REPRODUCTIVE HEALTH matters

From Project to Program: Tupange's Experience with Scaling Up Family Planning Interventions in Urban Kenya

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Abstract: *This paper describes how the Urban Reproductive Health Initiative in Kenya, the Tupange Project (2010-2015), successfully applied the ExpandNet approach to sustainably scale up family planning interventions, first in Machakos and Kakamega, and subsequently also in its three core cities, Nairobi, Kisumu and Mombasa. This new focus meant shifting from a "project" to a "program" approach, which required paying attention to government leadership and ownership, limiting external inputs, institutionalizing interventions in existing structures and emphasizing sustainability. The paper also highlights the project's efforts to prepare for the future scale up of Tupange's interventions in other counties to support continuing and improved access to family planning services in the new context of devolution* (decentralization) in Kenya.

Keywords: Family planning, scaling up, sustainable scale up, Kenya, Tupange, urban poor, devolution, decentralization, project approach, program approach, Urban Reproductive Health Initiative, ExpandNet

Introduction

There has been much discussion recently about the need to move from conventional project approaches to a systematic focus on sustainable scale up, starting from the time that projects are initially planned and designed.[1–4] However, making this transition is not easy. It requires creating ownership in the institutions that are expected to implement successful interventions on a large scale and working within existing system constraints or finding ways in which constraints can be alleviated.[5]

This paper describes efforts of Kenya's Tupange Project to learn about systematic approaches to sustainability and scale up and to apply them in its project in five Kenyan cities. The Tupange Project (2010-2015) is part of the Urban Reproductive Health Initiative funded by the Bill and Melinda Gates Foundation in four countries (India, Kenya, Nigeria and Senegal). It has sought to achieve significant improvements in family planning service delivery and community awareness in urban slums, initially in the three "core cities", Nairobi, Kisumu and Mombasa, and subsequently in the "expansion cities", Machakos and Kakamega. At the end of its project period, Tupange is exploring how key lessons from the project can be more broadly applied in the new context of *devolution* (decentralization) in Kenya, where power has been transferred from national level to the newly-created county level.

Project versus program approach to effecting change

Experience has shown that working in what is here described as a project approach may produce

notable improvements in health outcomes in local areas, but often does not lead to sustainable scale up.[1,6] The project approach refers to interventions that are focused on short-term results and not necessarily on what is needed to ensure sustainable scale up, even though large-scale impact is often stated as the ultimate goal. In this approach levels of financial, technical and human resources are unlikely to be available for subsequent implementation in routine programs and parallel structures to existing government or private sector programs tend to be created. Moreover, only limited attention is given to addressing the legal, policy, bureaucratic, institutional and programmatic frameworks essential for institutionalizing interventions.

Conversely, working in a program approach means organizing projects from the outset in ways that enhance the potential for subsequent sustainable scale up. The focus of such an approach is on the broader health system and on how the intervention implemented initially in the project will contribute to the national program. Efforts are made to limit external resources to what can be maintained or mobilized on a larger scale. Government ownership and a participatory process involving key stakeholders are central.

Key differences in the two approaches are captured in Table 1.

Background on the Tupange Project

Tupange is a project led by Jhpiego, an international NGO affiliated with Johns Hopkins University, in collaboration with a consortium of partners. Partners include the National Council of Population and Development (NCPD) under the Kenyan Ministry of Planning and Devolution, in charge of policy and advocacy activities; Marie Stopes International (MSI), responsible for strengthening the private provider network and service delivery in the core cities; Pharm Access Africa LTD, responsible for contraceptive commodity security; and the Johns Hopkins Center for Communication Programs, leading the demand creation activities. The goal of Tupange is to increase contraceptive use among the urban poor in five Kenyan cities. At the time Tupange was initiated, national health efforts were focused mainly on HIV and primary health care for the rural population. The family planning needs of the urban poor, by contrast, were not being adequately addressed, even though rapid urbanization has been transforming Kenyan cities.

Table 1. Project versus program approach to effecting change.

Key Dimension	Project Approach	Program Approach
Major purpose	Proof of concept	Proof of implementation
Government participation	Relatively limited	Extensive
Role of project staff	Implementers	Facilitators Technical assistance Mentorship
Emphasis on external resources and creation of parallel systems and structures	Extensive	Limited
Emphasis on mobilizing existing resources	Limited	Extensive
Focus on institutionalization and sustainability	Limited	Extensive
Preparing for large scale implementation from the outset	Limited	Extensive
Time frame	Relatively short	Long
Collaboration with non-project partners	Limited	Extensive

Tupange seeks to improve access to quality family planning services through multiple interventions, covering facility-based and integrated outreach services as well as demand creation. Supply-side activities include training and mentoring of providers, family planning orientation for all facility staff, and integration of family planning with other maternal, newborn and child health and HIV/AIDS services. Tupange is also supporting public and private health facilities to increase availability of long-acting and permanent contraceptive methods by sending a trained service team on a planned schedule to provide these services (referred to as in-reaches). Finally, provision of family planning is expanded through social franchising of private providers.

Demand-side activities involve: 1) supporting community health workers to promote family planning and distribute oral contraceptives and condoms; 2) organizing community dialogues and "edutainment", i.e., educational entertainment approaches involving local leaders, women's and youth groups; and 3) using mass media to increase community awareness. The project is also improving commodity security and creating a supportive policy environment through advocacy for increased resource allocation and the use of family planning champions.

Tupange's monitoring and evaluation include analysis of national service delivery statistics, baseline rapid assessments of facility readiness and community needs, client exit interviews and qualitative program monitoring visits. This is complemented by baseline, midline and endline surveys of women of reproductive age in project cities, conducted by the University of North Carolina's Measurement, Learning and Evaluation (MLE) Project and its local partners. The BMGF-funded MLE Project conducts independent evaluations of the four URHI country projects (India, Kenya, Nigeria, and Senegal).

According to the 2009 census, the total population of the five project cities was 4.4 million people. The 2009 national modern contraceptive prevalence rate (mCPR) for currently married women age 15-49 was 39% and for all women 28%.[7] 2010 baseline data from the MLE survey showed that mCPR for women age 15-49 was 44.4% in Kisumu, 29.4% in Mombasa, 43.7% in Nairobi, 46.0% in Kakamega, and 45.3% in Machakos (see Table 2).[8]

Methods

The authors of this paper are leaders of the Tupange Project, or members of the ExpandNet Secretariat* who have been providing technical assistance to the Tupange team. The paper represents the authors' reflections and is informed by data from baseline, midterm and endline surveys, rapid assessments, supervisory visits undertaken by project staff, as well as monitoring data and service delivery statistics. ExpandNet conducted nine visits to the project, including six site visits with Tupange team members to conduct interviews with health authorities, providers, community health workers, clients and other community members. The authors worked via electronic communication during the intervening periods. The paper was developed during a one-week workshop with key Tupange and ExpandNet authors.

Starting with a project approach

In the initial two years, Tupange followed a classic project approach. The project was conceptualized as an opportunity to conduct operations research, testing eight different interventions related to strengthening family planning service delivery and demand creation in Nairobi, Kisumu and Mombasa.

Consistent with the ways consortium partners were accustomed to working, activities were initiated with the project team leading the implementation, providing necessary funding to the Ministry of Health and other project partners to "get the job done". For example, the Tupange team planned and implemented training activities for public sector health providers, without considering whether the Ministry of Health would have the capacity to conduct such training after the project ends. The general sentiment was "we have to start ourselves to get things to take off".

The Tupange team did not have a strategy for supporting institutionalization and sustainability. How the national family planning program could implement the interventions and institutionalize them in the larger health system was not considered. The plan for scale up was to expand from the three core cities to two additional cities.

*ExpandNet is a global network of public health professionals working on scaling up, with a Secretariat located in California and France. It is not part of the Tupange consortium but has supported the project with scaling up since 2012.

Table 2. Demographic and family planning service provision and use for Tupange cities.

	Nairobi		Mombasa		Kisumu		Kakamega		Machakos	
	Baseline†	Endline‡	Baseline†	Endline‡	Baseline†	Endline‡	Baseline†	Endline‡	Baseline†	Endline‡
Population (1)	3,138,000		939,000		410,000		92,000		150,000	
Modern contraceptive prevalence rate (CPR) urban (%)	43.7	54.8	29.4	43.8	44.4	58.7	46.0	53.8	45.3	57.8
Modern CPR urban poor (two lowest quintiles %) (2)	41.2	59.8	26.4	43.5	46.0	60.4	46.8	61.7	47.6	63.9
Method mix (urban %)*										
Oral contraceptive pills	11.1	9.9	6.3	4.7	5	3.3	4.2	5.7	9.2	10.5
Condoms	7.2	5.5	3.9	7.2	9.6	8.9	6.2	4.4	5.5	2.7
Injectables	17.7	22.1	13.6	17.8	20.8	18.8	25.1	21.3	19.5	23.5
Long-acting and permanent methods (LAPM – includes implants, IUCD, male and female sterilization)	6.1	15.8	4.1	13.5	7.7	26.7	9.4	21.6	10.3	20.0
Number of health facilities covered by Tupange/total number reporting provision of family planning (3)	20 (234)	79 (339)	14 (114)	45 (147)	8 (52)	14 (52)	0 (19)	6 (24)	0 (27)	7 (30)
Number of Tupange-covered health facilities providing LAPM (4)	17	78	10	44	5	14	0	6	0	6

(1) 2009 Kenya Population and Housing Census.[11]

(2) MLE Urban poor (two lowest wealth quintiles).

(3) Project monitoring data as of December 2014.

(4) Kenya District Health Information Software II (DHSIII) as follows:

- Baseline uses period Jan-June, 2011, before implementation of Tupange.
- Endline uses period Jan-Dec, 2014.

*Method mix does not include other modern methods.

†MLE Baseline 2010, women ages 15-49.

‡MLE Endline 2014, women ages 15-49.[10]

Note: MLE baseline data was collected from a representative sample of women ages 15-49 in each city at baseline (2010). Baseline women were followed and interviewed again at endline (2014). Due to the nature of longitudinal data, the endline data is no longer representative at the city-level in 2014 and respondents will have aged and had more children; contraceptive use at endline is reported among women ages 15-49 to make the samples more comparable.

Kakamega and Machakos, but not beyond. Tupange expected to replicate the activities tested in the core cities in expansion cities, but with fewer resources. It was assumed that what worked in Nairobi would work in nearby Machakos, without recognizing that the interventions might have to be adapted to a different socio-cultural and service delivery context.

From the outset of the project, Tupange leadership had a close relationship both with the National Council for Population and Development and the Ministry of Health. NCPD has been a key member of the consortium and has played a major role in the project. The Ministry of Health was consulted regularly in the development and implementation of the project interventions. In the project cities, the Ministry of Health has participated in implementing project interventions to improve service delivery. However, these relationships were characterized by a project approach in that the expectation among all parties was that Tupange would take the lead and sustainability beyond the project end was not a major focus.

Moving to a program approach when expansion was initiated

In mid-2012 Tupange's monitoring of government service statistics, together with field observations by staff, revealed positive changes in the availability and quality of services, suggesting that expansion to Machakos and Kakamega would be appropriate. Family planning uptake was increasing in the core city slums and the method mix had improved substantially, with increasing use of long acting and permanent methods.

These results reflected successful capacity building, provision of equipment and contraceptives, mentoring of Ministry of Health personnel by Tupange staff and increasing access to family planning services through community-based integrated outreach and facility in-reach activities. Health providers were now more competent to offer a broader range of methods and provider biases had been reduced. Commodities were more widely available and stock-outs had been substantially decreased. Referrals by the community health workers increased and they had begun distributing oral contraceptives and condoms. The various demand creation activities no doubt contributed to increased numbers of family planning clients coming for services.

Learning about a systematic approach to scaling up

At the time these positive results became available, the Tupange team had an opportunity to hear about the ExpandNet approach for scaling up during a presentation at the annual Urban Reproductive Health Initiatives meeting.[†] Subsequently, a workshop was organized to provide the team with an opportunity to learn in greater detail about the lessons and principles of scaling up and to develop a scaling-up strategy for Machakos and Kakamega using the ExpandNet nine step tool[9] available at www.expandnet.net.

The nine-step tool can assist program managers, technical assistance personnel, researchers and policy makers with developing a scaling-up strategy. It engages participants in an analysis of key questions related to how the potential for scale-up success can be enhanced and what are appropriate strategic choices related to dissemination, advocacy, organizational processes, resource mobilization, and monitoring and evaluation.

The scale-up strategy developed as a result of this process guided subsequent expansion to Kakamega and Machakos. Implementation of the strategy was initiated after completion of a rapid assessment of facility and community needs undertaken towards the end of 2012.

Applying a program approach in Kakamega and Machakos

The brief initial exposure to the systematic approach for scaling up at the Urban Reproductive Health Initiative meeting had left the Tupange team puzzling over why a thorough planning exercise was needed for expansion to two additional cities. However, the subsequent workshop and strategy development exercise initiated a learning process that profoundly affected the team's approach to the two new cities and subsequently to the core cities as well. They recognized that sustainability had to become a core principle in their work and this represented a major shift in mindset.

Beginning scale up in Kakamega and Machakos with a program approach was initially received with some reservation by local authorities who were familiar with the classic project approach. For

[†]A meeting of the four BMGF-funded Urban Reproductive Health Initiatives has been organized on an annual basis by MLE.

example, they expected to receive a similar level of resources that had been available in the three core cities and therefore were surprised when that was not the case and dedicated project staff, vehicles and equipment were not made available.

The Tupange team presented the experience of introducing interventions in the core cities, including evidence from Tupange monitoring data showing changes in contraceptive uptake and method mix in the core cities. They then focused on what the authorities and the project could jointly achieve, emphasizing cost sharing, leveraging and using available local resources. This began to be appreciated by the local health team because it stood in stark contrast to projects which came with a predetermined agenda and targets. The participatory process which followed emphasized government leadership, ownership and coordination of the interventions in both the public and private sector, encouraged government managers to take initiative and produced constructive solutions which otherwise would not have emerged. The fact that Tupange elected not to establish offices in the two expansion cities reinforced the central leadership role of local health authorities in implementation.

New emphasis was placed on adapting interventions to the different local contexts and integrating them with ongoing activities. The package of interventions was simplified based on a review of how interventions could be more efficiently implemented or support leveraged, what adaptations were needed, and which were sustainable. For example it became clear that: 1) working with the private sector providers was not realistic in Machakos and Kakamega due to the lack of a strong presence of private clinics or practices; 2) the training program could be simplified; 3) a smaller number of community health workers needed to be attached to each participating facility; 4) the frequency of integrated family planning outreach activities could be reduced and their duration shortened; and 5) Tupange funding for in-reach activities could be replaced with other MSI funding, though at a reduced level.

Interventions were aligned with existing structures and institutions rather than creating parallel processes. For example, the project began to work with existing youth groups rather than creating new ones as had been done in Nairobi. The team also learned that training could be provided through the local government training center – a suggestion that was made by local managers themselves – and Tupange's role shifted from that of being trainers to mentoring trainers. Joint discussions also clarified that the districts had their own funds to carry out some of the interventions, for example the Long Acting and Permanent Methods mentorship efforts. Emphasis was placed on integrating activities into the district's annual work plan, which meant they could often be covered by available funds and supervised by local health management teams.

Data concerning key Tupange interventions were integrated into the government's health information system. As a result, the government teams began to own the data and to present the results to higher level health authorities rather than having the Tupange representatives do so. This brought the local government teams respect and appreciation and they now felt that "we own the process and we own the achievements". These changes represented a major shift in how Tupange had been working previously in the core cities. The local health management teams were now driving the process and the project was in a supportive role.

The participatory process and a new perspective on the potential contribution of all relevant stakeholders produced a new understanding of the benefits of collaboration. Other non-governmental organizations and project partners were already implementing or supporting similar activities and efforts were made to identify where these could contribute human and financial resources and produce efficiencies.

Moving from a project to program approach in core cities

Exposure to a systematic approach to scale up and the learning from Kakamega and Machakos convinced the Tupange team that a shift from a project to program approach was also needed in the three core cities of Nairobi, Mombasa and Kisumu. The questions that had been raised during the strategy-development exercise for Machakos and Kakamega now were considered for the core cities. While there was no separate strategy development exercise, the process of change was similar to that in the scale-up cities.

Transferring leadership responsibilities to government

Tupange city managers increasingly sought to transfer leadership responsibility to government in core cities. For example, the Tupange team had always participated in county health management review

and facility level meetings, attempting to ensure appropriate implementation of project activities and to overcome obstacles. However, now they also emphasized the need for assuring the sustainability of interventions through greater involvement of government counterparts; integrating interventions into the new sub-county (previously the district) work plans; and simplifying the intervention package wherever feasible.

Tupange team members also reduced their role in organizing and presenting at various technical meetings. While in the first two years Tupange convened such meetings, supported them financially, and made presentations about results, now Ministry of Health and NCPD officials and coordinators at national and county level began to assume many of these tasks. Meetings previously held in hotels were now taking place in government offices/venues and were planned by the local health management team.

Government counterparts increasingly began to implement project interventions such as integrated family planning outreach activities and supervision of facilities with less technical and financial input from the project. When core city authorities learned that health authorities in the scale-up cities were organizing integrated family planning outreach activities without support from the Tupange team, they began taking steps to do the same.

Expanding beyond project sites

When managers from non-project facilities learned what was taking place in Tupange-supported sites,[‡] they requested support to replicate activities. The local Reproductive Health Coordinator began providing these facilities with guidelines for conducting outreach activities and found creative ways to stretch her resources to enable the best Ministry of Health trainers to support the "new" facilities. The Kisumu Health Management Team took the learning gained from Tupange training on commodity forecasting and quantification beyond project facilities to train providers throughout the new sub-counties and began laying groundwork for sharing it even with other counties.

Simplifying the package of interventions

Steps were taken to reduce the number of activities and to simplify their implementation. Careful consideration was given to whether certain elements needed to be dropped because they did not fit with annual work plans, were too complicated or costly for the health system, or were not likely to be sustained after the project ended. This was especially important as Tupange expanded from the initial large high-volume facilities to smaller ones whose ability to absorb a fuller intervention package was lower.

As capacity was built, responsibilities became increasingly decentralized, enabling efficiencies not previously envisioned. For example, originally the Reproductive Health Coordinators were circulating to all the participating facilities around Nairobi, but later such supervisory tasks became part of the work of a member of each facility, which was both more sustainable and cost-efficient.

Family planning results

Table 2 provides demographic and family planning information for the core and scale-up cities based on the population-based baseline survey conducted by MLE in 2013 and the endline survey conducted in 2014-15.

Table 3 provides service statistics data on the percentage change in the total number of new family planning users in Tupange-supported facilities in the six months prior to start of implementation (in core and scale-up cities) and the period of January to June 2014.

These tables demonstrate that Tupange has achieved important results in both core and scale-up cities. The baseline and endline data for all of the five cities (representative samples of the entire city) demonstrate substantial increases in modern contraceptive prevalence, which are even greater among the lowest two wealth quintiles of respondents – the urban poor. The contraceptive method mix shows shifts to increased use of long acting and permanent methods, particularly to the use of contraceptive implants.[10]

Similarly the service statistics in Table 3 show that although the absolute numbers of new family planning adopters and those choosing

[‡]Tupange supported sites/facilities refer to public or private health facilities/sites that benefited from project inputs such as: capacity building, training and mentorship; equipment and supplies; commodity distribution and redistribution; quality improvement; integrated outreach and in-reach activities, strengthening the health management information system and demand creation.

Table 3. Number and percent change in new family planning users.				
	City	6 Months prior to implementation	2014 (Jan-Jun)	% Change
Number of new family planning users				
Core*	Kisumu	4,451	6,313	42%
	Mombasa	8,152	12,085	48%
	Nairobi	19,764	30,901	56%
Scale up**	Kakamega	2,286	2,808	23%
	Machakos	1,088	1,704	57%
Grand Total		35,741	53,811	51%
New long acting or permanent method users				
Core*	Kisumu	1,556	2,837	82%
	Mombasa	1,574	6,498	313%
	Nairobi	2,925	14,677	402%
Scale up**	Kakamega	520	1,306	151%
	Machakos	270	513	90%
Grand Total		6,845	25,831	277%

Note: This table presents data from 151 of 171 Tupange-supported sites selected for comparison purposes.
* Jan-Jun 2011 represents the period before implementation in the core cities,
** Jan-Jun 2012 represents the period before implementation in scale up cities.
New family planning users includes those adopting: oral contraception, injectables, IUCDs, contraceptive implants, female and male sterilization.
New LAPM users include those adopting: IUCDs, contraceptive implants, female and male sterilization.

long-acting and permanent methods are very different from city to city, the percent change in the numbers of new users between pre-implementation and the first half of 2014 are roughly similar among core and scale-up cities. Although the percentage increase in Kakamega was only 23% compared to above 40% in the three core cities, Machakos experienced the greatest increase at 57%. However, for new adopters of long-acting and permanent methods Kakamega achieved a 151% increase compared to 80% in Machakos. These results in the expansion cities are impressive given that the period of implementation is only about half that of the core cities.

Analysis of available service statistics suggest that shifting from the more intensive inputs and project oversight of implementation to greater emphasis on government ownership and the integration of project activities into the routine program context are producing good results.

Preparing for large-scale implementation in the context of devolution

Changing context resulting from devolution

The results achieved in Machakos and Kakamega and the expansion to new areas in the core cities, though an important stage in Tupange's learning, are only the first steps in what will have to be a

longer process of national scale up within the context of devolution. As mandated by Kenya's 2010 Constitution, significant political and budgetary authority has shifted from the national and provincial levels to the newly created counties. The financing and management of health services, including family planning, is now the responsibility of the counties, leaving the national government with the functions of stewardship for health policy and oversight of health services.

Most of the 47 new county governments have limited experience with implementing family planning programs and their priorities at this time of transition are likely to be other pressing high profile areas of health e.g., maternal, newborn and child health; HIV, and malaria. Economic development is their primary interest and most do not clearly understand the relationship between family planning and development. County governments have full freedom to spend their resources as they deem appropriate. The amount of funding allocated in each county for health and family planning is therefore highly variable.

Devolution has created a climate of uncertainty and flux at the county level. As a senior member of Nairobi Medical Services put it:

"We are in a transition period, at a cross road - there are many grey areas in management now."

For example, funding flows have been irregular and new commodity procurement procedures have been established with the Kenya Medical Supplies Authority (KEMSA) which is now operating as a business competing with other suppliers for commodity purchases by the counties. In addition, the new county-level decision-makers are struggling to familiarize themselves with their new roles and the technical areas for which they are responsible. Technical staff responsible for implementation of activities remain at the new sub-county level, but they require support working in the new political context.

At the same time, devolution has created new opportunities because the critical decision-makers are now located at the county level which makes them potentially more responsive to differing community needs. There is also now an opportunity to leverage and cost-share resources from the county budget across different specialties as long as relevant discussions are initiated early on when structures and procedures are still in their formative stage.

If Tupange interventions are to be scaled up more broadly, the next step is to support the counties to focus on family planning and institutionalize the needed changes in policies, budgets, regulations and information systems. This is a complex institutional and advocacy task that requires technical support. The Tupange team has considered these challenges and has begun preparing for the future. A main effort was the development of a web-based toolkit with guidance for county and sub-county level health managers for implementation of key Tupange interventions (http://fptoolkit.or.ke).

Toolkit providing guidance for Tupange interventions

The toolkit was developed in partnership with NCPD and the Ministry of Health at national and local levels. The eleven tools in the kit are based on national norms and guidelines, combined with simple, but practical guidance based on Tupange's experience implementing innovative approaches at county and sub-county levels. The tools address commodity security, strengthening health service delivery, demand creation, public-private partnerships and applied advocacy with local and county-level authorities. They provide links to national guidelines, training curricula, IEC materials and other program support materials, including tips on costing. This toolkit can be an important asset in the process of expansion and institutionalization, while at the same time contributing to strengthening the overall health system

However, county officials and providers will need motivation to invest in family planning and help in using these tools. Tupange's vision is to provide large-scale support to such an effort using the lessons about systematic scale up that have been learned in the project.

Conclusion

This paper has argued for a shift from a project to a program approach when service delivery and community interventions are tested with the expectation that successful results will ultimately benefit large numbers of people and lead to policy and program development. The special human, financial and other resources utilized for interventions organized within a project approach, as well as lack of government ownership, are major reasons for their lack of sustainability and successful scale up. This warrants a shift to new strategies dedicated to strengthening existing systems, collaborating closely with the institutions expected to

implement changes and making an effort to mobilize available resources, i.e., a program approach.

A shift from a project to a program approach was not only feasible within the Tupange Project, but initiated an important learning process as interventions were expanded from three core cities to two additional ones. A program rather than a project approach encouraged creativity and initiative among local stakeholders to find local solutions, to build local capacities and to use local resources efficiently.

Family planning results confirmed that this transition was associated with positive outcomes in terms of city-wide increases in contraceptive prevalence and substantial increases in family planning users, including among the urban poor. However, from the perspective of national impact the real challenge still needs to be addressed, and that is to discover how the Tupange Project can effectively disseminate its family planning lessons to other areas of the country in the new context of devolution in Kenya. The web-based practical toolkit developed by the project, though a useful beginning, on its own cannot accomplish this task.

The experience of transitioning to a program approach in the Tupange Project holds important lessons for the global health and family planning field where similar shifts are needed to break the cycle of implementing projects which are neither scalable nor sustainable. The Tupange Project has accomplished much in this regard. However, whether longer-term sustainability will have been achieved in the five cities cannot be taken for granted, but requires evaluation at least one year after the Tupange Project has ended.

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Résumé

Cet article décrit comment le projet Tupange (2010-2015), une initiative de santé génésique en milieu urbain au Kenya, a appliqué avec succès la méthode ExpandNet pour étendre durablement les interventions de planification familiale, tout d'abord à Machakos et Kakamega, puis dans les trois villes principales, Nairobi, Kisumu et Mombasa. Cette nouvelle orientation a exigé de passer d'une approche de « projet » à une approche de « programme », ce qui nécessitait d'accorder une attention au leadership et l'appropriation du Gouvernement, de limiter les contributions externes, d'institutionnaliser les interventions dans les structures existantes et de mettre l'accent sur la viabilité. L'article décrit également les activités pour préparer l'expansion future des interventions du projet Tupange dans d'autres pays en vue de soutenir et d'élargir durablement l'accès aux services de planification familiale dans le nouveau contexte de la décentralisation.

Resumen

Este artículo describe cómo la Iniciativa de Salud Reproductiva Urbana en Kenia, el Proyecto Tupange (2010-2015), aplicó exitosamente la estrategia *ExpandNet* para ampliar de manera sostenible las intervenciones de planificación familiar, primero en Machakos y Kakamega, y posteriormente en las tres principales ciudades: Nairobi, Kisumu y Mombasa. Este nuevo enfoque se centró en el "programa" en vez del "proyecto", lo cual requirió prestar atención al liderazgo y apropiación del gobierno, limitando aportes externos, institucionalizando intervenciones en estructuras existentes y haciendo hincapié en la sostenibilidad. Además, el artículo destaca los esfuerzos del proyecto por prepararse para la futura ampliación de las intervenciones de Tupange en otros países, con el fin de apoyar el acceso continuo y mejorado a los servicios de planificación familiar en el nuevo contexto de *devolución* (descentralización) en Kenia.