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# Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
<tr>
<td>CME</td>
<td>Continuous Medical Education</td>
</tr>
<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>CTU</td>
<td>Contraceptive Technology Update</td>
</tr>
<tr>
<td>CYP</td>
<td>Couple Year Protection</td>
</tr>
<tr>
<td>DMS</td>
<td>Director of Medical Services</td>
</tr>
<tr>
<td>DRH</td>
<td>Division of Reproductive Health</td>
</tr>
<tr>
<td>FHI</td>
<td>Family Health International</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GHG</td>
<td>Global Health Group</td>
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<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Management Organization</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
</tr>
<tr>
<td>IUCD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>KAIS</td>
<td>Kenya AIDS Indicator Survey</td>
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<tr>
<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
</tr>
<tr>
<td>KShs.</td>
<td>Kenya Shillings</td>
</tr>
<tr>
<td>LAPM</td>
<td>Long-Acting and Permanent Methods</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Rate</td>
</tr>
<tr>
<td>MoPHS</td>
<td>Ministry of Public Health and Sanitation</td>
</tr>
<tr>
<td>MoMS</td>
<td>Ministry of Medical Services</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>MSI</td>
<td>Marie Stopes International</td>
</tr>
<tr>
<td>ORS</td>
<td>Oral Rehydration Solution</td>
</tr>
<tr>
<td>PSI/K</td>
<td>Population Services International (Kenya)</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RHC</td>
<td>Reproductive Health Coordinator</td>
</tr>
<tr>
<td>RHE</td>
<td>Reproductive Health Educator</td>
</tr>
<tr>
<td>RHR</td>
<td>Reproductive Health Representative</td>
</tr>
<tr>
<td>RHT</td>
<td>Reproductive Health Trainer</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>TM</td>
<td>Tunza Mobilizer</td>
</tr>
<tr>
<td>UCSF</td>
<td>University of California San Francisco</td>
</tr>
<tr>
<td>VIA</td>
<td>Visual Inspection under Acetic Acid</td>
</tr>
<tr>
<td>VILI</td>
<td>Visual Inspection under Lugol’s Iodine</td>
</tr>
</tbody>
</table>
1.0 EXECUTIVE SUMMARY

The Kenyan population is estimated to be approximately 39 million and is increasing by one million people annually. The age-sex pyramid reveals a youthful population with an inbuilt momentum for increased population growth. There is a large (26%) unmet need for contraception.

The private healthcare system in the country is widely spread and patronised by the full spectrum of the Kenyan society. Private practitioners, however, are not well equipped in the provision of family planning, especially the long-acting reversible contraceptive methods.

PSI is a global health nongovernmental organisation with its headquarters in Washington D.C. Working in more than 67 countries, PSI promotes various health interventions using social marketing strategies. Its Kenyan affiliate PSI/Kenya (PSI/K) was founded in 1990, initially as a family planning program with the goal of increasing access to contraceptives through the social marketing of condoms and oral contraceptives, but has grown to embrace other aspects of health. The Tunza Family Health Network is its first clinical services intervention.

Tunza Family Health Network is a fractional franchise. This means that not all the services offered by the enrolled clinics are under franchise. Tunza in Kiswahili means “nurture or to care for”. Tunza network is currently comprised of 261 private practitioners country wide.

With the launch of the Tunza Family Health Network in December 2008, PSI/K has adopted a double-pronged strategy to empower lower income women to avoid unwanted pregnancies by accessing high-quality family planning (FP) services.

One prong of the intervention is the network of clinics with the brand promise of friendly, quick, affordable and high-quality FP services by a qualified and trained provider. The network offers a full line of family planning options. The program has placed special emphasis on increasing access to long-acting reversible methods, as these have been neglected (providers lack skills, and there is lower awareness among women about these as compared to other methods). Quality services are based on the elements of technical competence, client safety, informed choice, confidentiality, continuity of care and quality data.

The second prong consists of robust demand creation and a marketing team that assists uptake of services. The flagship of this team are 164 community-based Tunza Mobilizers.

As of September 2010, the franchise had already achieved a cumulative 169,642 CYPs through 27,680 IUCD and 4972 implant insertions. In addition, the Tunza network providers attended to 28,363 oral contraceptives, 59,831 injectables and 27,510 condom clients.

PSI/K provides the FP commodities at highly subsidised prices to the providers who are then required to offer affordable and quality services to their clients.

Looking ahead, Tunza Family Health Network will consider integration of HIV care and other aspects of RH, including Maternal and Child health.

“...friendly, quick, affordable and high quality FP services by a qualified and trained provider.”
METHOD

This case study comprises qualitative research based on a template designed by the community of practice (COP) of social franchisors led by Global Health Group (GHG) of the University of California, San Francisco (UCSF). It was conducted in October and November 2010.

Researchers conducted a desk review of relevant documents and carried out interviews with nine PSI/K staff. The researchers also visited six Tunza clinics across five regions. During these visits, they interviewed the providers, nine clients and six Tunza Mobilizers.

This document presents an overview of the design and implementation of the Tunza Family Health Network, a fractional social franchise at a given point in time.
2.0 CONTEXT

Kenya is geographically divided into eight provinces, which are further subdivided into districts. Seven of these provinces form the main regions in which the Tunza network is active. This setup is about to change with a new constitutional dispensation that replaces the provinces with 47 counties, but maintains the districts.

2.1 NATIONAL POPULATION AND HEALTH STATUS

<table>
<thead>
<tr>
<th>Kenyan Population (2009)</th>
<th>38,610,097</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent urban/rural (2009)</td>
<td>32% / 68%</td>
</tr>
<tr>
<td>Gross national income per capita (2008)</td>
<td>KShs 54,875</td>
</tr>
<tr>
<td>Life expectancy at birth (2009)</td>
<td>58.9</td>
</tr>
<tr>
<td>With HIV</td>
<td>M / F</td>
</tr>
<tr>
<td>Without HIV</td>
<td>M / F</td>
</tr>
<tr>
<td>Probability of dying under five (per 1000 live births, 2008)</td>
<td>74</td>
</tr>
<tr>
<td>Infant Mortality Rate (per 1000 live births, 2008)</td>
<td>52</td>
</tr>
<tr>
<td>Total expenditure on health per capita (Intl $, 2005)</td>
<td>88</td>
</tr>
<tr>
<td>Total expenditure on health as % of GDP (2005)</td>
<td>4.0</td>
</tr>
<tr>
<td>Percent of total expenditure on health that is private (2005)</td>
<td>58.6%</td>
</tr>
<tr>
<td>Percent of private expenditure on health that is out-of-pocket (2005)</td>
<td>82.8%</td>
</tr>
<tr>
<td>Maternal mortality rate</td>
<td>488</td>
</tr>
<tr>
<td>Unmet need for family planning (2008-09)</td>
<td>26%</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>46%</td>
</tr>
<tr>
<td>Contraceptive prevalence rate – modern methods</td>
<td>39%</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>4.6</td>
</tr>
<tr>
<td>HIV prevalence (adults 15-64) ( 2007)</td>
<td>7.1%</td>
</tr>
<tr>
<td>Adult literacy (15-49yrs) m/f</td>
<td>91.5% / 84.9%</td>
</tr>
</tbody>
</table>

Population

The Kenyan population as of the 2009 census was estimated at 38,610,097. This gives an intercensal growth rate of three percent, with a million Kenyans being added each year. The age-sex pyramid shows that 63.5% (24,516,523) are 24 years and below, while women of reproductive age constitute 24.3% (9,375,784). This youthful population structure implies an inbuilt population growth momentum due to an increase in the number of young potential mothers entering the reproductive age. That 46% of the population is either below 15 or above 64 in the face of high unemployment implies a high dependency ratio that does not augur well for economic growth.
The Kenya government adopted a national programme in 1967. In 1984 it issued sessional paper No 4 on population policy guidelines. In the year 2000, sessional paper No 1 on the national population policy for sustainable development was released. It outlined the population and development goals, objectives and targets that were to guide its implementation to 2010, by which time it projected the population would be 37.4 million people.

The unmet need for FP services; the quality of FP services; and regional and rural-urban disparities in fertility, mortality and FP knowledge are listed as emerging and continuing challenges. The National Programme’s objective is to increase availability, accessibility, acceptability and affordability of quality FP services for all those who need them. It recognizes that a multi-sectoral approach is required in its implementation and calls for collaboration with other agencies, including the private sector. Strategies to ameliorate the country’s rapid population growth are key in the realization of Vision 2030, an ambitious blueprint for rapid economic development.

“... a multi-sectoral approach is required in implementation.”
Fertility

The Total Fertility Rate is estimated at 4.6. This is the lowest ever since the country started doing demographic surveys and is a marginal drop from the 4.9 recorded in the preceding Kenya Demographic Health Survey (KDHS). Disparities are seen in rural/urban (5.2/2.9), regional (varying from 2.8 in Nairobi to 5.9 in North Eastern) and earnings (2.9 in the highest wealth quintile to 7.0 in the lowest).  

The CPR is 46% of married women. This reflects an increase from a CPR of 39% of married women in 2003 and is the highest ever. The CPR of 46% is comprised of 39% of married women using modern methods, and 7% of married women using traditional methods. The trend closely follows that seen in the TFR with a higher CPR in urban areas, amongst the educated and the employed.

Knowledge on FP methods is widespread - 88.5% of the women had heard of the injectables, 67.2% of implants and 61.1% of the IUCD. Of the women on contraception, 22% are on injectables while only 2% are on IUCDs. The government is the main source of FP commodities – currently supplying 57%. In 2003, this figure was 53% (KDHS), which demonstrates there is as a slight resurgence. The private sector’s contribution declined from 41% in 2003 to 36% in 2008. The largest decline is recorded by the private clinics and hospitals.

The unmet need for family planning stands at 26%, being equally distributed amongst those who need to space and those who need to limit child birth. Most (66.8%) HIV infected women have a desire to delay pregnancy by more than 2 years, or not to have any more children. Of these only 40.5% use a modern method of family planning. Fifty eight per cent of HIV infected women in married or cohabiting relations with a need for contraception are not on any method.

2.2 HEALTHCARE SYSTEM

The public healthcare system in Kenya is divided into six tiers:

- Level 1 Community (Community Health Workers)
- Level 2 Dispensaries
- Level 3 Health centres
- Level 4 Sub-district and District Hospitals
- Level 5 Provincial (Regional) Hospitals
- Level 6 National Teaching and Referral Hospitals

These form a structured referral system from level one to six, each increasing level being better staffed and equipped.

Levels 1 to 3 fall under the mandate of the Ministry of Public Health and Sanitation (MoPHS). They provide most of the primary healthcare, are heavily subsidized and offer services free or at an extremely low cost.

Levels 4, 5 and 6 fall under the Ministry of Medical Services (MoMSS) and clients visiting them have to pay a fee for curative services. They also offer primary healthcare services, some of which are free. The facilities are supervised by ministry officials at both district and provincial levels who in turn report to National headquarters.

Clinical services in the two ministries are coordinated by the Director of Medical Services (DMS) and Director of Public Health, for MoMSS and MoPHS respectively. The ministries are organized in Divisions e.g. Division of Healthcare Finance (DHCF), Division of Vaccines and Immunization (DVI) and Division of Reproductive Health (DRH). Some of these are further divided into programmes for line activities.

Some of the ministries’ mandates are carried out by parastatals like Kenya Medical Supplies Agency (KEMSA), Kenya Medical Research Institute (KEMRI) and Kenya Medical Training College (KMTC).
There is a National Health Insurance Fund that is mandatory for all employed people and optional for the rest. It meets the full inpatient cost for patients in public hospitals and part payment in private hospitals. It has plans to extend coverage to outpatient services but this has been caught up in a court petition.

There are other private health insurance firms in the market with a few successful Health Management Organizations (HMOs).

**Staffing**

<table>
<thead>
<tr>
<th>Registered Medical Personnel</th>
<th>No.</th>
<th>Personnel /100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>6,623</td>
<td>17</td>
</tr>
<tr>
<td>Dentists</td>
<td>974</td>
<td>3</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>2,860</td>
<td>7</td>
</tr>
<tr>
<td>Pharm techs</td>
<td>1,815</td>
<td>5</td>
</tr>
<tr>
<td>Clinical Officers</td>
<td>5,035</td>
<td>13</td>
</tr>
<tr>
<td>Nurses</td>
<td>45,990</td>
<td>118</td>
</tr>
</tbody>
</table>

These figures include those who are registered and are out of the country or not practicing.

There are 5,712 health institutions in Kenya, 41% are GOK, 15% are NGO-based and 43% are private (9,10) (though this could have changed recently with the use of devolved funds for building health centres in the constituencies and more centres being built under an economic stimulus plan).
2.3 PRIVATE HEALTH SECTOR AND REGULATORY FRAMEWORK

All health practitioners in the country are required by law to be registered by their respective registration bodies and further be maintained in the register by annual licensing. Relevant acts of parliament guide the process. Doctors are registered and licensed by the Kenya Medical and Dentist Practitioners Board (KMDPB), nurses by the Nursing Council of Kenya and clinical officers by the Kenya Clinical Officers Council. Registration and licensing requires demonstration of proper training, an internship period and proof of continuous professional development, depending on the cadre.

Several professional associations such as the Kenya Medical Association and the National Nurses Association of Kenya also exist and serve to articulate the views of their members on a wide variety of issues.

The private sector is widely spread in the country and serves the full spectrum of Kenyans.

Private practice licensing costs more than public sector licenses. Private clinics and hospitals have to meet the minimum criteria set by the MoPHS, and the District Public Health Officer and District Public Health Nurse both inspect clinics prior to licensing. The government recognizes the private sector’s role in achieving key public health indices and encourages their collaboration and engagement.11

2.4 MARKET OPPORTUNITIES (3, 12)

There is a large unmet need for FP. Whereas all methods are available, the IUCD accounts for only 2% of the method mix, not having increased in the last 5 years. Yet it is a cost-effective and reliable method. Knowledge of the IUCD is low – only better than lactation amenorrhea method (LAM), male sterilization and emergency contraception.

The Kenyan private sector, in comparison to the public sector, provides better client satisfaction in provision of FP services and, in general, has superior facilities and infrastructure. However, the private practitioners lack adequate skill and training opportunities in provision of long-term FP methods, with private clinics and hospitals accounting for only 27.1% of IUCD insertions.

The Tunza franchise addresses these gaps by recruiting and training private practitioners in the provision of a range of contraceptive methods, including the long-acting and reversible methods of contraception (LARCs), while promoting uptake in the community.

“...IUCD accounts for only 2% of the method mix...”
Population Services International (PSI) is an international NGO founded in 1970 with headquarters in Washington D.C. It is a network of more than 60 country-based platforms which use marketing strategies to promote health. PSI’s first 15 years were spent on family planning (which gave the organisation its name). However, since 1985 it has broadened its sphere to include five disease-prevention areas: HIV/AIDS, malaria, diarrhea, non-communicable diseases and maternal mortality reduction. These are also the priority for most developing country governments as improving them helps to achieve MDGs 4, 5 and 6.

PSI has grown to be a respected global health organisation and partners with both private and public sector entities to provide innovative health interventions with measurable positive impact.

In Kenya, Population Services International (PSI/K) was founded in 1990, initially to market condoms and oral contraceptives, but it has since embraced other health areas like its parent organisation. PSI/K operations are national.

*Tunza* is PSI/K’s fractional social franchise and was launched in December 2008 with the purpose of engaging private health providers and empowering low income Kenyan women to avoid unplanned pregnancies through access to high quality FP services.

To start with PSI/K hired private consultants who conducted a situation analysis on the status of FP in the country and especially of long-acting reversible contraception in the country. This informed programme design which was tailored using the PSI/Pakistan Greenstar model.

The brand name and logo creation for the franchise network were outsourced to Ogilvy & Mather, a local advertising agency. Their suggestions were tested by Consumer Insight, a market research company. The final modifications were made by PSI/K. The name *Tunza* was associated with care, protection and other positive concepts and was the most preferred by the target population.

*Tunza Family Health Network* is composed of 261 private health practitioners in Kenya. The brand is accompanied by the slogan: ‘*Ujuzi maalum kwa afya ya jamii*’ which loosely translated means ‘Experts in family health.’ *Tunza* clinics provide a full line of family planning options with an emphasis on long term reversible methods such as the IUCD and sub-dermal implants. Priority is placed on quality, with the core principles being:

- Technical competence
- Client safety
- Informed choice
- Privacy and confidentiality
- Continuity of care
- Quality and consistency of data

A double pronged approach includes a supply side (the providers) that guarantees the brand promise of friendly, quick, affordable and high-quality FP services by a qualified provider, with emphasis on providing the long-term reversible method of IUCD and sub-dermal implants, all in the context of informed family planning choice. The other side is composed of robust demand creation by a dedicated marketing team.

"*Ujuzi maalum kwa afya ya jamii*"
The Social Marketing Director is also the Reproductive Health Director and is charged with overseeing the success of the venture and supervising and steering all operations, both in the clinical and marketing departments. The RH Director ensures that demand creation parallels service uptake and that donor deliverables are met while adhering to Division of Reproductive Health (DRH) guidelines. The RH Director reports to and advises the PSI Country Director on RH issues.

The Deputy Director of Quality Assurance and Clinical Services (QA & CS) oversees the provision of clinical services and guarantees that high quality standards are maintained through the development, standardization and use of requisite protocols and checklists. The Deputy Director ensures that evidence-based best practices are applied. He is a medical doctor and oversees a field and office staff of 16 and reports to the RH Director.

The Training Manager is a health professional. She is charged with identifying training needs for both PSI staff and Tunza providers. She also develops the training designs and curricula that assure technical competence within the organization. She supports the RH Coordinators (RHCs) and RH Trainers (RHTs) in their field activities, while working closely with the Communication Manager to ensure coordination between clinical and marketing activities. The training manager reports to the Deputy Director of QA & CS.

The Reproductive Health Coordinator (RHC) supervises the Reproductive Health Trainer (RHT), yet both are health professionals with similar qualifications and responsibilities. Each team of two covers half a region. They are involved in the identification, vetting, recruitment and training of providers. They support providers and ensure Tunza quality standards are consistently met within the network. They coordinate logistical support to providers and ensure proper documentation and timely reporting. They coordinate the response to adverse events and are a link to regional MoH staff and other stakeholders. They work closely with the demand creation team for successful Tunza events and report to the Training Manager.
The Marketing team is headed by the Deputy Director of RH Marketing and consists of members as shown in the organogram. They coordinate branding, advocacy and promotion of the Tunza trademark and other RH services. They liaise with advertising and media agencies and maintain the relationship with them. Each region is now split in two and a clinical person and a demand person team up and work in one part, while the second team of a clinical and demand creation person covers the second part of the region. Both RHE and RHR report to the RH Brand Manager since the split. They oversee the Tunza Mobilizers and coordinate Tunza events in the field.

3.1.2 FRANCHISOR RELATIONSHIP WITH GOVERNMENT

PSI/K has a longstanding, and mutually beneficial, relationship with both the Ministry of Medical Services and Ministry of Public Health Services. PSI/K has representatives in several committees including the FP Technical Working Group (TWG) that brings all FP stakeholders to a quarterly meeting.

The Tunza teams worked with DRH trainers to update the Contraceptive Technology Update (CTU) curriculum and then implemented trainings jointly. This helped ensure that all the Tunza providers got certification from the Ministry. In the various regions, Tunza staff work closely with MoPHS staff during trainings, event days and in follow up supervision.

3.1.3 TUNZA PROVIDERS

There are 261 Tunza providers distributed in the 7 regions as shown in the map below.

The lower part of Eastern Province, Northern parts of Coast and upper Rift Valley are poorly represented. These are marginal areas with poor infrastructure. They are potential areas for future expansion.

Most of the Tunza providers are small owner-operated outlets, typically consisting of a reception, consultation room and a procedure room. However some are within nursing homes and others are medium-sized with more consultation rooms. Two of the six Tunza providers visited during the case study are NGO-owned, with other complementary services. Four of them were multiple providers; some of the providers had been trained by APHIA II, a USAID-funded program using the same curriculum.

Most of the clinics are staffed by nurses and clinical officers; they were deliberately targeted as they are the ones most patronized by the targeted population. A few doctors are found in the hospitals and maternity homes in Western and Nyanza provinces, but they are not engaged in day-to-day provision of the Tunza services. The RHCs and RHTs interviewed said that most doctors had a patronizing attitude towards Tunza services.

Not all the trained providers who work in the Tunza clinics may own the outlets. There is a preponderance of female providers, but this is unintended and reflects the profile of nurses and clinical officers in the country. Indeed all the providers visited during the field excursions were women, although clients in the areas covered did not generally exhibit gender preference – that is they don’t mind whether they are seen by a male or female provider.

Prior to joining the network, most of the clinics did not offer long-acting FP services and had rudimentary infection prevention techniques. Most did not offer IUCDs and implants due to lack of skills and the higher cost of offering the services.
3.1.4 TARGET POPULATION

These are the low and middle income women of reproductive age in urban and peri-urban areas. The KDHS 2008 identifies them as the population with a large unmet need for contraception. The clinic visited in the city attracted mostly middle income clients.

3.1.5 TUNZA SERVICES

Eight clients were interviewed during the case study, ranging from age 29 to 44 years. They had between one to eight living children and were either unemployed or with low income.

It is expected that all Tunza services are offered by trained and certified providers in a friendly, affordable and efficient manner while strictly adhering to national protocols and standards. The following services have been offered since inception; however, cervical cancer screening was introduced in the second half of 2010.

- Comprehensive Family Planning Counselling
- IUCD insertions (Cu T380A)
- Sub-dermal implant
- Cervical Cancer screening with VIA/VILI

It should be mentioned that short-term methods are also available in the clinics to meet the quality element of offering a wider choice. The providers are therefore required to stock at least five contraceptive methods in order to satisfy client choice.

Cervical cancer screening through VIA/VILI was a new service in all the facilities visited. Two clinics offered IUCD insertions prior to joining the network, but had low volumes. Now one of the clinics has had to hire two additional staff due to the increasing client numbers.

In five of the six clinics visited, Tunza services accounted for less than 30% of the workload in terms of client numbers and revenue. While one had over 50% of the clients visiting for FP services, this clinic had, prior to joining the Tunza network, marketed itself as a reproductive health center.

All clients who were interviewed knew of a clinic in the vicinity where similar services were offered cheaper, but opted to attend the Tunza clinic due to better services offered and reduced waiting time. Those who were attending for the first time vowed to refer their friends, and those who were coming for repeat visits had referred at least one person for a service.

Services being considered for the future include:

- Post partum IUCD insertions
- HIV Counselling and Testing (HCT)
- TB screening for HIV cases
- Prevention of Mother to Child Transmission of HIV (PMTCT)
- Voluntary Male Medical Circumcision (VMMC)
- Integrated Management of Childhood Illnesses (IMCI)

“Whenever I come here all the questions I have concerning my health are answered satisfactorily.”

- A client in the Tunza Family Health Centre, Embu
Currently there are 261 Tunza clinics. The network design was to have 250 clinics, the additional clinics are a buffer against attrition. This makes Tunza Family Health Network currently the largest FP social franchise in the country in terms of geographical coverage and number of clinics. Further scaling up of the network can only be planned if the project funding is increased. The other social franchise in the country offering FP services is Marie Stopes Amua Franchise, which has 186 clinics and is in its second phase of funding from KfW.

All the providers interviewed were agreeable to the introduction of more services within the franchise arrangement. They, however, felt it would be challenging if the new services require more space, equipment or technical staff. Meanwhile the franchise management felt introduction of new services will come with challenges unique to the service, in terms of enforcement of standards and increased workload, especially in terms of monitoring and reporting. The franchise is, however, well positioned to include a broad range of health services within its family health mandate and a number of opportunities exist for PSI/K to diversify the franchise service offering.

3.2.0 SUMMARY STATISTICS

Since the start of the project up until September 2010, there have been 27,680 IUCD and 4,972 Jadelle insertions. Of these, 11,018 IUCDs and 3,336 implants were administered in nine months of this year. This provides for a cumulative 169,642 CYPs. In addition, Tunza network providers attended to 28,363 oral contraceptives, 59,831 injectables and 27,510 condom clients.

3.3.0 SERVICE FINANCES

The cost of services and commodities varies amongst the providers, the PSI/K policy on user fee has also changed through the life of the network in response to donor requirements, providers’ expectations and clients’ needs.

Commodities are distributed to the providers at a subsidized cost, and other implicit subsidies in terms of training and support are a benefit to the providers. These are explained below.
3.3.1 PRICES FOR COMMODITIES AND SERVICES

At inception, IUCD insertions were offered free of charge to the clients who had been referred by Tunza Mobilizers. For each insertion the providers were paid KES. 400 (approximately 5 USD). A cost-sharing arrangement replaced this system, where the clients would pay half the amount with the franchisor giving the provider a similar amount.

However, starting in June 2010, all service subsidies were withdrawn and clients are now expected to meet the full cost of the services. PSI/K does not compensate providers for insertions nor does it impose obligatory prices for the franchised services. However, PSI/K provides consumable commodities to subsidize service provision in lieu of the earlier compensation and advises providers to charge affordable fees, recommending between KES. 400 – 500 (4.97 – 6.21 USD). Most providers comply with this requirement but some in the urban areas charge in excess of KES.1500 (18.62 USD). This is still below the private sector fee that can be as high as KES. 6000 (74.49 USD).

Some of the providers justified their high cost by claiming that clients were suspicious of the quality of the commodities if they were cheap. Most providers have a sliding scale mode for charging, and for those who cannot afford the services they accept less than their normal rates. Five of the six providers visited pointed out that they would waive the entire fee for the destitute. Prices are communicated to the clients during consultation and on enquiry at the reception desks, but the NGO-run facilities that were visited had price lists on their walls. All the clients currently pay out of pocket.

The commodities used for the franchised services are provided at subsidized cost. The IUCD is sold to the Tunza provider at KES. 30 per piece (0.37 USD), each coming pre-packed with the consumables required for insertion (a pair of sterile gloves and two sanitary pads). The implants are sold at KES. 100 each, (1.24 USD) in packs of 10.

3.3.2 SUBSIDIES

In addition, the providers are given a start-up kit that has the instruments required for insertions and removals. Infection prevention solutions are provided free with the quantity determined by the prior month’s workload (number of IUCDs inserted). PSI/K realized that the equipment and time taken during an IUCD insertion led to a provider bias against it, who in turn billed more for its provision. This created a barrier to access for low-income women. The current strategy of subsidies being linked to offering IUCDs has been imposed to deliberately address this bias.

IEC materials, protocols and working aids are given free of cost.

Training of the providers and CMEs are implicit subsidies as is the advertising and promotion of the Tunza brand. Providers are made aware of these additional benefits during the trainings and all appreciate it.

“IEC materials, protocols and working aids are given free of cost.”
3.4.0 FRANCHISE FINANCES

*Tunza* Network Operation Costs

The *Tunza Health Network* is in its first cycle of funding (July 2008 – Dec. 2010). By the end of 2010, it received USD 7,261,739, of which 84% had been spent by the end of September 2010.

3.4.1 COST SHARING / COST SUBSIDY

PSI/K has many programmes running, and some are integrated. Some staff do not work exclusively on *Tunza* activities, working on other RH activities as well.

The *Femiplan™* Brand of contraceptives promoted by PSI also gains from generic promotion of the *Tunza* services.

*Tunza* field teams work from the provincial offices that are cost shared with other health projects.

3.4.2 COST SUBSIDY PER UNIT

At the end of September 2010, 27,680 IUCDs and 4,972 implants had been inserted by the 261 providers, contributing 169,642 CYPs. Taking the total budget spending and dividing by the CYPs, the cost per CYP is approximately USD 35.95 and cost per franchised clinic is USD 23,371.1.

Needless to say this cost includes start-up capital expenditure like vehicles, materials and activities whose impact is likely to run throughout the life of the project.
4.0 TUNZA OPERATIONS

4.1.1 TUNZA PROVIDER SELECTION AND RECRUITMENT

All current Tunza providers were actively recruited. The providers were selected using a researched and pre-tested selection tool, which assesses, amongst other things: interest and willingness to join and adhere to the network’s protocols and ideals; staffing; and licensing and available equipment.

PSI/K staff on the ground also took into account provider’s prior reputation; proximity to the targeted population; and the location of the next provider.

After an induction training, the MOU is signed and KES 1000 (12.42USD) paid as an annual membership fee. Only five of the providers visited remember paying a registration fee. Two could not recall the amount while one did not recall ever paying. However, PSI/K confirm that several of the franchisees have paid the membership fee, and that they are serious about enforcing the franchise fee going forward.

All the providers visited, when asked, said they had been approached by at least one other fellow practitioner displaying interest in joining the network. However, as the targeted number of providers has been attained, recruitment has been suspended.

4.1.2 MEMORANDUM OF UNDERSTANDING

Providers sign an MOU with Tunza valid for one year, but this can be nullified with one-month notice by either party. The MOU stipulates that PSI/K responsibilities are training, ensuring flow of supplies, branding and demand creation. It also states the provider’s responsibility for reporting, staffing and provision of quality services. The other sections in the document include termination of agreement, monitoring and evaluation, and referral system. None of the providers we interviewed had any concerns while signing this document, nor any objections to its contents. It is a strong, clear document that is easily enforceable.

4.1.2 BENEFITS OF TUNZA MEMBERSHIP

- Comprehensive training and continuous medical updates
- Start-up kits (equipment for insertion and removal of implants and IUCD)
- Subsidized high-quality, branded commodities
- Tunza branding as a mark of quality, enhancing their profile
- Publicity and marketing of clinics and services
- Free promotional materials
- Supplies for infection prevention
- Professional support from the Tunza staff and within the network
- Awards for improvement and good service

All the interviewed providers said training was the best benefit of membership thus far.

4.1.4 MEMBERSHIP RETENTION AND ATTRITION

Twenty-two providers have been de-listed for failing to live up to the brand promise. Two providers have left of their own volition, one citing that the venture was no longer viable with the withdrawal of co-payment, while the other did not cite any reasons. This represents less than 10% attrition. Upon withdrawal of network membership the branding on the clinic walls are erased and sign boards taken down.

All members interviewed declared themselves committed to the network and deemed that PSI had done enough to cultivate loyalty.
4.1.5 COMMUNICATION

The providers and the field staff frequently communicate using mobile phones. Monthly supportive supervision visits and quarterly quality checks provide for dissemination of information. A quarterly newsletter providing network news and updates on FP is circulated free to the members.

Members in close proximity also form clusters and are encouraged to meet for interaction; some of these clusters incorporate non-network members. The Tunza cluster in Central Province is active and has gone ahead to incorporate a self-help unit that assists providers in acquiring autoclaves.

A quarterly meeting is also held of all providers in a region, during which feedback is provided from an evaluation that picks the best improved and best performing provider.

Memos are also distributed when there are urgent changes in policy and protocols. However, one of the providers pointed out that there is little interaction between providers and senior franchise management.

4.2.0 LOGISTICS

Commodities for Tunza services are procured by an international competitive tender process conducted by the parent organisation. They are warehoused by PSI/K and delivered to the providers through the marketing team. Other PSI-branded commodities are also delivered upon request from the providers.

Commodity security is ensured through monitoring of monthly consumption to ensure no provider ever has a stock out.

In Kenya private providers can get family planning commodities free of charge from the government stores when these are available. The providers are not obliged to acquire their commodities from PSI/K, but the pricing regime is such that PSI/K is the cheapest option in the absence of Ministry of Health (MOH) commodities. The supply of the Jadelle implant is restricted to 10 pieces at a time. This is due to its high cost, relative scarcity and risk of being sold to non-Tunza clinics. On one occasion, the DRH had to supplement the network’s stock of implants. In turn PSI/K has been called upon to bolster the government’s stock of DMPA, the three-month injectable.

Quality services are a key component of the Tunza Family Health Network brand. In living up to this promise PSI/K has several mechanisms in place to ensure that all of its franchise members are continuously providing high-quality services.
In June 2009 the franchise developed the Kenya Quality Assurance Plan to guide quality and measure it within the network. Quality service is a key component of the brand promise and it is defined in terms of six elements:

- **Technical Competence**
  - Provider selection – Careful and stringent selection criteria to ensure only trained and licensed providers are enlisted to the network.
  - Training – All providers, upon selection, undergo a residential Contraceptive Technology Update (CTU), which has a theoretical component and a practical component (both on humanistic models and on clients). The trainings are organized in consultation with DRH and certified by MoPHS.
  - Protocols – PSI protocols based on best practices and national guidelines are provided for all the franchised services.
  - Support supervision – Providers are supervised during the first 10 insertions before certification and supported to adhere to the guidelines. A comprehensive checklist is used for all the services offered. This checklist is used to assess the providers during each insertion for the initial 10 insertions or until the provider is proficient and confident. After this initial phase the checklist is used for all the providers at least once a quarter to ensure continuity of quality service provision.

- **Client safety**
  - At selection the clinic is assessed to ensure there is adequate equipment, space and facilities for service provision.
  - Emphasis on infection prevention during training and supervision.
  - Material support for infection prevention is provided to the high volume clinics.
  - Clear cut protocols to be followed in the case of adverse events.

- **Informed choice**
  - Providers have to comprehensively counsel patients on all FP methods and their merits and demerits. Job aids for counselling are available.
  - Protocols on counselling and checklists for its supervision are available and are used during supportive visits.

- **Privacy and confidentiality**
  - Providers are encouraged to have a separate Tunza room for service provision.
  - Franchise management has supplied providers with branded curtains to use in the rooms, ensuring visual privacy.

- **Continuity of care**
  - Tunza members are required to stock at least five methods (IUCD, implants, pills, three-month injectables and condoms).
  - Clients are given follow-up cards indicating the date of the next visit and also encouraged to contact the provider with any questions or concerns.
  - Providers are encouraged to refer for services they cannot offer, preferably to another Tunza provider.

- **Quality and consistency of data is assured**

Inability to adhere to any of these quality standards are grounds for delisting from the network.

### 4.3.1 QUALITY

The Training Manager and Director of Clinical Services are tasked with continuous revision of the protocols and checklists to ensure adherence to best practices. The RHCs and RHTs supervise in the field.
The table below shows average scores on assessment by checklist for quarter 1 and 2 and demonstrates improved quality across board.

<table>
<thead>
<tr>
<th>Quality Elements</th>
<th>Q1 Average Score</th>
<th>Q2 Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>65%</td>
<td>75%</td>
</tr>
<tr>
<td>Infection prevention</td>
<td>76%</td>
<td>83%</td>
</tr>
<tr>
<td>IUCD insertion</td>
<td>77%</td>
<td>81%</td>
</tr>
<tr>
<td>IUCD removal</td>
<td>81%</td>
<td>82%</td>
</tr>
<tr>
<td>Implant insertion</td>
<td>75%</td>
<td>82%</td>
</tr>
<tr>
<td>Implant removal</td>
<td>74%</td>
<td>81%</td>
</tr>
</tbody>
</table>

All the interviewed providers noted that their services have improved in quality and all the interviewed clients expressed satisfaction with the quality of service offered to them. Providers who consistently live up to the brand promise and serve many clients are eligible for quarterly and annual awards. Criteria based on quality of service, adequacy of stock, accuracy of records, timeliness in reporting and availability of equipment is used to determine the winner.

4.3.2 TRAINING

Within the clinical team there is a training manager who identifies training needs for both the staff and providers. She develops the clinical training design and curricula to conform to national guidelines. The training methodology is competency based and applies principles of adult learning.

All providers undergo CTU training and are further evaluated during support supervision before certification. Providers are undergoing training in cervical cancer screening using VIA/VILI through job training.

4.3.3 MANAGING ADVERSE EVENTS

A document titled PSI/K Policy and Procedures for Managing LARC Adverse Events or Complications has been prepared. It defines adverse events and outlines the steps to be taken in case of one. Clients who have suffered an adverse event might be handled within the Tunza facility or referred to a public hospital for proper management.

Each of these cases are investigated and documented; PSI/K meets the full cost of investigating and treating clients who suffer complications or adverse events in the network’s clinics.

The external audit team made specific recommendations about minor events that had been recorded and these are now included in the Tunza protocols.

“Clients who have suffered an adverse event can be handled...”
4.3.4 MONITORING AND EVALUATION

At inception there was a paper-based reporting system. This was replaced by a computerised SMS-based platform called Julisha. Incorporated in Julisha was a client satisfaction evaluation dubbed the panel study; it involved clients answering a few question via SMS on their experiences at the network clinics.

A large quantity of data is required and thus entering through SMS was prone to errors. Whenever an error was detected the system would send an SMS to the provider. Due to the errors and system difficulties the Julisha system and Panel study were abandoned and replaced by codified paper-based M&E tools, which are scanned at head office.

A client exit survey was conducted in April/May 2010, to establish the quality of services offered and reliability of data submitted.

A great deal of data is collected and informs important decisions. Through this it has been established that the Tunza Mobilizers are the main source of incoming referrals, informing the decision to invest more in them. It has also been established that new users are of a younger age group, a key determinant of increased CPR; this information has been used to revise marketing strategies that target them.

In August 2009 an external RH audit team from USA visited Tunza. The team had three experts – Drs. Sadia Hyder, Ila Dayananda and Mimi Zieman. They conducted a detailed quality audit which included briefings; desk review of documents; field visits to regional offices; direct observation of a sample of network providers and event days. The observations and recommendations were shared during the final debriefing session. On the whole the team deemed quality within Tunza as acceptable. PSI/K then prepared action plans to incorporate the experts’ recommendations to further improve quality in the network.

4.4 NETWORK LINKAGES

4.4.1 PROMOTIONS AND MARKETING

The marketing team engages in promotion of the brand and behaviour change communication that promotes uptake of IUCDs by dispelling myths and misconceptions. The marketing budget is equally divided between the branded and generic FP interventions. The following promotional and advertising channels are used:

- **Tunza Days** – These are network campaign event days that are conducted at selected Tunza facilities. They promote the host facility, while increasing volume and uptake of the long-term methods. They provide opportunity for the providers to sharpen their skills under supervision. Tunza days are preceded by community mobilization.

- **Tunza Outreach** – These are like Tunza Days. However unlike Tunza Days, they are conducted in government clinics and services are offered free of charge. Costs are met by the franchise. They are designed to target the very low income women.

- Branding of Clinics – Tunza network logo and colors are painted on the clinic walls. Providers are branded after three months of support supervision and demonstrated adherence to network protocols. Currently 174 of the 261 clinics are branded. Dismissal from the network is accompanied with removal of the brand from the walls to protect the remaining members.

- Promotional merchandise like pens, t-shirts, lab coats, partitioning curtains etc. are also provided to the staff and clinic.

- Road shows within the catchment areas.

- Strategically placed billboards.

- Flyers are distributed.

- Radio and television infomercials on popular stations.

- Talk shows on the radio stations, where PSI staff provide information, dispel myths and respond to calls from the public.
A hotel worker in Kisumu noticed the name of Juliana Nzau (an RHT in Nairobi) on her hotel’s guest list. She recognized it from a radio call-in session Juliana had hosted earlier. The talk show had increased her interest in the IUCD, and she sought out Juliana and ended up having an IUCD inserted during the Tunza event that was going on in Kisumu.

Prior to joining the network, all the clinics visited had their own advertising boards within the confines of their licensing regulations. The two providers that were NGO sponsored also had other promotional campaigns including distribution of flyers and organized community events.

Four of the six providers visited said most of their clients are referred by other satisfied clients.

4.4.1 TUNZA MOBILIZER STRATEGY

The team of 164 Tunza Mobilizers is the flagship of the demand-creation strategy. They are community-based, independent, contracted workers charged with creating demand within designated areas.

They are recruited in consultation with providers who work within their catchment areas. Most of them are literate women, with a background in community work. They undergo a comprehensive PSI/K training on basic FP and community education, after which they undergo supervision and further on-the-job training before being awarded certificates.

In the communities, they work with organized women’s groups and they may also go door-to-door. They are involved in creating demand for Tunza events and dispelling myths about IUCDs in the community.

Minimum deliverables of a Tunza Mobilizer are:

1. At least five group sessions of more than 10 women each week.
2. Timely submission of accurate reports.
3. Effective mobilization for Tunza events.
4. Good working relationship with providers and field staff.

Although no targets were set, the mobilizers did get paid a stipend on event days for their additional efforts in mobilizing the community. However there is evidence that mobilizers have a valuable impact on demand creation so this has led PSI/K to put them on a standard monthly allowance.

Currently they are the biggest source of referrals and they send potential clients to Tunza clinic with referral slips, which remain with the network provider and are used to evaluate their role in demand creation. Four of the six providers visited said most of their clients are referred by other satisfied clients. In one of the areas, the Tunza Mobilizer encountered a satisfied client:

The above pie chart shows that Tunza Mobilizers are the most effective method of marketing, accounting for more than 40% of the IUCDs inserted so far.
Ms. Ambasa, a *Tunza Mobilizer* in Majengo (Western Province), approached a lady in her community, who had seven living children after eight pregnancies. She counseled her on contraception and advised her to pick a method. Though the mother had resolved that she did not want any more children, she asked for time to consult and think about it. Unfortunately she conceived before making up her mind. After her ninth delivery, she sought out the TM and had an IUCD inserted. She is now a strong advocate of the IUCD and has referred several women to the *Tunza Jamii Medical Clinic*.

4.4.2 PARTNERSHIPS WITH OTHER ORGANISATIONS

PSI/K is currently partnering with FHI’s M4H, which is an SMS-based information channel. This channel enables target populations to send in their contraception questions via SMS and get responses from qualified counsellors. The goal of this partnership is to have *Tunza* providers included in the list of private providers where target audiences can be referred for FP services. In addition, PSI/K partners with LVCT, a local organization that runs a hotline where youth can call in and ask questions on contraception without the fear of being judged. Questions are answered by a trained counsellor. The network also has links with the FHI information network, who are known as champions of the long-acting reversible methods. The *Tunza* network also plays a complementary role to the MSI-K *Amua* social franchise.

“*She is now a strong advocate of the IUCD.*”
5.0 CHALLENGES AND OPPORTUNITIES

The challenges are both internal and external.

5.1 INTERNAL CHALLENGES

• The Tunza Health Network was the first PSI/K project that involved private sector clinical services provision, and as such, necessitated a significant amount of capacity-building for the staff and the providers.
• The Tunza providers, being private practitioners and therefore autonomous in running clinic affairs, posed challenges in scheduling trainings and joint activities. Most did not want to be away from their outlets for long durations.
• Standardising service fees was met with resistance as providers said they had different overhead costs and returns.
• NGOs in Kenya are often associated with financial abundance, which created higher expectations from the private providers than what the network could deliver.
• Areas under the jurisdictions of field teams are vast, posing difficulties in adequate supervision.

• Widespread myths and misconceptions about contraceptives in general and IUCDs in particular.

5.3 OPPORTUNITIES

• There is a large unmet need for IUCDs; the KDHS survey that shows only two percent of women on contraception use the IUCD means its potential has not been fully exploited.
• Integration of other RH and Child Health services can be undertaken as there is already a network of loyal Tunza providers.
• Interest in joining the network by non-franchised private practitioners is an opportunity to expand to areas that are yet to be adequately covered.

5.2 EXTERNAL CHALLENGES

• The Ministry of Health has provisions for supplying private clinics with free contraceptive commodities. This makes it challenging for social marketers to penetrate the same market with subsidised commodities.
• The Tunza Network in the country was preceded by the MSI-K social franchise branded Amua. However, Amua operations are confined to Western Kenya. In any areas where Amua and Tunza clinics are in close proximity, there is a possible duplication of effort, especially regarding community mobilizers. Family Health Options of Kenya (FHOK) is also an organisation that specializes in provision of reproductive health services, owning a few clinics of their own.
• Low male involvement.

Many women marvel when I show them the IUCD; some thought it was a big object more like a metallic mosquito coil

- Monica Wanjiku a Tunza Mobilizer in Umoja.
5.4 LESSONS LEARNED

- It is better to train providers who are also clinic owners to avoid the loss associated with trained providers moving out of the franchised clinics.
- It is better to rely on the database of registration and licensing bodies as a starting point for provider selection. Some providers later turned out to have had inadmissible certificates after the network had invested in them.
- Well-motivated community health workers (*Tunza Mobilizers*) can be an effective strategy in promoting IUCD and other contraceptive uptake.
- *Tunza* days and outreach activities provide good opportunities for private practitioners to sharpen their skills and RHTs and RHCs to assess competence.
- Integration of services should start early to avoid providers being associated with one service only.
- Price, however minimal, is a barrier to access for the very low income.
- Active promotion of IUCD and elimination of provider bias can lead to a higher uptake of the method.
- Use of an SMS-based reporting system is difficult when the data load is high.
- Collaboration with the relevant departments of the MOH adds credibility to the franchise and ensures support of the Ministry, who are a major stakeholder.
- Having distinct marketing and clinical teams, if not well managed, can reduce the synergy that is imperative for success. But when well built and well run, they can be the reason for success.
- Reckless statements on mass media have far-reaching implications. In November 2009, a popular TV station aired a clip alleging that expired implants were being inserted in the unsuspecting public. This report was unrelated to *Tunza*. However, many women went back to the clinics, to have their implants removed, including 203 within the *Tunza* network. After counselling 143 women opted to keep the method, though 60 clients had their implants removed.
Providers Visited for In depth Interviews

1. Hellen Mugisha, St. Thomas Health Centre, Nairobi
2. Egla Njeru, Family Health Centre, Embu (Eastern)
3. Eunice Areba, NACOHAG Medical Centre, Naivasha (Rift Valley)
4. Margaret Yalwala, Junction Medical Centre, Chavakali (Western)
5. Pamela Nyangweso, Jamii Medical Clinic, Majengo (Western)
6. Sr. Onyulo KMET Clinic, Kisumu (Nyanza)

Footnotes

1. 2009, Kenya Population and Housing Census Reports vol I (A, B, C) and II; KNBS; August 2010
6. www.who.int/nha/country/KEN
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