants,

community participation, and people-centred services as integral to PHC and UHC [1, 3, 7, 9-11, 37].

The significance of this reform lies not simply in expanding SBC activities but in embedding them within governance, planning, financing, workforce development, information systems, implementation, and accountability structures [35, 36]. This systems orientation addresses a common weakness of programme-specific behavioural interventions, which may achieve short-term results but remain vulnerable when external funding, emergency response structures, or vertical programme support decline [10, 12, 20-22, 26].

South Sudan's approach therefore extends the concept of SBC beyond communication and demand generation. It positions institutionalisation as a health-system reform requiring sustained government stewardship, institutional capacity, and integration with routine PHC structures.

Governance, Coordination and Sustainable Institutionalisation

Governance emerged as a central requirement for SBC institutionalisation. The Strategic and Operational Frameworks establish coordinated structures linking national, state, county, Payam, health-facility, and community levels [35, 36]. These arrangements are aligned with wider national reforms promoting decentralised PHC, community health, and integration of community-based networks [27-29, 32-36].

This finding is consistent with HPSR literature emphasising that sustainable reforms depend on interactions among institutions, actors, implementation processes, and contextual factors rather than technical interventions alone [38, 39]. Evidence from community health programmes similarly demonstrates that performance is strengthened when community-based actors are supported through clear governance, supervision,

integration, and accountability arrangements [17, 20-22].

For fragile health systems, institutional governance is particularly important because multiple humanitarian and development actors may operate simultaneously. Strong government-led coordination can therefore reduce duplication, align partner investments with national priorities, and strengthen institutional continuity during and between emergencies [26, 30, 35, 36].

Behavioural and Social Insights and Adaptive Programming

A major feature of the Strategic Framework is the institutionalisation of Behavioural and Social Insights (BSI) within routine planning and decision-making [35, 36]. Behaviour-change theory demonstrates that behaviours are influenced by interacting individual, social, and environmental determinants; effective interventions therefore require diagnosis of behavioural barriers rather than reliance on information provision alone [13-16].

The framework's emphasis on behavioural research, social listening, community feedback, human-centred design, and implementation research is consistent with WHO and broader SBC guidance promoting evidence-informed and adaptive approaches [7, 11, 12]. Institutionalising these functions can enable programmes to identify emerging behavioural barriers, misinformation, service-experience problems, and changing community priorities and to adapt interventions accordingly.

This is particularly relevant in humanitarian and outbreak settings, where perceptions, trust, and information environments can change rapidly. Routine BSI capacity may therefore strengthen both long-term PHC programming and emergency preparedness [18, 19, 23, 26].

Community Engagement, Service Experience and Trust

The findings reinforce the importance of connecting community demand with service

experience. Community engagement alone may have limited impact when services are inaccessible, disrespectful, or unresponsive, while technically available services may remain underused when communities lack trust, information, or meaningful participation [3, 9, 10, 37].

South Sudan's framework addresses this relationship by combining community engagement, interpersonal communication, community feedback, accountability, and people-centred service delivery [35, 36]. Boma Health Workers, community leaders, faith-based organisations, civil society organisations, women's and youth groups, and other community structures provide potential platforms for sustained engagement within the national system [29, 34].

This approach is consistent with evidence showing that community health interventions perform better when community-based actors are linked to formal health systems through supportive supervision, institutional recognition, and functional referral and accountability mechanisms [17, 20-22]. It also strengthens the relevance of SBC to immunisation and other essential services where confidence, service experience and community engagement influence uptake [24, 25].

Digital Innovation, Learning, and Sustainable Financing

Institutionalisation also requires mechanisms for continuous monitoring, learning, and adaptation. The Strategic Framework's integration of digital platforms, social listening, behavioural monitoring, community feedback, and routine performance review provides opportunities for more responsive SBC implementation [35, 36]. These mechanisms can strengthen the feedback loop between evidence generation, programme adaptation, and decision-making.

However, institutionalisation is unlikely to be sustainable without predictable financing

and workforce capacity. Reliance on short-term, disease-specific, or emergency funding can reproduce the fragmentation that the framework seeks to address. Integrating SBC into government planning, budgeting, workforce development and routine monitoring is therefore essential for long-term sustainability [6, 8, 10, 12, 35, 36].

Development partners remain important in fragile settings, but external support should progressively reinforce nationally led systems rather than create parallel structures. This requires alignment of financing, technical assistance, indicators, and implementation arrangements with national SBC priorities.

Contribution of the ISBCS-IF

The principal conceptual contribution of this study is the Integrated Social and Behaviour Change Systems Institutionalisation Framework (ISBCS-IF). Unlike approaches that conceptualise SBC primarily as communication or individual behaviour-change programming, the ISBCS-IF positions behavioural and social functions within the broader institutional architecture of the health system.

The framework integrates governance, BSI, community engagement, strategic communication, and digital innovation, workforce capacity, monitoring, adaptive learning, partnerships, and financing as mutually reinforcing institutional functions. This interpretation builds on behavioural science [13-16], health-systems thinking [3, 6, 8], community-health evidence [4, 16-18], and HPSR [38, 39], while adapting these perspectives to the institutional realities described in South Sudan's national frameworks [29, 34-36].

The ISBCS-IF therefore provides a testable systems model rather than evidence of effectiveness in itself. Its proposed relationships should be assessed prospectively as the Strategic Framework is implemented.

Implications for Fragile and Humanitarian Settings

South Sudan's experience has relevance beyond the national context. Fragile and humanitarian health systems commonly face disrupted services, constrained institutional capacity, multiple implementing actors, and dependence on external financing [26, 30, 31]. Under these conditions, maintaining separate SBC structures for individual diseases or emergencies can further fragment already constrained systems.

Institutionalising SBC within routine PHC offers an alternative approach by maintaining governance, behavioural evidence, community engagement, communication, monitoring, and workforce functions that can serve both routine programmes and emergency response. This may strengthen institutional continuity and adaptability while supporting more integrated, people-centred services [3, 9, 10, 18, 19, 26, 37].

However, transferability should not be assumed. Governance arrangements, financing capacity, decentralisation, community structures, and humanitarian conditions vary across countries. The ISBCS-IF should therefore be adapted and empirically evaluated within each implementation context.

Strengths, Limitations and Future Research

A key strength of this study is its application of an HPSR perspective to SBC institutionalisation, moving analysis beyond individual interventions towards governance, institutional arrangements, and system functions. Triangulation across national policies, strategic frameworks, international guidance, and peer-reviewed literature also strengthened the policy relevance of the analysis.

The study nevertheless has limitations. It is based primarily on documentary analysis and does not include primary empirical data from policymakers, health workers, community

members, or development partners. In addition, because the South Sudan SBC Strategic Framework (2026–2030) is newly developed, implementation fidelity, behavioural outcomes, health-service effects, cost-effectiveness, and long-term institutional sustainability could not yet be assessed.

Future research should therefore evaluate implementation fidelity, institutional capacity, financing, behavioural outcomes, service utilisation and community experiences as implementation progresses. Comparative research across other fragile and humanitarian settings would further test the applicability and transferability of the ISBCS-IF.

Conclusion

This study demonstrates that the South Sudan Social and Behaviour Change Strategic Framework (2026–2030) represents an important shift from fragmented, programme-specific communication towards institutionalising SBC as a cross-cutting national health-systems function [35, 36]. The analysis shows that sustainable institutionalisation requires coordinated governance, behavioural and social insights, community engagement and service experience, strategic communication and digital innovation, workforce capacity, monitoring and adaptive learning, multisectoral partnerships, and sustainable financing.

The proposed Integrated Social and Behaviour Change Systems Institutionalisation Framework (ISBCS-IF) synthesises these functions into a systems model illustrating how institutionalised SBC may strengthen PHC, community trust, service utilisation, emergency preparedness, health-system resilience, and progress towards UHC. The framework complements international approaches to integrated, people-centred PHC and behavioural science while adapting them to South Sudan's fragile and humanitarian context [3, 7, 9-11, 35-37].

The findings support recognising SBC not merely as communication or demand generation but as a strategic health-systems function requiring sustained government leadership, institutional capacity, financing, and integration into routine planning and accountability. However, because the framework has not yet been prospectively evaluated, future implementation research should assess its feasibility, effectiveness, sustainability, and transferability to other fragile and humanitarian settings.

Policy Recommendations

Based on the findings, the following priority actions are recommended:

- Institutionalise SBC within national health systems. Governments should formally integrate SBC into health policies, PHC strategies, governance structures, annual plans, budgets, routine information systems and performance frameworks [3, 6, 8, 10].
- Operationalise South Sudan's national SBC frameworks. The Ministry of Health should translate the Strategic and Operational Frameworks into costed implementation plans with clearly defined responsibilities across national, state, county, Payam, health-facility, and community levels [35, 36].
- Strengthen behavioural evidence and community accountability. BSI, social listening, implementation research, community feedback, and participatory approaches should inform routine programme design, adaptation, and decision-making [7, 11, 12, 18, 19, 26].
- Strengthen and integrate community systems. Boma Health Workers, Community-Based Networks, faith-based organisations, civil society, and other community structures should be linked with formal PHC governance, supervision, referral, and accountability mechanisms [17, 20-22, 29, 34].
- Invest in institutional capacity and sustainable financing. Government and development partners should strengthen SBC workforce competencies, digital systems, monitoring, and learning while progressively integrating SBC financing into routine health-sector budgets [8, 10, 35, 36].
- Align partner investments with national systems. Development partners should reduce parallel, disease-specific SBC structures and align technical and financial assistance with nationally led governance, implementation, and monitoring arrangements [26, 35, 36].
- Generate implementation evidence. Prospective research should assess implementation fidelity, financing, institutional capacity, behavioural outcomes, service utilisation, cost-effectiveness, and community experiences and test the ISBCS-IF in other fragile and humanitarian contexts.

This condensed version replaces the longer current recommendation lists for national governments, the Ministry of Health, development partners and future research.

Study Contribution to Knowledge

This study contributes to Health Policy and Systems Research in three principal ways. First, it reconceptualises SBC as an institutional health-systems function rather than primarily a programme-specific communication intervention. Second, it introduces the ISBCS-IF, integrating governance, behavioural and social insights, community engagement, strategic communication and digital innovation, workforce capacity, monitoring and learning, partnerships, and sustainable financing within a unified systems model. Third, it extends the application of behavioural science from individual behaviour-change programming towards institutional governance and

organisational performance in a fragile and humanitarian health system.

The framework therefore provides a conceptual and policy contribution that can guide implementation and future empirical evaluation in South Sudan and comparable settings. Its effectiveness and transferability should, however, be established through prospective implementation research.

Competing Interests

The author declares no competing interests.

Consent for Publication

Not applicable.

Author Contributions

Okello David Omwony conceived and designed the study, conducted the documentary review and analysis, developed the conceptual framework and figures, interpreted the findings, and drafted, reviewed, and approved the final manuscript.

Ethical Approval

The study analysed publicly available policy documents, strategic frameworks, technical reports, and peer-reviewed literature. No human participants or identifiable personal data were involved; therefore, formal ethical approval and informed consent were not required.

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Data Availability

Documents analysed in this study are available from the Ministry of Health, WHO, UNICEF, and other sources cited in the manuscript. Additional information supporting the analysis is available from the corresponding author upon reasonable request.

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