



USAID
FROM THE AMERICAN PEOPLE



LIVELIHOODS AND FOOD SECURITY
TECHNICAL ASSISTANCE



Designing Effective Clinic-to-Community Referral Systems: Analysis of Best Practices to Inform LIFT Technical Assistance

JUNE 2013

Designing Effective Clinic-to-Community Referral Systems: Analysis of Best Practices to Inform LIFT Technical Assistance

COOPERATIVE AGREEMENT NO. GHH-A-00-09-00007-00



DISCLAIMER

This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID). This technical document was produced by Dr. Susan Rogers and Mandy Swann under USAID Cooperative Agreement No. AID-GHH-A-00-09-0007-00. The contents are the responsibility of FHI 360 and do not necessarily reflect the views of USAID or the United States government.

BACKGROUND

The Livelihood and Food Security Technical Assistance (LIFT) project was initiated by the United States Agency for International Development (USAID) Office of HIV/AIDS (OHA) to provide technical assistance and strategic support to US government agencies, their implementing partners, and other public, private and civil society partners to improve the food and livelihood security of vulnerable households, with a particular focus on people living with HIV/AIDS (PLHIV), orphans and vulnerable children (OVC) and their caregivers. Since its launch, LIFT has conducted technical assistance assignments focused on improving livelihoods and food security for people living with and affected by HIV and AIDS in the Democratic Republic of Congo (DRC), Ethiopia, Lesotho, Malawi, Namibia, Nigeria, Swaziland and Tanzania.

HIV-affected households confront multiple challenges of personal illness and caring for sick family members or the death of family members which disrupts household livelihood patterns, reduces food access and income flow and increases health and other HIV-related costs. Food insecurity is one of the major causes of under-nutrition, and economic factors affect a household's ability to access sufficient quantities of food as well as the nutritional quality of the diet. Economic resilience of PLHIV, their caregivers and other vulnerable households can support sustained health outcomes by allowing them to continually meet their food and nutrition needs. In addition, a more economically stable household is more likely to be able to afford other health-related costs such as medications or transport to health facilities, thereby increasing adherence to ART and retention in care. Toward this end, LIFT supports the needs of HIV-affected households by expanding the continuum of care to include economic strengthening, livelihood and food security (ES/L/FS) support. To improve nutritional status among people living with HIV, the Nutrition, Assessment, Counseling and Support (NACS) approach integrates nutritional support into the standard of clinical care for HIV and AIDS. A critical component of LIFT's approach is the provision of technical assistance to establish or strengthen linkages that connect NACS clients and their households to appropriate, effective ES/L/FS opportunities within their communities. In order to achieve this, LIFT provides technical assistance to build or improve referral and wrap-around mechanisms between clinic and community services.

As a project of FHI 360, LIFT is committed to the 'science of improving lives' and the utility of evidence-based, empirical information to inform the design of its interventions. While referral systems have existed in the health sector for some time, there has been limited implementation experience and formal evaluation of bi-directional systems that link patients from health clinics to ES/L/FS support within the community. To establish an evidence-based approach to the provision of technical assistance, LIFT embarked upon a thorough review of the literature on existing referral system practices to promote knowledge management and appropriate internal guidance in the field. This technical brief summarizes the methodology used as well as the overall research questions guiding the literature review. Results of the review are presented below, including relevant referral system challenges and best practices. Most importantly, it discusses how these learnings can inform LIFT technical assistance with service providers in applicable communities.

Principles of good technical assistance are driven by community values and priorities, are based on best practice, and take the existing strengths and talents within a community as the starting point to empower people to act.

METHODOLOGY

A literature review was the primary method used to create this technical brief. Fifty documents related to health and/or economic strengthening (ES) referral systems in international settings were identified for the review which are summarized in Table 1. This included other technical briefs, guidance documents, reports, manuals, PowerPoint presentations, and referral tools. In that the objective of the technical brief is to inform evidence-based approaches to the provision of LIFT technical assistance, the review focused on existing processes and tools that have been used to establish clinic-to-community referral systems. It also focused on identifying the challenges that others had experienced in establishing and implementing referral systems - as well anticipated challenges that LIFT might encounter in expanding referral system practices to encompass ES/L/FS services - in order to inform LIFT solutions to these challenges.

WHAT HAVE WE LEARNED FROM PRIOR IMPLEMENTATION OF CLINIC-TO-COMMUNITY REFERRAL SYSTEMS IN INTERNATIONAL SETTINGS?

Review of the literature on clinic-to-community referral systems found important learnings for the application of LIFT technical assistance. These include: 1) viable referral system models for LIFT consideration; 2) essential elements of referral networks that can be instituted or strengthened by LIFT; and 3) challenges to be addressed by LIFT in implementing effective clinic-to-community referral systems. These learnings are discussed separately below.

1 – VIABLE REFERRAL SYSTEM MODELS

HIV REFERRAL MODELS

Based on FHI's guidance for establishing referral networks for HIV care in low resource settings (FHI, 2005), three viable clinic-to-community referral system models were identified. These models are defined by such factors as setting, scope of services and locus of coordination. Two main models are defined by the type of organization that coordinates the network (health facility-based referral networks and community-based referral networks) while the third model uses a case management approach.

With the **health facility referral model**, staff, often nurses, coordinate referrals between clients and services provided both within the facility and by community organizations. Facilities may operate an ad hoc referral network in which a particular service unit, such as those for prevention of mother-to-child HIV transmission (PMTCT) or voluntary counseling and testing (VCT), assumes the lead in making referrals to clinical and non-clinical service providers in the catchment area after discussions with the patient, caregivers or family members have identified their needs.

Other features of the model may vary based on its stage of development and available clinic resources: linkages and communication between organizations providing services may be formally established or informal based on client need; a written referral form may or may not be provided to clients seeking service(s); at the point of initiation, the referral may or may not be documented, based upon the unit's records system and/or use of a formal referral register; there may be a formal mechanism for tracking the success of the linkage, follow up to determine if the need has been satisfied or simply an informal discussion during the patient's next clinical visit. As the program matures, an ad hoc system can grow to become more formal and incorporate more essential elements (see elements discussed below).

While the objectives and processes in the **community-based referral model** are very similar to those of the health facility-based model, an organization based in the community coordinates the referral system. In this instance, a client who is diagnosed as HIV-positive at a VCT center or health facility is referred to a community-based organization (CBO) that provides other HIV-related services, such as prevention, advocacy, peer education or spiritual support, and, in doing so, the CBO assumes referral coordination as an additional function of its organization. In its coordination role, the CBO is responsible for establishing linkages, managing the network, developing and updating referral forms, and conducting quality assurance to ensure client linkage and satisfaction with services.

In the **case management referral model**, PLHIV and their caregivers are active participants in defining their needs and seeking options to meet these needs. They work collaboratively with a cadre of case managers who have been trained in the HIV disease process, community care, treatment and support services, and client access to needed care and services. Each case manager conducts outreach to clients, assesses needs of clients and caregivers, develops individualized service plans, links clients/caregivers to the service delivery system, monitors service delivery, advocates for clients and continues evaluation of their needs. Case managers may be employed by either a health facility or CBO that serve as the coordinating organization. Within their system, they use standardized forms and a directory of services. This model is utilized in the approach promoted by UNDP (2010) called the Continuum of Care (CoC) in which after HIV testing, the coordination of care is handled by case managers in a government agency, an NGO or a faith-based organization.

APPLICATION OF HIV REFERRAL MODELS IN THE FIELD

The application of HIV referral models, including linkages to economic strengthening for PLHIV, caregivers and family members, have resulted in several hybrid systems, all of which have utilized parts of the referral models discussed above while integrating various forms of civil society and/or government involvement.

In Mvomero, Tanzania, a district-wide referral network used a community-based referral model in which the District Continuum of Care Coordinating Committee (DCoCCC), established by Mvomero local government authority (LGA) and government and non-government health and social welfare facilities, played the coordinating role of the network. Similarly, the *Mkuta Mwana* program, an OVC initiative in Salima, Malawi, used a community-based referral model in which the Ministry of Gender, Children and Community Development spearheaded the coordination of the referral system. Individual focal persons provided oversight by thematic areas including health, education, livelihoods, justice, social welfare, and youth, among others. In the *Zambia Prevention Care and Treatment Partnership II (ZPCT II)* program in Zambia, operating in 42 districts in 5 provinces, also utilized a community-based referral model in which bi-directional referrals initiated at either the health facility or community level were managed at the district level by the District Health Office or the District AIDS Task Force to allow for coordination among service providers and the community.

The *Ethiopia Food by Prescription (FBP)* program utilized a community-based referral model with a unique approach to further economic strengthening. In this program clients were first referred to the government HIV/AIDS Prevention and Control Office (HAPCO) and then to a FBP referral coordinating committee made up of HAPCO, Bureau of Labor and Social Affairs, economic strengthening providers, including representatives of the private sector to link clients to formal jobs. At the committee level, referrals were either approved or rejected. There was less NGO/CBO involvement in this program model than in the traditional community-based model.

The India *CHAHA* program utilized a HIV community-based referral model with intensive involvement of outreach workers. Outreach workers made multiple visits to households to assess needs and accompanied clients to access health and other services. The program's sub-sub-recipients, project coordinators and outreach workers conducted several visits/meetings with all healthcare providers involved in patient HIV care to assure linkage and coordination with CHAHA. CHAHA also fostered linkages with village level functionaries to obtain nutritional and educational support as well as links to social security and income generation schemes of national and state government, as well as special linkages to local businesses, private doctors, private schools, trade unions, and other socio-economic linkages.

In 2012, Ministry of Health and Social Services in Namibia piloted a health facility-based model in which referrals were initiated at public health facilities but allowed for a bi-directional referral network between public and private health care facilities, private community home-based care (CHBC) organizations and other community service providers.

The *Ethiopia HIV/AIDS Care and Support Program (HCSP)* utilized the case management model to facilitate ES referrals, with some deviations. The process was initiated in the community before health facility involvement. Volunteer outreach workers identified PLHIV and facilitated referrals to health facility case managers who certified the client's HIV status and approval of referrals. ES referrals were made to selected HIV network associations that provided ES support, usually as small grants, job training or community gardening for sale or consumption.

The *Ethiopia TransACTION* program used a combination of components from all three HIV referral models to facilitate ES referrals. Health facility clients were referred by a counselor, nurse or case manager to local NGO, CBO or PLHIV network associations that had been pre-selected as key partners providing ES services. These partners either delivered ES services directly or through other community-based economic strengthening initiatives. Links were also made with a higher level forum such as local HAPCO to coordinate with wider set of NGOs/CBOs.

RELEVANCY OF REFERRAL MODELS FOR LIFT

While FHI's guidance for establishing referral networks for HIV care in low resource settings focuses on referrals for PLHIV, the three models (i.e., health facility-based, community-based or case management) have application beyond HIV care and support. Any of the three models can be used in achieving the LIFT objective of connecting NACS clients and their households to appropriate, effective ES/L/FS opportunities within their communities, as long as referrals are bi-directional between health-based and community-based services. What is critical for the achievement of LIFT's objectives is the strengthening of the referral model to identify and include all available ES/L/FS community services in the network, to strengthen the scope and quality of these services and to increase the capacity of all participating referral facilitators to conduct effective ES/L/FS counseling and for all referral focal persons to coordinate appropriate referrals, including the adaptation of referral forms and other documentation systems to capture the outputs and outcomes of ES/L/FS referrals in the community. This system strengthening is what encompasses the technical assistance work of LIFT. Below, the eight essential elements of referral networks are discussed with a detailed look at how LIFT can offer assistance related to each element to create or support a referral system that maximizes effective ES/L/FS referrals in the community.

2 – ESSENTIAL ELEMENTS OF REFERRAL NETWORKS

Regardless of the referral model used, experience has shown that there are certain best practices, or what is termed ‘essential elements’ in the literature, that need to be in place to optimize the referral system’s operational effectiveness and outcomes for clients and their households. These elements are summarized below along with a description of how LIFT technical assistance can strengthen each element.

ESSENTIAL ELEMENT 1: A GROUP OF ORGANIZATIONS THAT, IN THE AGGREGATE, PROVIDE COMPREHENSIVE SERVICES TO MEET THE NEEDS OF PLHIV, THEIR CAREGIVERS AND THEIR FAMILIES WITHIN A DEFINED GEOGRAPHIC AREA

To effectively address the client needs, the network should include as broad a range of services and organizations as possible, including ES/L/FS services. If a referral network is yet to be established, LIFT can foster community involvement and ownership in the initial stages of establishing the referral network and process so that the program can become self-sustaining. To do this, LIFT can collaborate with the referral coordinating organization, government body or other community entity to conduct participatory mapping exercises to obtain data on available ES/L/FS organizations and services in the identified catchment area. LIFT can also assist community/country teams with a feasibility analysis to assess the current and potential capacity of the identified implementing organizations’ requisite financial, technical and administrative capabilities to absorb new clients and deliver quality ES/L/FS services. In this regard, LIFT can help the network to balance the needs for quality service with increasing the number of beneficiaries and how to sensitively involve HIV-affected households without stigmatization, particularly when grants or subsidies are involved. These mapping and assessment activities can then help inform the development of strategic plans to address existing gaps and facilitate scale-up of promising practices related to ES/L/FS. In addition, LIFT can strategically assist U.S. government country operations in assessing both promising practices and gaps related to livelihoods and food security from a programmatic and geographic perspective.

To allow LIFT’s role in the network strengthening plan to be operational, LIFT should consult with stakeholders on an appropriate and feasible scope of system capacity strengthening to be implemented, including articulated objectives, outputs and outcomes of the assistance, and include this in a written action plan. Depending on the needs of the network, LIFT’s role can be as broad as providing substantive staff training on ES/L/FS regarding both making appropriate referrals and delivering quality services as well as assisting with amending the network’s infrastructure to effectively document ES/L/FS referrals and their outcomes. Most importantly, the scope of LIFT assistance will need to be driven by the network’s stage of development and existing strengths and talents of its own network members.

Overall, LIFT’s assistance should include support in establishing or strengthening existing referral and wrap-around, bi-directional mechanisms between clinic and community services to facilitate the linkage of graduating NACS clients or their caregivers with ES/L/FS programs and services that will help sustain the positive impacts of nutritional counseling, therapeutic feeding and clinical management of disease. While such an effort may feel overwhelming to community stakeholders, LIFT can help the network to set realistic objectives and expectations for what they can plan to accomplish together. As a community referral system matures, LIFT can also work collaboratively with referral systems to help resolve client access issues to service uptake.

ESSENTIAL ELEMENT 2: A UNIT OR ORGANIZATION THAT COORDINATES AND OVERSEES THE WHOLE REFERRAL NETWORK

Having one organization taking the lead in managing the referral network with formal agreements or relationships with service providers has been shown in the literature to result in a stronger system. This organization or unit in the network serves as the locus of responsibility for the network and its performance (in addition to its regular duties) and is often referred to as the coordinating organization or unit. Its primary functions include convening regular meetings of providers within the network, working with providers to address gaps and other inefficiencies in the system, updating the service directory, providing standardized tools and forms for referrals, tracking referral outcomes and performing quality assurance for the referral system. At the coordinating organization/unit, there is a specific person designated to fulfill these tasks.

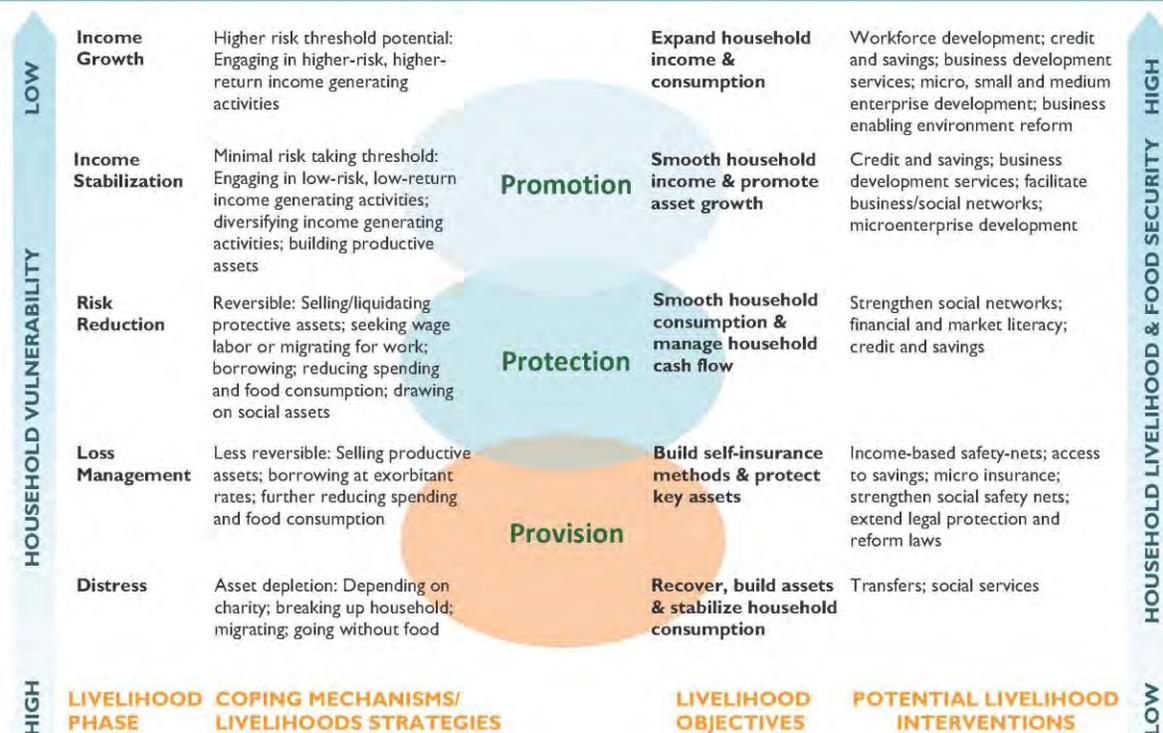
In the LIFT context, since clinical facilities are not equipped or staffed to identify appropriate livelihood services or track referral outcomes, it is important to identify a community intermediary agency, organization or individual to coordinate the ES/L/FS referral process. The referral coordinator should be knowledgeable about ES/L/FS services and how to conduct client assessments, make referrals to appropriate services and manage the feedback process. Government social workers, home-based care providers, NGOs and CBOs, or PLHIV support groups are all potential resources to serve as the referring agency/organization. LIFT capacity building with a designated community intermediary organization can prepare relevant staff with the knowledge, skills and resources to effectively refer clients for ES/L/FS services.

Prior to referring a patient to ES/L/FS services, a rapid diagnostic assessment of the client's needs and abilities should be conducted by the referral coordinator. Specific ES/L/FS programs may also have their own assessment/intake procedures to determine whether potential clients are eligible. Within a referral system or network, the purpose of such an assessment is to determine which of the available programs and services are best suited to an individual client's needs at that time prior to making a referral.

LIFT can provide assistance to the referral coordinator in use or adaption of LIFT's country-specific ES/L/FS rapid diagnostic tools which allow a coordinator to assess household poverty and food security conditions. The tool is based on LIFT's Livelihood and Food Security Conceptual Framework which categorizes services and types of interventions that would be best suited for different types of households. This includes the categories of: 1) provisioning activities, best suited for destitute households to provide temporary support to help households recover assets, put food on the table and meet basic needs; 2) protection activities that target vulnerable households struggling to make ends meet and help them to strengthen household money management and retain key assets; 3) promotion activities best suited for households that are ready to grow by assuming risk and investing capital and other resources for future gains.

LIFT's conceptual framework overlays the three categories of livelihood interventions with a 'livelihood pathway' that considers five key outcomes that indicate decreasing levels of vulnerability and increasing levels of livelihood and food security: 1) recover assets and stabilize household consumption; 2) build self-insurance mechanisms and protect key assets; 3) smooth household consumption and manage household cash flow; 4) smooth household income and promote asset growth; and 5) expand household income and consumption. While the outcomes on the pathway are sequential, a household's progression along the pathway is not necessarily sequential. LIFT's referral model should aim to target ES/L/FS assistance based on how households move on the livelihood pathway. This approach can also build an understanding among donors and practitioners of how to perceive and manage client risks and what their livelihood needs are at various stages.

Household Livelihoods and Food Security: *Conceptual Framework*



ESSENTIAL ELEMENT 3: PERIODIC MEETINGS OF NETWORK PROVIDERS

Regular meetings of organizations in the referral network provide a venue for ongoing communication, exchange of information about the referral process, discussion of challenges and gaps in service, tracking of referrals and clients lost to follow up, and can be an important form for updating the service network directory. The meetings promote collaboration and commitment to the referral process as an essential component of service delivery. LIFT assistance related to this essential element can encourage information sharing among practitioners that support collective learning, quality assurance and innovation, and increases the return of donors' investments. Where possible, LIFT can provide in-service capacity strengthening during meetings related to making and tracking referrals for ES/L/FS services and, among ES/L/FS providers, how services could be strengthened. In addition, LIFT can disseminate existing proven tools or guidelines related to ES/L/FS to support quality programming and minimize duplication of efforts.

ESSENTIAL ELEMENT 4: DESIGNATED REFERRAL PERSON(S) AT EACH ORGANIZATION

The designated person at each organization within the referral network has responsibility for processing referrals efficiently and expeditiously and managing core referral activities, such as tracking and documenting referrals and attending network meetings. Referring clients specifically to this designated person helps clients gain access to needed services. Each organization in the referral network including

clinical sites, community-based intermediaries, and service providers should have a dedicated focal person. This person could be a nurse, counselor, social worker or other type of staff member and it is recommended that their role as referral coordinator be documented in their job description and performance review plan.

LIFT can support organizations in the network to identify referral focal persons and support them to include referral tasks as part of that person's job description and performance monitoring/review plan. Capacity building in the effective provision of ES/L/FS referrals should include all such designated focal persons in the network to ensure proper, consistent use of referral tools and processes. In addition, for health systems that are often overburdened, LIFT can train a case manager or para-social worker who can be embedded in the system or located at the health facility or coordinating organization to effectively conduct ES/L/FS referrals.

ESSENTIAL ELEMENT 5: A DIRECTORY OF SERVICES AND ORGANIZATIONS WITHIN A DEFINED CATCHMENT AREA

The referral network should ideally include organizations in a defined geographical area that are providing a full range of health and other services, including ES/L/FS. A directory needs to be distributed to all organizations in the network and needs to be constantly updated to ensure that information on service providers is current and accurate.

As discussed previously related to essential element 1, LIFT can play a key role in assisting referral networks with mapping and organizational network analysis exercises to identify available ES/L/FS organizations and services for inclusion in the network's directory of services. In addition, LIFT can help a network design a useful directory similar to ones used in the field (see Table 1 for sample directories), which generally contain information on the name of organization/network member, types of service(s) provided; cost of the service(s); eligibility criteria for services; the days and hours of operation; and contact names and relevant telephone numbers/addresses.

ESSENTIAL ELEMENT 6: A STANDARDIZED REFERRAL FORM

A referral form—either a card or piece of paper—that is standardized throughout the network ensures that the same essential information is provided whenever a referral is initiated and that this information is received by the organization fulfilling the referral. Referral forms should have a clear mechanism to provide feedback on referral completion, such as a section of the form that can be returned to the referring organization. Depending on the technical capacity of the network, referrals can also be made via mobile phones so that both the client and agency to whom the client is referred receives referral requests and can provide feedback via mobile technology. This arrangement is especially advantageous in rural areas where patients have to travel long distances between service points and may be limited in their ability to travel to receive a referral or return a feedback slip to the referring organization quickly.

LIFT can assist referral networks with designing user-friendly referral forms or adapting forms that can capture ES/L/FS referrals for paper or for mobile phone use. A myriad of referral forms for PLHIV, care givers and family members are available in the field (*see Table 1 for sample referral forms*) which are able to document: the date of the referral request; the type of service needed; the name of the client; the name and contact information of the organization initiating the referral request (referring organization); the name and contact information to which the referral request is directed (receiving organization); and the names of the designated contact persons at both organizations. It is also useful for the section of the

referral form completed by the receiving organization to indicate what type of follow-up may be needed for the client that was served.

ESSENTIAL ELEMENT 7: A FEEDBACK LOOP TO TRACK REFERRALS

As noted above, a system to track a referral from point of initiation to point of delivery and, as a feedback loop, from point of service delivery back to point of initiation is needed to ensure that the client accessed the service(s) to which they were referred. Written feedback provides evidence that the referral process was completed and the service was delivered, and it can note whether there were any challenges. After the services are completed and the referral is fulfilled, there should also be a clear process whereby the receiving organization provides feedback to the referring organization, or alternatively, the referring organization follows up with both the client and the receiving organization. Common methods for referral feedback include having the client return part of the referral form completed by the service provider to the referring organization, using a drop box at each organization where referral feedback forms can be collected regularly by the referral coordinating organization, or having a standard process for following up by phone on all referrals made.

The ultimate goal of a referral network is to ensure that clients receive needed services and are satisfied with these services. Documenting this information is part of the monitoring and evaluation (M&E) management component of the system. Evaluating referral networks provides feedback for quality assurance and for informing planning, design and implementation of future services, including ES/L/FS services. LIFT is well equipped to assist referral networks with this component. This includes working with network coordinating mechanisms to track the success of their ES/L/FS referrals and document how well clients' needs are met.

If staff time is limited, LIFT can help organizations in the network create a more effective referral feedback system that relies on returning completed referral feedback. Ideally, LIFT can also assist referring organizations to take the initiative to do formal follow-up with clients about the services for which they were referred and to regularly follow up with receiving organizations about completed referrals. LIFT can also support receiving organizations to provide regular feedback on service delivery to organizations initiating referrals. Further, referring organizations can build into their client counseling protocols to ask whether ES/L/FS referrals were completed, satisfaction with these referrals and, if relevant, understanding why referrals were not completed. LIFT can advise on specifics of these counseling protocols too assist referral focal persons to refer clients to ES/L/FS support along the provisioning, protection, promotion spectrum, understand how these services have impacted the household and to what extent the household has progressed along the livelihood pathway. The use of mobile technology to reduce the time burden on both staff and clients can be explored to expedite making and tracking appropriate referrals.

Further, to facilitate the tracking of appropriate information on referrals, LIFT can work with referral networks to develop appropriate performance indicators which can be useful in tracking and reporting on performance related to ES/L/FS referrals. Common indicators used for tracking referrals overall include: 1) total number of referrals made; 2) number of referrals received; 3) number of referrals made to which services (i.e., ES/L/FS-related and others); 4) number and percent of referrals completed; 5) number and percent of clients who report their needs were met; and 6) number and percent of clients who report satisfaction with referral process. LIFT can advise on the use of specific ES/L/FS performance indicators which have been used in the field. In addition, LIFT's diagnostic tool that is used for the initial assessment of clients ES/L/FS needs can also be used to track specific outcomes related to household poverty and food security.

ESSENTIAL ELEMENT 8: DOCUMENTATION OF REFERRALS

At both ends of the referral (referring organization and receiving organization), a written record of the referral is needed to document outcomes. Both the site initiating the referral and the site fulfilling the referral are responsible for documenting their respective roles in the referral process. A standardized referral register can be used to document a large number of referrals.

Again, LIFT can be helpful in assisting referral networks to design referral registers based on available documents currently in the field (see Table 1 for sample registers). If the referral system has developed performance indicators, registers should be set up to collect all data related to these indicators. Generally such registers contains around 20 lines with each line representing each individual person referred. Registries overall capture the following information by column: the ID number associated with the referral; client name; sex; date of birth; name of organization referred to; services referred for (codes for services are listed on another part of registry); services provided; name of referring officer; place for signature of referring officer; place for remarks.

While referral networks often use paper registries, LIFT can be helpful in assisting network administrators and providers with setting up a database to capture registry information which can allow for more efficient tracking of referrals. This can be done for individual agencies in the network or be web-based so that all network members can enter referral information and easily track whether clients have received services at agencies where they were referred. As with paper documents, databases that contain identifying client information are highly confidential and LIFT assistance can be provided in how to maintain confidential forms/records.

Finally, LIFT can provide assistance on how to most effectively use the registry information for evaluation and program improvement purposes. LIFT can advise on how to set up quarterly reviews of the register – either one maintained by each service provider in the network or by the coordinating mechanism – to identify missing information, incomplete service delivery and other service or documentation problems. These findings can be discussed with service providers in the network at monthly meetings to share findings and develop solutions to cross-cutting issues.

3 - LIFT RESPONSE TO IMPLEMENTATION CHALLENGES IN THE FIELD

Review of the literature found that several challenges exist regarding the establishment and management of referral networks. These challenges are categorized below based on whether they are client demand-driven or network supply-driven. Suggestions are provided on how LIFT could address these challenges.

CLIENT DEMAND-DRIVEN CHALLENGES

CHALLENGE: *Clients may not know how to ask for non-traditional health related services, may not value network ES/L/FS services and/or may operate in a culture of dependency.*

Partly due to a history of government direct provisioning of food subsidies and cash/grants for HIV affected households, PLHIV, caregivers and family members have learned to expect such provisioning as the viable method of addressing poverty. Many may not know to ask for services that encourage personal responsibility for long term livelihood, may feel incapable of taking such responsibility or may be doubtful about the value of enrolling in such programs.

To promote the demand side of ES/L/FS services among the target population, LIFT should assist the community with developing and implementing communication campaigns that increase awareness of the

various types of ES/L/FS services and initiatives, promote the family pride that can result from gaining specific knowledge, skills and financial independence through key communication messaging, and identify key community spokes people who can serve as role models and peer advocates for ES/L/FS initiatives.

In addition, LIFT can assist on the supply side to improve service offerings within the network. With many NGOs and CBOs only offering one type of economic strengthening support to all clients, LIFT can assist agencies with tailoring services for clients based on their unique economic vulnerabilities and capabilities. LIFT can also assist agencies to conduct a market assessment to understand the demand for products, services and employment, and use these data to designing or advocate for services to address the needs of the community.

CHALLENGE: Demand for ES services often outstrips the supply of service providers and results in referral systems becoming overburdened.

To address this challenge, LIFT can offer assistance to the network's coordinating committee to help the network mitigate the challenge of demand vs. supply by sharing information across organizations about when ES/L/FS opportunities for clients will be available. In addition, LIFT can facilitate the referral network's connection to representatives of the private sector to encourage job opportunities for clients. LIFT could work with the referral network to design a comprehensive job readiness approach to prepare individuals to meet employer requirements, and develop a systematic way of aligning the available job opportunities with qualified candidates.

NETWORK SUPPLY-DRIVEN CHALLENGES

CHALLENGE: Members of the referral network may lack skills in community mobilization or may be unaware of potential available services to get a network system off the ground.

Health facility staff generally have limited knowledge of community-based services, especially those not health-related. In addition, ES/L/FS service providers may be unfamiliar with the concept of referrals when compared to health providers. LIFT can play a productive role in helping stakeholders undertake intensive community mobilization and promotional and public awareness activities to build demand for services offered by the referral network. In addition, LIFT can work with stakeholders to seek support of church and educational leaders, medical providers and policy makers to use their influence to increase community support for the referral network. Finally, LIFT can conduct a formal assessment of the various knowledge and skill competencies of network members, or potential members, and use these data to develop a strategic plan for increasing capacity and assisting with targeted capacity development.

CHALLENGE: Eligibility criteria for patients to take part in ES/L/FS programs of partner organizations may not align with profile of clients referred from HIV and/or NACS services.

The misalignment of clients' particular skill sets and productive capacity with the relevance of the ES/L/FS service is a common challenge. For example, NGOs and CBOs may provide skills training in carpentry, tailoring and basket weaving without knowing if their target audience would qualify or be interested in the training. At the same time, more traditional ES/L/FS providers may not target products or services to the vulnerability level of individuals coming through the health system.

LIFT can address this challenge by building the skills of the network coordinating mechanism to map and manage information on the most relevant and successful service providers and the different economic strengthening needs of clients. This can be accomplished by building the capacity of the coordinating mechanism to conduct a preliminary market assessment to understand the demand for products and

services, or employment, in the ES/L/FS sector. In addition, LIFT can help build capacity in conducting a household vulnerability assessment to better allow the capabilities and needs of PLHIV to be aligned with available ES/L/FS services. LIFT can also support traditional ES/L/FS service providers such as microfinance institutions and vocational/skills training institutions to tailor their services or add services that meet the needs of the NACS client base.

CHALLENGE: *While health facilities and some CBOs are used to having clients show up at the facility and services are rendered, many community-based service providers may have different modes of identifying and serving program participants.*

Unlike health facilities, some ES/L/FS services, CBOs or PLHIV networks may not be accustomed to clients 'showing up' to receive services and may not have a physical office as an entry point for services. This can impact how referrals to these services are received and responded to in LIFT's network approach. To address these issues, LIFT should conduct capacity strengthening with ES/L/FS service providers to educate them about the nature of referral networks, their role in the network and how to effectively receive and refer clients for other services. Moreover, through dialogue early in the process of establishing the network, there will need to be clarity on if and how specific services can be accessed through a referral model. ES service providers will also need to be educated about working with PLHIV clients and fully clarifying upfront with clients and network members about the eligibility criteria and/or the seasonality of the services that they provide.

In addition, as part of encouraging community ownership of the referral network, LIFT can promote the development of more formal collaborations and 'quid pro quo' arrangements between network members. CBOs that do formal outreach to PLHV, care givers and their family members can encourage, refer and accompany individuals to health facilities while health facilities can provide a limited amount of facility space to allow a CBO staff person to conduct relevant services. Moreover, LIFT can be conduit in connecting with the private sector to encourage collaboration between for example, CBOs conducting job readiness programs in space provided by employers and the same or other employers providing job opportunities for program graduates.

CHALLENGE: *While the government may have a coordinating mechanism to foster a multi-sector response, overall, the HIV response is seen largely as a 'health response.'*

Traditionally government agencies have worked in individual 'silos', establishing certain 'realms of authority' based on their background and expertise. When government agencies consider the best response to HIV to be a health response only, ES/L/FS services are often not a priority. Having largely a single focus also results in HIV government units not taking responsibility in collecting referral forms other than those associated with health referrals, which results in limited accountability, follow-up and tracking of referrals.

Moving away from this way of operating not only involves addressing infrastructure issues, it requires making a mind shift from compartmentalizing client needs to addressing needs holistically. To address this challenge, LIFT should advocate that government coordinating mechanisms take a more formal multi-sector approach with members from different ministries. This can be accomplished in several ways including conducting formal meetings or summits on the topic with participants from different sectors. Such gatherings can present models and best practices in the field of referral networks and outline the advantages of the multi-sectoral approach for serving the broad needs of PLHIV, care givers and family members with the various sector participants prepared to discuss how its sector and initiatives could contribute to clients' well-being.

CHALLENGE: Healthcare systems are overburdened and struggle to meet other than basic health care needs of clients, including doing referrals to meet ES/L/FS needs.

Clinical staff are often stretched in providing basic client services and find it difficult to meet additional healthcare needs, such as nutrition support, or make referrals for other services, such as ES/L/FS services. Doing so often includes the challenge of adding additional tracking mechanisms to client charts and reporting processes within the health system.

LIFT can provide assistance in trying to streamline the system and reduce burden on the health facility staff by, for example, providing input on how to add simple yes-no items to existing documentation systems related to counseling and referral for other multi-sectoral services, including ES/L/FS services. A more long range solution would be for LIFT to train a case manager or para-social worker who could be added to the health facility staffing configuration or staff of the referral coordinating mechanism and take responsibility for client ES/L/FS referrals.

CHALLENGE: Task shifting in healthcare systems may make it difficult to ensure everyone is fully trained in the referral process and can result in lost referrals when patients move from one unit of a facility to another. In addition, patients having to travel to multiple sites or units for services can result in low uptake.

While task shifting in healthcare systems is a structural issue, LIFT can encourage the use of and train a case manager or para-social worker in unique skill sets to: 1) identify key economic strengthening needs and assets, including previous client work experiences; 2) provide counsel on potential referral options by explaining the opportunities available within the community; and 3) follow up on the success of the referral through home visits and visits to network partners. This trained individual would be embedded within health facilities or referral coordinating organizations to take on responsibility for economic strengthening counseling and referral decision-making. Another way health facilities and other referring agencies can assure more successful referral rates is by putting in place a PLHIV accompaniment program where volunteers can accompany clients to referred agencies.

CONCLUSIONS

A typology of three HIV referral network models exists (health facility, community-based, case management) with several hybrid applications of these models in the field that integrate various forms of civil society and government involvement. In the LIFT context, any of the models can achieve the objective of connecting NACS clients and their households to ES/L/FS opportunities, though a community-based referral model seems most feasible. What is critical is the provision of LIFT system strengthening to ensure that the most appropriate and effective ES/L/FS referrals are provided and services are utilized by NACS clients.

LIFT system strengthening of referral networks in the areas of ES/L/FS must be driven by best practice, the stage of development of the network and the strength of its members. In the context of 'essential elements of referral networks,' LIFT is a global technical leadership mechanism capable of enhancing each essential element in collaborative relationships with Missions, implementing partners and government counterparts. This includes developing the tools and processes required to establish a referral system (i.e., community mapping, evaluation of available services, client assessment, referral tracking, monitoring and feedback processes, evaluation of clients' experience and outcomes), as well as provide training to staff involved in the referral network.

LIFT technical assistance must be able to grapple with common field challenges that local referral networks confront including client demand-driven challenges as well as those that are network supply-driven. Through field-based research and analysis, LIFT has prepared its Livelihood and Food Security Conceptual Framework, eight Standards of Practice in Economic Strengthening and a host of practical resources to improve the quality of existing ES/L/FS services. LIFT's organizational network analysis and diagnostic tools help to guide appropriate referrals as well as identify gaps in available services and support advocacy to local NGOs, donors and government institutions in these areas.

Table 1: Documents Reviewed

Document & Author	Document Type	Synopsis
<p>1. Increasing the Sustainability and Impact of NACS by Linking Patients to Economic Strengthening Services (LIFT, FHI 360)</p>	<p>Technical Brief</p>	<p>Discusses LIFT's model to link NACS patients to economic strengthening services. This includes:</p> <ul style="list-style-type: none"> • Diagram of process • Key components of referral system • Community ownership • Identification and evaluation of available services • Referral points of contact • Establishment of referral committee • Community referral coordinating mechanism • Assessing individual patient needs and capacity <p>Promotes LIFT capacity to provide TA in:</p> <ul style="list-style-type: none"> • Development of tools and processes required to establish the referral system: • Community mapping • Evaluation of available services • Patient assessment • Referral tracking • Monitoring and feedback processes • Evaluation of patients' experience and outcomes • Staff training in referral networks
<p>2. Livelihood and Food Security Conceptual Framework (LIFT, FHI 360)</p>	<p>Technical Brief</p>	<p>Section 5 on livelihood interventions provides relevant information for understanding appropriate referrals of clients for livelihood services/ interventions based on vulnerability and need. It discusses:</p> <ul style="list-style-type: none"> • Three categories of livelihood interventions (provisioning, protection, promotion) • The livelihood pathway (used to locate a household on the pathway to increased income and reduced vulnerability; pathway includes five household

Document & Author	Document Type	Synopsis
		<p>livelihood outcomes which are associated with different types of proposed interventions)</p> <ul style="list-style-type: none"> • Larger conceptual framework consolidates several key concepts discussed in the brief
<p>3. Establishing Referral Networks for Comprehensive HIV Care in Low Resource Settings (FHI)</p>	<p>Guidance</p>	<p>Discusses:</p> <ul style="list-style-type: none"> • Referral network models and provides examples; • Nature of relationships in network; • Quality assurances of model referral networks; • Essential elements of networks; • Steps for starting, strengthening referral network; • How to make a successful referral; • M&E component of referral network <p>Tools provided:</p> <ul style="list-style-type: none"> • Directory of services • Referral form • Client tracking form • Referral register • Diagram of referral process and what form to use at stages of process
<p>4. Promising Practices for Linking Economic Strengthening and Clinical Services (Save the Children)</p>	<p>Report</p>	<p>Results of literature review and field research with Ethiopia referral programs [Food by Prescription (FBP), TransACTION and the HIV Care and Support Program (HCSP)]. Discusses (across programs):</p> <ul style="list-style-type: none"> • Model referral systems used in the different programs • Challenges experienced • Promising practices/lessons learned • Recommendations for program improvement <p>Includes:</p> <ul style="list-style-type: none"> • Recommended guidance materials for implementing partners

Document & Author	Document Type	Synopsis
		<ul style="list-style-type: none"> • Forms and referral tools: <ul style="list-style-type: none"> ○ Monthly monitoring sheet (submitted by every network member) ○ Individual referral form
<p>5. Building linkages and referrals – a step towards sustainability: Alliances India Experience (International HIV/AIDS Alliance)</p>	<p>Report</p>	<p>Discusses CHAHA program experience (health, education, social security and livelihood related):</p> <ul style="list-style-type: none"> • Process for developing and implementing referral network of coordinated care • Factors that promote linkages • Factors that inhibit linkages
<p>6. A referral system for care and support services for PLHIV and their families in the community (UNDP)</p>	<p>Guidance</p>	<p>Discusses:</p> <ul style="list-style-type: none"> • Conceptual Model of continuum of care • Makeup of network • Services in network (including skills training/ Livelihood/Employment) • Advantages of/outputs of a referral system • Essential elements of a referral system • Process of establishing a referral system • How the system works (diagram) • The referral process and corresponding forms (diagram) • Indicators of successful referral system • Competencies of service providers <p>Tools included:</p> <ul style="list-style-type: none"> • Intake form • Consent form • Referral for service form • Referral feedback form • Referral registry

Document & Author	Document Type	Synopsis
		<ul style="list-style-type: none"> • Directory of resources
7. Namibia – Guidelines for Bidirectional Referral System (Ministry of Health and Social Services, Namibia)	Guidelines	<p>Discusses:</p> <ul style="list-style-type: none"> • What is referral system; • Names Tool to facilitate process (Directory of services, referral form book, referral register, referral focal person, referral committee, referral reports); Referring process; • Involvement of private sector and community based health care services; • M&E of referral system
8. Namibia – Draft report for evaluation of bi-directional referral system (Intrahealth)	Report	<p>Discusses:</p> <ul style="list-style-type: none"> • Findings; • Best practices; • Challenges; • Conclusions & recommendations
9. Malawi - Salima Referall network guidelines (FHI 360)	Guidelines	<p>For FHI program, Mkuta Mwana for vulnerable children in Salima district. Discusses:</p> <ul style="list-style-type: none"> • Goals and objectives of referral network • Agencies in comprehensive integrated network • Elements of a referral network • Coordinated structure and focus persons • Meetings, feedback mechanism and reporting • Steps to developing/strengthening network • M&E of referral network • Standard tools, tracking system, documentation and QA
10. Malawi Salima Operational Manual for System (FHI 360)	Manual	<p>For FHI program, Mkuta Mwana for vulnerable children in Salima district. Discusses:</p> <ul style="list-style-type: none"> • Objectives, guiding principles of referral network • Roles and responsibilities of organizations and persons

Document & Author	Document Type	Synopsis
		<p>in referral network</p> <ul style="list-style-type: none"> • Essential elements of referral network • Monitoring and QA mechanisms • Standard operating procedures (How to make a successful referral, the referral form and register, directory of services, reporting on referral activities)
11. Zambia - Referral Networks (Zambia Prevention Care and Treatment Partnership)	Brief	<p>Discusses:</p> <ul style="list-style-type: none"> • Technical strategy • Key activities • Challenges
12. Zambia: Neighborhood Health Committees (Zambia Prevention Care and Treatment Partnership)	Brief	<p>Discusses:</p> <ul style="list-style-type: none"> • Approach in involving NHCs as a complimentary community mobilization strategy • The benefits of utilizing the NHCs in achieving its objectives
13. Zambia: Community mobilization and referral model (Zambia Prevention Care and Treatment Partnership)	Brief	<p>Discusses:</p> <ul style="list-style-type: none"> • Model goals and components in diagram
14. Tanzania: CONTINUUM OF CARE NETWORKING FOR HIV/AIDS and Powerpoint on CoC (FHI 360)	Report	<p>Discusses:</p> <ul style="list-style-type: none"> • Experience with continuum; • Challenges; • Gaps and lessons learned <p>Includes:</p> <ul style="list-style-type: none"> • Questionnaires for district leaders, service providers and PLHIV
15. Nigeria Referral Network training (intro)	PP training	Includes info on essential elements of network
16. Nigeria Referral Network training	PP training	Includes essential services in network (lists material support but not formal ES/L/FS)

Document & Author	Document Type	Synopsis
(needs of PLHIV)		
17. Nigeria Referral Network training (steps)	PP training	Steps to start a referral network or strengthen
18. Nigeria Referral Network training (tools and processes)	PP training	<ul style="list-style-type: none"> • How to make a successful referral; • Standardized tools <ul style="list-style-type: none"> ○ Directory of services; ○ Client referral tracking form; ○ Client referral form: Part A Referral Slip ○ Rreferral register; ○ Client referral form: Part B Services Provided
19. Zambia: Prevention Care and Treatment ZPCT II Monitoring and Supportive Tool (FHI)	Tool	Used to determine the performance in implementing ZPCT II community mobilization and referral network activities
20. Zambia: Referral Register (FHI)	Tool	Registers up to 12 clients
21. Zambia: Zambulance service for expectant mothers (FHI)	Policy guidance	Community based transport improvement
22. Zambia: BICYCLE POLICY FOR COMMUNITY VOLUNTEERS (FHI)	Policy guidance	For health community outreach
23. Nigeria GHAIN referral directory (FHI)	Tool	By state, provides info on: <ul style="list-style-type: none"> • Name of agency; • Type and cost per service; • Days/hours; • Contact names and telephone numbers
24. Nigeria GHAIN Referral services monitoring checklist (FHI)	Tool	Monitors: <ul style="list-style-type: none"> • Elements of good system; • Materials and supplies needed;

Document & Author	Document Type	Synopsis
		<ul style="list-style-type: none"> • Referral focal person; • Client referral form; • Referral registry; • Intra and inter facility referrals; • Feedback system;
25. Malawi IP registry of enrollees (FHI 360)	Tool	Collects data on guardian, child, enrollment and demographic information
26. Malawi Registry of HHId Beneficiaries (FHI 360)	Tool	Collects data on children and adults in household
27. Malawi Household Registration Form (FHI 360)	Tool	Collects data on children and adults in household
28. Malawi Registry of Program Beneficiaries (FHI 360)	Tool	Collects data on guardian, child, enrollment and demographic information
29. Malawi Referral Form (FHI 360)	Tool	Two parts with tear off from organization that responds to referral for what is next
30. Malawi Incoming Referral Register (FHI 360)	Tool	Form to record referrals for up to 20 clients
31. Malawi Outgoing Referral Register (FHI 360)	Tool	Form to record referrals for up to 20 clients
32. Malawi Child Support Matrix and Care Action Plan (FHI 360)	Tool	Child support matrix for OVC (including livelihood items) and ability to develop plan from scoring
33. Malawi Household registry form (FHI 360)	Tool	Summarizes info on children and adults' possible OVC services
34. Malawi - Client FU & Referral Form (IMPACT)	Tool	Place for follow-up appt details and referral to community-based services
35. Malawi –Confidential Health Referral Form (IMPACT)	Tool	Client details, reasons for referral, referred by, FEEDBACK HEALTH PROVIDER FOR HCC OR PMTCT REFERRALS
36. Malawi –Child Status Index Impact	Tool	Measurement tool for CSI

Document & Author	Document Type	Synopsis
Program (IMPACT)		
37. Malawi –Beneficiary Enrollment Tool (IMPACT)	Tool	A scoring sheet; list 12 household livelihood factors and factor indicator scales for each; Includes a Impact Beneficiary Enrollment Tool
38. Partnership Agreement for Referral of Women who Seroconvert in FEM-PrEP Clinical Trial (unknown)	Tool	Check off for all information on services received by client
39. SEROCONVERTER REFERRAL CARE FORM (unknown)	Tool	<p>Summarizes all info on:</p> <ul style="list-style-type: none"> • the individual referral; • if client was given a referral; • if didn't connect why; • if did connect what services received
40. Referral matrix (unknown)	Tool	<p>Similar to a directory but full page of info on network partner:</p> <ul style="list-style-type: none"> • name/location of facility and hours; • nature of relationship; • services offered; • support services offered; • costs and access issues
41. FHI FEM-PrEP Clinical Trial (FHI)	Guidelines	Guideline document for procedures for HIV positive women (including guidelines for referral manager)
42. Tanzania – Referral Form	Tool	<p>Collects info on:</p> <ul style="list-style-type: none"> • person getting referral; • person providing referral; • where person was referred; • info on other referrals; • tear off for after services were provided for return of info to original source

Document & Author	Document Type	Synopsis
43. Project HOPE Namibia – H101 Client referral form	Tool	Collect info on: <ul style="list-style-type: none"> • person getting referral and caregiver; • COST OF THE TRANSPORT AND SERVICES REQUIRED; • place to sign if services were received
44. Project HOPE Namibia – T102 TB Patient Discharge	Tool	Includes: <ul style="list-style-type: none"> • place for interviewer information (including place coming from and being discharged to) • patient demographic information (including plans for follow up)
45. Project HOPE Namibia – T103 Patient Education Verification	Tool	Allows for rating of patient knowledge of health conditions (TB/HIV)
46. Project HOPE Namibia – T104 Treatment Defaulter/Interrupter Follow-up	Tool	Allows for information on TB medication defaulting and reason for defaulting
47. Project HOPE Namibia – T106 Referral form ()	Tool	Collects: <ul style="list-style-type: none"> • demographic data on TB client and TB suspect; • service provided by health professional and whether follow up visit (instructions are for patient to give back to Field Promotor who referred)
48. Project HOPE Namibia – T 105 DOT Supporter Meeting Form	Tool	Collects data on: <ul style="list-style-type: none"> • topics discussed at meeting • DOT supporters attended • info on TB client being supported
49. Project HOPE Namibia – TH 101 Household Visit	Tool	Collects data on: <ul style="list-style-type: none"> • demographic of persons interviewed; disease; • TB treatment management; • contact tracing in household;

Document & Author	Document Type	Synopsis
		<ul style="list-style-type: none"> • OVC's health, nutrition & development, shelter and care, education, protection, psychosocial support, and care
50. Project HOPE Namibia – TH 102 Health Education Form/Community Outreach Form	Tool	Collect data on: <ul style="list-style-type: none"> • where HE activity took place; • what was discussed; • reactions of participants; • challenges, successes with outreach; • info on persons in HE session

