Ministry of Health

A Model for Health Financing Reforms in Kenya
Policy Brief

August 8th 2014

TABLE OF CONTENTS

1.0 INTRODUCTION 1
2.0 THE CONTEXT OF HEALTH FINANCING IN KENYA.....................................1
2.1 Introduction 1
2.2 Funding Sources – Challenges of Resource Mobilization 1
2.3 Political Goodwill 2
2.4 Access to Health Services in Kenya – Challenges in Risk Pooling 2
2.5 Health Financing and Service Provision – Challenges in Purchasing 3
2.6 Service Quality, Administrative Efficiency and Accountability...............................4
2.7 Improvement and Rational Utilization of Health Services 4
2.8 Conclusion...5

3.0 PREFERRED "HEALTH FINANCING MODEL" FOR KENYA.......................5
3.1 The "Preferred Option" for Health Financing Model 5
3.2 Justification for the Preferred Health Financing Model for Kenya...........................6

4.0 REGULATORY FRAMEWORK AND MANAGERIAL ASPECTS 12
4.1 Legal and Regulatory Framework...12
4.2 Managerial Considerations...13

1.0 INTRODUCTION

This Policy Brief on Universal Health Coverage (UHC) is the summary of a discussion by experts on June 10th, 2014 in the Ministry of Health (MOH). The discussion was based on the paper "Options for Kenya's Health Financing System" by the P4H-group, which itself summarizes all relevant papers on UHC and Health Financing in the country.

The recommendations for health financing reforms contained in this Policy Brief pay special attention to the role of Counties in a devolved government system, equity in financing and equality in access, efficiency and effectiveness in service delivery and to the importance of health service quality. The specific recommendations are presented in Part 3.0 for the respective areas of reform followed by comments on legal and managerial aspects. This Policy Brief does not go into administrative and managerial details but concentrates on concepts and strategies. With regard to financing of health services, some particular attention has been given to accreditation of health care providers, registration of populations, and contracting units for purchasing of care.

2.0 THE CONTEXT OF HEALTH FINANCING IN KENYA

2.1 Introduction

Kenya has struggled to build a health system that can effectively deliver quality health services to its population. The overall under-five child mortality rate remains high,73 per 1000 live births and the maternal mortality rate stands at 400 deaths per 100,000 live births (World Bank, 2012). Access to health care varies widely throughout the country and major disparities exist between rural and urban communities and between the rich and poor. The high cost of healthcare services and poor access to health facilities are two factors that prevent healthcare from reaching a larger proportion of the population. Individuals currently carry the highest burden of healthcare costs, above both government and donor organizations. Hence, there is a vital need for a revamped health financing structure that can reduce the burden of out of pocket spending on health.The key health policy issues are not whether a government uses general revenues or payroll taxes, but the amounts of revenues raised and the extent to which they are raised in an efficient, equitable, and sustainable manner. The following sub-sections discuss challenges in the Kenyan health financing system.

2.2Funding Sources – Challenges of Resource Mobilization

Fragmentation of pools is also an issue for revenue collection. Schemes collect, bank and invest their own revenue. This is administratively inefficient. The bigger challenge, however, is the insufficient amount of (especially domestic) public funds in the system. In

2009/10, domestic public health expenditure was only USD.12 (MOH, National Health Accounts 2009/10). While the specific financing requirements depend on the package of services made available under UHC, the WHO estimated that USD.42 was necessary to purchase a package of basic services in 2010, rising to USD.60 by 2015 (WHO, World Health Report 2010).

2.3 Political Goodwill

There is commitment by the top Kenyan political leaders for the achieving Universal Health Coverage. This is shown by the current initiatives e.g. prioritizing the coverage of the indigents and maternal health care. The Kenyan Constitution, 2010, Art. 43(1) stipulates that "Every person the right to the highest attainable standard of health, which includes the right to health care services". This constitutional objective provides the framework for health care and health care financing reform in Kenya. Kenya's Vision 2030 states that Kenya aims to achieve Universal Health Coverage by same year. In line with this, one key objective of the current Government of Kenya (GOK) is that "Every Kenyan should have access to high quality health care" (Jubilee Coalition, 2013). GOK recognizes that access to care not only entails the physical availability of services, but also the protection from financial hardship. In short, GOK is committed to achieving Universal Health Coverage.

2.4 Access to Health Services in Kenya – Challenges in Risk Pooling

Access to services for individuals and households is fragmented by coverage scheme, while the poor and vulnerable are largely excluded. While average total health expenditure (THE) per Kenyan at USD 42.2 in 2009/10 was sufficient to buy a basic package of essential health services, there is strong variation around this mean. Out-of-pocket spending was 25% of THE, showing that many Kenyans cannot rely on equitable pre-paid financing mechanisms (MOH: NHA 2009/10, n.d.). Nearly 15% of Kenyans spent more than 40% of non-food expenditure on health care, thus health care is a major source of financial distress for Kenyans. The small share of the health sector in the Government budget (in 2009/10 only 4.6%) points to a general underfinancing of publicly provided services, even though some services, especially HIV/AIDS and Malaria, some of the gap is made up by spending by development partners (MOH n.d.).

This is related to the co-existence of several different coverage schemes. The main ones among these are the GOK free-care initiatives at primary health care facilities (dispensaries and health centres) and for free maternal care especially deliveries at higher levels, GOK subsidized access for other care at referral levels, the National Hospital Insurance Fund (NHIF), as well as Private Health Insurance (PHI). Some small

Community Based Health Insurance also exists. The existing schemes are isolated and are not connected through financial or risk equalization mechanisms.

Figure 1 provides an overview over the current coverage among the population (ranked by wealth on the X-axis) and across different service categories included in different benefit packages (on the Y-axis). It simplifies the scheme coverage by wealth categories i.e. some wealthier Kenyans may not be covered by NHIF or PHI, while some less wealthy are, but by and large this principle does hold. Access to health services is very unequal and the poor are currently financially excluded from access to many services.

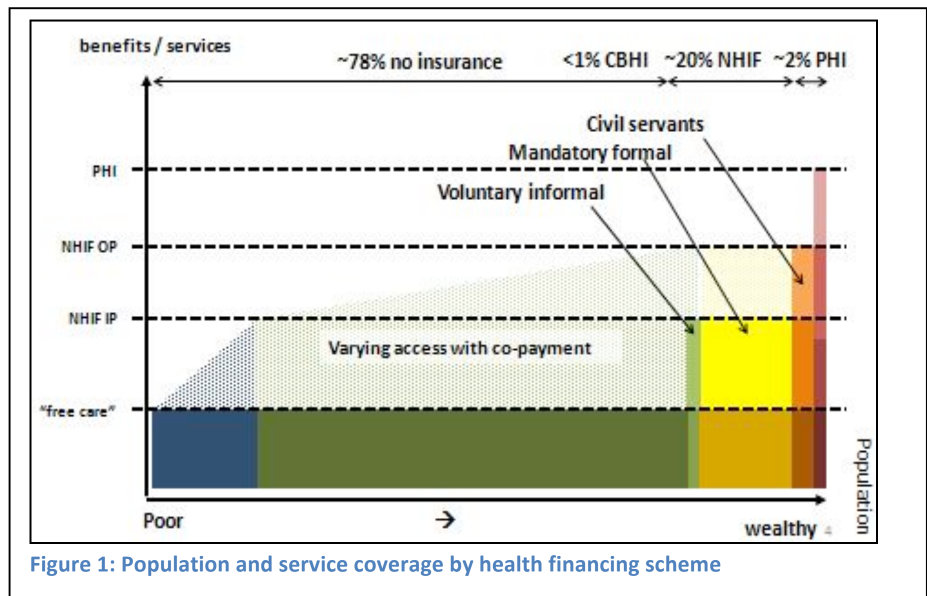

Figure 1: Population and service coverage by health financing scheme

Devolution adds to the complexity, as Counties are now expected to finance health service provision for primary and secondary care services from their block grant allocation. Access to publicly provided services (the "free care" and subsidized / "co-payment categories" in Figure 1) therefore depends on the budget allocations at County-level, which further fragments financing of health services and hinders equal access to care.

2.5Health Financing and Service Provision – Challenges in Purchasing

The fragmentation of the health financing system also creates obstacles for an integrated service provision. Ideally, patients are treated where medically most effective and economically most efficient. Fragmented financing mechanisms can create incentives working against this principle.

Patients have an obvious incentive to seek care where they are covered against the costs of treatment. Where hospital treatment is covered, patients may bypass primary facilities where adequate treatment can be provided at the lowest possible costs.Providers also have incentive for unnecessary referrals if costs can be avoided by referring patients to another "budget". For example, County facilities may refer patients to tertiary hospitals since these are not financed by the County, but by the MOH. Varying payment mechanisms

may compound this issue. The more fragmented the financing system, the more difficult it is to avoid negative effects.In addition, the flow of medical information is often inhibited where different funding sources are involved in data collection. This can have obvious negative impacts on health outcomes and on the governance of the health sector.

A fragmented health financing system can also create challenges for assuring equitable and efficient investments into services if no integrated system of investment planning and/or licensing is in place. The fragmentation of health financing schemes brings inefficiencies in service provision and investments.

2.6 Service Quality, Administrative Efficiency and Accountability

There is lack of a quality assurance mechanism to guarantee that scarce funding is used to fund care of sufficient quality only. The different external quality assessment systems of health insurers including the NHIF are not harmonized and/or sufficient for assuring high quality services across all facilities, which means that providers face varying requirements and may be able to get away with providing inadequate care. With regards to the NHIF, there is the need to reduce its current high administration costs since money spent on administration is lost for service provision. There is lack of trust in health financing institutions due to maladministration, fraud and corruption, which will need to be addressed in future reforms.

2.7 Improvement and Rational Utilization of Health Services

A functioning primary care or first line service is the precondition for rational use of health services and control of costs. A well-trained primary care health provider can cope with 70 to 80% of all illness episodes.The primary provider would initiate only necessary referral to higher and more expensive levels of diagnosis and therapy. A patient can visit a higher-level service directly but expenses will be covered by insurance only if a referral letter from a primary care provider is presented.

Primary care, following the principles of family medicine as formulated by WHO, will also contribute to reducing cost by encouraging disease prevention. To be close enough to the community and trusted by the families the target group for a primary care provider should not be larger than 4,000 community members. This means that approximately 10,000 primary care providers are needed to cover the Kenyan population. At the moment, Kenya has approximately 80 Family Physicians and only about 800 General Practitioners who do not working in hospitals. There is need to plan strategies to accelerate the increase of primary care providers in the country. The profession of family medicine needs to be advocated for, training in close cooperation with private and public universities has to be accelerated, and clinical officers as well as nurses must be involved

after respective re-orientation to provision of primary care services. It is recommended to establish primary care as a system based on the concept of family medicine and focusing on prevention, rational referral, as well as continuing professional development.

2.8 Conclusion

Kenya faces three sets of key challenges in health financing. First, access to services for individuals and households is fragmented by coverage scheme, while the poor and vulnerable are largely excluded. Second, the fragmentation of health financing schemes also brings inefficiencies in service provision and investments. Third, a diverse set of challenges exist that are related to health systems and public governance issues; key among these are the lack of an effective quality assurance mechanism and ineffective corporate governance and accountability mechanisms, which has led to a trust-deficit in Kenyan health financing institutions. All areas need to be addressed to make significant progress towards UHC.

3.0 PREFERRED "HEALTH FINANCING MODEL" FOR KENYA

3.1 The Preferred Health Financing Model

The quality of health services and an efficient financing system are closely interlinked and should be developed concurrently. This "Brief" provides the basis for developing a system of universal access to essential health services that is *viable, sustainable, equitable, accountable* and *efficient.*The proposed model of health financing must be community-oriented services input-based and individual-oriented services output-based.At the core of health financing reforms is the institutional arrangement of purchasing individual-oriented care.

There are threelevels of health care services with their own structures in the Kenyan health system. 1) Primary Care (PC): This is the level of first contact for all patients with the health system. It provides ambulatory clinical services and the close contact to the community makes it the most effective level for disease prevention and health promotion. These services are offered at community level,clinics, dispensaries, health centres, and outpatient departments of hospitals. 2) Secondary Health Care (SHC): This is the first referral level for ambulatory and basic inpatient care. The services are offered in specialized clinics of the outpatient departments in hospitals and through inpatient care. 3) Tertiary Health Care (THC): This is care on a highly specialized level in the outpatient but mainly inpatient departments of National Referral Hospitals.

The preferred model of health financing suggests having "NHIF for all Kenyans contracted by Counties and MOH". In this option, all primary care and secondary health care (PC/SHC) services for the informal sector (especially the poor) would be funded through the County funds while NHIF premiums would fund PC/SHC for the formal sector and civil servants. The funds would be pooled at the County level for the informal sector PC/SHC services while Ministry of Finance (MOF) would pool the funds from the premiums for civil service and private formal sector employees. The tertiary health care (THC) services would be funded from the general government revenue for the informal sector and funds would be pooled at the national level preferably at the MOH, while funding for civil service and formal sector employees would come from NHIF contributions and would be pooled at the national level by MOF. This would leave the Counties and MOH with a bigger budgetary responsibility. This may increase acceptability of the proposal for Counties and MOH, but reaching UHC would depend more on the willingness of Counties to allocate sufficient funding for the health sector. Table 1 shows a summary of the preferred model for health financing for Kenya.

Table 1: Preferred for Pooling and Purchasing of Individual-Oriented Services

The Financing Model	Level	Target population	Financing source	Pool	Purchasing agent	Providers
NHIF for all (MOH/Counties contracting option)	PC	Informal sector (esp. poor)	General revenue	**County**	*SSHIA	Public & Private
		Formal private sector & civil service	NHIF premiums	MOF	*SSHIA	Public & Private
	SHC	Informal sector	General revenue	**County**	*SSHIA	Public & Private
		Formal private sector & civil service	NHIF premiums	MOF	*SSHIA	Public & Private
	THC	Informal sector	General revenue	**MOH**	*SSHIA	Public & Private
		Formal private sector & civil service	NHIF premiums	MOF	*SSHIA	Public & Private

*SSHIA = Single Social Health Insurance Agent

3.2 Justification for the Preferred Health Financing Model for Kenya

3.2.1 The Target Population

Based on the current health financing architecture, the key population groups to be considered are: The informal sector (including the poor), the formal private sector, and

the civil service / public sector employees.Considering that 78% of all Kenyans are in the informal sector and have no any form of health insurance scheme and of these, 48% are too poor and cannot afford to pay for insurance, akey concern is to provide those people currently without physical, financial or socio-cultural access to health care services with a set of minimum essential services that can be expanded as additional resources come into the system. This means that a specific focus is on poor and vulnerable individuals, households and communities.

3.2.2 The Financing Sources

In the proposed model, it is suggested to havemixed sources of fundingfrom 1)general government revenue and2) health insurance premiums. This in turn implies a strengthening of inclusive pre-paid risk-pooling schemes, because only when the healthy and wealthy contribute via taxes or premiums according to their economic ability, can the sick and poor benefit according to their need.

The Government budget share for the health sector was 4.6% in 2009/10, which shows a general underfinancing of publicly provided services in comparison to the recommended 15% (WHO, 2005). In 2009/10, domestic public health expenditure was only USD.12 (MOH, National Health Accounts 2009/10) in comparison the WHO estimated expenditure of USD.42 per capita (WHO, World Health Report 2010).Therefore, an alternative is to raise more funds through health insurance premiums in order to reduce the deficit. It should be acceptable to an employed Kenyan to pay a set percentage of his/her salary for health insurance. Employers should be ready and persuaded to pay 50% of this premium for their employees. Since the income of a tax paying self-employed is known, the calculation of the premium could follow the same pattern to simplify administration and render the process more robust. Kenyan citizens in the informal sector should pay a premium to assure appreciation of the common good “insurance” and spread the spirit of solidarity and reasonable use of services. The population in the informal sector minus the 5% wealthy self-employed constitutes 73% of the whole population. Half of them (36% of these population group) can most probably afford a flat rate premium. The other 48% (11-14 million), who earn less than 1.USD a day, may apply for free care having their economic status being confirmed by the local chief. These 48% will be the population that could be covered under the general revenue for PC, SHC and THC services. The principle of solidarity and social justice must apply.

A third and important source of funding is development partners’ contributions. At the moment there are several health financing model initiatives taking place by various development partners. There is need to harmonize these initiatives so that they are in

harmony with the proposed "preferred option" of financing and therefore compliment the efforts towards increasing service coverage.

Recommendation:

1) Introduce payment of salary- and income-related premiums for all civil servants and employees in the formal sector, for the tax-paying self-employed, and as a flat rate also for those 78% of the population in the informal sector except those 48% in this sector who live on less than a 1 USD a day. 2) Develop policies that will ensure allocation of "sufficient funds" for the health sector both at the National and County level if we are reach UHC. 3) Harmonize all donor-driven health financing initiatives so that they compliment the efforts of the proposed option of health financing in Kenya.

3.2.3 The Funding Pool

This is the place where funding is administered, before it is passed on to the purchaser. In the proposed model, it is recommended to pool funds at the county level for all general revenue funds and Ministry of Finance for health insurance premiums from civil service and formal private sector employees. The pooling options considered are the Counties and MOF and this may increase acceptability of the proposed health financing reforms for Counties and MOH.

Fund pooling at the County level will be in line with the current constitution and it will respect the fact that the counties receive a bigger share of funds when revenue is shared between national and country governments (65%-35%) to run the various County Government sectors including the health sector. It should be considered that, first, it will be difficult to withhold the health sector funds at the National Government and therefore the option in the short term is to pool at the County level where the funds already are. Second, all the public primary and secondary care health facilities are owned and run by the County Government. There is need to respect this institutional structure which will give more responsibilities to the County Governments and probably increase acceptability of the health financing reforms and plan for incremental changes in the future. Third, this will ensure that the County Health Sector is responsibility to assure continuity in provision of health services, it remain close to services provision and oversees quality of services provision at county level. Forth, in future the County Governments have the responsibility to mobilize its constituents in the enrollment into the health insurance scheme in order increase their sources of funding for the health sector and to increase health services coverage in their respective counties. Five, the number of the extremely poor will vary from county to county (nationwide about 11-14 million) being in need of a subsidy and the county funding pools will receive subsidies from the equalization funds according to a formula that will be agreed upon.

The second funding pool will be at the MOF for the civil service and formal private sector employees. The Kenya Revenue Authority (KRA) has a good performance record and could be the collector of premiums from the formal sector employees, civil servants, and proportion of informal sector and also hold the “pool” with this largest portion of income. This will be in line with the current practice where the civil service employees’ monthly contribution of health premium remains with the Ministry of Finance. This pool should be expanded to include pooling of health insurance premiums from Kenyans in the informal sector. The proposed change in this case, will be to pool all health insurance premiums paid by Kenyans, both from formal or informal sectors, for provision of both PHC and SHC services. The advantage is that, it will ensure standardization in the calculation and pooling of health insurance premiums in the whole country and across all target populations. Funds pooled at the national level (MOF) will also be used to purchase THC services.

Recommendations:Start with County and MOF funding pools for informal sector population especially the poor and civil service and formal sector employees respectively. Expand the MOF fund pool to include all health insurance premiums paid by Kenyans, both from formal or informal sectors, for provision of the minimum benefit package of essential health servicesat all service levels.

3.3.3 The Purchasing Agent(s)

The Purchaser:The purchaser is the organization buying services from the providers, with money passed on by the pool. In the proposed model, it is suggested that the purchasing agent be different from the pool holder. It is proposed to have one purchaser. It has been said before that NHIF is the best “qualified” to be the single purchaser in the proposed health-financing model, but NHIF is still recovering from considerable shortcomings in the management of finances.It is suggested that the collector of premiums and the pool holder may be different for the time being.

It is desirable to have one main purchaser because the broad experience and the uniform approach will facilitate administration of funds, will assure integrated services provision and efficiency. Insufficient financing will result in badly equipped facilities and unmotivated staff, financing mechanisms may induce irrational use of services, e.g. patients bypassing primary care services because they need to be paid for out-of-pocket while hospital care is covered by insurance, providers refer patients unnecessarily to protect their capitation budget, a county hospital refers a patient to a tertiary hospital where treatment is paid from another budget. The schemes of insurance coverage should be as much harmonized as possible. It is necessary to introduce standard packages of essential care for all levels and recommended fees for all services. It is preferable to start with an effective minimum benefit package of essential health services, which can be

financed adequately and offered to everybody and to expand the package when the national economic situation allows it. Hopefully, a reformed NHIF will be up to the task.

One disadvantage of a single purchaser would be encouraging non-competitiveness in the market and therefore monopoly. However, this must be seen in light of the current Kenyan situation where capacity among purchasers is limited and there are funding constraints, which would hinder establishment of an effective competitive market. The goal should be to establish a single purchaser for the provision of an integrated minimum service package.

Establishing new regional public insurers is not feasible solution, at least in the short term, because of there is insufficient capacity among potential purchasing agents, and two it would be more costly to establish such regional insurers.
Recommendations: Havea single social health insurance agent (SSHIA) as the main purchaser of health services at all service levels. Observe NHIF-performance and insist on reduction of management cost to 15% or less in the next 5 years.

Minimum package of essential health care:Due to limited the resources universal health coverage can only be achieved by defining aminimum package of essential health care for all Kenyans.The basic minimum package of essential health care should cover all Kenyans. Additional services maybe included, as funds become available. It should be kept in mind, that fragmentation of the population into too may target groups, leads to inequality and higher administrative costs.
Recommendations:The three key steps of implementation should be 1) Define the minimum package of essential health care for all the three levels of care. 2) Determine the criteria for referral. 3) Estimate the cost of providing this minimum package of essential health care services.

Mode of payment for services purchased:It must assured that financial incentives are aligned with service delivery objectives. There will be need to define a minimum benefit package of health services that will be offered to a wide population.In addition, prize schedule should be developed in order to assure uniformity in service provision. There are several methods that have been proposed on purchasing health services. Purchasing services using Fee-for-service is administratively cumbersome and it carries an “inborn” incentive for higher prices. However, it is useful in low-productivity settings and/or to provide incentives for providers to report additional performance data.

On the other hand, capitation budget can be used, where calculating the expected average expenses of a provider for a disease episode in terms of time spent on health education

and consultation, materials use, drugs prescribed will allow determining the budget needed for e.g. 3 months and advance it to the health facilities. This way, the health care provider has a guaranteed income, which allows organizing health services efficiently. The system of capitation-based advanced budgets needs to be accompanied by a system of quality control and complaint management on County level. Kenya could borrow examples from Thailand.
Recommendations: Progressively move away from paying fee-for-service and introduce capitation-based advanced budgets. Consult Thai or any other experts for introducing capitation and respective trainings. Assure quality assurance and user-friendly complaint management.

Purchasing Contracts and Contracting Units: In the proposedmodel, the providers will be both public and private health facilities that enter into a contract with purchaser to offer the specified health services. Primary care providers can be family physicians, general practitioners, clinical officers, and nurses in their private clinic/practice or in dispensaries, health centres, and the primary care section of a hospital. Individuals or families choose their primary care providers in the locality, who can be changed after one year or whichever period that will be agreed upon. The prices for stipulated health services will be determined and fixed for standardization. Purchasing services need to be based on a contract. In some countries, e.g. Thailand, the contracting unit is a whole district and the capitation budgets are distributed proportionately to the different public providers in the district. The part of the capitation calculated for referral care at tertiary health care is not transferred to the primary care provider to follow the patient to higher levels of care. It is retained and reserved for the provider at the referral level to be paid against claims related to DRGs (Diagnosis Related Groups).
Recommendations: It will not be feasible to have a contract with every single primary care provider. The proposed model for Kenya is work through contracting unit.At the level of primary and secondary health care service, 20 to 40 single providers could form one Primary Care Network, which becomes the contracting unit for the purchaser, organizes continuing professional development, and refers patients to higher level of care. The contracting unitfor the tertiary care is the hospital itself, which claims payment on the basis of DRGs. These reforms could be introduced slowly with the assistance of external experts.

3.3.4 Registration of Population for SHI

In the proposedhealth financing model, it is recommendedto simplify administration and strengthen the spirit of solidarity, membership in the new Social Health Insurance should be compulsory for all Kenyans regardless of their coverage by another insurance scheme or their ability to pay any premium. All Kenyans must be registered, as members of

theSHI scheme. Members including dependents should be furnished with membership or health cards, which in the future will have electronic features. It should be anticipated that this policy might meet strong resistance by other insurers and by insured who feel comfortable with their existing health insurance arrangements.

Recommendations: Register all Kenyans under the Social Health Insurance Programme with their primary care provider and provide them with an individual and in the future electronic "health card". Include those who are unable to pay a premium and as well as those with other forms of private health insurance.

3.3.5 Accreditation of Providers

Services will only be purchased from accredited providers. Accreditation criteria need to be defined by the Ministry of Health for service providers on all service levels. The authority assessing service quality, providing accreditation, and monitoring quality needs to be close enough to the services and should on the long run be established at county level. To start, it could be a Department within the Ministry of Health, which accredits facilities and does continue training on quality improvement. Close cooperation with professional organizations such as hospital groups or medical professional bodies e.g. The Kenya Association for Family Physicians for the accreditation of primary care providers should be explored.

Recommendation: Establish a capable office for accreditation first in the MOH later in each county, which accredits public and private providers at all service levels.

4.0 REGULATORY FRAMEWORK AND MANAGERIAL ASPECTS

4.1 Legal and Regulatory Framework

There will be need for reforms as the MOH embarks on the movement towards UHC. Among key legal aspect include:

1) There is need to reform NHIF in order to regain lost "trust' among stakeholders in its ability to serve as an effective and efficient purchaser for the interests of the beneficiaries.
2) There is need to establish laws that support earmarking funds for health at the National and County Governments.
3) Reformate the mandate of the Insurance Regulatory Authority (IRA) in order to support the proposed health-financing model.
4) Establish a health facilities accreditation body for external quality assessment and continuous quality improvement.
5) Introduce a classification system for diseases.

6) Establish a health tariffs forums or body, which included key stakeholders.

4.2 Managerial Considerations

Success of thiscomplex reform process depends on political will and the right management approach. The following strategies and management principles are recommended:

- Advocate seriously for the importance of the reform and its different components.
- Analyze the interests of the main stakeholders and respect them without betraying the main concepts of SHI.
- Inform thoroughly all stakeholders and actors and assure participation in order to create ownership feeling on all levels from MOH and NHIF to counties, health facilities, staff, and community.
- Involve professional organizations such as Association of Clinical Officers or family physicians for self-administration and introduce a culture of mutual control.
- Develop a 5-year implementation plan based on a logical framework with a solid component for internal and external monitoring.
- Pilot parts of the plan but only parallel to careful nation-wide implementation in order to save time and avoid bias by experiences in highly attended and supported pilot projects.
- Apply strategies appropriate in the Kenyan context.
- Avoid fragmentation of the approach by accommodating donors and external experts with preferences to specific target groups and strategies.
- Give the process time to grow organically and fully supported by all local actors.