What Does "Stewardship" Mean for the Market Development Approach in Health?

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Introduction

There is growing recognition that harnessing the collective capability of all market actors[1] will be necessary to drive faster and sustainable access to family planning (FP), maternal, newborn, and child health (MNCH), and other health products and services.[2] While, to date, there have been many individual successes driven by private-private and public-private approaches, scaling up such efforts and guaranteeing their sustainability at the country level requires looking at system issues, especially the enabling environment within FP, MNCH, and health transactions take place.

Today, there is a growing understanding of why markets for FP and MNCH products and services fail to operate in alignment with key goals, such as the increased use of modern contraceptives and increased institutional deliveries, and how the enabling environment can be influenced to create that alignment. Creating and sustaining an enabling environment for FP, MNCH, and other health product services is referred to as "stewardship." Under USAID's Frontier Health Markets (FHM) Engage, and consistent with the market development approach (MDA), stewardship is viewed in functional terms, focusing on *"what is done," "what should be done,"* and *"who should do it"* to ensure that a health market performs well to achieve a country's stated national health goals (see Box 1).

Further evidence is needed to elicit information on key questions, including: (i) ***what stewardship functions*** are needed to bring market operations (including investments by multiple development partners) into alignment with country level priority FP and MNCH goals? (ii) ***which entities (public or private) in the market system*** have the greatest capacity and incentive to perform such functions? (iii) ***what capacities and incentives*** are needed to strengthen stewardship to perform its key role in setting a vision for a well-functioning market, aligning both public and private actors for FP and MNCH toward this shared vision, and coordinating these market actors by leveraging each other's skills, structures, and resources? and (iv) ***how can stewardship be dynamic and flexible*** to adapt to health market shocks like COVID-19?

[1] Frontier Health Markets (FHM) Engage uses market actors to describe stakeholders of a given market. These include individuals and entities who demand or buy services; private organizations that supply or sell services, products, and information; government regulatory bodies; financing institutions;

[2] By other health products and services, we refer to those regarding HIV/AIDS, TB, and malaria

FHM Engage has developed two products on stewardship: an MDA brief and a technical report. Although both technical products target the same audience – policymakers, private sector actors, and development partners working in health markets in low- and middle-income countries – they have different purposes. This technical report draws upon international research undertaken to date on stewardship and stakeholders' experience working on stewardship, such as USAID, the World Bank, and World Health Organization (WHO), to propose a stewardship framework to apply to MDA under FHM Engage. The MDA brief, based on the technical report, serves to disseminate basic stewardship concepts related to MDA and describe FHM Engage's approach to stewardship.

Why does stewardship matter for MDA?

A health system encompasses all individuals, organizations, and resources that deliver health care services and products to meet the health needs of target populations. Clearly, health systems are complex social institutions, incorporating a variety of different types of actors that have different *ownership structures* (state-owned health facilities, for-profit and non-profit health facilities, religious and secular organizations), *organizational scales* (from 'sole-trader' operators, and small and mid-size enterprises (SMEs), through to large investor-owned and sometimes multinational corporations), *legal structures* (formal and informal operators), and *scopes of activity* (including manufacturers, distributors, retailers, educational institutions, and private health insurance companies). In this sense, all health systems are "mixed."

The nature and extent of this "public-private mix" matters a great deal if health system stakeholders – e.g., *Ministries of Health and other national health authorities*, sub-national health authorities, *private sector groups* such as faith-based and nongovernmental organizations and commercial healthcare businesses, and *development partners* – are able to achieve a country's national goal of improving access to and uptake of high-quality FP and other health products, services, and information. For such stakeholders, gaining a full understanding of health challenges and their origins – and opportunities for responding to these – requires an understanding of what is taking place across the whole health system,

Box 1. What is Stewardship?

Stewardship is concerned with *"what is done," "what should be done,"* and *"who should do it"* to ensure that a FP market performs well. Under FHM Engage and consistent with the market development approach (MDA), the stewardship function will be carried out by multiple market actors (both public and private). Important stewardship functions include: (i) formulating a strategic vision for the health system and specific market systems; (ii) collecting analyzing and disseminating information about health-related products and services; (iii) regulating the activities of 'care-seekers' (health consumers) and 'care-providers' (healthcare service providers and product suppliers) in ways which safeguard population health but also enables appropriate market development and growth; (iv) financing to shape / support the activities of market actors; and (v) mobilizing market actors through the creation / maintenance of platforms for inclusive policy dialogue.

As stewardship is concerned with the operation and performance of the market, as opposed to advancing any individual actor's narrow interests, stewardship functions are often performed by state authorities, which have the formal mandate to ensure markets work well on behalf of the population. However, such functions can also be performed by multiple different actors, including public market actors representing the wide and diverse range of government actors at national and regional levels; private market actors comprised of agencies, councils, and professional / industry associations; and civil society groups representing key segments of FP consumers such as youth, pregnant women, and mothers.

including the part of health system over which government does not directly manage – the private health sector.

Governments and their development partners are becoming increasingly aware of the "system failures" that lead to FP and other health markets poor performance. A few examples include: regulations restricting key private healthcare cadres, such as private nurses and pharmacists, to deliver long-acting and reversible contraceptive (LARC) methods like injectables limits access; information asymmetries prevents 'care-seekers' ability to make informed choices on where to seek appropriate FP counseling and information or quality MNCH services; public financing mechanisms such as national health insurance schemes only partially remove economic barriers as many do not include FP products or comprehensive MNCH services. Failure to address these market failures can lead to what Sania Nishtar has termed the "mixed health system syndrome": a stratified system comprised of large unregulated private sector leads in which private hospitals, clinics, and pharmacies target better-off consumers, while the public sector alongside a large number of private shops, dispensaries, shops, and pharmacies are used by poorer people.[3]

Without pro-active and effective stewardship, key health markets like those in FP and MNCH will continue to underperform. Stewardship requires taking action to ensure that market actors' incentives, capacities, and accountability structures are aligned to achieve good/improved health outcomes. For example, overregulation of the private sector, on the one hand, can potentially drive the private health sector underground (informal, illegal operations) which is not a good outcome for either the health system or consumers. Yet weak regulation of the private sector can lead to consumers exposed to potentially high costs and poor-quality health products and services. Stewardship of a health market is a balancing act involving multiple market actors and using different policy instruments to shape FP and MNCH markets.

What are stewardship objectives in a mixed health system?

In mixed health systems, effective stewardship calls for an *over-arching vision to underpin the stewardship activity*. But what are possible objectives associated with the private health sector? What kind of mixed health system structure should "stewardship" be seeking to establish? The work of Maureen Mackintosh and her colleagues is useful.[4] Drawing on various global data sets (e.g. country-level Demographic and Health Surveys (DHS), WHO World Health Surveys, other household survey data, and facility surveys), they generated a typology of mixed health systems characterized as follows:

- Type 1: A dominant private sector alongside a deteriorated public sector (e.g., India, Pakistan, and Nigeria)
- Type 2: A non-commercialized public sector and complementary private sector (e.g., Sri Lanka and Thailand)
- Type 3: A high-cost private sector at the top of a stratified system (e.g., Argentina and South Africa)
- Type 4: A highly commercialized public sector (e.g., China)
- Type 5: A stratified private sector shaped by low incomes and public sector underfunding (e.g., Ghana, Malawi, Nepal, and Tanzania)

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[3] Nishtar, S (2010), The mixed health system syndrome, Bulletin of the World Health Organization, Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2802440/

[4] Mackintosh M, Channon A, Karan A, Selvaraj S, Cavagnero E, Zhao H. What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. Lancet. 2016 Aug 6;388(10044):596-605. doi: 10.1016/S0140-6736(16)00342-1

Some mixed health system types perform better than others in terms of ensuring broadly equitable access to health products and services. In particular, Type 2 mixed health systems – those with *a non-commercialized public sector and complementary private sector* – are more successful than others across a range of related indicators, recording for example: (i) lower incidence of out-of-pocket payments and related harms (e.g., catastrophic and impoverishing health-related costs), (ii) lower differences in utilization rates according to socioeconomic position, and (iii) lower levels of competition between public and private sectors for scarce resources, such as staff, supplies, and equipment.

In contrast, Type 1, 3, 4, and 5 mixed health systems tends to create or reinforce social and economic inequalities, while the two sectors compete for scarce resources in a zero-sum game. In such systems, a concentration of health system resources in the private sector (which tends to serve the more affluent in society), reduces the resources available to the public sector (which tends to serve the majority), undermining the quantity and quality of care available to many people, especially poor and vulnerable groups.[5]

Although this is a descriptive framework, it also has analytical value for "stewards" as they diagnose health system challenges, define what is/should be the overall private sector engagement objective[6], and consider responses to them. Preker and Harding offer a simple framework of four key private sector engagement objectives for "stewards" to consider:

- **Grow:** Governments with small a private health sector can establish policies to encourage greater investment to increase the number of private sector facilities and activities. Often governments establish this goal to grow the total size of the health sector as a strategy to increase access.
- **Harness:** Governments with a large private sector that is not integrated nor compliant with Ministry policies and regulations can use policies and incentive to align private sector activities and improve performance. Additionally, governments can leverage those well-functioning segments of the private sector to complement and/or fill in gaps (i.e., serve targeted population groups or provide critical services) and/or harness them to improve coordination to assure geographic distribution and coverage.
- **Convert:** Governments that are shifting from a service delivery provider to purchaser of services and products through various public financing mechanisms (i.e., service contracts, voucher programs, national health insurance schemes) or leverage private sector resources and expertise to expand/improve public health infrastructure and services.
- **Restrict:** There are several examples in which governments will want to 'crowd-out' certain private sector practices, such prescribing out-of-date treatment regimes, and illegal private practices, like informal providers and open drug markets.

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[5] Kutzin J. Health financing for universal coverage and health system performance: concepts and implications for policy. Bull World Health Organ. 2013 Aug 1;91(8):602-11. doi: 10.2471/BLT.12.113985.

[6] Harding, A., Precker, A. Private Participation in Health. 2003.

From stewardship of mixed health systems to individual health market systems

Moving from stewarding a mixed health system, the concept of "stewarding" a health market is concerned with "what is done," "what should be done," and "who does it" to ensure that an FP market performs well. In large part, the performance of a health market like FP is determined by the **attributes** of the market system – the supporting functions, rules, and regulations – that collectively support, shape, inform, enable, and constrain interactions between "care-seekers" and "care-providers" in an FP market. The actions of multiple actors within the FP market system create these characteristics. It is the goal of FP market "stewards" to ensure that such attributes *are* present and performed *to the standard required* to achieve a government's FP goals and objectives. Therefore, considering the concept of stewardship is not an abstract exercise; on the contrary, stewardship is ***pro-active, consultative, and facilitating***. Stewarding an FP market directs market actors' attention to the following four questions of major operational importance:

- What supporting functions, rules, and regulations are required to ensure that FP market operations generate good/improved health systems (e.g., quality, equity, and financial protection) and FP outcomes aligned to government FP goals and objectives?
- Are these supporting functions, rules, and regulations present and adequately performed and/or aligned to achieve the stated FP goals and objectives? Are the supporting functions performed at the required level? Do the rules, regulations, and/or norms support or hinder the achievement of the FP goals and objectives?
- What changes in the supporting functions, rules, and regulations are needed to support/facilitate achieving the FP goals and objectives?
- How will such changes be realized in practice – and by whom?

Stewardship involves aligning the **incentives**, **capacities**, and **accountability** structures among diverse market actors to address the underperformance of key market functions so that the FP market operates in a manner that improves FP outcomes. Various tools and instruments of government help market actors operationalize stewardship, put into practice the market system attributes required, and measure their performance. Key stewardship functions include (but are not limited to):

- **Function 1. Co-creating a shared vision** of a well-performing FP market that aligns the market actors' – public, private, and consumers – roles, responsibilities, and actions.[7] The market vision should be aligned and support the government's overarching private sector objective (grow, harness, convert, or restrict). It is important to note that a government can have different private sector engagement strategies for different markets.[8]

- **Function 2. Collecting, analyzing, and disseminating market intelligence** about health-related products and services to influence market actors' incentives and behaviors.[9] This function also includes using this data to diagnose the FP market's core market operations and market

[7] World Health Organization. 2020. Strategy Report: Engaging the private health service delivery sector through governance in mixed health systems. Geneva: World Health Organization.

[8] Harding, A., Precker, A. Private Participation in Health. 2003.

[9] Mangone, E, and Romorini, S. 2021. *Private Sector Engagement in National Health Management Information Systems: Barriers, Strategies, and Global Case Studies*. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates Inc.

systems performance and to monitor performance and hold market actors accountable through performance data.

- **Function 3. Regulating activities** of 'care-seekers' and 'care-providers'[10] through inclusive processes to design and implement policy and regulations directly shaping FP markets.

- **Function 4. Ensuring financing** that supports/shapes 'care- seekers' and 'care-providers' activities (see Box 2)[11]. Financing can include public financing mechanisms (i.e., contracting, insurance, others) as well as private financing (i.e., capital and debt).

- **Function 5. Mobilizing and consulting market actors** through the creation / maintenance of platforms for inclusive policy dialogue.[12] This combination of stewardship functions has been a driving force behind the establishment of a broadly equitable and high-performing family planning market in Kenya (see Box 3). However, in many country contexts, the goals of stewardship may be more modest, seeking, in the short-term improvements to 'jump start' market performance.

Box 2. Definitions

'Care providers' in a FP market includes suppliers of both services and products. To differentiate the type of supply offered, suppliers of FP and health services are referred to as ***'providers'*** and suppliers of products are ***'suppliers'***. 'Providers' vary, including community-based organizations, different levels of health facilities, and retail outlets like pharmacies and drug shops. These service 'providers' can be public, for-profit, and not-for-profit. 'Suppliers' of FP products include manufacturers, wholesalers, and distributors that supply products to the points of service.

[10] Riley, P, Callahan, S, and Dalious, M. 2017. *Regulation of Drug Shops and Pharmacies Relevant to Family Planning: A Scan of 32 Developing Countries*. Bethesda, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates Inc.

[11] Estévez, I, Ladha, H. 2022. Unlocking Finance for the Private Health Sector. Brief. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Association.

[12] Bossert T, Hsiao W, Barrera M, Alarcon L, Leo M, Casares C. Transformation of ministries of health in the era of health reform: the case of Colombia. *Health Policy Plan.* 1998; 13, 59-77.

Box 3. Creating an efficient public-private mix for family planning products and services in Kenya

In Kenya, mCPR has grown rapidly over the last three decades. The private sector has played a significant role in overall market growth – especially in relation to injectables, implants, and condoms. Between 1993 and 2014, users accessing injectables from private clinics and pharmacies increased from approximately 36,000 to 765,000 users. Between 2008 to 2009 and 2014, the number of users accessing implants from private clinics and NGO facilities increased from 28,000 to 181,000 users. Between 1993 and 2014, users accessing condoms from pharmacies and shops increased from 13,000 to 201,000 users. The overall result is a well-balanced FP market that is, over time, reducing dependency on donor/state funding through increased domestic and private financing. That balance has been obtained without compromising stakeholders' commitment to equitable access to FP. As of 2015, there was only a one percentage point difference in overall mCPR across the highest and lowest wealth quintiles.

These positive outcomes were supported by several critical stewardship functions – in which government and private stakeholders (including the Pharmaceutical Society of Kenya, the Kenya Pharmaceutical Association, and the Kenya Healthcare Federation) have played important roles. This has been enabled by the Government of Kenya's conscious attempt to mobilize a range of market actors (*function 5*), including, from 2015, the establishment of a formal total market approach (TMA) working group for FP stakeholders reporting to the National FP Working Group. In terms of an overall strategy for FP market growth (*function 1*), the Government of Kenya has a long-standing commitment to enhancing access to FP services by engaging the private sector in an institutionalized manner. This was initially achieved by granting private clinical facilities (both commercial and NGO facilities) access to free, publicly procured FP commodities as part of routine facility registration processes (*function 4)*.

The Government of Kenya also established and built the capacity of a cadre of community health workers (CHWs), who were trained in providing short-acting methods, and worked to increase demand for FP. Private sector actors were allowed to engage with CHWs, who offered both free and private sector brands to community members. In 2015, the Ministry of Health's Reproductive and Maternal Health Service Unit (RMHSU) and stakeholders co-developed a TMA plan, focusing on strengthening stewardship and cross-sector stakeholder engagement, with specific outcomes and an implementation timeline. On information (*function 2*), USAID-funded implementing partners worked with the Ministry of Health to improve awareness and understanding of FP markets and the role of the private sector in them. This demonstrated, among other things, that relatively high percentages of the top two wealth quintiles were accessing their methods through the public sector (29% for pills and 48% for injectables), indicating the potential for future private sector growth in these areas. The growth in private sector FP supply has not required significant deregulation, as, in Kenya, the regulatory environment was already conducive to private sector development and growth – with, for example, relatively few restrictions on the import of products, and the availability of an extensive wholesale and retail network to support the distribution of imported products to end users.

In Kenya, the combination of multiple stewardship actions directed towards increasing the quality of information available in the market, reducing the cost of private sector supply, and maintenance of a regulatory environment that supports a relatively well functioning commercial sector supply chain, enabled the private sector to grow within the context of a well-balanced, sustainable, and equitable FP market.

Lessons can be learned from previous experiences – directed towards improvement of market attributes relating to specific providers, with specific scopes of service (see Box 4).

Box 4. Improving access to high-quality FP products in the private sector in Tanzania

Informal drug sellers are a major source of health care and medicines for the poor in many countries with mixed health systems (Type 5). In Tanzania, many people, especially in rural and per-urban areas, historically sought health care and medicines from such providers – the *duka la dawa baridi*. However, in 2001, a Tanzania Ministry of Health study found severe problems with the country's 4,600- plus government authorized private sector drug stores, including questionable medicine quality, inadequate storage for medicines, untrained staff, inadequate compliance with regulations, and illegal dispensing of prescription medicines. As a response in 2002, the Tanzania Food and Drug Authority, in collaboration with Tanzanian sub- national authorities, embarked on a program – piloted initially in one region – to establish a regulated system of accredited retail drug dispensing outlets (ADDOs).

This process incorporated several stewardship functions, including:

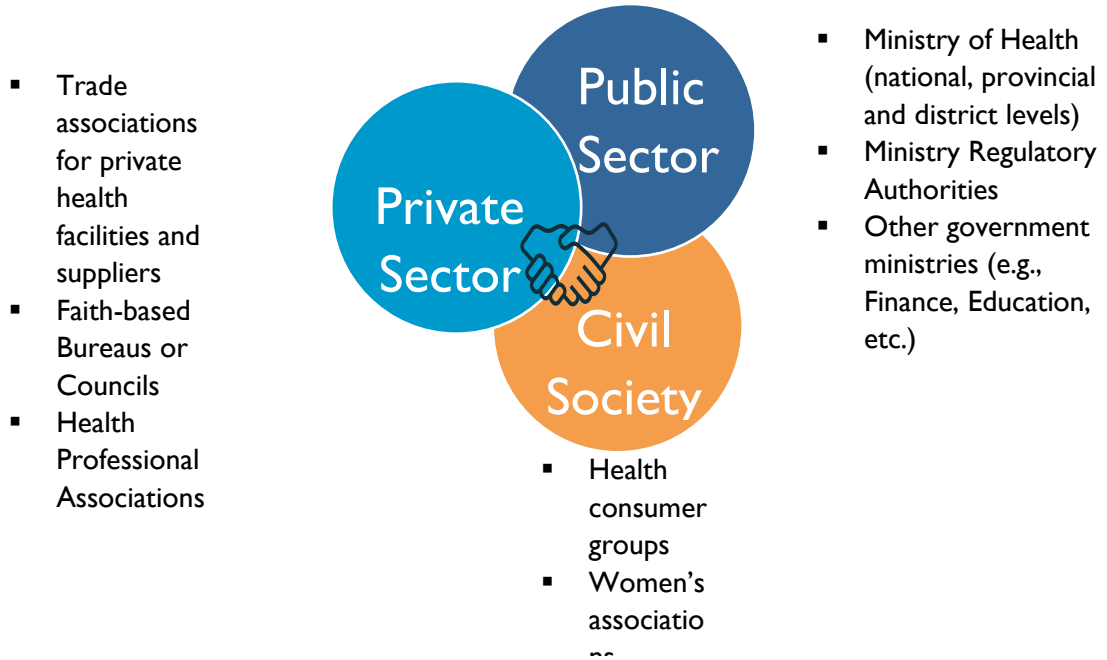
- strengthening of regulations (*stewardship function 3*), through development of accreditation based on government-instituted standards and regulations, and the creation of a public sector-based regulatory and inspection regime;
- financial incentives (*stewardship function 4*), by providing ADDO owners with access to microfinancing and legal authorization to sell a limited list of essential prescription medicines; and facilitating access to convenient and reliable sources of quality medicines; and
- enhanced market information (*stewardship function 2*), by improving awareness of customers regarding
  quality and the importance of treatment compliance through marketing and public education.

After early evaluation results provided evidence that ADDOs could improve access to high-quality health products and services, - with substantial gains in product quality, availability, and shop profitability - the Ministry of Health and Social Welfare (MOHSW) approved the scale-up of the ADDO model across the country and announced the phase-out of the *duka la dawa baridi.* As of 2022, more than 14,000 accredited shops or close-to-being-accredited shops were serving the 25 regions of mainland Tanzania. While government-led, the implementation of the ADDO concept came directly from the effort, time, and resources spent by donors and implementing partners to fully connect with a range of stakeholders at all levels.[18] The ADDO experience is illustrative of the use of stewardship functions to create a pathway to formalization for previously informal providers, at the market system level, and thereby address a major limitation of mixed health systems of Type 5 – the tendency for a large and dominant formal private sector to exclude poor people from sources of high-quality care, leaving them dependent on poor quality, underqualified private providers.

Who performs stewardship in mixed health systems?

Market actors that perform stewardship – i.e., "stewards" – can come from any sector (see Figure 1). Any entity, public, private, or civil society, is acting as a steward when its activities are targeted at improving the operation and/or performance of the system, as opposed to advancing its own narrow interests, or those of a small number of other actors. While many aspects of stewardship are most naturally performed by government authorities, which have the incentives and the formal mandate to do so, the stewardship of health market systems can be performed by multiple different actors, including the following:

FIGURE 1: ILLUSTRATIVE STEWARDS FOR AN FP AND OTHER HEALTH MARKET



- **Public market actors** representing the wide and diverse range of government actors at national, regional, and district levels are responsible for setting the rules governing the market as well as leveraging different policy instruments (e.g., economic regulations, financing) to create incentives;[13]

- **Private market actors** comprised of associations representing both for-profit and not-for-profit FP providers, suppliers, and training institutions as well as healthcare professions[14] are charged with specific tasks such as setting and/or overseeing quality standards, coordinating, and mobilizing private sector resources and expertise, and advocating and representing private sector perspective in policy design and implementation; and

- **Civil society groups** that represent FP and other health consumers are responsible for ensuring their constituent's voices are reflected in policy design and implementation and also for ensuring their FP and

[13] Sriram V, Sheikh K, Soucat A, Bigdeli M, 2002, Addressing governance challenges and capacities in Ministries of Health. Geneva: World Health Organization; 2020.

[14] Sriram V, Sheikh K, Soucat A, Bigdeli M, 2002, Addressing governance challenges and capacities in Ministries of Health. Geneva: World Health Organization

other health needs and preferences are met by both public and private providers.

Box 5 offers the Uganda example of how the Ministry of Health delegated a stewardship function to a private sector entity. Even in such circumstances, however, government authorities often retain ultimate responsibility – as the most legitimate representatives of the public interest – to monitor and sustain progress on population health outcomes. For this reason, the government in general, and the Ministry of Health in particular, can be regarded as *"the steward of the stewards"* in the mixed health system,[3] and they have a particularly important role to play in ensuring that all actors have the incentives and capacities they need – alongside an appropriate *accountability environment* – to ensure the availability of safe, affordable, and appropriate health products and services.

Many stewardship functions are mostly provided by state authorities. The reasons for this are clear. States face political pressures to ensure broad population access to high-quality health products and services, and, indeed, often have a formal mandate to do so (e.g., under the International Covenant on Economic, Social and Cultural Rights/ICESCR, signatory states must take reasonable steps towards ensuring that essential health products and services are accessible for poor and marginalized groups). That requires them to engage in strategy formulation, information-collection and sharing, regulation, financing, and policy dialogue, among many other things. However, while government authorities (especially Ministries of Health) undoubtedly have a unique role in stewardship, their role is not exclusive. Other players can *and do* perform stewardship functions – and indeed, in many cases, they have stronger incentives and capacities to do so. For example, professional associations charged with setting quality standards to underpin professional and/or facility licensing (and enforce them through inspections) often have stronger incentives and capacities to, e.g., set standards in line with contemporary evidence, and ensure that only staff/facilities competent to provide health products and services in line with those standards are allowed to do so.[15]

[15] Sriram V, Sheikh K, Soucat A, Bigdeli M, 2002, Addressing governance challenges and capacities in Ministries of Health. Geneva: World Health Organization; 2020.

Box 5. Stewardship by State and Non-State Actors in Uganda

In Uganda, multiple development partners (USAID bi-lateral Private Health Sector (PHS), the World Bank, and the Italian Cooperation) supported public and private actors to work together to perform different stewardship functions.

- The Ministry's Public-Private Partnership (PPP) Unit, with support from USAID and the Italian Cooperation assisted, established the Public Private Partnerships for Health (PPPH) Technical Working Group (TWG). The PPP Unit, as the legal representative to engage the private health sector, delegated the PPPH TWG's secretariate role to the Uganda Healthcare Federation (UHF). UHF assisted the PPP Unit to identify and mobilize the relevant private sector actors to jointly carry out a critical stewardship function – policy design. Through the PPPH TWG, the public and private sectors collaboratively developed the Uganda National Policy on PPP in Health and the PPPH Five Year Strategy. In addition, UHF assumed the responsibility to disseminate both policy documents among its membership.
- The Ministry of Health (MOH) Quality Department, with USAID support, led a multi-year initiative to engage the private sector to develop minimum quality standards for the private health sector. Once again, the MOH leadership turned to UHF to mobilize its members who actively participated in the technical discussions. The collaborative initiative resulted in new clinical standards for health services at primary, secondary, and tertiary levels of care. Later, the MOH expanded and developed minimum quality standards for laboratories, radiology centers, and pharmacies. At the end of this process, the MOH approved these new guidelines and agreed to use a self-regulatory approach to implement them.
- To facilitate a self-regulatory approach, with support from USAID the MOH and UHF jointly developed a digital system – the Self-Regulatory Quality Improvement System (SQIS+) – to assess quality in private healthcare facilities, from hospitals and clinics to medical and health centers. SQIS+ has recently expanded to include other facilities, such as private laboratories, radiology centers, and pharmacies. To create incentives for private facilities to conduct the SQIS+ assessments, all the Ministry councils responsible for facility licensing require an annual SQIS+ score to renew their license. The Ministry Quality Department also reviews SQIS+ scores as a tool to monitor private sector quality. Ultimately, the MOH delegated the responsibility to UHF for training, coaching, and reporting SQIS+ scores to the relevant regulatory licensing authorities.
- The MOH councils – Medical, Nurse Midwives, and Pharmacy – modernized their systems to license health care professional and facilities. With support from USAID and the World Bank, these councils developed a common platform – eLicensing Platform – allowing private facility owners and *all* healthcare professionals to apply and renew their facility licenses and professional certifications. UHF was an active partner in the digital platform development by advocating it be simple and accessible for all private sector actors and by helping train and get its members registered on the eLicensing Platform

However, not all market actors will consider themselves "stewards." Indeed, many will not be. Examples of actors who are not stewards may include commercial finance and insurance firms, health products suppliers, and technology providers. Market actors such as these perform important functions, many of which are critical to the market's core operations (supply and demand) and overall performance. However, as such activities are driven by commercial incentives and not by the intention to ensure good health outcomes, they fall outside the definition of "stewardship." They are, however, still important market actors and targets for FHM Engage interventions.

How to strengthen market stewardship?

Strengthening market actors' ability to steward an FP market effectively will often – though not always – be an important focus to improve FP market performance. There are two areas to strengthen stewardship of FP markets: 1) building market actors' capacity to become effective stewards, and 2) building market actor's capacity to implement the policy instruments and government tools that support critical market functions.

Building market actors' stewardship capacity can take many forms. The market diagnosis process landscapes the full range of market actors and identifies those who can potentially play a stewardship role complementary to and/or in support of the Ministry of Health. The same diagnosis process also identifies existing policy platforms and/or coordination mechanisms that can convene and coordinate these market actors to become, as a group, stewards of an FP market. Supporting the convening platform and building the group's coordination and collaboration skills to achieve a common purpose – in this case, improving the FP market performance – are also necessary areas for capacity building.

Maximizing the performance of critical stewardship tools/instruments/actions is another approach to strengthening FP market stewardship. A market system requires specific rules and supporting functions to be present and performed well (though exactly what attributes are needed is context specific!). Where critical attributes are absent, they must be created. Where they are present, but performance is poor, that also needs to be addressed. This can mean working with the government (and often, the Ministry of Health) to improve and strengthen governmental activities across a mixed health system, regulating private actors and supporting demand, mobilizing/consulting market actors, etc. It is important to focus on what market functions are important, and who is best placed to perform them, rather than focusing on specific actors. As the Uganda example in Box 5 and the joint inspections example in Kenya illustrate, sometime the best market actor maybe a non-state one.

A key feature of the MDA is market facilitation. Market facilitation is temporary and a project like FHM Engage – as market facilitators – strives to be a catalytic change that works through market actors – including stewards – to achieve large-scale, inclusive, and sustainable change in an FP market. A market facilitator never becomes a market actor. In the context of MDA, it is operationally useful – and perhaps less confusing – to think of "stewardship" and "market facilitation" as different things. In effect, market facilitation is what a project like FHM Engage *does*. Stewardship of the health market system is what market actors *do.*

Stewards of the health market system are ***internal*** to the market. For example, the Ministry of Health will always be an integral part of the market system beyond the life cycle of any single donor program. Its activities will always play a powerful role in determining a market system's incentive and accountability environment. To ensure the sustainability of impact, the Ministry of Health is (or should be) involved in creating supporting functions and rules that impact the operations and performance of all other market actors. This same principle holds true for the other market actors performing stewardship role and stewardship-like functions. These non- state entities – private and civil society alike – are integral players in an FP market system and will therefore remain in the market, ensuring continuity and sustainability of the stewardship function they are performing.

In contrast, a project like FHM Engage as a market facilitator, is ***external*** to the FP and other health markets. Market facilitation supports specific market actors, in this case, to better perform their "stewardship." Although market facilitation can be seen as a form of stewardship, a project like FHM Engage does not play a stewardship function in a market system. Instead, through market facilitation, it strives to strengthen stewardship capacities and functions – whether performed by the state or some other actor in the market system.

Annex 1 provides examples of strengthening stewardship functions through market facilitation.

Conclusion

The concept of "stewardship" is concerned with "what is done," "what should be done," and "who should do it" to ensure that a given health system – or an individual market system – performs well in terms of the objectives set for it. At the health system level, stewardship is a critical key means through which well-balanced health markets are created and can thrive.

The technical brief makes the case for why and how stewardship is a critical element for well-performing FP and other health markets. The country case studies, such as Kenya, have demonstrated that employing a range of stewardship functions can build an FP market while at the same time achieve the government's UHC goals of access, quality, affordability, and equity. Similarly, an actively performed range of stewardship functions were instrumental in providing informal drug sellers with a pathway to formalization, conditional on achieving material improvements to their quality systems, resulting in important gains in product quality and availability to the benefit of the country's rural and peri-urban poor. And the Uganda case study illustrated how government still retains its authority as the steward of stewards of the health sector while delegating a stewardship function to a non-state actor like the Uganda Healthcare Federation.

Strengthening market actors' ability to steward an FP market effectively will often be an important focus to improve FP market performance. Building market actors' capacity to become effective stewards can take many forms: landscaping market actors' roles, responsibilities, and capacity as a potential market steward; identifying and supporting mechanisms to convene and facilitate coordination, cooperation, and alignment; and building the market stewards' skills to work together effectively to steward an FP market.

Building market actor's capacity to implement the policy instruments and government tools that support critical market functions in an FP market is equally important. This entails working with the government

to identify critical market functions, identifying who is best placed to perform that market function, and building their capacity.

International donors and the implementing partners have an important role to play in building FP market actors' stewardship capacity. A market facilitator, FHM Engage is not "in" the market, but a facilitator of it. Nonetheless, working with stewards will be an important means of realizing FHM Engage's program objectives in terms of achieving equitable access to high-quality FP and MNCH products and services on an inclusive and sustainable basis.

Annex I. Examples of market facilitation efforts focused on strengthening stewardship functions

Targeted (stewardship) function	Focus of (market facilitation) efforts
Mobilization of market actors through the creation / maintenance of platforms for inclusive policy dialogue.	• In Tanzania, SHOPS Plus worked with private retail outlets – ADDOs – that are a popular source of FP and other essential medicines to help them participate in credible and representative associations to give greater legitimacy and voice to these providers in dialogue and negotiations with the public sector.[22] • USAID bi-lateral PHS in Uganda supported the Uganda Private Health Association to become a fully operational and sustainable organization representing 65 members - predominantly associations. Recognized as the legitimate representative of the private sector, UHF serves as the co-chair of the PPP Technical Working Group that meets on a quarterly basis to discuss a wide range of policy challenges and partnership opportunities.[23]
Collection, analysis, and dissemination of information on health-related products / services.	• SHOPS Plus partnered with the Senegal Ministry of Health to undertake a Private Sector Census.[24] • SHOPS Plus supported the Madagascar Ministry of Public Health, Ministry of Health Stats Office, and private sector stakeholders to define/agree on an action plan to address barriers to private sector integration in the Health Management Information Systems.[25] • Several development partners (World Bank Global Financing Facility (GFF)/United States Agency for International Development) have supported health ministry efforts to generate more accurate data on private sector facilities and activities to improve planning, coordination, and alignment of resources. This includes conducting a nationwide census of private health facilities to update and digitize its licensing registry in countries like India, Ivory Coast, Senegal, and Tanzania, to name a few.[26]

Targeted (stewardship) function	Focus of (market facilitation) efforts
State regulation of 'care-seekers' or 'care-providers'.	• World Bank/GFF supported the Ivory Coast Ministry of Health in conducting a consultative process with private actors to update its policy and regulatory framework. This included a comprehensive review of all (over 33) policy documents to identify barriers to private sector development and the introduction of a new regulatory framework to license/accredit and prepare private facilities in anticipation of the newly introduced strategic purchasing policy. • SHOPS Plus partnered with *Association des Pharmaciens et Propriétaires d'Officine du Rwanda (APPOR)* to advocate for reform of the regulatory framework to enable administration of injectables by private pharmacists. The Ministry of Health in Rwanda approved the reform in February 2020 (Riley et al 2020).[27]
Financing to support/shape activities of 'care-seekers' or 'care-providers'.	• In Senegal, the Health Systems Strengthening Plus (HSS+) program brokered a PPP incorporating the Agence de la Couverture Maladie Universelle (aCMU) and the Alliance du Secteur Privé de la Santé du Sénégal to increase the scale and scope of contracts between *mutuelles* and private providers to cover priority health products and services such as family planning and other reproductive health services.[28] • Strategic Purchasing for Primary Health Care (SP4PHC) assisted PHILHEALTH and the Ministry of Health in mapping the roles, functions, and public and private spending to understand PHILHEALTH's FP benefits package – which includes long-acting and reversible contraception.[29]

FHM ENGAGE
Healthy Markets for Healthy People

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Frontier Health Markets (FHM) Engage works to improve the market environment for greater private sector participation in the delivery of health products and services and to improve equal access to and uptake of high-quality consumer driven health products, services, and information. FHM Engage is implemented by four core consortium partners: Chemonics International (prime and co-technical lead), Results for Development (co-technical lead), Pathfinder International, and Zenysis Technologies, and a host of Network Implementation Partners (NIPs).

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