
South Sudan Private Health Sector Assessment



Recommended Citation: Armand, Françoise, Sean Callahan, Maggie Stokes, Buchay Othom and Jane Alphonse. 2021. *South Sudan Private Health Sector Assessment*. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates Inc.

Cooperative Agreement: AID-OAA-A-15-00067

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About SHOPS Plus: Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is USAID's flagship initiative in private sector health. The project seeks to harness the full potential of the private sector and catalyze public-private engagement to improve health outcomes in family planning, HIV/AIDS, maternal and child health, and other health areas. SHOPS Plus supports the achievement of US government health priorities and improves the equity and quality of the total health system.

Cover photo: Buchay Othom



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This report is made possible by the support of the American people through the United States Agency for International Development (USAID). The contents of the report are the sole responsibility of Abt Associates and do not necessarily reflect the views of USAID or the United States government.

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Acronyms

Amref	African Medical and Research Foundation
DFCA	Drug and Food Control Authority Act
E2A	Evidence to Action
HPF	Health Pooled Fund
IUD	Intrauterine device
LARC	Long-acting and reversible contraception
mCPR	modern Contraceptive Prevalence Rate
MOH	Ministry of Health
MSI	Management Systems International
PHSASS	Private Health Sector Association South Sudan
PPP	Public-Private Partnership
PSE	Private Sector Engagement
PSA	Private Sector Assessment
RHASS	Reproductive Health Association of South Sudan
RHSC	Reproductive Health Supplies Coalition
SHOPS Plus	Sustaining Health Outcomes through the Private Sector
SSNAMA	South Sudan Nurse and Midwife Association
SSP	South Sudanese Pound
SSPA	South Sudan Pharmacists Association
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WISH	Women's Integrated Sexual Health
WRA	Women of reproductive age

Executive Summary

Located in eastern Africa, South Sudan is one of the world's newest nations. Currently home to over 11 million people, South Sudan has faced multiple challenges in its first decade of independence: relapses of insecurity and conflict, global fluctuations in the price of oil that heavily shape its economic outlook, widespread poverty and food insecurity, and poor infrastructure that constrains economic growth and commercial activity. The public sector has limited health infrastructure and is heavily reliant on donor support, with projects such as the Health Pooled Fund (HPF) responsible for supporting much of the delivery of basic public services. This gap has limited access for many and resulted in generally poor health indicators. In addition, family planning (FP) uptake—which is very low—faces demand-side barriers, such as cultural norms supporting large families, lack of awareness, and high levels of myths and misconceptions about modern methods.

To help the country improve access to FP products and services, USAID/South Sudan engaged the global Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project to conduct a private sector assessment (PSA). The PSA is intended to inform the mission's private sector engagement (PSE) strategy and addressed four key topics:

1. Policy and legal barriers to private procurement and delivery of FP products and services
2. Potential strategies to incentivize private providers and private distribution channels to increase access to high-quality, affordable FP products and services
3. Opportunities to strengthen the capacity of private associations to better organize, represent, and support the private health sector in South Sudan
4. Opportunities to adapt proven mechanisms for public-private engagement to the South Sudan health context

SHOPS Plus completed this assessment between November 2020 and April 2021. The assessment team began with a desk-based review of over 50 policy documents and reports, along with available data sets. Following this review, the project conducted a combination of remote and in-person key informant interviews with representatives from 20 donors and NGOs, public officials and regulators, and private sector associations, as well as with almost 50 private health facilities, pharmacies, and supply chain actors.

The assessment highlighted several opportunities for PSE. Overall, the private health sector in South Sudan is significant and growing. Stakeholders estimated that the private for-profit sector serves nearly 20 percent of the population. In Juba alone, official registries indicate that there are nearly 800 registered private outlets, including health facilities at multiple levels, pharmacies, and drug shops. Because South Sudan's health system is relatively decentralized, these outlets mainly engage with the public sector at the state or local level. This engagement typically focuses on registration, with multiple licenses and fees required; stakeholders report that limited oversight of the products and services in the private sector occurs. This light touch, though, means that pharmaceutical suppliers face few barriers to registering, importing, and selling new health products and medicines, which has important implications for the introduction of new FP methods in the private sector.

The private sector already offers a number of family planning modern methods available at various price points. For the most part, the contraceptive method mix in the private sector is concentrated on short-acting methods and products that can be sold without a service component. Typically, private facilities and retail outlets procure these products through the

private supply chain. Branded contraceptives (mainly condoms, oral pills, and emergency contraceptive pills) can be found throughout the private sector, imported from India, Turkey, Cyprus, East Africa, and Europe. DMPA injections are also available for sale—and administered—at pharmacies and drug shops. Long-acting reversible contraceptives and permanent methods are typically unavailable at private health facilities. Providers cite lack of demand for these methods, commodity access barriers for implants and intrauterine devices (IUDs), and limited opportunities to access clinical trainings as the main barriers to increased provision.

Several nascent professional associations have emerged in recent years that are seeking to actively support the private sector. The South Sudan Private Health Sector Association is aiming to become an umbrella coordinating body for actors across the private sector and has links to similar organizations across east Africa. The South Sudan Nurse and Midwife Association has already started working with donors to train more nurses and midwives on FP. And the South Sudan Pharmacists Association is able to organize seminars and workshops that can reach its 200+ members to capacitate them to better counsel and offer modern FP methods.

While the private sector is generally willing to increase its provision of FP products and services, multiple challenges need to be addressed to make it a viable market. Limited access to certain commodities and training for private providers, combined with widespread poverty and low demand for FP contribute to slow market growth. Furthermore, private facilities and supply chain actors lack access to capital and financing needed to invest in their own growth. And price fluctuations on imported products, poor transport infrastructure, and high transport costs all raise the costs of doing business. Although government health policies call for greater PSE and leveraging private resources in support of national FP goals, the policy and regulatory framework lacks detailed guidance to support this engagement.

Going forward, USAID/South Sudan can support strategic PSE to increase FP use. Two potential segments exist. First, women who already are going to the private sector could be better served through interventions that help the private sector increase the range of methods it delivers. Second, women who live nearby private facilities but face financial barriers to access could benefit from public-private partnerships or donor interventions that partner with private outlets to increase access to subsidized products and services. As priority interventions, USAID should consider:

1. Generating additional comprehensive quantitative data about the size and location of private health sector
2. Strengthening the policy framework for PSE
3. Ensuring the continued availability of contraceptives in private retail outlets
4. Increasing the number of private facilities able to respond to demand for FP services
5. Developing commodity partnerships with the private sector in underserved areas
6. Investing in provider-led demand creation for FP services

Introduction

Located in eastern Africa, South Sudan is one of the world's newest nations. After decades of conflict, the country gained independence from Sudan in 2011 and is currently home to over 11 million people. South Sudan has faced relapses of insecurity and conflict in the years following its independence, which has greatly undermined its stability, security, and economic growth. South Sudan's economy heavily relies on oil production and importation of most goods, making it vulnerable to fluctuations in oil markets, volatile exchange rates, and rampant inflation (MSI 2020). Poor infrastructure—such as bad roads—and insecurity contribute to slowing down commercial activity and economic growth (Ibid.). Social, economic, and health infrastructures are largely underdeveloped and many basic services for the population, such as health and education, are provided by NGOs (World Bank 2019). South Sudan is still experiencing a humanitarian crisis with over 75 percent of the population below the poverty line, and 50 percent food-insecure (United Nations 2020). It is estimated that over 8 million people in South Sudan are in need of humanitarian assistance (World Bank 2021b).

Health indicators in South Sudan are generally poor. Life expectancy is low at 57.9 years, while maternal and child mortality rates are estimated at 1,150 maternal deaths per 100,000 live births and 98.6 deaths per 1,000 live births for children under 5 years of age (United Nations Development Programme 2021). South Sudan also has a high total fertility rate of 4.6 births per woman (World Bank 2021a). The country has a high unmet need for family planning (FP) services; uptake of these services is hampered by cultural norms and challenges with product and service accessibility. South Sudan has high rates of malaria and faces other preventable disease outbreaks generally linked to weak surveillance and monitoring, poor sanitation, malnutrition, and poverty (World Bank 2019). Many health facilities in South Sudan have been shut down by conflict and insecurity and the country faces a severe shortage of health care workers, as well as a widespread lack of training and resources (World Health Organization 2021). Looting and destruction of health facilities have also been reported in South Sudan and a significant portion of public facilities are in need of renovation or replacement (World Bank 2019). Such security challenges also present threats to the safety of health care staff and aid workers, further limiting the provision of key health services (Ibid.). The country also has an unequal distribution of health facilities, with approximately 74 percent of the population living over an hour walking distance to a public health facility (Macharia et al 2017). Despite challenges, the private health sector is noted to be growing in response to unmet need for health care.

The South Sudanese government historically has a limited capacity to address health challenges in South Sudan and relies heavily on external funding for the provision of basic services, and government financing for health is historically low (World Bank 2021b). Funding for health, in fact, represents a high portion of external aid received (World Bank 2019). Organizations such as the World Bank and programs such as the Health Pooled Fund (HPF) represent a large presence of health aid to South Sudan and programs focus on both emergency and basic aid, as well as health infrastructure improvement strategies more broadly (Health Pooled Fund 2021; World Bank 2017). Although the health sector remains highly fragmented, the South Sudanese government has developed health sector policies designed to strengthen the health system, such as the National Health Policy (2016–2026) and the Health Sector Development Plan (2012–2016) (Ministry of Health 2012; Ministry of Health 2016). The South Sudanese government also has a documented FP strategy (2013) that cites the need for a FP regulatory framework, and emphasizes the need to support public-private partnerships

(PPPs) and community engagement efforts for increased provision and use of FP services in the country (Ministry of Health 2013).

Assessment purpose and methodology

The USAID-funded Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project conducted this assessment at the request of the USAID/South Sudan mission to inform a private sector engagement (PSE) strategy focusing on increasing the use of FP services.

The private sector assessment (PSA) included the following objectives:

1. Identify policy and legal barriers to private procurement and delivery of FP products and services
2. Develop strategies to incentivize private providers to increase the volume and improve the quality of FP services, and to leverage and strengthen private distribution channels to improve access to high-quality, affordable products
3. Develop recommendations to strengthen the capacity of private associations to better organize, represent, and support the private health sector in South Sudan
4. Explore opportunities to adapt proven mechanisms for public-private engagement to the South Sudan health context

SHOPS Plus and its predecessor project, SHOPS, have conducted over 25 PSAs. This type of analysis is designed to assess important actors and provider types, donors, and sources of financing in a country's private health sector, identify available services and products, and assess client accessibility to these services. This PSA focused on FP in South Sudan and closely followed the SHOPS Plus methodology (Figure 1).

Figure 1. Steps in a private sector assessment



PLAN: The PSA process began with a desk review of existing literature pertaining to the broader health system in South Sudan and the policy and regulatory environment, the private health sector, FP in the country, stakeholders and donor presence, and other key components of the health context in South Sudan. The PSA team examined approximately 51 policy documents and reports, 16 implementing partner and donor websites, and 4 online databases. The findings from this research helped to form a list of key stakeholders that SHOPS Plus spoke with in the next phase of the PSA.

LEARN: During the next phase of the PSA, SHOPS Plus conducted interviews with 20 representatives of health and development NGOs, regulatory institutions, professional and private industry associations, and donor-supported health programs (December 2020 through January 2021) (Figure 2). The interviews allowed the team to document current and planned activities in the FP area, and discuss opportunities to engage the private sector in these efforts. The US-based SHOPS Plus team worked with two Juba-based consultants to help identify and conduct key informant interviews.

Figure 2. Organizations interviewed by SHOPS Plus

Palladium	World Vision	World Relief	Chemonics	MSI
IntraHealth	PSI	Jhpiego	RHASS	IOM
FCDO	UNFPA	Pharm. & Drug Supply Auth.	Drug and Food Control. Auth.	MOH
AMREF	Juba SMOH	SSNAMA	SSPHSA	SSPA

Between February and March 2021, the consultants also recorded the type, origin, and prices of contraceptives available for sale through pharmaceutical outlets and interviewed private wholesalers and facility-based health providers. These interviews included 12 private for-profit health facilities, interviews with 6 pharmaceutical wholesalers, and visits to 31 pharmacies and drug shops. This step resulted in important information on current practices, challenges, motivations, and incentives for the availability of FP products and services in the private health sector.

ANALYZE: During this phase, the project team synthesized findings from desk research and all interviews to produce major learnings from the assessment, opportunities for PSE, and recommendations for future programming.

SHARE: This step consisted of two debriefs with USAID/South Sudan in March and April 2021, and a webinar designed to inform USAID implementing partners, government counterparts, and USAID/Washington staff. SHOPS Plus also developed this report to further disseminate the findings of the assessment.

ACT: The PSA was intended to support actions and programming for increasing FP provision and uptake in South Sudan. Its findings and recommendations are expected to inform the IMA World Health-led MOMENTUM Integrated Health Resilience program, whose scope includes strengthening voluntary FP in South Sudan.

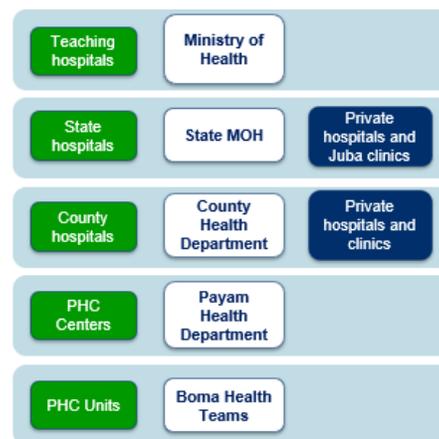
South Sudan's health system and the private health practice

Decentralized governance of health services

The private health sector does not operate within a vacuum. The context created by the broader public health system and private sector landscape shapes the opportunities and challenges for the private health care industry. Overall, the South Sudan health system is decentralized, characterized by a regulatory and oversight system that features supportive policies on paper but focuses largely on registration and fee collection in practice; as well as a crowded and varied competitive landscape.

The South Sudan health system is decentralized, characterized by the delegation of governing powers to state ministries of health (MOH), county health departments, Payam health departments, and boma health teams (Ministry of Health 2016). This governance structure is primarily focused on the management of public health services provided by state and county hospitals, and primary health care centers or units. At the lowest level, Boma Health Teams implement a range of community-based outreach and services. Private sector hospitals and clinics also operate under the jurisdiction of state and county health authorities (Figure 3).

Figure 3. South Sudan's decentralized health system and the private sector



Interaction between the public sector and private providers at the state and county levels typically focus on the completion of administrative procedures and the payment of fees. In order to create and maintain a practice, health care providers must be licensed by the relevant professional council and pay an annual fee. For example, doctors must register with and pay the Medical Council a fee of 5,000 South Sudanese Pounds (SSP) (approximately \$38 USD). The health facility itself also must be registered with the respective state MOH and local chamber of commerce, which requires providing up-to-date licenses for all clinical staff and paying an annual fee. Annual registration fees vary by facility type. In Juba, the city council charges 30,000 SSP for the required trading license. The Central Equatoria state MOH charges 60,000 SSP (\$460) for clinics, to 100,000 SSP (\$768) for medical centers, and 300,000 SSP (\$2,309) for hospitals. This fee has increased substantially in recent years, from 20,000 SSP, with little input from providers. The private sector viewed this increase as the result of pressure to raise public revenues and expressed frustration with the seemingly arbitrary change. The Central Equatoria MOH reported that private facilities may have to seek as many as 14 different local certifications, a burden that the MOH would like to rationalize. Private providers otherwise experience minimal hurdles in obtaining a license. While the state MOHs are required to carry out three site visits as part of the registration process, these are focused on checking for required documentation and suitability of the facility space. Providers report that regular clinical supervisory or inspection visits from government authorities are rare — and do not seem to be required.

With support of donors and implementing partners, South Sudan's MOH has invested in a robust policy framework for the country's health system. A 2020 policy review identified as many as 16 policy documents that focus explicitly on issues related to FP and reproductive health. They include the 2013 *Family Planning Policy*, *The National Health Strategic Plan (2016–2020)*, the 2018 *National Reproductive Health Strategy*, and the 2017 *Health Strategic Plan* (Belaid et al. 2020). These documents highlight the government's commitment to FP and set out high-level goals of increasing equitable access to FP, improving quality, and increasing the modern contraceptive prevalence rate (mCPR) (Ministry of Health 2013). As part of its involvement in the global FP2020 initiative, the government set the goal of doubling mCPR among married women from 5 percent in 2016 to 10 percent in 2020 (Track20 2018). To operationalize these objectives, the MOH has developed policies and guidelines on task shifting and community-based interventions to support more accessible and integrated sexual and reproductive health products and services (Track20 2018).

Despite these positive developments, gaps in the policy framework remain. The 2020 policy review revealed little progress toward implementing the policy framework, largely due to insufficient financial and human resources (Belaid et al. 2020). In addition, existing health policies do not specify a role for the private sector or provide guidance for when and how to engage private actors, including in FP programs. The *National Health Policy (2016–2026)* calls for developing a PPP policy, capturing better collection of private sector data, and exploring mechanisms to purchase services from private providers (Ministry of Health 2016). However, these recommendations have not yet moved forward. The specific vision for the private sector's role in the FP market and the clear mechanisms and guidelines for engaging them in the national FP program are needed to leverage private resources more strategically in support of national policies. Beginning in 2019, the MOH and its development partners began developing a new national FP costed implementation plan. This plan was not yet finalized at the time of the assessment and will include additional recommendations for strengthening the policy environment and engaging private providers.

Private provision of health services

There are two broad categories of private health care providers in South Sudan, and they engage with the public sector in different ways. The first category consists of international and local NGOs that work as key implementing partners on donor-funded health programs. Many are contracted through the HPF to deliver services on behalf of the public sector in public facilities. The HPF is funded by USAID, the UK and Canadian governments, the Swedish International Development and Cooperation Agency, Gavi—the Vaccine Alliance, and the European Union to support the operations of the public health system in six states and one administrative area, including Central Equatoria state, where Juba is located. HPF provides technical and operational support across the health system, especially related to commodity supply chains and service delivery. This support is largely provided by the NGOs that it contracts in each of its geographic areas. Stakeholder interviews indicated that as part of their relationship with HPF, NGO staff work out of public health facilities and do not typically own and operate their sites. As part of its FP strategy, HPF currently supports efforts to increase access to and use of FP services by integrating delivery of high-quality FP products and services in health facilities; supporting partner NGOs to conduct community-based outreach, education, and demand creation; and advocating with community and local government leaders to support FP programming (HPF 2018).

Outside of HPF partners, NGOs that own and operate their own clinics are rare in South Sudan. The Reproductive Health Association of South Sudan (RHASS), a local affiliate of the International Planned Parenthood Federation, owns and operates its own facilities with a focus on FP/reproductive health services in three states. RHASS is currently funded by the UK government to implement the three-year Women’s Integrated Sexual Health (WISH) 2 ACTION project (see textbox).

The second category of private health providers consists of for-profit health hospitals and clinics. This sector has little interaction with the government beyond obtaining licenses, registration, and permits and paying fees and taxes. Some providers, however, reported occasional participation in disease-specific vertical health programs (e.g., HIV, tuberculosis).

In Juba, the private for-profit sector is large and diverse. The Central Equatoria state MOH informed SHOPS Plus that 754 private health care businesses are registered in Juba alone, including 340 health facilities (private hospitals, medical centers, and clinics), 187 pharmacies, and 227 drug shops. For the sake of comparison, there are only 486 public facilities across the entire state (Ministry of Health 2020). Several stakeholders noted during interviews the presence of unlicensed “quacks” and unregistered drug shops, though their exact number isn’t known.

Recent assessments by the African Medical and Research Foundation (Amref) and Management Systems International (MSI) suggest that private facilities vary significantly in size, scope, and quality. These facilities generally lack financial resources, equipment, and staff—but still provide better salaries and are able to attract and retain more staff compared to the public sector (MSI 2020; Korsuk 2021). In addition, stakeholders highlighted that dual practice, where public providers also own or moonlight at a private facility, is legal and common. Interviews with private providers in Juba revealed additional findings about their operations. Broadly, private providers reported that they tended to see an average of 20 to 25 clients per day. This clientele is reportedly younger and wealthier than public sector clients. This is important, as facilities reported that they typically rely on out-of-pocket cash payments for revenue. A few facilities told SHOPS Plus they accept private insurance, but reported troubles related to payment delays. Though some facilities said insurance-covered services are not a major source of revenue, others reported that at least half of their clients have an insurance plan. For clients who could not afford to pay for the cost of the service, providers reported that they would generally offer an installment plan or work with the client to come to an alternative arrangement so that financial costs did not become a barrier to care.

Engaging private providers through the WISH 2 ACTION Project

RHASS currently provides technical assistance to 17 health facilities in three states under the WISH2 project to help scale up the provision of integrated sexual and reproductive health information, products, and services, with a focus on underserved women and girls. The target population for this project are youth under 20 years old, women from lower socioeconomic groups, and women living with disabilities. Of the 17 facilities that the project support, 7 are in the for-profit private sector and 6 of those are in Juba. RHASS provides these facilities with donated FP commodities, sterilization equipment, and IUD removal kits procured through UNFPA; FP clinical trainings; and community-level outreach and radio ads to generate new FP clients.

Source: Key informant interview with RHASS staff

The pharmaceutical sector in South Sudan

The 2012 Drug and Food Control Authority (DFCA) Act regulates the production and distribution of pharmaceutical products in South Sudan through specific licenses costing between 70,000

and 200,000 SSP (about \$140 to \$400) (Ministry of Justice 2012). A class A license authorizes registered pharmacists to import raw materials and manufacture products (Table 1). Class B licenses cover the importation of finished products for resale through wholesale and retail outlets. Both are issued by the DFCA Board, but class A has not been used as there is no manufacturing base in South Sudan. Other licenses issued by the state MOH authorize registered pharmacies (Class C) and drug stores/community medicine shops (Class D) to retail drugs and treat common ailments. The main differences between C and D licenses are whether the outlets are owned by a registered pharmacist and are larger than 40 square meters, or by a registered pharmacy technician and are between 20 and 40 square meters. Class D licenses also limits the range of products sold in drug stores and community shops compared to Class C.

Table 1. Summary of DFCA licenses for production and distribution of pharmaceutical products

	Manufacturing (A)	Importation (B)	Registered pharmacy (C) >40sqm	Drug store / community medicine shop (D) >20sqm
Issued to	Registered pharmacist	Registered pharmacist	Registered pharmacist	Registered pharmacy technician
Activities	Import raw material, manufacture	Import and distribute wholesale	Retail drugs, treat common ailments	Retail drugs, treat common ailments
Fee	Undetermined	200,000 SSP (about \$400)	150,000 SSP (about \$300)	70,000 SSP (about \$140)
Issuing authority	DFCA Board	DFCA Board	State MOH	State MOH

Private health sector organizing bodies

Several nascent provider organizations seek to strengthen and support health care service delivery in South Sudan and include private sector members. Three of the most relevant to the scope of this FP-focused assessment include the South Sudan Nurse and Midwife Association (SSNAMA), the South Sudan Private Health Sector Association (PHSASS), and the South Sudan Pharmacists Association (SSPA).

South Sudan Nurse and Midwife Association

The SSNAMA is recently-founded, active voluntary organization that is actively looking to partner with donors to expand the role of public and private nurses in FP. Founded in 2011, SSNAMA was largely dormant until 2017, when it began partnering with the United Nations Population Fund (UNFPA) (through Amref) and the Canadian Midwives Association. The association is governed by a 16-member board of executives, from which a 5-member secretariat is drawn to oversee daily operations. As of March 2021, SSNAMA reported 1,862 fully paid members across the public and private sectors. The association does not record whether members work in the public or private sectors, but related that widespread prevalence of dual practice means that many (if not most) of its members likely work in both.

SSNAMA's main activities include implementing advocacy and public health campaigns, providing continuing medical education and quality improvement opportunities to its members, and supporting professional regulations through its participation in the Nursing and Midwifery Technical Working Group. With funding support from UNFPA and technical support from AMREF, this support has included convening nurses and midwives for one-off clinical FP

trainings. This training focused on providing a foundational knowledge of FP and the full range of modern methods, as SSNAMA reported that participants lacked basic understanding of various FP methods and how they worked. Following this experience, the association is now looking to expand its training curriculum to build the skills of its members in IUD insertion and removal, provision of DMPA-SC, and implants. However, it indicates that doing so will require funding and donor support to access the necessary commodities.

Private Health Sector Association South Sudan

The PHSASS was established in 2015 to unify and coordinate the private the health care industry in South Sudan. PHSASS's goal is to help the private health sector better organize its service delivery and to build linkages between the public and private sectors. It aims eventually to upgrade to a federation that brings together all the relevant organizations that represent private sector, including SSNAMA, faith-based organizations, and NGOs across the country. PHSASS is led by an executive committee based in Juba, with support from a nationally representative 40-member council. PHSASS also is affiliated with several African regional organizations—including the African Health Care Federation and the African Health Business Symposium—and looks to leverage these affiliations to support its operations and growth. As of March 2021, the association had 168 members on its rolls, although this figure may not be up to date. It does not collect membership fees, but plans to start doing so in the future to fund its activities. Providers interviewed as part of this assessment indicated that they had not yet seen much benefit from their membership, indicating a need on PHSASS's part to generate more resources to better engage and support its target audience.

PHSASS states that its main activities focus on coordinating the private health sector, promoting facilities to report and improve services, and building linkages between its members and government to advocate for better policies and respond to health emergencies like COVID-19 and Ebola. In an interview with SHOPS Plus, a PHSASS representative cited the lack of a PPP unit or focal point within the MOH, as well as the absence of a policy framework for public-private engagement in the health system at either the national or state level as significant challenges to the association's advocacy work and services to its members.

PHSASS indicated that the main challenges faced by the private sector are financial in nature. The recent hike in registration fees was seen as arbitrary and solely intended to raise revenue for the government. PHSASS also mentioned two key factors that limit the ability of facility owners to invest in and expand their practices: difficulties obtaining hard currency and limited use of private financing due to strict eligibility guidelines, short repayment timelines, and interest rates as high as 20 percent.

PHSASS has had some success in addressing these challenges. The government of South Sudan recently reduced the import tax on medical equipment to 1 percent. As a result, the association is now trying to help its members to import new equipment needed to improve and expand their service offerings, with a focus on PCR (polymerase chain reaction) machines, gene-Xpert, and CT machines, which are not available in the public sector.

South Sudan Pharmacists Association

Like the SSNAMA and PHSASS, the SSPA is a new organization. The association currently represents 200 pharmacists from the public and private sectors. These members pay an annual fee of 3,000 SSP (about \$6.00), and a monthly fee of 500 SSP (about \$1.00) to support SSPA's operations. Pharmacy technicians and assistants—who account for many drug shop owners—can also join as associate members. SSPA is governed by an elected council with

representation from relevant institutions such as the MOH and academia, as well as an executive secretariat.

To date, SSPA has focused on capacity-building activities for its members. These have mainly included seminars and workshops and may include annual symposiums and conferences in the near term. SSPA is interested in partnering with government, donors, and implementing partners to help build the capacity of pharmacists and drug shop owners in administration, financial management, and program management.

Key challenges in the private health sector

In summary, the literature and key informants highlighted six major challenges in the private sector:

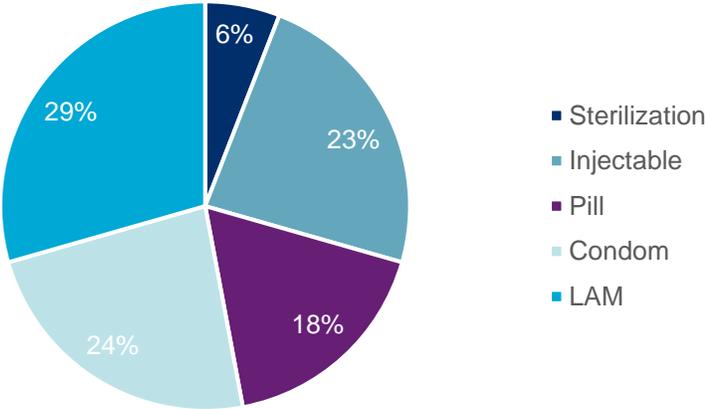
1. *Affordability*: High unemployment and widespread poverty limit the number of people who can afford fully commercial prices for products and services, and thereby the size of the private market. While some private health insurance plans limit out-of-pocket costs for members, their population coverage is very limited at only 5 percent of the population (Basaza et al 2017), mainly foreigners or the wealthy.
2. *Infrastructure*: Limited roads of poor quality, unreliable electricity, and insecurity reportedly affect the ability of private actors to access and distribute products and offer health services, except for Juba and a few other large towns.
3. *Access to finance*: Limited access to affordable financing and hard currency shortages, and an inability to secure default insurance all limit the private sector's ability to invest in its own expansion.
4. *Smuggling*: Black market smuggling is rampant in the pharmaceutical sector and disrupts market prices, negatively affecting the business viability of law-abiding suppliers.
5. *Lack of enabling environment*: Despite policy documents recognizing the need to create an enabling environment for the private health care sector, South Sudan lacks a detailed framework or mechanism for stewarding, engaging, and partnering with this sector.
6. *Clinical skills*: Private for-profit providers have limited access to support and resources needed to ensure high-quality health services. In-service training and continuing medical education are needed to maintain the providers' clinical knowledge and skills. Private facilities receive little technical oversight or support from the public sector, but recent programs have begun to leverage professional associations that could fill this gap.

Family planning in South Sudan

Understanding South Sudan’s FP market is challenged by limited available data. Due in part to the high levels of insecurity, the country lacks a recent population-based survey, such as a USAID-funded Demographic and Health Survey or Gates Foundation-funded Performance Monitoring for Action study, that typically sheds light on use and sourcing patterns. The most recent assessment—a UNICEF-funded Multiple Indicator Cluster Survey—took place before independence in 2010. The most readily available data come from the global Track20 project, which provides a high-level overview of use and method mix. The Reproductive Health Supplies Coalition (RHSC) database also summarizes donor-funded commodity shipments to South Sudan. While this source provides an overview of supplies in the public sector only, it does help understand which methods may be popular and can help inform what the total market looks like. Unfortunately, the only data available on sourcing patterns in the public and private sectors—the RHSC Commodity Gap Analysis—rely on regional data to model South Sudan’s market. While useful for higher-level planning, this modeling does not provide an accurate enough picture of South Sudan’s unique context to define the size and scope of the private sector’s role in the FP market.

The limited data available on South Sudan suggests low use of modern methods and potential opportunities for growth, especially in the private sector. Track20 estimates that only 4.2 percent of married women—and 3.2 percent of all women—use a modern contraceptive method (Track20 2020). Of those using, almost two-thirds are using a short-acting method and almost a third rely on lactational amenorrhea (Figure 4). Notably, these estimates leave out emergency contraceptive pills. While Track20’s estimates indicate that there are minor differentials based on wealth, age, and location, these differences are minor in light of the overall low usage.

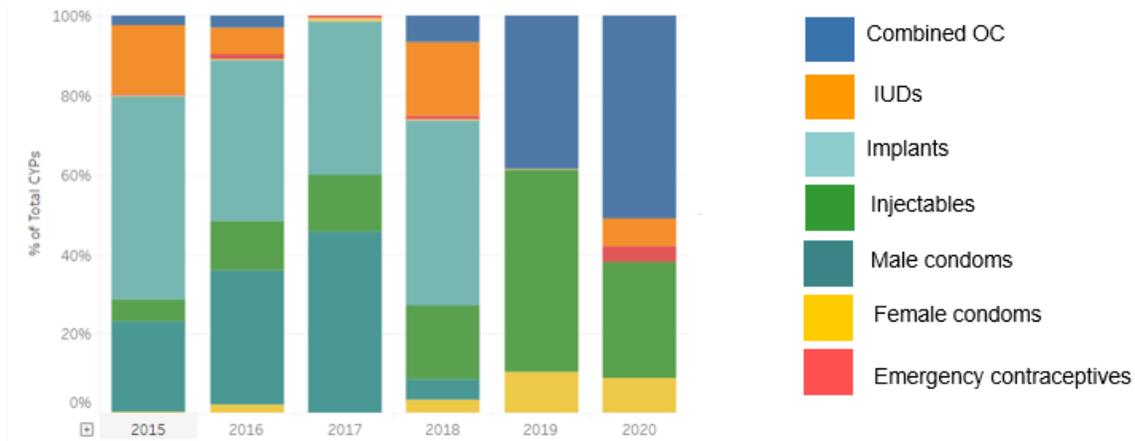
Figure 4. Modern contraceptive method mix



Source: Track20 2020

FP commodity shipment reports from the RH Viz database largely validate these estimates (Figure 5). Donated commodities shipped by UNFPA and channeled to public health facilities through the HPF reflect a growing shift toward short-acting methods, especially oral contraceptives and injectables.

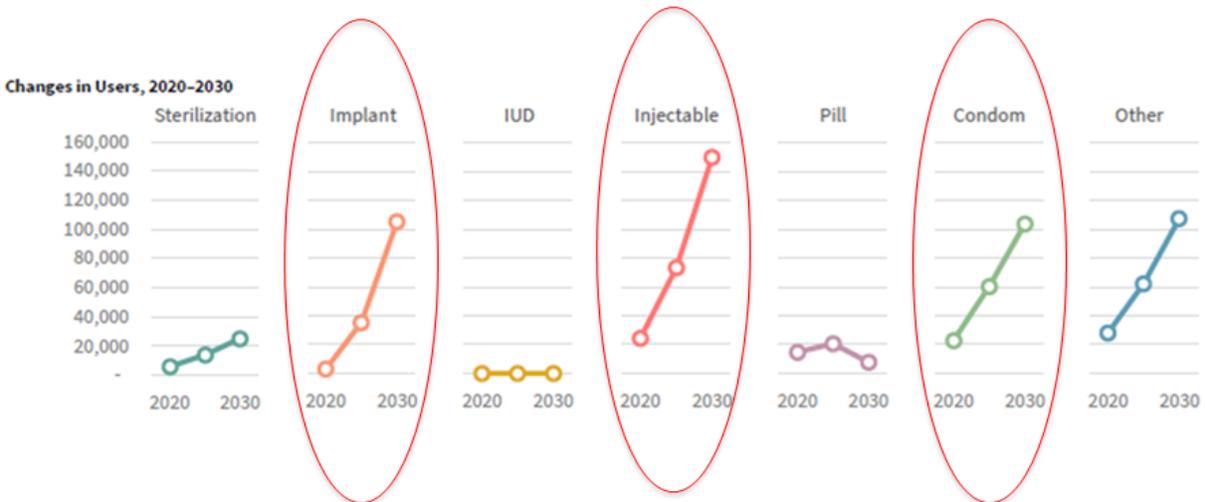
Figure 5. Mix of methods shipped to South Sudan, by contribution to couple years of protection



Source: RHSC 2020

Despite a very low mCPR, there are indications that there is room for relatively rapid growth. Track20 estimates suggest that 30.7 percent of married women have an unmet need for FP and that only 14.7 percent of demand is satisfied by a modern method. In line with these estimates, the 2019 RCHS Commodity Gap Analysis estimates that FP use will grow almost fivefold between 2020 and 2030 (Figure 6). Most of this growth is projected to come from increased use of three methods: implants, injectables, and condoms (RHSC 2019).

Figure 6. Projected growth in South Sudan's family planning market



Source: RCHS 2019

To achieve this level of growth, FP stakeholders will have to address the main barrier to use: very low demand. Factors behind low demand are well documented and include strong preferences for large families, socio-cultural factors such as postpartum spousal separation that reduce the saliency of modern methods, fears and misconceptions about modern methods, high levels of gender-based violence, and power dynamics that emphasize the role of the husband in women's health care decision-making (Pillsbury 2011; Kane et al. 2016; Elmusharaf. 2017).

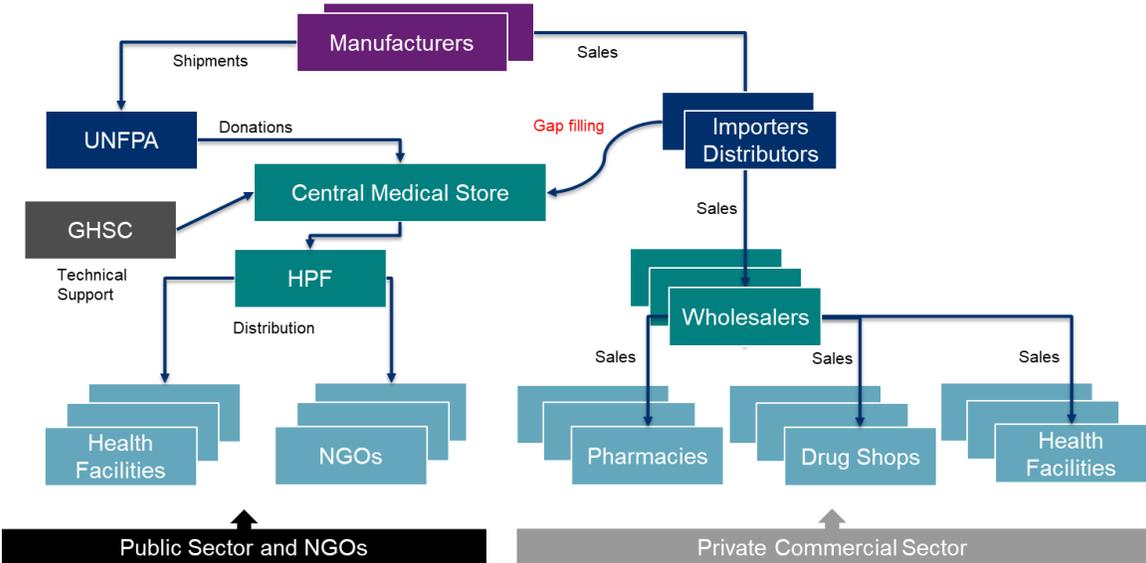
As is discussed in the next section, private providers and pharmaceutical suppliers interviewed for this assessment indicated that they would be willing to expand their product and service offerings if they felt there was demand for them. Although supply-side improvements in the FP market could stimulate increases in demand, the private sector is primarily reactive, and many of the current barriers to use are normative and entrenched. Consequently, significant investments in behavior change and other demand side interventions are likely needed to justify increased private sector participation in this market.

Provision of FP products and services

Product supply

FP products in South Sudan are channeled through two distinct, mostly independent supply chains (Figure 7). Large quantities of contraceptives used in South Sudan are supplied by UNFPA and delivered through humanitarian and development projects. Donated contraceptives are for the most part channeled through the HPF program, which picks up commodities from the government’s Central Medical Store and delivers them to public facilities and NGOs. An unknown volume of commercial brands is also channeled through the private pharmaceutical supply chain for sale through retail and service delivery outlets. Commercial products are directly ordered by private importers from a variety of suppliers around the world. The two supply chains (public/NGO and private) rarely intersect unless the Central Medical Store or an NGO needs to source additional products or supplies from commercial importers, but those do not usually include contraceptives.

Figure 7. FP product supply chains in South Sudan



The private market for contraceptives: Structure and main

Several private organizations import, distribute and sell FP products in Juba, where the pharmaceutical sector is strongest. Distributors holding a Class B importation license procure contraceptive brands from Europe, Asia, and East Africa for resale to wholesalers, retailers, and private health care facilities. Wholesalers outside Juba do not usually import drugs but purchase what they need from Juba distributors. The sale of hormonal short-acting contraceptives (emergency contraceptive pills, oral contraceptive pills, injectables, etc.) through retail outlets is legally restricted to registered pharmacies; however, these products are commonly found in drug shops, including at those offering DMPA injections. Large pharmacies tend to have a higher variety of products and brands compared to drug shops. Little is known about the presence and sale of contraceptives in unregistered or otherwise illegal outlets.

Clinic-based private providers can legally store and sell products needed to administer treatment (such as injections). In addition, many clinic owners also own pharmacies, which allows them to earn additional income from the sale of medicines. Most of the health providers interviewed reported selling contraceptives to their patients.

Unlike most neighboring countries, South Sudan does not have a social marketing program involving the sale of subsidized contraceptives through commercial outlets. Products sold at private pharmacies are purchased from private wholesalers and sold to clients at full price, without any external financial assistance. In this sense,, the current supply of FP products in the private sector is commercially and financially sustainable. However, this sector faces several limitations: it serves a limited client base with the ability to pay current commercial prices; it likely only has a limited geographic coverage in areas with sound enough infrastructure (e.g., Juba, Wau); and it does not have to comply with product range and quality requirements found in other sectors. Consequently, it may not by itself serve all South Sudanese clients. However, it still provides opportunities for donor-supported initiatives to expand access to contraceptives outside government and NGO programs, notably through subsidized interventions such as social marketing.

The assessment team also identified products imported from Uganda and Kenya that are marketed through social marketing programs and likely sold to the trade at a subsidized price. While the products' distribution in South Sudan is privately financed, the products may eventually become unavailable to importers if the social marketing programs end. The Abt team did not find evidence of donated public sector commodities in commercial outlets, though a more systematic survey might reveal leakages, particularly in areas outside of Juba that commercial suppliers cannot reach adequately.

Distributors in Juba import a variety of brands in the same formulation to meet their different client segments. These companies tend to know their market well and seem adept at finding low-cost products, such as branded products sold by generic manufacturers in Asia (known as branded generics). In interviews, wholesalers and retailers acknowledged that there is demand for contraceptives in Juba but their low-cost/low-volume profile make them relatively unprofitable. One wholesaler said that he brings in contraceptives on demand as a way to build client loyalty.

Contraceptive products available in Juba outlets

FP products found for sale in private outlets include condoms, oral and injectable contraceptives, and emergency contraceptive pills. No products associated with long acting reversible contraceptive methods (i.e. hormonal or non-hormonal IUDs, implants) were found for sale at private retail outlets. Overall, pharmacies and drug shops offer a surprisingly wide range of condoms and contraceptives at different prices. The assessment team found at least 10 brands of condoms imported from India, Indonesia, Malaysia, and Thailand. The company with the largest presence in pharmacies is Lifestyles-Suretex, which owns *Flavours*, *Skyn*, and *Rough Rider* brands, retailing between \$3.00 and \$7.00 for packets of three condoms. Social marketing brands diverted from their intended markets in neighboring countries include *Trust* and *Kiss* (DKT International) and *Lifeguard* (Marie Stopes Uganda), all selling under \$1 for a pack of three condoms.

Table 2. Condom brands sold in pharmacies and drug shops

Brand	Owner	Origin	Price US\$ (low)	Price US\$ (high)
Super Protector x3	Pharma Vista	India	0.21	0.64
Lifeguard x3	MSI Uganda	India	0.64	1.06
Lifeguard x3	MSI Uganda	Thailand	0.43	1.06
Kiss x3	DKT International	Thailand		3.19
Trust x3	DKT International	India	0.64	3.19
Flavours x3	Lifestyles-Suretex	Thailand	3.19	
Skyn x3	Lifestyles-Suretex	Thailand	4.26	
Powerplay x3	Contempo	South Africa	4.26	
Simplex	Contempo	Indonesia	5.32	
Rough Rider x3	Lifestyles-Suretex	Thailand	4.26	7.45
Romantic Love x3	Takaso Rubber Products	Malaysia	4.26	

Second-generation oral contraceptives brands made by Bayer and Pfizer are also available in pharmacies and drug shops, including *Microgynon* and *Microgynon Fe* (for developing markets), retailing between \$3.00 and \$6.00 per cycle. Pharmaceutical outlets also tend to carry branded generic formulations equivalent to the above, including Zinnia (Mylan), retailing for about \$4.00, and diverted social marketing brands Pilplan and Femiplan, retailing between \$1.00 and \$2.00.

Table 3. Oral contraceptive pill brands sold in pharmacies and drug shops

Brand	Formulation	Owner	Origin	Price US\$ (low)	Price US\$ (high)
Microgynon	Lev. 0.15 EE. 0.03mg	Bayer	Turkey	6.38	6.38
Microgynon ED Fe	Lev. 0.15 EE. 0.03mg FE Sa 75	Bayer	Belgium	1.06	7.45
Cyclo-Progynova	Estra.Val.Norg 2/2/0.5	Bayer	Germany	4.26	10.64
Yasmin	Drospir. 3mg/ EE 3mcg	Bayer	Turkey	21.28	
Microlut	Lev. 0.03mg (POP)	Bayer	Germany	3.19	6.38
Pilplan Plus	Lev. 0.15 EE. 0.03mg FE Sa 75	FHI360	Germany	1.06	
Femiplan	Lev. 0.15 EE. 0.03mg	PSI	India	1.06	2.13
Zinnia P	Lev. 0.15 EE. 0.03mg	Mylan	India	4.26	4.26

Injectables available in both outlet types include *Depo-Provera* and branded generic equivalents *Injectaplan*, *Mygesty*, and *Triclofem*. These products retail between \$1.00 and \$5.00.

Table 4. Injectable DMPA brands sold in pharmacies and drug shops

Brand	Formulation	Owner	Origin	Price US\$ (low)	Price US\$ (high)
Depo Provera	DMPA 150mg/1ml	Pfizer	Turkey	1.06	5.32
Sayana Press	DMPA 104mg/1ml	Pfizer	Belgium	1.06	
Injectaplan	DMPA 150mg/1ml	FHI360	Uganda	1.49	3.19
Majesty	DMPA 150mg/1ml	Mylan Lab	India	2.13	
Triclofem	DMPA 150mg/1ml	P.T. Tunggal Pharma	Indonesia	0.64	2.13

It should be noted that Sayana Press is likely not purchased directly from Pfizer but either leaked from the public sector or imported from a neighboring country where it is marketed as a social marketing brand. Because none of the 10 wholesalers interviewed for the assessment import Sayana Press, it is likely sourced locally from a public or NGO source.

Emergency contraceptive pills are the best-selling contraceptive method in pharmacies. Brands include *Postinor 2* and *Norlevo* retailing between \$1.70 and \$5.00, as well as branded generic equivalents priced between \$2.00 and \$4.00.

Table 5. Emergency contraceptive pill brands sold in pharmacies and drug shops

Brand	Formulation	Owner	Origin	Price US\$ (low)	Price US\$ (high)
Postinor 2	Levonorgestrel 0.75mg	Gedeon Richter	Hungary	2.13	5.32
Norlevo	Levonorgestrel 1.5mg	HRA Pharma	France	1.70	
Exeltis	Levonorgestrel 0.75mg	Exeltis	Spain	2.13	3.19
Backup	Levonorgestrel 1.5mg	Acme	India	6.38	
I-Pill	Levonorgestrel 1.5mg	Cipla	India	7.45	
Generic EC	Levonorgestrel .75m	Lab. Leon Pharma	Indonesia	3.19	4.26

Most hormonal contraceptives found in Juba outlets are approved by the World Health Organization or other Stringent Regulatory Authority and can be considered quality products. There was no evidence of counterfeit products in the stores visited for the assessment.

Supply gaps and challenges to market growth

Some contraceptive products are not available in commercial outlets

Pharmacies and drug shops supply products that they perceive to be in demand, including condoms, oral pills, injectables, and especially emergency contraceptive pills. The assessment team did not find any IUDs in retail outlets, most likely because no one asks for them as few private providers are trained in the method. As in other countries of the region, implants manufactured by Merck and Bayer are only distributed through public and NGO channels and not accessible to commercial wholesalers.

Private wholesalers lack incentives to invest in FP products

Investment in the pharmaceutical sector is geared toward maximizing the availability and sale of products in retail outlets. Successful distributors spend time and resources seeking the right mix of suppliers and optimizing their orders to minimize stockouts and manage cash. They also aim to achieve a high return on investment by building a portfolio of products that maximizes both volume and income. To this end, they often invest in discounts, sales commissions, and sometimes limited advertising campaigns focusing on specific products. Presently, private importers and retailers of contraceptives have little incentive to promote or expand this class of product because it generates minimal profits or volume. Wholesalers outside Juba may be even less likely to prioritize contraceptives as transportation costs are high and demand for these products probably lower. This, however, would need to be verified.

Low-cost condoms, pills, and injectables may come from unsustainable

The lowest-priced products available in pharmacies and drug shops tend to be social marketed products diverted from their intended market. These important options for South Sudanese users may not be sustainable if the social marketing programs that market them in neighboring countries come to an end. Wholesalers looking for more reliable alternatives may have difficulty identifying products of equivalent quality at similar prices on the world market.

Contraceptive suppliers know very little about FP

Distributors and wholesalers do not have much insight into the market for FP products. There is no evidence that pharmacists or drug shop attendants have ever received any training in contraceptive technology, and distributors indicated that their sales teams do not promote contraceptives. However, several distributors and wholesalers interviewed by SHOPS Plus said they would welcome more collaboration with donor-supported programs focusing on this class of products.

FP services in the private sector

Provision of FP services in private facilities

Scant information is available about private facilities in South Sudan, particularly their contribution to the supply of FP services. The most notable effort to document this sector has been a UNFPA-supported Amref assessment of private provider readiness for inclusion in a social franchise. Amref assessed 150 facilities (about half of all registered facilities) in Juba and Wau and found that only a minority provide FP services. About half of the 4 percent of clients who ask for FP methods are referred to other facilities because their method of choice is not available. Interviews of private providers indicated that client demand for FP tends to exceed the supply of products or related services, condoms excepted (Korsuk 2020). This is especially the case for implants as only 50 percent of clients seeking the method were able to obtain it. The AMREF assessment noted that some private providers were interested in offering FP and expanding services for young people. However, the assessors found great variations in readiness across clinics, medical centers, and hospitals, suggesting that capacity building would need to be tailored.

SHOPS Plus conducted interviews with 10 Juba facility owners who estimated the percentage of clients requesting FP services at 2–5 percent of their total client volume. Facilities usually provide FP services in the context of primary care, pediatric, obstetrics/gynecology, and antenatal services, but not as a stand-alone service. Most providers reported offering condoms, combined oral contraceptives, emergency pills, and injectables, which are available at wholesalers and generate sales income. Some larger facilities order their own products directly, typically from Uganda or Sudan.

Some providers were interested in offering IUDs and implants. Most, however, are not trained in these methods and cannot find needed products and supplies. As a result, they typically refer clients who ask for these methods to public facilities. Providers who expressed interest in expanding FP services planned to continue to offer FP as part of general or Ob/Gyn services. General practitioners appeared least motivated to grow their FP services for lack of time, space, or financial incentive. One large polyclinic that offers removal services for implants and IUDs was not interested in expanding their offering to include additional FP services because they are not in high demand. One facility would not offer FP for religious reasons. Only one provider (a gynecologist with a large practice) expressed interest in providing stand-alone FP services if his staff is trained in long-acting and reversible contraception (LARC).

The pricing of FP services in the private sector tends to be inconsistent (Table 6). Providers who own pharmacies on site or nearby consider contraceptives to be an important source of revenue. Because most FP clients request condoms, pills, or injectables, charging for products rather than services may be more profitable for some providers. FP services offered in the context of another paying service (such as Ob/Gyn, which may cost between \$2.00 and \$4.00 for a consultation) are free but typically lead to the purchasing of contraceptives from the provider. Implant or IUD removals, which do not involve buying a product, cost around \$5.00 at a gynecology practice. The pricing of contraceptives at private facilities is linked to their procurement costs at the wholesale level where inflation and currency fluctuations trigger frequent increases. A reliance on out-of-pocket payments for these products, coupled with a low ability to pay, limits the upper range of these price fluctuations.

Table 6. Prices of contraceptives in private facilities

Method	Price to client
Condoms (3 pack)	\$0.5 - \$2.00
Injectable DMPA	\$2.00 with injection
EC	\$1.00 - \$5.00
Combined pill (cycle)	\$2.00 - \$6.00
Progestin-only pill (cycle)	\$3.00 - \$9.00

Source: Korsuk 2020

The Amref report indicated that clients seeking FP services in clinics, hospitals, and pharmacies account for 4 percent of all clients (Korsuk 2021). In the Amref report, private sector users were described as relatively affluent, as determined by their ability to pay for services. Most of them were married women seeking a FP method, and teenagers looking for condoms and emergency pills (Ibid.). Providers interviewed by SHOPS Plus also mentioned married women as the main FP clientele, and in the case of a large general practice, sex workers. Providers reported a client preference for discreet methods like DMPA-SC and emergency contraceptive pills, a general lack of awareness of LARC, or fear of side effects linked to these methods.

Gaps and challenges in the delivery of FP services

Private providers face significant barriers in meeting the demand for FP services, some context-driven, and others specific to this class of service.

Private facilities face the same constraints as other businesses in South Sudan

Many providers struggle to keep their practice afloat in a fragile economic context where medicines and supplies are expensive and accessing credit and financing difficult, and average citizens have limited resources to spend on health services. Private providers face significant constraints as they try to break even while maintaining a loyal clientele and ensuring a steady income for the practice is an overarching preoccupation. Most facilities have a mix of insured and non-insured clients whose ability to pay influences business practices, such as the organization of services and the prices extended to clients. Some providers are unable to grow their practice because they lack the space needed for new services or the resources to train staff and buy equipment.

Private providers are limited in their capacity to offer a full method mix

The limited demand for FP from private sector clients is mostly met through emergency contraceptive pills and other short-term methods. Because very few facilities currently have the capacity to provide implants or IUDs, the few clients who request one of these methods are

referred to a public facility. The combination of these two factors keeps the private FP practice to a strict minimum and highly dependent on short-acting, resupply methods.

Private facilities are unlikely to change their business model

An important finding of the Amref assessment is that the high cost of labor leads private facilities to rationalize the use of clinical staff (Korsuk 2020). This is one factor that contributes to the integration of FP services into general medicine or Ob/Gyn practices, to prevent the need for additional specialized staff. This can be challenging if the goal is to establish a provider franchise where FP services are required to have a dedicated space of sufficient size and staff. According to Amref, few facilities are willing to create a dedicated FP unit that might tie up staff who could be doing something else. In addition, the legal requirement that restricts ownership of a for-profit health practice to licensed doctors prevents midwives from opening their own clinics and becoming major FP providers as is the case in Uganda.

Private providers are essentially on their own

The Amref assessment stressed the need for supportive supervision of private providers and improved government collaboration with this sector (Korsuk 2020). Providers interviewed by SHOPS Plus confirmed that they rarely receive visits from government staff and only interact with them as is required in the context of registration and the payment of taxes and fees. The involvement of private providers under donor-supported FP initiatives has also been very limited, apart from the activities described below.

Engagement of private providers under donor-funded FP programs

Evidence to Action

Under the Evidence to Action (E2A) project, IntraHealth built the capacity of six providers working in three for-profit health facilities. The facility owners entered into an informal agreement with the project to provide voluntary FP services at no charge in return for free commodities and the consumables and equipment needed to provide LARC methods. E2A supplied free condoms, pills, injectables and implants, and trained the facilities staff in comprehensive FP services, including counseling and follow-up, and provision of FP methods, including DMPA-SC injection and implant/IUD insertion. Support from the project did not include the promotion of FP services or other forms of demand creation that might help attract new clients. The outcome of the partnership ranged from a small uptick to a 55 percent increase in client flows for FP at one facility.

While supplies lasted, the supported facilities provided contraceptives at no charge, except for emergency contraceptive pills, which were not provided by the program and remained for sale. When SHOPS Plus visited the three facilities in February 2021, the facilities reported having last received supplies in November 2020 and had begun to run out of some methods. These facilities planned to return to commercial procurement in the future and indicated that they would reintroduce fees to cover their costs. One facility had hoped to attract new clients for other services but found that few were paying clients and decided to charge a fee for FP services while supplies lasted.

Women's Integrated Sexual Health 2 ACTION project

This three-year program funded by the UK Foreign, Commonwealth & Development Office (formerly the Department for International Development) supported the RHASS to provide

integrated sexual and reproductive health information, products, and services to underserved populations. These groups included youth, lower-income women, and people living with disabilities. The intervention included partnerships with seven private facilities and included donations of sterilization equipment, IUD removal kits, and the training of clinical staff. WISH 2 ACTION also supported communications to help create demand for the new FP services through both community-based outreach and radio advertisements. The program allowed providers to charge up to \$0.5 to \$1.00 for consultation fees. As a result, the number of clients receiving services at supported facilities increased from 10–15 to over 100 clients/month. The WISH 2 ACTION program is currently implementing a pilot that involves partnering with facilities to train women to administer self-injections.

AMREF/UNFPA FP franchise

As of April 2021, UNFPA had supported AMREF to train 117 service providers in 51 facilities located in Juba and Wau, some of which have begun to offer FP services. Building on this base, AMREF hopes to roll out a franchise model involving the provision of free FP commodities and supportive supervision to facilities willing to offer FP services for a minimal fee and report into the national health database. The program would start with 30 facilities deemed ready based on criteria including physical space, provider interest, and clinical skills. At the time of the assessment, the franchise project was still at the concept stage as questions remain about funding, the role of the government, and what facilities should be allowed to charge for FP services.

Kimu clinic in Juba

This primary health care clinic staffed by nurses and midwives was able to register as an NGO because it operates in partnership with the Central Equatoria state MOH. KIMU receives free commodities from the state and in turn provides vaccination, antenatal care, and antiretroviral therapy services at no charge to clients. For all other services the practice charges a consultation fee of 200 SSP (about \$0.40) and sells drugs at commercial prices. KIMU is supplied by Health Link South Sudan, a non-profit NGO that handles drug deliveries to public facilities and occasionally provides them with FP commodities.

KIMU offers condoms, pills, injectables, and implants at no charge to paying ante- and postnatal care clients as long as supplies last. The facility has partnered with WISH 2, the E2A project and Amref from which it has received various deliveries of FP commodities over time. At the time of the assessment, however, KIMU was out of FP products and reported frequent stockouts.

Private sector engagement strategies to increase use of voluntary FP

Opportunities and challenges

The SHOPS Plus assessment in Juba identified significant unused capacity for private actors to help grow the market for voluntary FP services and increase the availability of, access to, and use of FP information, products, and services. Several positive factors would justify engaging this sector in both the pharmaceutical and health services sectors (Table 7). In the areas in and immediately around Juba, there is substantial infrastructure in the private health sector that is already offering some voluntary FP information, products, and services, and has demonstrated an ability to respond to demand. There is a supply chain capable of sustainably introducing and delivering new methods. And there are associations that can serve as aggregators to reach large numbers of private providers and retail outlets with clinical trainings to support the introduction of new methods.

Table 7: Positive factors for private sector engagement

Pharmaceutical sector	
<ul style="list-style-type: none"> • A functional pharmaceutical infrastructure, at least in Juba • Established importation and distribution of contraceptives at commercially sustainable prices • General availability of low-cost generic products in retail outlets • Few barriers to the registration of new products • A customer base with the ability to pay for commercial contraceptives • Provision of injectable services in pharmaceutical outlets • Capacity to disseminate information about contraception through pharmacies 	<ul style="list-style-type: none"> • A large number of for-profit facilities (300 in Juba at last count) • Demonstrated unmet need for FP services among private sector clients • A client base with the ability to pay for services and a demonstrated willingness to pay for modern methods (e.g., emergency contraceptive pills) • For-profit facilities willing to offer expanded FP services at affordable prices • Professional associations with the potential to represent and build the capacity of private providers

The limitations inherent to the for-profit nature of private health services must be mitigated for PSE to be productive. These challenges can be grouped into two categories: clinical and business-related. On the clinical side, the for-profit health sector currently lacks any kind of mechanism for routinely building the skills and knowledge of its health workforce in FP and of ensuring the quality of the FP services offered. Many facilities would also need to make capital improvements to have an adequate private space to offer FP counseling and a broader range of services. And for-profit facilities need increased access to commodities, consumables, and equipment needed to offer the full range of modern methods (i.e., IUDs and implants). In many neighboring countries, donors have invested in social franchising programs that support private providers to address these exact challenges. However, the time, financial, and technical requirements needed to make these programs work are substantial and difficult to sustain over time.

On their own, private for-profit providers are unlikely to make the investments needed to scale up FP offerings due to the business-related challenges. Because of the market difficulties (e.g., high costs, difficulty accessing finance, and limited ability to pay for a fully commercial LARC service), private providers have adopted business strategies that aim to control costs and optimize profits as much as possible. This need is incompatible with stand-alone FP services due to their low profit margins and very low demand. While there are partnership models that leverage private facilities to distribute donated contraceptives at a free or heavily subsidized price, these models need to be carefully designed so as to recognize the financial needs of private facilities and avoid undercutting existing private sustainable supply chains for commercial brands. Additionally, building demand to create a market that is large enough for a viable low-margin, high-volume strategy requires addressing entrenched socio-cultural barriers to FP use in South Sudan. Addressing these barriers singlehandedly is not within the capacity or the business interest of the for-profit health sector and would require substantial investments from the government of South Sudan and its donor partners. Ideally, demand creation messages would mention the availability of FP services from a variety of sources, including private clinics and pharmacies.

Prioritized market segments and proposed interventions

The findings of this assessment suggest that improved, strategic PSE could support the growth of the FP market in South Sudan. There are two potential market segments that the private sector could better serve:

1. ***Women of reproductive age (WRA) and couples who are currently already using the private sector for FP or other services***, including those who have an unmet need, those who are currently using a short-acting method and want to switch to a long-acting reversible contraceptive or permanent method, and those who may have a need for FP in the next two years, such as newlyweds. These groups are assumed to have ability to pay for private sector services (though affordability is still important to them). Their FP intentions and needs, however, may vary, so enough private providers must be capable of offering a broad method mix to ensure that women can easily find their preferred method from a private source. For this user segment, the focus should be to capacitate private providers to offer a broader range of methods at affordable prices and maximize the use of private wholesalers able to source and distribute commercially priced FP products. Public supplies in this case would be limited to products that cannot be procured commercial such as implants and Sayana Press.
2. ***WRA and couples who would benefit from increased availability of FP in the private sector***, including those living in areas with limited access to FP services through either sector, and those who cannot afford to pay commercial prices for FP products and services but live near private outlets. For this segment, the strategy should be to explore the use of PPPs to expand access to subsidized commodities and donor-funded programs. Such a PPP model should include reasonable eligibility criteria for private providers, facilitate access to any needed clinical trainings, and link private providers to clinical mentors to ensure quality as services are introduced and scaled up. They should also include a comprehensive strategy to finance the model – whether through a combination of donor subsidies, out of pocket payments, or other financing mechanisms – so that for-profit providers are able to cover all of the costs of participating in the partnership and have a financial incentive to promote the services.

To better serve these segments, USAID should also consider supporting interventions that increase the body of knowledge about private sector presence and capacity, strengthen supply chains for contraceptives, and increase the demand for modern FP methods.

Generate additional quantitative data about the private health sector

This assessment and others like it are just the first step in identifying opportunities to work with the private sector. To make detailed plans and strategies, donors and governments need to know more specifically where private providers are located and what services they are currently offering. This type of data already exists in paper-based facility registries kept at the state level and are relatively up to date because they are used to collect registration fees. Once obtained and converted to a user-friendly format, this information will provide a baseline for estimating and growing capacity and resources in the private sector.

USAID should also consider supporting a census of private health facilities operating beyond Juba. This census could include questions related to service offerings and clinical capacity to help map the private health sector in other states and identify opportunities to leverage its footprint.

Strengthen the policy framework for private sector engagement

To better integrate the private sector into the broader health system, USAID may want to support the development of a policy framework for PSE. As noted, the MOH has yet to develop detailed guidance or a mechanism to enable PPPs. USAID can support PHSASS, or other associations with ties to regional federations like the East Africa Healthcare Federation and the African Health Business Symposium, to adapt PPP models that have proven successful in neighboring countries. These efforts should include incorporating detailed PSE guidance in the FP Costed Implementation Plan and developing mechanisms and resources for PPPs at the state and county levels.

Ensure the continued availability of contraceptives in retail outlets

Private importers in South Sudan have demonstrated the ability to source and distribute FP commodities, at least in Juba and its immediate surroundings. The assessment, however, reported some gaps and risks that could compromise efforts to scale up overall access to FP in the private sector. The selling and use of social marketing products not intended for South Sudan raises the risk of product stockouts or price increases should donors in other countries decide to end these programs. To address this risk, USAID should consider helping commercial importers identify low-cost alternatives to these products on the global market.

USAID may also consider supporting the distribution of implants and DMPA-SC in select pharmacies. The absence of implants at wholesalers and pharmacies is a serious barrier that once lifted could make a considerable difference in the sourcing of this method through private facilities. While the implants supplied by UNFPA are intended for the public sector, other implants may be imported by distributors for resale to private providers, such as the two-rod Sino-Implant implant marketed as Levoplant in developing markets. The lack of IUDs in commercial channels is much easier to solve, as these products are both easy to import and very affordable. Demand, however, is what is needed for wholesalers to start carrying them. Finally, USAID could engage select wholesalers and pharmacies in a partnership to distribute DMPA-SC to capitalize on ongoing pilots to train women in self-injection.

Increase the number of facilities able to respond to the demand for FP

The most effective way to rapidly increase the availability of FP services to private facilities is to provide one-time FP training for all clinical staff authorized to provide these services. Besides nurses and midwives, general practitioners, obstetrician/gynecologists, and even pediatricians should be considered potential FP providers since their practices in theory already include these services. Rather than removing FP from specialty practice to create stand-alone FP practices that may not be profitable, the goal should be to maximize their integration with services that clients are already using and paying for. The one-time training could then be transitioned to on-demand training courses offered by professional associations such as PHSASS, SSNAMA, or SSPA.

Develop partnerships with the private sector in underserved areas

In areas where public facilities cannot serve everyone, it may be possible to equip and train private providers to offer a full range of FP information, products, and services. In these areas, commercial FP products may also be harder to procure, and potential FP clients may be unable to pay normal private fees for product and services. In this context, subsidizing the cost of both FP commodities and services makes sense. USAID, together with UNFPA and the HPF project, can supply private clinics with FP commodities either directly or through NGO-operated public facilities. Additionally, donors should consider how the costs of consumables and equipment needed to offer IUD and implant insertion and removal, as well as deliver permanent methods, will be covered – either through similar access to donated resources or by linking private providers to low-cost sources where they can purchase the materials themselves. This partnership model also requires training and supportive supervision to ensure quality of care and is similar to the proposed Amref network in South Sudan. While products are donated and expected to be passed on at no charge to clients, facilities must still be able to charge a fee to cover their staff, equipment, and overhead costs. Alternatively, they could be contracted by a program or the state government to provide voluntary FP services for a negotiated fee. Under this model, delivering stand-alone FP services may be financially feasible for private for-profit facilities, but its sustainability is still predicated on significant increases in the demand for FP services.

Investing in provider-led demand creation for FP services

Investing in behavior change and FP promotion is a function of any program aiming to access to, availability of, and use of voluntary FP. In the private sector, FP clients depend on the ability of doctors and pharmacists to counsel and subsequently refer them appropriately, even if they cannot themselves offer the desired service or FP method. Potential FP clients in South Sudan are likely to face untrained pharmacists and doctors who hesitate to raise the topic or negative views towards the use of modern FP methods, calling for the large-scale education of these key influencers so they may provide a better service to their clients. This requires building more than just the clinical knowledge of providers—research from Ghana indicates that pharmacists and drug shop vendors especially require additional training in negotiation skills to help counsel, walk interested clients through their options, counter myths and misconceptions, and advise them on which FP methods might best suit their needs (El-Khoury et al 2016). These efforts should be linked to broader interventions to build demand for FP, similar to the support that facilities received under the WISH 2 ACTION project.

Conclusion

As a young country with new institutions, limited resources, and a persistent conflict, South Sudan faces numerous challenges in delivering health services to its population and struggles to address a high unmet need for FP. The private sector, especially in and around Juba, can help meet a substantial portion of the demand for FP through its presence, enterprising spirit, and resources. The findings and recommendations in this report were intended to inform USAID and its partners of low-hanging opportunities and approaches that can help better leverage this sector to improve availability, access, and use of voluntary FP information, products, and services.

To realize these opportunities, efforts should focus on reducing supply and capacity gaps in the private health care sector and reducing risks and financial barriers inherent to private practice in South Sudan. Strategies recommended by SHOPS Plus include investing in the large-scale clinical training of general practitioners, specialists, and midwives and effective quality assurance systems to support them as they begin offering the full range of modern FP methods; increasing the availability of implants, DMPA-SC, and IUDs in private sector channels; building an enabling environment for PPPs; and supporting demand-creation activities to reduce entrenched misconceptions about modern methods of contraception.

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