Family Planning & Expanded Program on Immunizations (EPI) Integration in Nimba County, Liberia: A Report

Developed for the Nehnwaa Project
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### Abbreviations

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<th>Abbreviation</th>
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<tbody>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
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<tr>
<td>CBFPI</td>
<td>Community-based Family Planning Intervention</td>
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<td>CGV</td>
<td>Care Group Volunteer</td>
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<td>CSS</td>
<td>Community Support Services</td>
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<td>EPI</td>
<td>Expanded Program on Immunizations</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>FP/EPI</td>
<td>Family Planning/Expanded Program on Immunizations Integration</td>
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<tr>
<td>gCHV</td>
<td>General Community Health Volunteer</td>
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<td>GUMH</td>
<td>Ganta United Methodist Hospital</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
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<tr>
<td>KPC</td>
<td>Knowledge, Practice, Coverage</td>
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<td>MNH</td>
<td>Maternal and Newborn Health</td>
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<td>NCSP</td>
<td>Nehnwaa Child Survival Project</td>
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<tr>
<td>TTM</td>
<td>Trained Traditional Midwife</td>
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<tr>
<td>U5</td>
<td>Under-five (child is under five years of age)</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive Summary

Curamericas Global is an international non-governmental organization operating in Latin America, the Caribbean, and Africa. Curamericas Global Liberia is based in Monrovia, Liberia with programs in Nimba and Bong Counties. In 2008, Curamericas, along with sub-recipient Ganta United Methodist Hospital (GUMH), established the 5-year USAID Nehnwaa Child Survival Project (NCSP) in Ganta, Nimba County, Liberia.

In July 2011, the Community-Based Family Planning Intervention (CBFPI) was introduced as a supplement to the NCSP. The project received funding for one year, and in July 2012, the project was completed with exceeding results and an increased demand for family planning (FP) services. In order to ensure that FP clients in Nehnwaa communities could still receive commodities, NCSP began integrating FP services into those already performed by Expanded Program on Immunizations (EPI) staff.

The following is a report of our findings from September 2012 to April 2013 and is only intended as a review of our process, procedure, results, and challenges. We provide an overview of the basics of FP/EPI integration, including why it is important, what must be considered, and who is involved, as well as our experiences in community-based FP/EPI integration. While FP/EPI integration is possible at all levels (the health facility, the community, and the household), our existing project infrastructure allowed for integration at the community level only and therefore we can only provide insight into the process of community-based integration.
Curamericas Global & The Nehnwaa Project

Curamericas Global, Inc. (Curamericas) is a Raleigh-based international non-governmental organization that partners with local communities in Guatemala, Haiti, Bolivia, and Liberia to develop and implement sustainable health education, prevention, and awareness methods. To accomplish its mission, to partner with underserved communities to make measurable and sustainable improvements in their health and wellbeing, Curamericas works through local organizations to serve vulnerable populations and unreachable communities by providing technical assistance and building organizational capacity. One of the main programmatic interventions involves addressing high mortality rates in developing nations. In order to maximize effectiveness, Curamericas utilizes its unique Census-Based Impact-Oriented (CBIO) methodology that has systematically been proven to addresses low maternal and child care coverage rates while involving community stakeholders in project planning, needs assessment, service provision, and the monitoring of indicators and vital events (birth, death and pregnancy). This comprehensive approach increases access to health care for everyone and the availability of health care services among all communities.

In Liberia, Curamericas has established a five-year Child Survival Project in Ganta, Nimba County—the Nehnwaa Child Survival Project (NCSP), a rough translation to “struggle for the child” in the local Mano language. This project has seven intervention teams: Integrated Management of Childhood Illnesses (IMCI), Maternal and Newborn Health (MNH), HIV/AIDS, Community Support Services (CSS), Expanded Program on Immunizations (EPI), Health Promotion, and Water and Sanitation. Nehnwaa utilizes a version of World Relief’s Care Group Model to reach the most beneficiaries in the catchment area, including CSS Officers, General Community Health Volunteers (GCHVs), and Care Group Volunteers (GCVs). The latter two are selected from members of their own communities, to ensure sustainability and ownership of the project.

In 2011, Curamericas received additional funding from USAID and World Learning to implement a one-year Community-Based Family Planning Intervention. The project was highly successful and after its end in 2012, the Nehnwaa Project absorbed the family planning staff and responsibilities to continue service provision. In particular, family planning services were integrated into the EPI services already being provided to under-five children and pregnant women. While FP/EPI Integration targets postpartum mothers, it also increases availability of FP education and service provision to all women (and men) of reproductive age.
The Basics of Family Planning & EPI Integration

- **Why even integrate family planning and EPI?** Family planning (FP) provides couples with the ability to maintain the size of their families as they deem appropriate; as a result, maternal and child health is improved through the healthy timing and spacing of births and encourages economic development as the financial burden is decreased. According to the World Health Organization (WHO), the appropriate time between births is 24 months. Postpartum women (up to 12 months after a birth) are also simultaneously encountering EPI services throughout the two years of their child’s life, providing an opportunity for education and counseling on additional services. Because EPI services are highly utilized all over the world, integration of FP and EPI services addresses two needs simultaneously, saving time and resources for both the program and the client.

- **What should be considered when planning to integrate?** In the planning stages of FP/EPI integration, there are many factors to consider in order to determine the plausibility of integration. Foremost, the support of all stakeholders is necessary, particularly implementing EPI staff. Integration of services will increase their workload, so EPI staff must be willing to accept additional responsibilities. Similarly, it is important to determine whether integrating FP and EPI services will introduce new time constraints and create a burden for EPI service provision; steps should be taken accordingly to provide additional support and resources to EPI staff as necessary. A comprehensive service provision project like NCSP also has the option to extend responsibilities to additional staff members; for example, MNH staff work exclusively with pregnant and postpartum women and shoulder some of the burden of postpartum FP education and counseling to their clients. Additionally, one of the most important factors to consider is the feasibility of continuous and reliable supply chain. Oftentimes, we encountered a delay in delivery or a limited supply of commodities, which inhibits successful service provision for both EPI and FP.

- **Who is involved in the integration process?** There are many stakeholders involved in the FP/EPI integration process who all play a role at some level. Foremost, the implementing partners (in our case, Curamericas Global Liberia and GUMH) are responsible for coordinating logistics of health education and service provision, including supplies, resources, technical assistance, and commodities. Integration of FP and EPI services requires a continuum of stock, importantly vaccinations and family planning commodities. Stock out of supplies for either, or both, interventions will hinder successful uptake of both services.

  Secondly, the support of implementing staff is absolutely necessary to provide continuous and successful integrated services. NCSP EPI (and original FP) staff were trained to provide quality education, counseling, and services to community members, as well as support gCHVs in community-based service provision and referrals. For those women who choose to seek FP separately at the GUMH community depot, one staff member is available on a daily basis (Monday – Friday).

  Thirdly, the community health volunteers – gCHVs and Trained Traditional Midwives (TTMs) – are the continuous voice of health promotion throughout the month when NCSP staff are not physically in the communities. They provide follow-up of behavior change communication (BCC) messaging and are equipped to provide limited services. They are also the source of referrals for community
members for a wide variety of services, but particularly EPI and FP. The continuous support of community health volunteers is required for successful FP/EPI integration.

Lastly, the community members themselves play a vital role in the integration process. Without acceptability of combined services (or, even either service), target beneficiaries may be less inclined to seek either service and therefore integration would prove as an ineffective solution. Successful FP/EPI integration requires a thorough understanding of community members’ wants and needs as well as current barriers to service uptake.

- **Where can the integration process take place?** FP/EPI integration can occur at multiple levels: the health facility, the community, or the home. At all levels, EPI providers have the opportunity to deliver information about family planning and refer the client to a FP depot or office, while providing one of the two services. Similarly, FP/EPI integration can also be combined service provision, where both FP and EPI education and services are available in one location (i.e. same day service). Community-based combined service provision also utilizes the efforts of community health volunteers (in Liberia, gCHVs and TTMs) who have established relationships with potential and returning clients. Referrals to community depots or health facilities are also available from gCHVs and TTMs to receive commodities that are not distributed at the community level, such as Depo and the Implant.

- **When should a project integrate family planning and EPI?** Separately, FP and EPI service provision systems require a significant amount of time and resources, including staffing, management, monitoring, financing, and supplies. Many established integrated programs have found an initial need for successful EPI coverage and/or a strong foundation in FP service provision; the high rates of new FP users may have resulted from an already high rate of EPI coverage in NCSP communities, as well as a high demand for FP services.

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Our Integration Process and Procedure

The process and procedure implemented by Curamericas Global Liberia & the Nehnwaa Child Survival Project follows four phases: training; service provision; supply chain management; and monitoring, evaluation, and supervision.

Phase 1: Training

Post-funding of the CBFPI project, the five EPI staff were trained in Family Planning. This training considered the follow areas:

- The various types of Family Planning methods
- Counseling of the client, including informed consent
- Advantages and disadvantages of Family Planning, including side effects
- Family Planning eligibility for special sub-populations (HIV+ women, etc.)
- Community-based Family Planning, including distribution, private sector partnerships, and community depots
- Stock Management
- The role of the gCHV in Family Planning education, distribution, and referral

Additionally, staff received the USAID online e-learning course in Family Planning Policy and Legislation.

Further, gCHVs in the community are equipped for community-based distribution. gCHVs have been trained in the following areas:

1. Awareness and education about Family Planning methods
2. Distribution of commodities for continued users (new users are only counseled by the staff)
3. Monthly reporting to EPI staff
4. Proper storage of community-based commodities, such as the pill or male and female condoms
5. Referrals to health facilities and/or project staff in case of problems related to use
6. Referrals to health facilities and/or project staff for use of methods not distributed by the gCHV, such as the Depo shot or the Implant

Phase 2: Service Provision - Process and Procedure

Step 1: Preparing to visit the community

Preparation for the visit occurs both at the community and office levels. When the PHC team is scheduled to visit a given community, they will send communication informing the community, addressed to the Town Chief. The PHC Team Member who carries the communication/letter to the community will also inform the gCHV in this town of the visit. The gCHV then consults the Family Planning cards (one for each client) to determine which continued users are due for a return visit. These users are informed of Nehnwaa’s upcoming visit. Similarly, gCHVs check the register to determine which children will need to be vaccinated on this visit and their mothers are also informed. On the morning of the intervention, when the EPI staff arrives in the office, they refill working supplies for both EPI and FP needs based on the quantities previously distributed, as recorded in the staff ledgers.
Step 2: Community Mobilization & Visitation

When Nehnwaa arrives, in collaboration with leaders and influential people of the community, the gCHV and TTM mobilize the community to come together for the large group intervention. After the Chief, gCHV, and Trained Traditional Midwife (TTM) prepare the Town Hall, the Palava Hut, or other common meeting area for the PHC Team, each team will give their respective health talk for the month to the larger group. When EPI staff gives their BCC message, they also inform their clients (typically under-5 mothers) of the option to receive Family Planning counseling and commodities during the one-on-one visit. Women of reproductive age without children, or who do not need EPI services at that time, men, and couples are also encouraged to visit the EPI staff for Family Planning services. After the large group breaks up, the EPI staff will collect all the vaccine cards from the mothers to check for child return dates and then vaccinate the children. EPI staff also ask if there are women and mothers who are also interested in Family Planning. Depending on the overall demand, EPI staff will conduct Family Planning sessions first and then immunizations (or vice versa).

For non-users of Family Planning, EPI staff are also sensitized to the knowledge and acceptance levels of these clients, so they judge on a case-by-case basis how to introduce Family Planning. At this point in the integration process, the majority of community members know that EPI staff also provide Family Planning services. Similarly, other intervention teams compliment the EPI and FP BCC messages by discussing Family Planning; for example, the HIV team also disseminates information about condom use. IMCI and MNH also educate about birth spacing and refer clients to EPI for commodities. Further, the gCHV and TTM also relay this information throughout the month when Nehnwaa is not physically present. When clients wish to seek services but cannot visit the facility, they inform the gCHV, who acts as an agent of change. The gCHV provides some commodities in the community to continued users (male and female condoms, the pill) and refers to Nehnwaa staff or health facility for other methods (Depo, the implant, IUDs). Additionally, Nehnwaa provides radio BCC messages about FP and FP/EPI integration on a rotational basis.

Step 3: Providing the Family Planning Services

The EPI staff will form a line near a closed and/or separate place they will provide privacy. Each mother will visit the vaccinator with her child and is attended to one at a time. When a mother comes with their child/children for immunization, the EPI staff will follow the usual EPI protocol (including using the immunization card for the child to explain to the mother which vaccine the child needs on this day). Additionally, the vaccinator will talk with the mother and attend to her Family Planning needs if she is eligible and consenting. With her initial consent for Family Planning services, she will sign a consent form once. This consent form will stay on file and she will be noted as a returning user in the future. The visit will end with a schedule for the next visit date, both for Family Planning and the next vaccination. Mothers are strongly advised to pay attention and respect both return visit dates. Each EPI staff member is responsible for recording the commodity given to each mother and the total amount of inventory distributed to each community. Each staff member should also record the number of women and men counseled for Family Planning, even if they do not choose to receive services the same day.

In particular, postpartum women are counseled on birth spacing and lactational amenorrhea method (LAM) in both the large intervention and in the one-on-one session. The IMCI, MNH, and HIV teams also repeat this information in their respective sessions. Men are engaged during health talks to speak with EPI staff and these messages are complimented by other teams (for example, HIV also
distributes condoms and discusses the importance of safe sex practices). For men who may not feel as comfortable talking to a female about FP, the fact that more of NCSP EPI staff are male may facilitate the process of men seeking services. Oftentimes in the health facility, men accompany their wives to seek services.

For the commodities that cannot be distributed in the community (IUDs and implants), project staff refer clients to the Nehnwa community depot. NCSP staff from multiple intervention teams provide FP counseling and services at the depot, including IMCI, MNH, CSS, and all EPI staff, on a rotational basis. At the depot, all commodities are available, including condoms, the pill, Depo, and Implants. In all other cases, staff are equipped to provide the commodities in the community. gCHVs also provide referrals for Depo, IUDs, implants, and any conditions/issues with commodities, as well as providing referrals for first-time users. The gCHV calls the staff member to tell about those clients wishing non-community based commodities and staff record that information. The gCHVs record this referral information in the general referral forms, but most of the time they inform staff by calling or on visits.

**Phase 3: Supply Chain Management**

*National Stock Management*

Nehnwa has a formal agreement with the Ministry of Health (through the Nimba County Health Team) to supply FP commodities because of the partnership with GUMH. The requested amount is made on a quarterly basis (two weeks after the quarter) and is based on patient load and requests. When this is done, the document is sent to Monrovia for approval at the Ministry of Health for signature of the Family Planning focal person at the Family Health Division at the MOH. When these are completed the form is then taken to the UNFPA warehouse (at JFK Medical Center compound in Monrovia) where the storeroom keeper takes the request and gathers the commodities requested. The supplies are taken to the Curamericas Global Liberia Head office. Then, the Curamericas driver transports these supplies to the field in Ganta. These supplies are delivered with proof of receipt note signed by the Nehnwa Project Manager. The stocks are recorded and entered on the Central Stock form. The supplies are now available to be requested on demand by the EPI staff on a weekly basis.

*Office Stock Management*

As a result of Nehnwa’s Community-Based Family Planning Intervention (CBFPI), gCHVs, TTMIs, CBFPI staff, and now EPI staff, have been trained in stock management and how to develop stock reports. At the intervention level, the stock management systems consists of a database of central stock at the NCSP project offices, which allows for data input in terms of distribution to CBFPI team members, gCHVs, and clients who visit the project office for services. The EPI staff and gCHVs can now keep track with similar, yet adapted, ledgers to ensure distribution and quota. Stock is also tracked on a commodity basis; not only can one examine how much stock each team member and gCHV currently has, but in understanding how much stock is available overall, a commodity-by-commodity breakdown is available. Monthly reports are then compiled and given to the Curamericas Liberia Head Office and to GUMH for subsequent reporting to the Nimba County Health Team (NCHT).

As a result of the robust stock management system, EPI staff are equipped to continue monthly reporting. The NCSP continues to receive commodities from UNFPA and the MOH and is able to
implement FP integration into EPI programming because of support from the MOH, NCHT, and the Reproductive Health Technical Committee. EPI staff are trained in the Nehnwaa Family Planning tracking system, which includes the following tools that aid in reporting: the community register; the gCHV Monthly Family Planning Report; the daily Activities Tracking Form; the Consolidated Monthly Report; Family Planning Order Form to the MoH; and the Central Stock Report to provide a holistic understanding of commodities received, distributed, and on-hand at any given time. They are also equipped to complete a range of monthly reporting forms, including the MoH national template, the GUMH tracking form, and the Curamericas’ monthly tracking and reporting forms.

**Community Reporting of Service Provision**

The PHC team’s existing relationship with gCHVs and project communities provides an opportune platform for FP integration into EPI programming. Further, the NCSP Community Register contains a section for Family Planning, where the following information of each community member is recorded: commodity used, date of provision of commodity, if counseling was received, and indication if the client is a new user (along with the additional of vital events, age, household number, etc). As the client returns for resupply, this information is added to the register so that a complete record of Family Planning history is recorded. In addition, the NCSP team utilizes ledgers (one ledger per team member as they travel to different locations daily) during distribution. Each gCHV is allotted a ledger as well for use during distribution. A ledger is also kept at the NCSP community depot at GUMH for those clients that utilize this location as a distribution point. The gCHVs in the communities also complete the gCHV Family Planning Monthly Report form, which has the reporting period, the name of the community, and the supply received, used, and remaining balances at the end of the month. This information, together with the staff ledgers, is compiled to complete the Consolidated Monthly Report form. The EPI staff use the data from the gCHV Monthly Report to enter it into the Consolidated Monthly Report at the end of every month, in addition to commodities distributed in the office. These reports are kept in the project database, which is handled by the project’s Monitoring and Evaluation (M&E) Officer.

**Phase 4: Monitoring, Evaluation, and Supervision**

Our overall strategic objectives of Family Planning component are to increase 1) access, 2) knowledge, and 3) practice of FP methods for WRA. Baseline data for the integration process comes from the final survey conducted in July 2012 for the CBFPI. Throughout this process, the stock management system above monitors the level of access and practice for NCSP FP clients by measuring how many commodities are distributed. In addition to the stock management system, knowledge and practice of FP methods are measured through the daily Activities Tracking Form. This form records how many individual beneficiaries (direct and indirect) are attending the FP large group intervention sessions, receiving family BCC messages, participating in FP listening discussion groups, and/or are listening to the radio FP BCC campaigns in each community. In addition, this form tracks how many gCHVs, TTM, and CGV are trained in FP education and able to provide FP counseling or referrals.

At the community level, the gCHVs in the communities are given monthly Family Planning commodities supplies. The supplies given to the gCHVs by the EPI staff are recorded on the gCHV FP Monthly Report. At the end of the month, the gCHV Monthly Report shows the remaining balance. These supplies are given and followed up with on a monthly basis. This information is collected and entered into the project main database, where it is used for central stock ordering and monthly reporting. Success of the integration process is also measured by the community members’ responses; an increase
in the number of clients signals an increase in awareness of Family Planning and demand for seeking services. This mobilization, in turn, motivates other WRA to utilize the available Family Planning services. NCSP also implements the Census-Based Impact-Oriented (CBIO) methodology, which utilizes household and community mapping to track the progress of health promotion and service provision in project communities. The CBIO methodology allows for the recognition of individuals and households who need Family Planning counseling and/or services by singling out WRA, pregnant women, under-two mothers, as well as indirectly tracking men of the community and those who are eligible for Family Planning but do not currently receive services. The registers utilized with the CBIO methodology allow for long-term tracking, so that over the years, project staff can see how births are spaced and if couples are responding to education about Family Planning appropriately.

In terms of periodic supervision, the Family Planning integration into EPI process utilizes the already existing EPI team. For example, one EPI staff member is responsible for each clan in the project catchment area, who in turn are managed by the EPI supervisor. Each EPI staff member is responsible for collecting and entering the gCHV monthly data, which is overseen by the EPI supervisor and the Family Planning focal person. In addition, the Nehnwaa Project Manager oversees all FP activities completed and commodities distributed. In coordination, this supervision allows for continuous quality improvement. Foremost, as the EPI team undergoes this integration process, they will discuss the challenges and lessons learned within the team in order to improve the service provision. Similarly, EPI will discuss Family Planning challenges and concerns with other teams, particularly, IMCI, HIV, and MNH so that the services provided by NCSP as a whole can be improved. The EPI staff, the Family Planning focal person, and the Project Manager will meet on a monthly basis to discuss the monthly activities, as well as any challenges or concerns. When the EPI staff visit the field, they will continually meet with both the gCHV and the TTM to again discuss any progress and challenges for improvement. At the end of the quarter, refresher trainings will be held for gCHVs per clan to ensure that the best possible education and services are provided to communities.
Our Findings in Liberia

Upon the end of the CBFPI funding in July 2012, a final survey was conducted. At this point in time, the contraception prevalence rate (CPR) among selected women in Nehnwaa communities was 61%. The FP/EPI integration process formally began in August 2012, when EPI staff were trained in FP counseling, education, and service provision (see previous section). Given the challenges associated with integration of two previously separate and unrelated interventions, data collection did not differentiate between service providers (EPI staff and other staff) until January 2013. However, data from September 2012 through December 2012 shows the level of EPI and FP services received, as well as attendance and number of BCC sessions. Data from January 2013 onward is disaggregated by service provider, where the impact of FP/EPI integration can be seen.

Importantly, FP/EPI integration allowed for a continuity of care for many continued FP users. A Knowledge, Practice, Coverage (KPC) survey was conducted in August 2013, which asked mothers of children under two years about their current contraception use. The survey found that 61% of mothers were using some modern method of contraception to space or prevent births – the same percentage of women surveyed a year before in July 2012. Without additional financial or human resources, the Nehnwaa project sustained a relatively high CPR for at least one year. It is sufficient to say that FP/EPI integration allowed for the project to continue FP counseling and service provision through training of more staff to be available for more service provision, as well as continue support of community-based family planning distribution via gCHVs.

Figure 1 shows the popularity of different FP commodities over the first year of FP/EPI integration. In particular, Depo-Provera, condoms, and the pill (Microlut or Microgynon) are the most regularly popular commodities among NCSP communities.
Once data was disaggregated by service provider in January 2013, BCC education and counseling was also high in the months after integration (see Figure 2). It is important to note that gCHVs also conduct FP counseling in the communities regularly; given the challenges associated with logistics (lack of transportation to NCSP office) and community reporting, the gCHV monthly FP reports are typically not reliable individual sources of data. Therefore, the gCHV data is not included separately in Figure 2. Counseling services provided by EPI staff are highly targeted to WRA, namely postpartum women and under-five mothers, as evidenced by the exceeding number of WRA counseled in 2013.

While the data on family planning into EPI integration is limited, it does show that integration sustained already high levels of contraception use among women in Nehnwaa communities without few additional resources. FP/EPI integration also allowed for more beneficiaries to be counseled, which may lead to an increase in new users moving forward, providing further support for FP/EPI integration.
Advantages, Challenges, & Lessons Learned

Advantages & Benefits to Integration

- **Cost effective - utilizes existing staff and resources**: Because NCSP had a strong and successful foundation in the provision of both FP and EPI services, the integration process equipped existing staff members to carry out the implementation. Further, given the strong community-based interventions and active community health volunteers, FP services and the referral system were strengthened. Limited additional resources were needed to carry out intervention activities since teams were already traveling to target communities monthly.

- **Scaling up of comprehensive service provision**: NCSP already provided comprehensive health services at the community level, increasing the efficacy of FP/EPI integration at the community level. Nehnwaa staff were able to handle the increase in both demand and service provision because of the coordination between staff and gCHVs—gCHVs are equipped to counsel and give commodities to continuing users as well as refer new users to NCSP intervention visits or the FP office at GUMH. gCHVs also record who has been educated on FP for follow-up as necessary, as well as who and how many community members are referred.

- **Synergy of efforts**: EPI is the largest and most successful intervention in Nehnwaa communities. Similarly, the 2011-2012 community-based family planning project exceeded its goals and created a huge demand for FP services. The FP/EPI integration process joined two major interventions to have a greater impact overall.

- **Meeting demands for services**: NCSP’s CBFP created a huge demand for family planning services and the subsequent completion of the project resulted in service delivery gaps. By finding an avenue to continue FP service provision, FP/EPI integration eliminates the gaps at the community level. Furthermore, continuing service provision at the GUMH depot allows for continued access to services that are not available at the community level, such as Depo or the Implant. As a community-based integration system, demand for both FP and EPI services is met because staff is available to serve any interested beneficiaries, including postpartum women, U5 mothers, and women of reproductive age.

- **Potential continuum of FP service provision by current implementing partner**: Integrating FP and EPI services at the GUMH community depot also builds the capacity of the implementing partner (GUMH) to continue providing services. By referring to a community depot that is located near a health facility as an option, clients are also able to have continuity of care for other health concerns, for themselves and/or their families.

- **Utilizes a robust community mobilization & intervention system**: Integrating FP and EPI services into NCSP were well-received and effective in part due to the already-existing strong community ties. As opposed to FP/EPI integration in a health facility, we found that our community health...
education system proved effective for changing anti-FP cultural norms and increasing acceptability of FP services in two ways—NCSP staff BCC messaging and follow-up with community health volunteers. NCSP provide EPI BCC messaging to the large group during interventions, where they also have a captive audience for introducing the option for FP services. Similarly, other interventions who work closely with pregnant and postpartum women and U2 and U5 mothers also have a platform for introducing FP services, providing education and counseling, and referring to EPI for services. Continuous, quality FP education is necessary to reinforce BCC messaging and ultimately increase the uptake of services. Community health volunteers were also able to employ existing relationships and educate indirect beneficiaries who directly influence a woman’s choice to initiate FP services, including husbands/partners and mothers-in-law.

Challenges to Integration

- Increased workload of EPI staff: By absorbing FP responsibilities, EPI staff had an increase in education and service provision, as well as an increased responsibility in data collection and reporting. In the future, it may be necessary to provide a small, performance-based incentive for EPI service provision only to ensure that the integration process does not negatively affect EPI coverage.

- Combining FP & EPI data collection & reporting tools: Because FP and EPI previously had different indicators, FP/EPI integration required changes to program data collection. EPI staff are now required to maintain two service provision ledgers, as well as two activities forms to track the total number of counseling sessions and commodities provided on a daily basis. To ease the EPI burden, the former FP supervisor from the 2011-2012 is still a NCSP staff member and is responsible for compiling all daily reports and completing monthly reports, as well as maintaining the central stock of commodities and filing orders.

- Logistics: Because the number of clientele that EPI may encounter in a community visit may increase, more staff may be needed to carry out FP and EPI service provision, particularly in larger communities. Challenges with logistics may impede service provision, as roads become impassable or vehicle problems arise. As a result, there may be an increase in expenses for more visits or vehicle maintenance.

- Commodity Stock-outs: An increase in the number of FP programs has positively led to an increase in demand. As such, there may be a stock-out of FP commodities if the increase in clients is not appropriately planned. For NCSP, an increase in the use of Depo, for example, in Liberia led to a country-wide shortage of Depo as provided by UNFPA. Additionally, Implants were temporarily stocked out, halting the number of new Implant users. Likewise, the PENTA3 vaccine, received from the Ministry of Health via the Nimba County Health Team, was recently unavailable in large enough quantities to meet the need of NCSP communities. To mitigate the effects of a national and/or governmental stock-out, EPI staff tracked monthly numbers of new and continued users of each commodity to order each kind in advance to prevent a local stock-out.

Lessons Learned

- FP integration into EPI community outreach activities is feasible: Our FP/EPI integration process was an attempt to continue supplying FP clients with counseling and commodities and reach new
users who have little to no access to services, after funding that had created a demand ended. After one year of integration, our results show that FP/EPI combined service provision is not only feasible, but sometimes even the preferred method of service delivery for many types of clients, not just postpartum women and U5 mothers.

- **FP/EPI integration reaches multiple types of beneficiaries:** Integration of FP into EPI community outreach activities can provide services to both clients who traditionally do not attend health facilities as well as those in the habit of health facility visitations. FP/EPI integration reaches more mothers of children under five as well as those who want to use FP in the postpartum period.

- **EPI teams should align their EPI/FP BCC strategy to appeal to non-EPI service users:** This includes young people, men without children, and other indirect beneficiaries, particularly those who benefit from BCC messaging, not just service provision (i.e. mothers-in-law). Similarly, other intervention teams who encounter FP targets should also align their messaging to increase education and awareness of FP and continue referrals to EPI for commodities, such as MNH for postpartum women or IMCI for other U5 mothers. We found that extending the responsibilities to all Nehnwaa teams for health promotion reduced the burden on EPI staff, but also ensured a continuity of care for all clients, regardless of the services they are seeking.

- **EPI teams should modify the service provision setting to address confidentiality:** At the community level, clients are not automatically offered the protection of an office, as in a health facility. As such, the issue of privacy and respect for confidentiality arise, particularly when services at the community level are offered in a common area, and not the client’s home. NCSP EPI staff use a closed off area for FP counseling for new users and to answer any questions or concerns of returning users. This area is sometimes in a smaller Palava hut, or inside an open structure. EPI services are already typically provided in a shaded area to protect the quality of the vaccinations, so providing a closed off area for FP confidentiality was not difficult. We learned that FP clients are much more inclined to inquire and receive FP services when done so in a private area, even if they are also regular EPI clients. Importantly, we also found that many clients may use the façade of EPI to seek only FP services when they are worried about confidentiality, which is important for future FP programming.