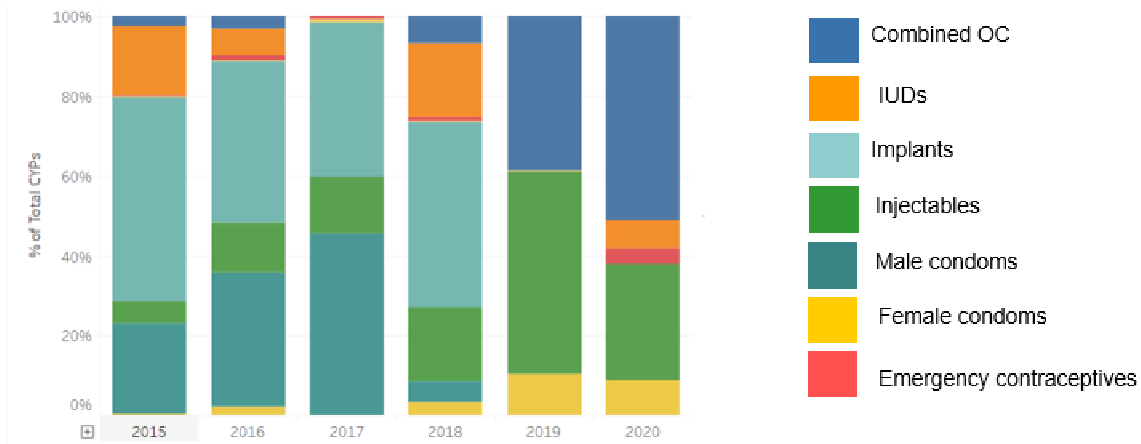
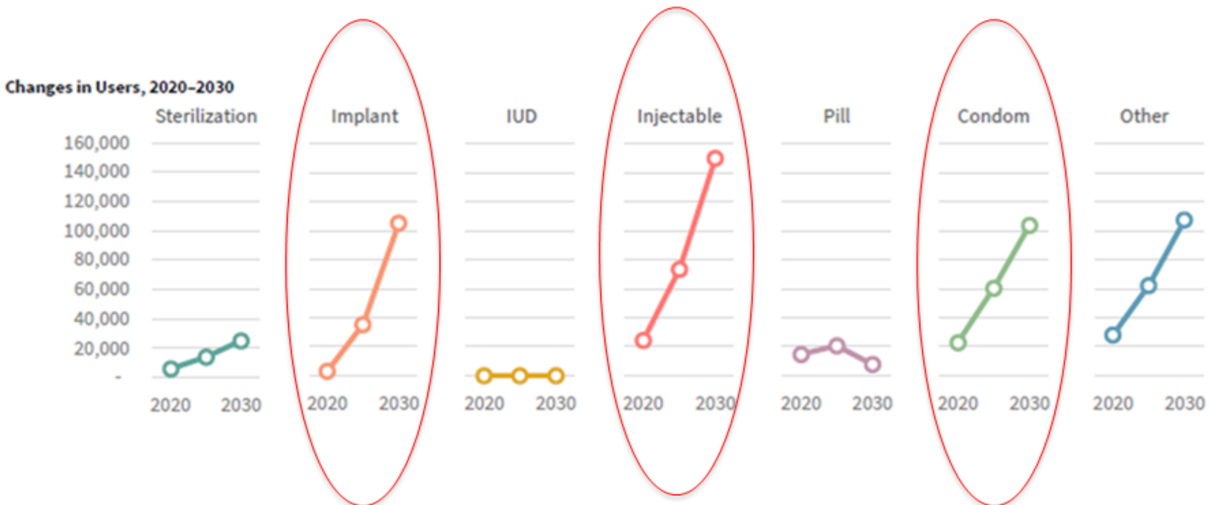
Figure 5. Mix of methods shipped to South Sudan, by contribution to couple years of protection



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

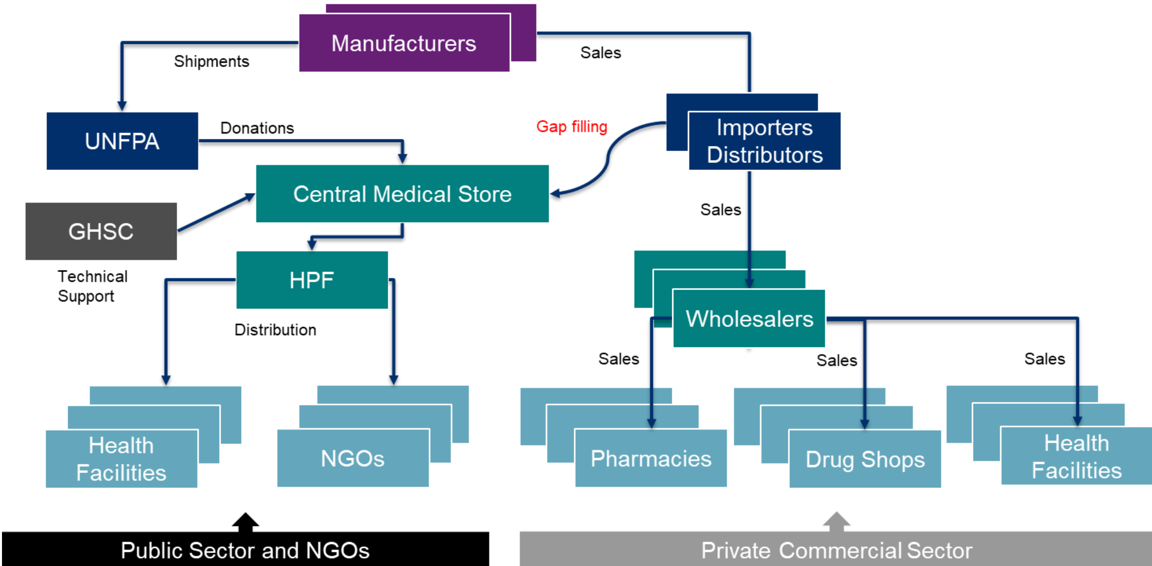
To achieve this level of growth, FP stakeholders will have to address the main barrier to use: very low demand. Factors behind low demand are well documented and include strong preferences for large families, socio-cultural factors such as postpartum spousal separation that reduce the saliency of modern 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).

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.

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.

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 products, 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

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	
• 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	• 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.

References

Basaza, R, PK Alier, P Kirabira, D Ogubi, and RLL Lako. 2017. "Willingness to Pay for National Health Insurance Fund among public servants in Juba City, South Sudan: a contingent evaluation." *International Journal for Equity in Health* 16 (158).

Belaid, L, P Bayo, L Kamau, E Nakimuli, E Omoro, R Lobor, B Samson, and A Dimiti. 2020. "Health policy mapping and system gaps impeding the implementation of reproductive, maternal, neonatal, child, and adolescent health programs in South Sudan: a scoping review." *Conflict and Health* 14 (20).

El-Khoury, Marianne, Kathryn Banke, Phoebe Sloane. January 2016. Introducing zinc through the private sector in Ghana: Evaluation of caregiver diarrhea treatment practices. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.

Elmusharaf, K, E Byrne, and D O'Donovan. 2017. "Social and traditional practices and their implications for family planning: a participatory ethnographic study in Renk, South Sudan." *Reproductive Health* 14 (10).

Health Pooled Fund. 2018. *FP Technical Strategy, 2019-2023.* Juba: Health Pooled Fund.

———. 2021. *Health Systems Stabilisation & Delivery*. Accessed 15 April 2021. https://hpfsouthsudan.org/health-systems-stabilisation/

Kane, S, M Kok, M Rial, A Matere, M Dieleman, and JEW Broerse. 2016. "Social norms and family planning decisions in South Sudan." *BMC Public Health* 16 (1183).

Korsuk, BJ. 2020. *The Private Sector Readiness for Clinical Social Franchising of Family Planning Services in South Sudan.* Juba: Amref Health Africa.

Macharia, PM, PO Ouma, EG Gogo, RW Snow, and AM Noor. 2017. "Spatial accessibility to basic public health services in South Sudan." *Geospat Health* 12 (1) 510-518.

MSI. 2020. *South Sudan Private Sector Mapping.* Washington, DC: Management Systems International.

Ministry of Health. 2012. *Health Sector Development Plan 2012-2016*. Juba: Ministry of Health.

———. 2013. *Family Planning Policy.* Juba: Ministry of Health.

———. 2016. *National Health Policy 2016-2026.* Juba: Ministry of Health.

———. 2020. *9th Annual Report: 2019 Health Management Information System (HMIS).* Juba: Ministry of Health.

Ministry of Justice. 2018. *Drug and Food Control Authority Act, 2012. ACT No. 37.* Juba: Ministry of Justice.

Pillsbury. 2011. *Child Spacing & Family Planning in South Sudan: Knowledge, Attitudes, Practices, and Unmet Need.* Washington, DC: The Global Health Technical Assistance Project.

RHSC. 2019. *Commodity Gap Analysis – Overview for South Sudan.* Brussels: The Reproductive Health Supplies Coalition.

———. 2020. *RH Viz Database*. Accessed December 2, 2020. https://www.rhsupplies.org/activities-resources/tools/rh-viz/tool

SHOPSPLUS

Public-private engagement for better health

SHOPSPlusProject.org