LIFT II
LIVELIHOODS & FOOD SECURITY TECHNICAL ASSISTANCE

Clinic to Community Referrals: Linking Health and Economic Strengthening to Improve Client Outcomes

PRACTITIONER GUIDE

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contents

acronyms

ART	Antiretroviral Therapy
CARE	CARE International
CBO	Community-Based Organization
DRC	Democratic Republic of the Congo
ES	Economic Strengthening
ES/L/FS	Economic Strengthening, Livelihoods and Food Security
FGD	Focus Group Discussion
HTC	HIV Testing and Counseling
IP	Implementing Partner
IRB	Institutional Review Board
LIFT	Livelihoods and Food Security Technical Assistance II Project
LTFU	Loss to Follow-Up
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
NACS	Nutrition Assessment, Counseling, and Support
NGO	Nongovernmental Organization
OHA	USAID Office of HIV/AIDS
ONA	Organizational Network Analysis
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
QA	Quality Assurance
QI	Quality Improvement
RC	Referral Coordinator
RN	Referral Network
TA	Technical Assistance
UNAIDS	United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
USG	United States Government
VSLA	Village Savings and Loan Association

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foreword

A formalized network of referral providers is crucial for increasing access to a range of HIV and economic strengthening, livelihoods and food security (ES/L/FS) services for those in need, and for ensuring the long-term permanence of that service delivery. However, little information regarding creation of integrated, multi-sectoral referral networks and few standardized tools to facilitate effective referral network functioning are available. This guide aims to describe the referral network development and maintenance process, and to provide sample tools for use within a bi-directional clinic-to-community referral network. The guide is intended for implementers, stakeholders and service providers at clinic and community levels who need guidance on creating or improving referral networks serving populations infected and affected by HIV and AIDS, particularly those focusing on connecting these populations with ES/L/FS support in hopes that the connection will improve health outcomes.

The tools included as annexes to this guide were developed for use under the Livelihoods and Food Security Technical Assistance II (LIFT) project and can be modified as necessary. These tools have been tested and refined from experiences in six countries: the Democratic Republic of the Congo (DRC), Lesotho, Malawi, Namibia, Tanzania and Zambia. This guide will continue to be improved and refined as needed.

contact

Please send any feedback to lift@fhi360.org.

how to use this guide

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introduction

The Livelihoods and Food Security Technical Assistance II (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 United States government (USG) 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 and AIDS (PLHIV), orphans and vulnerable children (OVC) and their caregivers. As with the LIFT project as a whole, the focus of this guide is multi-sectoral, with an emphasis on economic strengthening, livelihoods and food security (ES/L/FS), HIV/AIDS and nutrition sectors.

Bi-directional clinic-to-community referrals work to improve the health of individuals and the communities in which they live. Therefore, developing strong referral linkages is beneficial for improving health outcomes, particularly for populations living with HIV and AIDS. The President's Emergency Plan for AIDS Relief (PEPFAR) 3.0 commitment to support the United Nations Programme on HIV/AIDS' (UNAIDS) 90-90-90 global goals[1] for sustainable control of the HIV epidemic has further changed the care needs of PLHIV, increasing the importance of referral systems. Effective planning for HIV diagnosis, care and treatment programs should include consideration of how referrals between clinical facilities and communities can be maximized, and developed as an integral part of the continuum of care. Notably, referrals enable the health sector to function as part of a larger system of support for PLHIV, thereby promoting service integration and improving patient diagnosis, adherence and retention in long-term HIV care and treatment.

referral network objectives

- Formalizing a network of organizations and health facilities that can provide bi-directional linkages for clients
- Setting in place systems for making, tracking, and completing referrals that meet clients' holistic needs
- Increasing understanding of client support needs and facilitating access to priority services
- Improving client follow-up with the aim of reducing loss to follow up (LTFU)
- Enhancing quality of care for PLHIV and other vulnerable populations, their caregivers and family members
- Promoting communication, integration and coordination among service providers

The particular goal of clinic-to-community referral networks is to create a sense of shared responsibility and establish a platform for ongoing dialogue between the health system and the community. Referral networks can include government, civil society and community-based service providers, and they provide an important forum for information, education, and communication across these entities, many of which would not otherwise interact. Referral networks also address the need for a systematic referral process between health and community-based service providers.

LIFT developed this document as a practical guide for project staff, implementing partners and stakeholders interested in bi-directional linkages between clinical facilities and community-based services, particularly ES/L/FS services, supporting vulnerable populations such as PLHIV and OVC. The guide includes five components to lead its user through the planning, implementation and monitoring of a referral network: 1) collaborative planning, 2) core referral network elements, 3) referral network implementation and operation, 4) the referral process, and 5) monitoring and

[1] By 2020, 90% of PLHIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90% of all people receiving antiretroviral therapy will have viral suppression.

evaluation. It is meant to be a practical guide that can improve understanding of these essential components in order to assist in the creation and strengthening of efficient, productive and effective referral networks.

The Clinic to Community Referrals Practitioner Guide leads users through the important steps and considerations in the formation and operation of sustainable referral networks. It also provides an array of tools which can be utilized and adapted by new and existing referral networks. The material contained in this guide was developed from the experiences and lessons learned by the LIFT project through its work supporting referral networks in six sub-Saharan African countries. This guide is not intended to represent a rigid instruction manual for referral network creation; rather, it provides tools and guidance that can, and should, be adapted to best fit the referral network context. Using the guide as a reference, we hope that stakeholders will develop new ideas during the application process to inform future revisions of this document.

how is this guide set up?

Component 1- Collaborative Planning: describes important considerations in the ***design and planning*** of referral networks, with a particular emphasis on the need for engagement and active participation of stakeholder groups.

Component 2- Core Referral Network Elements: lays out the crucial ***elements in a referral network***, providing detailed descriptions, exploring lessons learned by the LIFT project, and linking to a range of practical, customizable ***referral tools***.

Component 3- Referral Network Implementation and Operation: provides an explanation of how the elements described in components 1 and 2 in this guide can be woven together to result in ***formation and operation*** of an effective, bidirectional clinic-to-community referral network.

Component 4- The Referral Process: guides practitioners through the major steps involved in ***making referrals*** within a bidirectional clinic to community referral network, highlighting the importance of adhering to ***consistent and routine processes***.

Component 5- Monitoring and Evaluation: provides guidance around ***monitoring and evaluation (M&E)*** as related to referral networks, and provides sample indicators that referral networks might consider adopting to measure and track their activities.

component 1: collaborative planning

This component describes important considerations in the design and planning of referral networks, with a particular emphasis on the need for engagement and active participation of stakeholder groups.

Before a referral network can be implemented, the foundation for its success must be laid through a multi-stakeholder, collaborative planning approach. Often the referral network is the first time these various stakeholders are interacting in a professional capacity; therefore, it is critical to begin fostering a shared understanding of the potential value of the referral network and the important contributions of each stakeholder from the initial planning stages. The information below provides additional detail about essential elements of a collaborative planning process to establish a referral network. These elements can also be applied to existing referral networks to strengthen stakeholder engagement and expand the services offered to clients.

implementation tips: stakeholder involvement

- Meet with local (and even regional, if necessary) government early on to explain the rationale for a referral system and to solicit design input
- Develop key planning documents such as service directory and MOU early, and incorporate stakeholder feedback to help ensure buy-in around common goals
- Plan for media campaigns (through radio or plays) early on, and encourage referral network members to display signs welcoming referral clients, especially at larger hospitals where clients need to arrive at a particular office

Community Participation – In the context of referral networks, community includes PLHIV and their families, as well as the health workers, volunteers and community-based organizations (CBOs) that provide a wide array of support services in their catchment area. PLHIV rely on regular medical contact and support from the health center to adhere to, and be retained in, treatment. However, the clinical facility alone cannot provide all of the support needed by PLHIV and their families. Community structures have an important role to play in promoting adherence and retention in care, in close collaboration with the clinical team, and their participation is also critical for effective and sustainable referral network operation.

Organizational Network Analysis – Prior to forming a referral network, it is critical to map and evaluate the full breadth of services available in the proposed network catchment area. This mapping should consider health clinics and other health facilities, as well as non-health-related government and community-based services, such as ES/L/FS services. It is also important to look beyond formal service providers, capturing all the places to which community members might go to receive services, such as informal women's groups or PLHIV support groups.
LIFT has produced a detailed Practitioner Guide for Completion of an Organizational Network Analysis (ONA), which is available via the LIFT website.

Service Provider Engagement – Once the number and types of service providers in the proposed network catchment area are known, it is important to bring those service providers together and engage them in the process of designing the referral network. It is key that as many service providers as possible participate in the early stages of network planning and operationalization, particularly given the diverse nature of service providers in a bi-directional clinic-to-community referral network, many of whom may not have collaborated previously. Also, by working together to define network priorities, establish roles and responsibilities, and determine joint action steps, the service providers will have the opportunity to build relationships and a sense of collective identity, which are crucial for long-term sustainability of the network.

how do I conduct an Organizational Network Analysis?

LIFT II has produced a comprehensive practitioner guide which provides instructions and customizable tools for conducting an ONA. This guide can be accessed via LIFT's website, here.

component 2: core network elements

This component lays out the crucial elements in a referral network, providing detailed descriptions, exploring lessons learned by the LIFT project, and linking to a range of practical, customizable referral tools.

A productive referral network is dependent on the existence of core network elements that generate the environment needed for making and completing referrals. The core network elements that are described below also ensure that the referral network itself is well coordinated, has clear communication structures and utilizes high quality referral processes and monitoring systems.

Network Members: As HIV and AIDS have become chronic diseases, patient-centered approaches have emerged to encourage self-management and involve communities more actively in patient care. A patient-centered approach must address client treatment and care holistically, going beyond basic medical needs and addressing other issues, such as family relationships, education, financial well-being, livelihoods, and overall health and nutritional status, while also being cognizant of the need to sensitively engage HIV-affected households without stigmatization. In order to address this continuum of needs, a referral network should be made up of a group of member organizations, including health facilities and service providers, that offer a comprehensive range of services in a defined geographic area. Also, when creating or growing a referral network, it is important to balance the need for a greater quantity of services with the need for quality services. Crucially, these service providers are the engine behind an effective referral system, providing comprehensive services for clients when they are functioning together as one network.

Service Directory: A 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. Information on each of these organizations should be compiled in a Service Directory, which will serve as a centralized source of key information on each of the member organizations. Information gathered during an ONA is the ideal source of input data for a Service Directory. However, if conducting a full ONA is not feasible, at minimum, information should be collected to allow the Service Directory to list the name of the organization, type of service(s) offered, when and where services are offered, whether service/s are currently available/new clients will be accepted, cost of the service(s), client eligibility criteria to receive service/s, days and hours of operations, contact names and relevant points of contact. The completed directory needs to be distributed to all organizations in the network and should be routinely updated to ensure that information on service providers is current and accurate. Network Meetings provide a valuable platform for sharing changes in member programming or staffing, so that all partners are aware, and adjustments to the Service Directory can be made accordingly.

implementation tip: RC checklist

Many of the responsibilities of the RC include recurring tasks. Checklists can be useful in helping to ensure that these activities are completed routinely, and according to schedule.

LIFT has produced a RC checklist to be used as a job aid for completion of recurring RC responsibilities. This checklist can and should be adapted to suit particular referral network needs.

Referral Network Coordinator: During the referral network planning phase, network members should collectively select an entity to assume responsibility for the coordination and monitoring of overall network activities and performance. This referral coordinator (RC) role can be performed by whichever network member the member organizations deem the most appropriate. The advantages and disadvantages of different types of member organizations acting as the RC are explained in Table 1 and should be considered by the referral network when selecting its RC. The primary functions of the RC may include:

- Convening monthly meetings for referral network members
- Working with the referral network members to address service provider gaps and inefficiencies in the network

- Updating Service Directories with changes to member organization information or status
- Providing referral network members with standardized tools and forms
- Improving client follow-up to ensure as many clients as possible are completing their referral and receiving the service(s) to which they were referred
- Facilitating communication and coordination among the referral network members
- Instituting a dues system that addresses the cost associated with referral network coordination
- Managing referral data and promoting quality improvement (QI)

It is important for referral network members to agree upon and document the roles and responsibilities of the RC so that expectations are understood and work is planned appropriately. This documentation can take the form of Terms of Reference, which explicitly lay out the duties and activities for which the RC will take responsibility.

Table 1. Advantages and disadvantages of organizations serving in the RN Coordinator role

	Advantages	Disadvantages
Ministry of Health Facility	- Referral operations embedded within government institution - May allow for easier targeting of PLHIV and vulnerable populations by connecting new (and possibly untested) clients to existing government-supported clinical and community services - Opportunity to capitalize upon existing community support mechanisms - Staff are often familiar with client case management and data analysis	- Can be difficult to truly institutionalize referral network management within normal government operations - Potential budgetary and administrative issues (e.g. resource availability, government timelines, strict administrative procedures) - Staff workload may already be heavy
Community-Based Service Provider (includes economic strengthening, livelihoods, and food security services, as well as others such as private clinics, FBOs, or NGOs.)	- More freedom to make decisions without multiple layers of review/approval - May have more budgetary liquidity - May be more inclined to see the value of referral network operation and how their leadership role could be utilized to enhance collective community service provision, and also to increase their own reputation - Community referral network members may be more comfortable having a similar entity manage operations	- Funding may be more unpredictable, which could impact referral network sustainability and consistency of leadership - Time available to dedicate to referral network support may fluctuate as their primary responsibility is to their own donors and clients

Local Authority/ Government Office	- Already have a coordination function within the community - Potentially have an existing specific platform for HIV/AIDS-related coordination - Ability to integrate referral process into local government programs and operations	- Can be difficult to truly institutionalize referral network management within normal government operations - Government offices usually have budgetary constraints and may not be able to support additional roles such as coordinating referrals - Government priorities may be affected by political considerations and competing interests, which may result in the referral network becoming a lesser priority

Network Member Referral Focal Persons: While it is optimal for all staff and volunteers of referral network member organizations to be familiar with the purpose, structure and operation of the network, it is often more practical that each organization designates an appropriate number of official referral network focal persons. These focal persons will be responsible for processing referrals efficiently and expeditiously, as well as managing core referral activities, such as tracking and documenting referrals and attending network meetings. While the type of staff member (i.e. nurse, counselor, social worker, etc.) holding this position may vary, it is recommended that their role as a referral focal person be documented in their job description and performance review plan to ensure that the role is afforded the appropriate amount of time within their work schedule.

lessons learned

Focal persons often require intensive training to be able to perform their referral role. In Malawi, LIFT facilitated several 1-2 day workshops to develop referral tools and train staff. In addition, project staff aimed to visit service providers at their offices at least every other week to support focal people by making sure that they a) understood referral tools, b) were able to receive referrals, and c) had answers and support to work through questions or difficulties related to referral work.

Despite this, referral network members noted that even more training would have been welcome during a focus group discussion (FGD) conducted at the end of LIFT's activities in Malawi. Specific examples of support requested included training related to:

- the LIFT project as a whole (only an overview was provided as LIFT is a technical assistance rather than implementation project)
- strategies to encourage clients to act on a referral, especially considering distances to reach services can be great
- understanding the services available within the referral network. For example, one FGD participant explained that while Village Savings and Loan Associations (VSLAs) were a very common service, many focal people did not understand the meaning of VSLA or what the service did.

Therefore, is it important to ensure that focal persons are provided with adequate training and tools that are easy to use and understand, such as service directories with thorough explanations of the services offered by each organization, to enable them to fulfill their important role in the network. Focal persons who are well trained and thriving in their role are essential for sustainability.

Network Meetings: Regular referral network meetings provide a venue for important ongoing communication and dialogue between network member organizations, allowing the network to be better prepared to respond to changing client and community needs. Meetings should promote collaboration and commitment to the referral process, as well as provide opportunities for exchange of information about the referral process, challenges and gaps in service, and tracking of referrals and clients lost to follow up to reinforce a collective network identity that is more likely to be sustainable. It is recommended that referral network meetings occur on a monthly basis, be guided by a formal agenda, and be documented with minutes that are shared with all network members. (Sample Meeting Agenda)

Standardized Referral Tools: Given the diverse nature of clinic-to-community referral network organizations, and the complexity of bi-directional referral networks – which require members to be capable of both making and receiving referrals – it is crucial that referral network members operate using a set of standardized referral tools. It is particularly important to have a standardized referral form used throughout the network so 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 also 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 a mobile phone app or tool so that both the client and the service provider to whom the client is referred receives referral requests and can provide feedback via mobile technology.

Implementers are encouraged to adapt the LIFT-developed referral network toolkit components, provided in the annexes, to suit the particular needs of their network. In some cases, translation of the referral tools into a preferred local language will be required to increase usability by service providers making and receiving referrals. Additionally, implementers should take care to discover and incorporate, to the degree feasible or necessary, any existing guidelines. For example, Namibia developed comprehensive guidelines and tools for bi-directional referrals, which were then adapted for use within the clinic-to-community networks supported by LIFT.

implementation tips: referral tools

- ***Create and maintain a change log***. All referral forms should have version numbers, generally in the form x.y were x is a major update (such as new questions, new sections, or other large revisions that require a training for referral network members) and y is a minor update (such as corrections to spelling errors or translations, adding additional answer choices to a question, or fixing a programming error in a digital survey). Change logs should indicate the new version number, date of change, reason for change and name the person responsible for the change.

- ***Keep translated tools in one file***. Whether using paper based tools designed in Word or digital tools designed in Excel, it is important to keep translations together. When a minor update is made to one language version, it should simultaneously be made for all other languages. It is very easy to skip this step if tools are saved in separate files.

- ***Use existing client IDs whenever possible.*** Referral clients need to be identified and tracked. To preserve clients' privacy this is best done through associating each client with an ID number, which can be linked to identifiable information only when necessary, and only by an appropriate referral network member. LIFT has created several versions of client IDs for use in referral sites, often a concatenation of service provide code and the date of referral. However, if possible, it is helpful to use existing IDs, such as a client's ART number if they are HIV-positive and enrolled in treatment. In this case, a backup ID process would still be necessary for clients who are not PLHIV and/or not enrolled in treatment, but use of an ART (or other pre-existing) ID number can help link referral records to client medical records, which is essential for tracking health outcomes. The feasibility of using ART numbers depends on location as it can be seen as very sensitive data, even though it is virtually impossible to personally identify a client based on ART number. If well-designed, an alternate ID for HIV- clients can and should closely mimic ART numbers to preserve clients' privacy and HIV status.

Referral Tracking System: A system to track referrals from the point of referral initiation to the point of service delivery, and then feed referral completion information back to the point of initiation is necessary to ensure that clients are using the services to which they are referred, that these services respond to their felt needs and that any challenges are noted. A standardized system of referral tracking, with a feedback component, can also ensure that:

- Access to needed services is occurring in a timely manner
- Client confidentiality is being maintained
- There is consistent monitoring of referrals, regardless of the referral directionality (e.g. clinic to community, or community to clinic)
- Referral completion and outcomes, particularly adherence and retention in HIV-related care, can be tracked

Some common methods for referral feedback include having the client return part of the referral form completed by the service provider to the referring organization. This can be achieved by using a drop box at each organization where referral feedback forms can be collected regularly by the RC, or feedback be received by having a standard process for following up by phone on all referrals made.

Practitioners also need to consider the data system that will be used to enter and aggregate referral data on an ongoing basis (generally each month). Table 2 presents benefits and challenges of four different systems, all of which LIFT has used with referral networks. There are several paper-based system options, including the use of mHealth apps (LIFT uses Open Data Kit, or ODK though many data collection platforms are available), Microsoft Excel, and Microsoft Access (or other database software). LIFT has also used completely mobile data collection and aggregation platforms (including CommCare) to allow referral data to be collected and shared amongst network members in real time.

Table 2. Potential Benefits and Challenges of Several Referral Tracking Data Systems

	Paper-based (using mHealth app)	Paper-based (using Excel)	Paper-based (using Access)	Mobile (using CommCare or similar app)
Potential Benefits	- Open referral process – any SP can refer to another directly - Low programming costs after initial hardware purchase and training - Lead referral entity coordinates data entry using tablets - Aggregated ODK datasets can be used to create summary reports for partners	- Open referral process – any SP can refer to another directly - No equipment or licensing costs incurred (computer needed for Excel data entry) - Low cost to replicate/scale - Easily adapted/ updated - System is functional offline - Paper-based systems may be familiar which can lead to quicker uptake	- May complement existing referral forms and/or feed government databases - Rapid integration of additional service providers - System is functional offline - Database enables merging client data collected at different sites	- Open referral process – any SP can refer to another directly - Allows real-time data-sharing among referral network members - Easy export and analysis of de-identified client data - Varying degrees of access to ensure confidentiality - Programming enables SPs to check on referrals, flagging inactive clients for follow-up - Key messages to be delivered to clients can be built into the system - Operational offline, though data sync requires network or Wi-Fi

	- Ability to replicate with low investment			- Free for up to 50 mobile users - Does not require much available data to be on device for proper functionality - Data easily compiled for sharing with RN members
Potential Challenges	- Printing - Data entry burden - Some training costs/time associated with converting ODK data files to usable dataset, and subsequent summary reporting	- Printing - Data reporting will be burdensome - System cannot merge client data from different sites	- Printing - Network-wide data are not accessible until data merge is performed - Data entry burden (computers required)	- Database development and maintenance - Steep learning curve for local staff - Need for continuous and repeated training - Sustainability of phone and data costs - Maintenance of equipment – hardware can become outdated due to increased OS requirements - Need for regular updates to forms and referral network member information for app to function effectively

Whichever referral tracking data system is used, there are some common considerations which should be kept in mind:

- Staff training essential regardless of data management system
- Smart phone/tablet data entry provides quick and more accurate data collection
- Capacity to use smart phones/tablet varies based on location
- Care should be taken to integrate data management system with existing processes
- Must ensure that client data are stored and only accessible to appropriate parties
- Ensure that service providers are able to accommodate referrals—accurate documentation of eligibility criteria is vital
- Network functionality relies on consistent upkeep of service/referral directories and data collection tools

Referral Documentation: At both the point of referral initiation and the point of referral service delivery, a written or electronic record is crucial to document outcomes. Organizations at both ends of the referral process have a responsibility to document their respective roles in the referral process. To assist in this process, a standardized referral register can be used to document a large number of referrals This data can then be used to inform M&E activities, as well as QI processes (see component 5).

what should be in my referral toolkit?

The following are recommended resources and tools to support network members in the implementation of a referral system:

- Referral network ***standard operating procedures*** to ensure processes are documented and agreed upon by all network members.
- Referral network ***process diagrams*** to clarify the relationships between network members and the flow of clients through the network system.
- ***Memoranda of Understanding (MOUs)*** between network members to ensure roles and responsibilities are clear.
- ***Service directories,*** with current, accurate information for all network members.
- ***Client intake and consent forms,*** which should be used consistently for all referrals within the network.
- ***Referral registers***, which provide an important record of referrals being made and received within the network.
- ***Change log*** to document updates to referral forms and registers.
- ***Reference guides*** for referral tools with clear instructions for using and completing referral tools. These are particularly important for training new staff who may not be familiar with referral network procedures, or as a job aid for existing staff.
- Client assessment ***diagnostic tools,*** which enable referring organizations to identify the most appropriate services to which to refer a client.
- Referral ***counseling guidance,*** which supports service providers with strategies and best practices for discussing referrals with their clients.
- ***Data tracking systems*** that allow the activities of the referral network to be tracked and monitored by members, in order to identify areas for improvement, assess changes over time, and highlight effective processes.

component 3: referral network implementation and operation

This component provides an explanation of how the elements described in components 1 and 2 in this guide can be woven together to result in formation and operation of an effective, bidirectional clinic-to-community referral network. In general, elements from component 1 are under the direct control of a project responsible for facilitating the creation of a referral network and are therefore easier to complete. Elements from component 2 require a significant amount of collaboration with stakeholders of the nascent referral network.

As items in components 1 and 2 near completion, practitioners can transition to trainings and meetings that focus on referral network operations rather than referral network rationale, constituents, tool design, and a tracking system. At this stage, practitioners will want to launch the referral network while still keeping the tools and data systems flexible so they can adapt to unanticipated changes in network membership, needs or scope. Table 3 below organizes some key considerations for practitioners and stakeholders into those that should be done before or during the launch of the referral network, and those that should be considered once the referral network matures (perhaps 3-6 months after launch).

Table 3. Considerations for discussion before/during referral network launch and once the referral network has matured.

Stage	Consideration	Lessons from LIFT
Considerations for discussion before or during the referral network launch	Embedding (if possible) referral network management or oversight within a government agency (MoH, MoAg, etc.)	- This is a foundation for sustainability and local ownership, if it can be done. - You may be able to register the referral network with local government as LIFT did in Tanzania, to ensure participation of relevant government stakeholders at planning and review meetings - If RN cannot be embedded within government agency, work with RN partners to "elect" a lead entity from among the network members responsible for promoting active referral participation amongst all members, planning and leading review meetings, troubleshooting issues, etc.
	Develop a detailed MOU and a "referral network constitution" or by-laws	- One MOU may be between the practitioner and the Referral Coordinator, to specify how and when technical assistance will be given, and any other duties - A constitution or set of membership by-laws is important between referral network members to acknowledge they understand the rights and responsibilities of membership
	Consider any special equipment (notably mobile phones or tablets) that may be lent to referral network members	- If technology employed/provided by project for data collection or other purposes, then propose a cost-sharing scheme with RN partners - If phone airtime support provided, develop and share a transition plan at the outset of implementation that cascades down over time to ween RN off external support - Develop and maintain an equipment inventory. For mobiles and tablets, the project should note the International Mobile Station Equipment Identity (IMEI) Number

		- Agree on circumstances where a device would be replaced or when RN member will be held responsible for damage caused, loss, theft, etc. Also agree on documentation that may be required, such as police reports
	Referral Network Meeting planning	- Discuss and decide where review meetings will be held each month/how they will be supported by RN members - Ensure it is clear who will send invites, and how many participants are expected from each organization - In general, network members will want to send executives or project directors to initial planning meetings, however, over time it is more appropriate for members to send staff who deal with clients face-to-face, as they will have the most to say about the benefits and challenges of referrals - Discuss any transportation stipends that may be available, and exactly how much they are and any criteria for claiming them
	Data Management Tools	- While the referral tracking system may be decided by the practitioner or technical assistance project responsible for facilitating network creation, all RN members should discuss data management tools since they will ultimately own all data and be responsible for the processes to collect data. Considerations include: o How members want to organize the data? o Who has access to data (especially client names, phone numbers or other identifiable information) o Who will analyze data, and what kinds of skills (Excel, Access, mHealth apps) are required? o How much data will there be? It will likely be mostly quantitative, but even then will involve text, numeric, and date/time variables o How will data be shared, and how does that influence reporting format (CSV file, Excel, other report)? o Does the Referral Coordinator have sufficient access to a computer? o How will data be protected?
	Data Management Timeline	- Discuss and agree upon a realistic timeline for data submission. This includes when partners will be expected to submit completed referral forms to lead entity, when lead entity will compile all forms received to produce summary reports, and when summary reports will be shared back with RN members - Also discuss how the data collected will be used by RN partners and/or the project

	Finalize a Referral Network Operations Manual	- This should include items such as:
		  o Detailed explanation of referral
		  o Outline of any agreements between members
		  o Overview of the referral process a client goes through
		  o Explanation of different forms/tools being used as part of the system
		  o Explanation of roles and responsibilities of RN members
		  o Tips or job aids in case of challenges confronted
		  o Contact information of key members (Leads)

Considerations for discussion once the referral network has matured	Referral Network Membership Dues	- Facilitate conversation around membership dues, which could be maintained by lead entity and used for RN operations - This may be added in to a referral network as practitioner's direct support to the network wanes or transitions to another technical assistance partner
	Incentive Schemes to promote referrals	- LIFT has offered phone airtime support, as well as capacity-building workshops on any subject of interest to the majority of RN partners. LIFT has learned that often RN partners are slow to start actively expending time/energy on referral work, but once they get going they start to observe benefits for their clients (opening up and linking to other needed services) and themselves (receiving new clients from other RN members and/or having clients come to them because they heard about the RN and want to be formally linked somewhere else)
	Awareness Campaigns and Media	- Discuss with members how referral awareness will be spread within communities so that people understand opportunities available to them - LIFT has supported locally driven awareness campaigns/events prior to the launch of several referral networks
	Printing and Distribution of Referral Tools	- Initially it is likely that the practitioner will help produce referral materials (service directories, tools, etc.) however eventually this burden should be transferred to the referral network members - This may be a planned transition (along with incentive schemes or dues mentioned above) and included in a first round Constitution or By-laws
	Revise the Referral Network Materials	- After some time has elapsed members will likely want to review and update the RN Operations Manuel, Tools, and possibly revise the MOU and Constitution/By-Laws

	Update the Referral Network Tracking System	- Once RN members fully understand the operations of the network, it is likely they will want to have updates to the system to improve the ease and efficiency of following up with clients, identifying clients who have not completed their referral(s), and other challenges that can be easily addressed with useful data
	Measuring Referral Network Performance	- Once RN members become accustomed to regular referral data sharing and review, it may be time to use a participatory appraisal to decide on indicators for "network performance" and how they might be measured in the future - This is also a juncture where it is appropriate to begin quality improvement (QI) activities
	Enhancing Referral Availability and/or Increasing Referral Volume	- LIFT has conducted a number of Economic Strengthening Fairs (ESFs) and used "referral corners" at health facilities or community events/gatherings as a platform to reach many clients at once. This is best done once the kinks in referral operations are worked out to ensure the higher than normal client volume is handed efficiently. - ESFs and referral corners work like this: Service providers sensitize clients present at facility about services available in the community, and explain that they can make a referral if service can't be delivered then. Alternatively, a referral coordinator could attend these events, raise awareness and facilitate referrals to other service providers. Interested clients speak with service providers and enroll in the referral system on the spot!

component 4: the referral process

This section guides practitioners through the major steps involved in making referrals within a bidirectional clinic to community referral network, highlighting the importance of adhering to consistent and routine processes.

Making sure that a client's holistic needs are met involves three main goals:

1. Coordinating linkages between health facilities and community services. For LIFT, this included promoting linkages to HIV Testing and Counseling (HTC), care and treatment.
2. Forming partnerships and relationships among clinical and community organizations to fill gaps in needed services.
3. Promoting patient, family and community involvement in HIV care and treatment.

Referrals can play an essential part in achieving all three goals. However, in order to do so, the referrals must be appropriate, timely, and effective. Given the complexity of a bidirectional, clinic-to-community system of referrals, making such referrals can be challenging and requires that all members of the referral network adhere to a standard process for making and receiving referrals. Based on LIFT's experience, we have conceptualized the following as the major steps in making appropriate, timely and effective referrals. However, we would encourage implementers to adapt this guidance as appropriate for their context

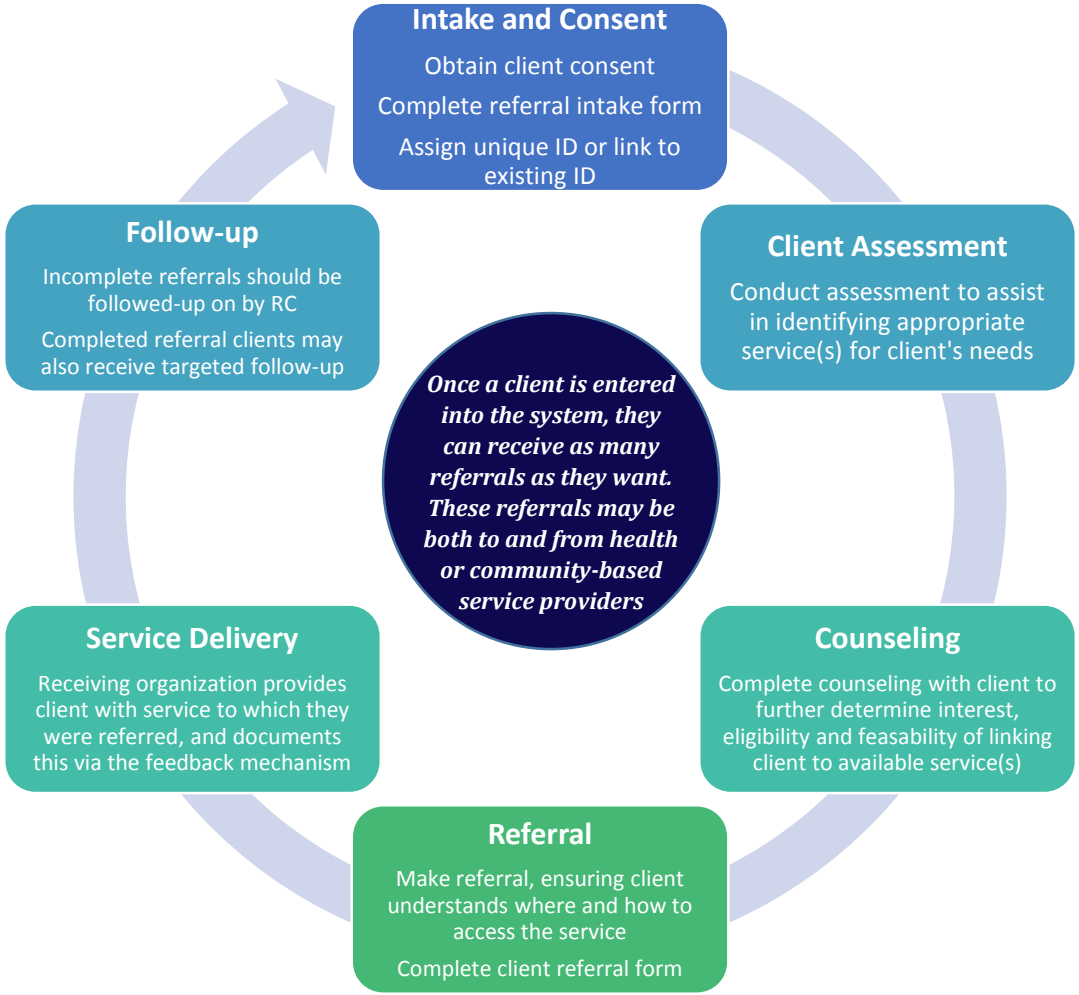


Figure 1. Visualization of the referral process, as implemented within LIFT-supported referral networks.

Step 1: Intake and Consent
Regardless of whether a client enters the referral network via a health clinic or a community service provider, the intake procedure should be the same, utilizing the standard referral intake form. Whenever making a referral to a new client, the referral network member should create a file for that client and keep this information in a secure location. If they have not already been issued with a unique client identification number during a previous visit to the service provider, the client should now be provided with one in order to allow for tracking and management of their case, and to ensure that their information remains confidential. At the time of intake, the referral network member must also obtain informed consent from the client to share their information with other members of the network. By providing consent, the client is allowing service providers within the network to share information, which can then be used to confirm referral completion and for follow-up purposes.

Step 2: Client Assessment
A client assessment can help to classify households – for example, according to their level of vulnerability and food security, as was the case in LIFT-supported referral networks – in order to assist in making appropriate, targeted referrals based on client needs. Matching client needs with available support and ensuring compliance with eligibility requirements is critical to referral completion. Conducting an assessment prior to making a referral also provides valuable baseline data regarding the client's current status. If the referral network wants to understand and quantify the value it is providing to clients, it may then repeat the assessment at an appropriate interval – at least one-year post-referral is recommended – to assess client-level changes over time.

implementation tip: informed consent

The FHI 360 Institutional Review Board (IRB) required the LIFT project to ensure that all clients referred through LIFT-supported referral networks were provided with informed consent at the time of their referral, as well as at the time of any follow-up contact where data would be collected. However, even if referral network activities are not reviewed by an IRB, it is valuable to provide clients with the basic elements of an informed consent statement out of respect for their autonomy. Informed consent should include discussion or information about:

- A description of the referral process
- Any foreseeable risks or hardships from referrals
- Expected benefits of referrals
- Disclosure of alternate means to access services e.g. a client could go to another service themselves without a formal referral if they so choose
- Confidentiality of records and data
- Compensation or reimbursement, even if none is available that should be made clear to clients
- Contact information for the referral network coordinator and focal people
- A clear statement that participation in the referral network is completely voluntary

why conduct a client assessment?

If referral networks are made up of many different service providers, it may be challenging for the individual making a referral to determine which service(s) might be most beneficial for a given client. Client assessments, such as vulnerability or food security assessments, are valuable in providing information that can help appropriately match a client to an available and, most importantly, relevant service.

LIFT utilized the Progress out of Poverty Index (PPI) and the Household Hunger Scale (HHS), validated measures of household vulnerability and food security respectively, in order to assess clients during the referral process, and determine the correct service for their needs.

Step 3: Counseling

Counseling based on key probing questions as well as on the services available in the catchment area can help ensure that the referrals take into consideration key factors and barriers that affect clients' ability to act on referrals made. These counseling sessions will be somewhat context specific, but all should address important issues, such as those listed below, before a referral is made (Sample Counseling Guidance Form).

- Does the client meet eligibility criteria for certain services?
- What service(s) is the client most interested in?
- What time constraints exist and does the client have the ability/willingness to commit time to participate?
- Will time spent on an activity/service detract from other productive activities (child care, other employment, etc.) to the extent that it will have a negative impact on the household?
- How far can the client travel to access services? How frequently?
- Can the client meet the physical demands of various services/activities?
- Can the client pay fees towards receipt of a service, if fees are required?
- Are there government grants that the client is eligible for and can be linked to?

Step 4: Referral

Once all of the proceeding steps have been completed, the referring organization should have all of the information needed in order to complete the referral form and direct the client to the appropriate service for their needs. The minimum information required on the referral form should include: date, name of the referring organization, client identification number, client age and sex, name of the organization the client is being referred to, focal person at the organization client is referred to, and client telephone number. It is vital that the individual completing the referral form captures all of this required information so that the referral is recorded properly and appropriate follow-up with the client can be completed, if needed.

Step 5: Service Delivery

Upon exiting the referring organization, some clients may proceed directly to the referral network member to which they were referred. Other clients may take days, weeks or months to complete their referral. And some clients may not complete their referral at all (proceed to Step 6).

When a client presents at a referral network member with a referral, they should be provided with the services for which they were referred in a timely manner. This process should be documented by the receiving organization using the appropriate referral feedback mechanism. Ideally, the following information would be recorded as part of the referral documentation process:

- The date the client visited the organization to obtain services
- Whether the client received the service to which they were referred
- If the client did not receive the service to which they were referred, determine why this was and ensure this is documented
- If the service to which the client was referred was deemed inappropriate, was an alternative service provided or a secondary referral made?
- The level of client satisfaction with both the referral process and the service provided.

Step 6: Follow-up

If a client fails to complete a referral, it is important to conduct proper follow up to identify why a service was not accessed. Referral focal persons should carefully log referrals made, and on a regular basis (i.e., monthly) review referral feedback. When incomplete referrals are identified, create a plan on how to best follow up, either through phone, SMS or by visiting the client. In some contexts, community volunteers may be utilized to follow up with clients who have not acted on their referrals.

implementation tip: service provision

When clients take time to travel to an organization in order to obtain needed services, it is crucial that the service is available when they present themselves. Referrals that are made to inappropriate or unavailable services erode community trust in the service providers, as well as the referral network as a whole. At all times, this should be avoided and referral network members should be encouraged to meet the needs of all referred clients, to the best of their capacity.

component 5: monitoring and evaluation

This section provides guidance around monitoring and evaluation as related to referral networks, and provides sample indicators that referral networks might consider adopting to measure and track their activities.

Referral networks extend the continuum of care for PLHIV, their families and caregivers. In order to determine the extent to which a referral network is achieving its intended objectives, and whether client needs are being met, monitoring and evaluation (M&E) systems must be put in place to gather a range of performance and outcome data. Ongoing data analysis and feedback can also contribute to valuable QI activities, a sample QI Guide is available in the annexes of this guide.

Process indicators help to track referral network activities, and can be used to identify bottlenecks or issues in the day-to-day operation of the referral network. Regardless of the referral toolset employed at a site, all referral data collected by local network members should be reported to the RC as part of a regular monthly data management routine and also logged in a central referral register . This data is essential for creation and tracking of process indicators. Data collected by partners should be as complete as possible, to allow for productive disaggregation of data by sex, age, location, service type, etc. and to illustrate the collective progress of a network over a given period of time. Ideally, the RC should compile data received by all referral network members into one dataset from which summary reports can be quickly developed and shared back with members to stoke discussion around QI, promote accountability and local ownership, and facilitate follow-up to clients who have not completed referrals by accessing services.

Depending upon the data collection system utilized by a referral network (see Table 2 in Component 2), this may require training and/or development of supplemental data analysis tools, such as data "dashboards". At several sites, LIFT has successfully employed Excel-based dashboards to automatically sort and clean raw referral network data received from RCs each month, then populate summary tables of interest to the project and referral network members, such as: # referrals made and # referrals completed (disaggregated by age, sex, HIV status); # referral network members making and/ receiving referrals each month; # referrals made for each service option; # OVC served via referral, among others. The dashboards not only are an efficient mechanism for sharing progress reports with referral network members, but also add value when developing sampling frames for studies with specific client eligibility criteria.

Outcome indicators are important to determine how effectively a referral network is achieving its broader objectives. They can measure client-level outcomes, such as changes in health or nutrition of clients as a result of receiving a service through referral system participation, or referral network outcomes, such as changes in the level of communication and collaboration between different service providers (see basic logical framework below for examples). Tracking outcome indicators helps identify best practices in referral implementation and should contribute to the wider evidence-base on how integrated service delivery via referral systems may benefit vulnerable clients/households and strengthen service providers themselves. Outcome indicators can help demonstrate longitudinal changes over time (e.g., household poverty and food security status, or referral completion rates). Certain outcome indicators may require additional data collection beyond what is routinely collected from clients at the point of referral and referral completion. For example, to understand whether a referral network member has benefited from a capacity-building workshop (possibly delivered to incentivize initial referral activity), a follow-up survey may be necessary. For more complex outcomes, especially those concerned with clients and changes in their lives since referral, methods such as clinical record reviews by facility staff, in-depth interviews and/or focus group discussions may prove beneficial. Process and Outcome indicator examples can be found in Annex XII. As a PEPFAR-funded technical assistance project, LIFT focused on client outcome indicators related to changes in anti-retroviral treatment adherence and food security, but other practitioners will likely need to adopt alternate indicators to reflect their specific target beneficiaries and/or adhere to donor requirements. The following is a general framework LIFT has followed when providing TA to existing service providers in an attempt to contribute to improved client outcomes.

INPUTS	ACTIVITIES	OUTPUTS	RN OUTCOMES	CLIENT OUTCOMES
Formal and informal service providers operating in a defined geographic area Clients (PLHIV, non-PLHIV, OVC, OVC caregivers) Results of an Organizational Network Analysis Money/funding	One-time activities: - Create service directory - Create RN toolkit of standardized forms and tools - Select organization focal persons - Select RC - Establish referral tracking system Ongoing activities: - Maintain and update service directory - Hold referral network meetings - Make referrals - Collect referral feedback - Track and report on referral outcomes - Implement QI initiatives	Service directory Customized RN toolkit Organizational focal persons Referral Coordinator Referral tracking system RN meetings Bidirectional referrals (clinic to community and community to clinic) Longitudinal referral process and outcome data (e.g. rates of referrals made, proportion of referrals completed)	Increased awareness of service gaps in catchment area Increased coordination and collaboration between local service providers Increased community awareness of available services in catchment area More efficient system of linking clients to needed services Increased ability to track and follow-up with clients Increased organizational commitment to supporting clients meet their needs across the continuum of care	Improved resilience, food security and health status of clients, including improved adherence to treatment and retention in care amongst PLHIV population

annexes: Integrated Referral Practitioners Toolkit

Annex I Service Directory

A Service Directory is a core tool for a referral network and is meant to formalize the list of service providers who are participating in the referral network.

The essential elements of a service directory include:

1. A cover page, which displays the name of the referral network and the date of the latest revision to the directory;
2. A table of contents listing the name of each organization, in alphabetical order, whose details are in the directory;
3. A page for each service provider's information (see example below), listed alphabetically.

It is important to note that a Service Directory is meant to be a useful tool for referrals, rather than an extensive introduction to each service provider's programs. Therefore, it is important to keep the following guidelines in mind when updating or adding new entries:

- The Directory is not for marketing purposes—descriptions should be short and clear
- It is important to provide correct contact information for each service provider
- When possible, programs should describe specific eligibility criteria (or targeting information) to help users quickly determine if someone can use a service or not. These criteria should specify any restrictions to enrollment (i.e., if programs are ONLY for clients who are PLHIV, or OVC, or women, etc.)

[Name of Organization]

Main Service Areas: *List primary types of services offered by organization e.g. vocational training, HIV testing and counseling.*
Contact: *Name of referral network focal person at organization.*
Phone: *Telephone number for organization.*
Email: *Email address for organization.*
Address: *Physical address of organization.*
Location of Services: *Provide additional information that may assist a client in locating the organization e.g. organization is in located in the same complex as the District Hospital.*
Hours/Frequency of Service: *Provide information describing when the organization will be open to receive clients e.g. 08:00am to 3:30pm weekdays.*
Currently Accepting New Clients: *This needs to be updated regularly so that a referral network member knows whether it is safe to send a client somewhere else and can be confident the client will access the needed service. This helps avoid client frustration and improves trust in local institutions.*

Program Area/Services	Eligibility Criteria	Program Contact – Email/phone (if applicable)
Example 1 **Vocational Training**	Any youth (male or female) aged 12 - 24 years. Some initiatives give priority to vulnerable groups.	Contact Name Contact Email address Contact Phone number
Example 2 **Reproductive Health Training**	Open to all adults, and adolescents over age 16.	Contact Name Contact Email address Contact Phone number
Example 3 **Referrals to Health Services**	Open to all.	Contact Name Contact Email address Contact Phone number

Annex II Terms of Reference

Terms of Reference for [Insert Name of Organization], Referral Coordinator for [Insert Referral Network Name]

This document describes the suggested role of the organization serving as the Referral Coordinator (RC) in supporting the [Insert Name of Referral Network]. These roles and responsibilities should be adapted to suit the referral network context through discussion, and with the agreement of, all referral network members.

The RC will provide leadership in the following areas:

1. Support the development and implementation of an effective clinic-community referral network in [Referral Network Catchment Area]

2. Provide clear and timely communication to the network and about referral activities in [Referral Network Catchment Area]

3. Share emerging lessons from the referral network and referral resources with other referral network members and key stakeholders, including [List primary stakeholders, considering organizations, donors and government ministries at the district, regional and national level].

Specifically, the RC will:

- Support referral network members to adhere to referral processes (including making and receiving referrals, referral form completion, referral feedback and data collection/management)
- Be responsible for collecting monthly reporting forms from all other service providers in the network and entering all data into the tracking system
- Lead referral network data analysis, generating monthly reports on referral system activity (i.e., numbers of referrals made, completed, etc.), and disseminating data reports to network members
- At least quarterly, convene meetings of the referral network to discuss referral data, progress and challenges
- Lead the collection and dissemination of relevant updates and other information or materials to the referral network
- Liaise with network members to update service directory (soft copy) and announce/disseminate updated versions on a regular basis
- Occasionally convene a broader group of stakeholders to discuss the functionality of the referral network and possible replication. Participants may include referral network member organizations, local and regional government, national government representatives from the Ministry of Health, Ministry of Community Development, other government ministries, donors and/or its partners.

Annex III Referral Coordinator Checklist

Referral Coordinators should understand and be able to explain the following items related to referral work:

Communication	☐ Copies of all referral tools and data entry forms ☐ Frequency of referral network meetings ☐ Contact information for referral network member focal persons ☐ Special events the referral network may have (such as health fairs or economic strengthening fairs)
Funding Stability	☐ Costs associated with membership (fees, dues, or other costs) ☐ Funds available to reimburse travel to meetings or airtime, if available ☐ Planned or possible changes to funding in the future
Leadership	☐ Lead technical assistance partner (when a Ministry, development project, or other) ☐ Ministry and local government contacts ☐ Directors or managers of services that are referral network members (these may be different staff than referral network focal people, and they may not deal directly with clients)
Organizational Capacity	☐ Service directory that lists all referral network members, their office locations (or locations of services), eligibility criteria, and other useful information ☐ Maximum capacity for referrals (will vary by organization—not all organizations can serve all clients referred to them. It is important to discuss service limits during referral network meetings
Partnerships	☐ Membership documents that each referral network member signs upon joining, if necessary (this may be necessary in situations where equipment such as phones or tables are loaned to members)
Political Support	☐ Memorandum of Understanding that guides referral network operations ☐ Required reporting to local and national government, as well as donors
Program Adaptation	☐ Junctures at which referral tools and processes can be updated, as it is likely referral network members will need to tweak tools after the launch of the referral system
Program Monitoring and Evaluation	☐ All indicators associated with referral network membership and operations ☐ Expected targets for the referral network
Strategic Planning	☐ Expected uses for referral network data ☐ Anticipated performance or quality improvement initiatives ☐ Research or assessments which may be conducted to understand how referral clients benefitted from their referral

Annex IV Referral Network Meeting Agenda Template

[Insert referral Network Name]
Monthly Meeting Agenda
[Date of Meeting]

1) **Welcome Remarks and Introductions** (Name of Presenter)

2) **Review Agenda for Meeting** (Name of Presenter)

3) **Review Updates from the Past Month** (Name of Presenter)
   - Address any questions raised during prior meeting

4) **Referral Data Sharing** (Name of Presenter)
   - Each organization shares data (# referrals made/received, etc.) since prior meeting
   - Review monthly data reporting template
   - Discuss whether referral network members are satisfied with current numbers, and where they see opportunities for improvement.

5) **Success and Challenges** (Name of Presenter)
   - What successes/encouraging signs have organizations experienced since last month?
   - What challenges have organizations experienced since last month?
   - Discussion of how organizations can overcome challenges; what problem-solving solutions do referral network members suggest?

6) **Other Important Topics** (Name of Presenter)
   - This might include topics such as planning for special events, e.g. a Community Awareness Campaign or training workshop, or new tools to be introduced to referral network members.

7) **Next Steps** (Name of Presenter)
   - What actions need to be taken based on topics discussed during the meeting, and who will be responsible for these actions?

8) **Meeting Closing**
   - Remind attendees of the date, time and location of the next meeting.

Annex V Change Log Template

A change log should allow an individual to quickly see when a change was made to a referral network tool, who made the change, and what the change included e.g. addition of new data points, changes to variable names, corrections to translations. The first row in the sample change log below provides an example of how the change log should be completed. Additional columns can be added to the change log, if desired, to allow a referral network to track other necessary information related to referral tool updates.

Date of Change	Who Made Change	Forms Updated	New Version Number	Changes
dd/mm/yyy	*Sarah Smith*	*Referral Intake Form*	*1.2*	*Provide a detailed description of changes made e.g. Added a new question to the Referral Intake Form. This data point is called "Client Education" and collects the number of years of schooling completed by the client.*

Annex VI Sample Referral Forms

Sample Client Intake and Consent Form

This form should be completed the first time an organization/facility in the network has contact with a new client.

INTAKE

1. Organization/Facility Completing Intake: _____

2. Date of Visit: __ __ - __ __ - __ __ __ __

(day) (month) (year)

3. This referral is for: ☐ Client☐ Child in client's care

4-5. Client/Child Name (first name, surname): _____

6. Does the Client/Child have a referral network ID number? ☐ Yes ☐ No

If YES, enter their existing number; If NO assign the client/child a number:

7. Client/Child ID Number: __ __ __ - __ __ __ - __ __ __ __ __ - __ __

8. Date of Birth: __ __ - __ __ - __ __ __ __ OR Estimated Age: _____ years

(day) (month) (year)

9. Sex: ☐ Male ☐ Female

10. HIV status? ☐ Positive (P) ☐ Negative (N) ☐ Unknown (U) ☐ No Response (NR)

11. If HIV+, have they started ART? ☐ Yes (Y) ☐ No (N) ☐ Unknown (U) ☐ No Response (NR)

12. If the Client is on ART, are they adherent to treatment (i.e. takes medication every day as directed)?

☐ Yes (Y) ☐ No (N) ☐ Unknown (U) ☐ No Response (NR)

13. Are any household members HIV+? ☐ Yes (Y) ☐ No (N) ☐ Unknown (U) ☐ No Response (NR)

14. Have any household members died from HIV/AIDS during Client's lifetime?

☐ Yes (Y) ☐ No (N) ☐ Unknown (U) ☐ No Response (NR)

15. If referral is for an adult, will this referral directly benefit a child in client's care? ☐Yes ☐ No

16. In the past 30 days, how many times was there no food to eat of any kind in your house because of lack of resources to get food? ☐ 0 times ☐ 1-2 times ☐ 3-10 times ☐ 10+ times

17. In the past 30 days, how many times did you or any household member go to sleep at night hungry because there was not enough food? ☐ 0 times ☐ 1-2 times ☐ 3-10 times ☐ 10+ times

18. In the past 30 days, how many times did you or any household member go a whole day and night without eating because there was not enough food? ☐ 0 times ☐ 1-2 times ☐ 3-10 times ☐ 10+ times

REASONS FOR REFERRAL (tick all that apply):

___ 19. ARV therapy

___ 20. Adherence counseling

___ 21. PMTCT

___ 22. Counseling and testing

___ 23. Home based care

___ 24. NACS

___ 25. Savings group

___ 26. ES/L/FS (specify):_____

___ 27. OVC (specify):_____

___ 28. Other referral (specify):_____

29. Is this a referral for a long-term service? ☐Yes ☐ No

30. Client Telephone Number: _____

31. Client Address: _____

CONSENT

Read the following information to the client and then ask if they have any questions:

a) The only risk you have from participating in this referral system is that you may access a service in your community that may be new to you.

b) You will not receive any direct benefits (such as payment or other materials) from being part of the referral system.

c) You are free to decide if you want a referral, and you may stop at any time without penalty.

d) No private, identifiable information will be reported to the network.

e) Your choice to participate in referrals will not affect the services you receive from service providers in the network.

32. Does client/caregiver consent to be referred? (Sign, if able, or put a cross) _____

Sample Referral Form

[Form Number]

Referring service provider stamp

Part A – Referral
To Be Completed by REFERRING Service Provider

1. Date __ __ - __ __ - __ __ __ __

2. Referring Organisation _____

3. This referral is for: ☐ Client ☐ Child in client's care

4. Client/Child ID Number __ __ __ - __ __ __ - __ __ __ __ __ - __ __

5. Client/Child Age: ___ 6. Client/Child Sex: ☐ Male ☐ Female

7. If referral is for an adult, will this referral directly benefit a child in client's care? ☐Yes ☐ No

8. Referred To _____ 9. Focal Person _____

10. Org. Address/Location _____ 11. Org. Phone _____

REASONS FOR REFERRAL (tick all that apply):

___ 12. ARV therapy
___ 13. Adherence counseling
___ 14. PMTCT
___ 15. Counseling and testing
___ 16. Home based care
___ 17. NACS
___ 18. Savings group
___ 19. ES/L/FS (specify):_____
___ 20. OVC (specify):_____
___ 21. Other referral (specify):_____

22. Is this a referral for a long-term service? ☐Yes ☐ No

23. Referral Notes: _____

24. Referred By Name _____ 25. Signature _____

26. Designation _____ 27. Phone _____

28. Does client/caregiver consent to be referred? ☐Yes ☐ No

[Form Number]

Part B – Feedback

Referring service provider stamp

To Be Completed by RECEIVING Service Provider

29. Date _____

30. Client ID Number ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___ - ___ ___

31. Feedback To _____ 32. Focal Person _____

33. Feedback From _____ 34. Attending Officer _____

35. Designation ¬¬¬¬_____ 36. Address/Phone _____

37. Services Delivered? ☐Yes (specify):_____ ☐ No

38. Remarks _____

39. Follow-up Required? ☐Yes (specify): _____ ☐ No

40. Date of Next Visit _____ 41. Attending Officer Signature _____

Sample Referral Card

[Insert name of Referral Network] Referral Card		
1	Referring Organization Number	[_ _]
2	Referral Network ID:	[__ __. __ __.__ __.__ __.__ __ __] D D M M Y Y O O C L # Where OO is organization number and CL# is client number (from 001-999)
3	Client Age	[_ _]
4	Client Sex	☐ Female 0 ☐ Male 1
5	Date	[__ __ / __ __ / __ __] D D M M Y Y
6	Type of Referral (circle)	**01** **02** **03** **04** **05** **06** **[Insert types of services available within Referral Network]**
7	Organization Referred To:	[_ _] Staff name and Signature:

To be completed by organization receiving client.			
Referral Network ID:	[_ _. _ _ . _ _. _ _ . _ _ _ _] D D M M Y Y O O C L #		
Date client received	[_ _ / _ _ / _ _ / D D M M Y Y	**Org #**	[_ _]
Staff signature:			

[Insert name of Referral Network] **Referral Card**				
1	Referring Organization Number	[__ __]		
2	Referral Network ID:	[__ __. __ __ . __ __. __ __ . __ __ __] D D M M Y Y O O C L #		
3	Client Age	[__ __]		
4	Client Sex	☐ Female 0 ☐ Male 1		
5	Date	[__ __ / __ __ / __ __ / D D M M Y Y		
6	Type of Referral (circle)	**01** **02** **03** **04** **05** **06**	**[Insert types of services available within Referral Network]**	
7	Organization Referred To:	[__ __]	Staff name and Signature:	

To be completed by organization receiving client.			
Referral Network ID:	[__ __. __ __ . __ __. __ __ . __ __ __] D D M M Y Y O O C L #		
Date client received	[__ __ / __ __ / __ __ / D D M M Y Y	**Org #**	[__ __]
Staff signature:			

[INSERT REFERRAL NETWORK NAME]
OUTGOING REFERRAL REGISTER

Fill in for each client that you refer out to another organization.

Fill in When Making a Referral														Fill in as Feedback is Received		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Date	Form No.	Client ID Number	Name of Person Referred	Client Contact Info. (address/phone)	Age	Sex	Service(s) Provided to Client	Referred to (Org code)	Service(s) Referred for (list A-H) A. Clinical HIV B. Counseling & testing C. Education support D. Social protection E. Economic strengthening F. Parenting/caregiver G. OVC (other) H. Other (non-OVC)	Long-term/ Recurring Service? (Y or N)	HIV (P, N, U or NR)	ART (Y, N, U or NR)	Adherence (Y, N, U or NR)	Feedback Received? (✓)	Referral Completed? (Y or N)	Month feedback was reported to network (MM/YY)

[INSERT REFERRAL NETWORK NAME]
OUTGOING REFERRAL REGISTER

Fill in for each client that comes to your organization through the referral network

1	2	3	4	5	6	7	8	9	10	11	13	14	15
Date	Form No.	Client Name	Client ID Number	Client Contact Info. (address/phone)	Age	Sex	HIV (P, N, U, or NR)	Referred From	Service(s) Referred for	Service(s) Provided (list A-H) A. Clinical HIV B. Counseling & testing C. Education support D. Social protection E. Economic strengthening F. Parenting/caregiver G. OVC (other) H. Other (non-OVC)	Referral Completed (Y or N)	Feedback Given to Referring Org? (✓)	Follow-up with Client Needed? (Y or N)

Annex VIII Standard Operation Procedures (SOP) Template

SOPs are a critical tool to ensure all referral network members understand the purpose of the referral network, their role within it, and the specific steps involved in making and receiving referrals, and being an active participant within the network. These sample SOPs are adapted from SOPs developed by LIFT for one of the referral networks the project supported in Malawi. This document can and should be adapted to fit individual referral network needs and processes.

SECTION 1: REFERRAL NETWORK BACKGROUND

The Need for a Referral Network

A description of the background to the referral network, particularly describing who was involved in the initial planning and design of the network, and why the network was formed. This can be helpful when orienting new members or speaking with external organizations about the network.

Purpose of the Referral Network

A clear description of what the referral network is designed to do. Such as:

a. To formalize a network of organizations that provides relevant services in the community
b. Put in place systems for making and tracking informed referrals to better meet client's holistic needs
c. To increase understanding of client support needs and facilitate access to needed services
d. Improve client follow-up and ongoing support
e. To enhance quality of care for clients
f. To promote communication and coordination among the service providers within the district
g. To reduce duplication and wasting of resources

Definition of Key Terms

- **Referral**
  This is a process by which client needs for comprehensive care and support services are assessed and clients are helped to gain access to relevant services.
- **Referral Network**
  This is a group of organizations that in the aggregate provide comprehensive services to meet the needs of vulnerable households, including those affected by HIV and AIDS and malnutrition.
- **Referring Organization**
  This is the organization that makes the referral.
- **Receiving Organization**
  This is the organization to which the client is referred for services.

Network Catchment Area

Describe the geographical area within which the referral network will operate. For example, will the network only include organizations within a designated town or municipality? This section may be deleted if having a strict geographic definition is not appealing or would be difficult to agree on.

Qualifications for Membership in the Network

List the criteria which organizations must meet in order to be included in the network e.g. providing a certain type of service, or addressing the needs of a particular population.

SECTION 2: ROLES WITHIN THE REFERRAL NETWORK

This section should describe the activities to be completed by the organizations and key individuals within the referral network. These activities should ensure that the referral network operates effectively and efficiently, while being realistic in light of existing organizational and individual capacity. You might consider the following:

Roles and Responsibilities of Referral Focal People

Each organization in the network must designate a referral focal person who is trained in the referral process and who will process referrals and coordinate and manage all core referral activities within the organization. The referral focal person will assume the following roles:

- Process referrals effectively and expeditiously and manage referral activities for the organization
- Discuss and identify client's needs and provide appropriate referrals, or oversee other staff performing this function
- Tracking, documenting and submit referral feedback information to the referral coordinator in a timely manner
- Attend referral network meetings on behalf of their organization
- Monitor the organization's activities related to the referral network

Roles and Responsibilities of Organizations in the Referral Network

1. Referral Network Member Organizations

Referral network member organizations are the health facilities, community-based organizations, faith-based organizations, non-governmental organizations and government service providers that make and receive referrals. Referral network member organizations agree to:

- Act as a referring and/or receiving organization within the network
- Serve clients sent to the organization through the referral system to the best of its ability
- Document and submit data on referrals made and received according to agreed process
- Appoint a referral focal person within the organization to serve as the primary point of contact for all referral activities
- Train organization personnel in referral network processes and tools
- Attend network meetings to discuss, resolve issues and to promote collaboration and commitment
- Make available logistics and in-kind support to implement referral activities (e.g. stationery for referral forms, time for a referral focal person, transport money for focal person to attending meetings, occasionally host network-related meetings, etc.)
- Formalize involvement in the network and relationships between service providers by signing an MOU

- Collaborate and communicate with other network members to exchange information about services and the referral process and identify other possible points of collaboration that benefit the network
- Update the organizations' services directory and other referral tools in accordance with changes made by the referral network
- Conduct quality assurance to ensure the services are meeting the satisfaction of the clients
- Over time, address access barriers and gaps in the services
- Overtime, contribute to documenting referral best practices and instituting changes to make the system more effective

2. Referral Coordinator (RC):

The Referral Coordinator organization will serve as the locus of responsibility for the network's performance and function as the secretariat. The RC will serve as the administrator for the network database and lead the management of all network data. In addition to their duties as a referral coordinating organization, the specific functions of the RC include:

- Manage and maintain the referral database
    - Regularly collect referral feedback forms/information from all other service providers in the network and enter into the database
    - Compile monthly reports to network members on referrals made and completed
    - Manage updates to the database and/or data entry forms, as needed

- Convene regular meetings of network members
    - Integrate referral network business into existing meetings/forums and encourage regular attendance by all network members
    - Convene regular meetings of the referral network: send invitation notices; arrange venue; develop an agenda with the stakeholders; keep and circulate minutes of the meeting; keep meeting attendance record

- Receive, update and disseminate information relevant to the network
    - Request members to submit timely relevant data reports and report on occurrences and experiences related to the referral network
    - Distribute network-related materials (both electronic and print media, as needed)
    - Keep all members abreast of current situations in the referral network
    - Lead the process of updating referral tools and forms, as needed, and ensure all member organizations receive copies of the updated versions
    - Liaise with network members to update service directory
    - Mobilize real and in-kind resources to ensure the continued functionality of the network (materials, staff time, venues, etc.) resources

- Explore opportunities for network expansion and strengthening
    - Facilitate the entry of new members into the network
    - Orientate new network members on the referral process and tools
    - In liaison with other network members, identify capacity needs of the network and solicit for relevant technical assistance
    - Identify specific tasks necessary for the smooth running of the network and facilitate the creation of voluntary working committees for the execution of such identified tasks
- Represent the network in relevant fora

SECTION 3: REFERRAL NETWORK TOOLS

This section should describe the tools to be used by all referral network member organizations. It is important both to list the name of the tool and provide a description of how the tool is intended to be used and by whom. This might include the following tools:

- Referral Forms e.g. client intake form, feedback form, referral card, referral register
- Referral Tracking System used to capture data to track referrals
- Service Directory
- Client Assessment Tool(s)
- Referral Counseling guidance
- MOUs

SECTION 4: STANDARD OPERATING PROCEDURES

This section should provide more specific details about the procedures to be followed for completion of referral network activities. These instructions should be laid out clearly, and the procedures reinforced during trainings and referral network meetings. SOPs should especially be developed for the following:

- Completion of referral forms
- Client tracking, follow-up and referral feedback
- Referral documentation
- Data sharing within the network
- Referral network meetings
- Maintaining the Service Directory
- Maintaining referral network tools

SECTION 5: DETAILED REFERRAL PROCESS

Outline the step-by-step process for making and receiving referrals. Ensuring that all member organizations are following the same steps for making and receiving referrals is essential in guaranteeing that client needs are met, the referral network is providing high quality service, and that network activities can be tracked and assessed. The major steps in the referral process for LIFT-supported referral networks is described in component 4 of the Clinic to Community Referrals Guide. However, each referral network should adopt its own process, as dictated by the network's structure and needs.

SECTION 6: MONITORING AND QUALITY ASSURANCE MECHANISMS

This section should describe how the referral network intends to monitor and evaluate its activities, and conduct quality assurance (QA). Referral networks might consider establishing a quality assurance team to lead activities related to referral network quality assurance. There are many potential QA activities that can be implemented within a referral network, such as the following:

1) Minimum Requirements Assessment

The quality assurance team may make an assessment of the availability of key essential elements within each of the referral network member organizations. The assessment looks to see that each organization meets the following minimum requirements:

- Presence of a referral focal person
- Attendance at referral meetings
- Presence of a directory of services
- Availability of standardized forms
- Availability of referral register or database

2) Client Satisfaction Survey

The quality assurance team may randomly select clients to participate in the survey and shall ask whether the services received from both the referring and receiving organization were satisfactory using a client satisfaction survey form.

3) Random Site Visits

The referral focal point person at the RC may conduct random visits every quarter, completing the minimum requirements checklist and client satisfaction survey at this time.

4) Regular Network Meetings

During regular network meetings, gaps and challenges in service can be discussed and addressed.

SECTION 7: PRINCIPLES OF THE REFERRAL NETWORK

This section should describe the core principles agreed to by all organizations in the referral network. This might include:

Commitment to Collaboration

All network member organizations are expected to sign an MOU with the RC as commitment to collaboration. All network member organizations shall participate fully in the network activities and are required to meet and adhere to the network principles, standard operating procedures and other guidelines. Effective communication between referral network members is highly encouraged. Network member organizations should be willing to provide support and logistics to the network

Honoring Referrals

All network member organizations must agree to honor the referrals from other network members, attending to clients promptly and providing feedback to the referring institution. In rare cases where a referral cannot be completed, the receiving organization should work with the client and the RC to identify an alternative service that meets the client's needs.

Maintaining Confidentiality and Anonymity

The referral system will collect data from clients. This data is critical and will inform our understanding about how the system is working and to monitor the effectiveness and appropriateness of the referrals being made to different services. Some of the data is sensitive. All network members are expected to keep all client level data confidential and maintain client confidentiality.

Quality Service Provision

All network member organizations shall provide quality services to clients.

Annex IX Memorandum of Understanding (MOU)

It is important that MOUs be developed on a case-by-case basis, taking into consideration the referral network context, organizational structures, and the roles and responsibilities of the organizations entering into the agreement. Organizations are also recommended to utilize any existing organizational MOU templates, if available. If creating a new MOU, the details below are the suggested elements which to include. This list is not exhaustive, and should be adapted and amended as required.

- An introductory heading or paragraph which lists the names and addresses of the organizations entering into the agreement, and the period of time in which the agreement will be in effect.
- ***Purpose and Objectives***, which lay out the rational for the MOU, and the goal and objectives of the collaboration e.g. "The purpose of this MOU is to describe the collaboration between Organization A. and Organization B. involved in the Referral Network. The organizations will work together to…"
- ***Period of Collaboration***, which states the time period covered by the MOU.
- ***Areas of Collaboration***, listing the activities for which both organizations have responsibility, or which they will be completing jointly.
- ***Roles and Responsibilities*** of each party to the MOU, detailing the specific activities assigned to each organization under the MOU.
- ***Resolution of Disputes*** to document how disagreements between organizations will be addressed and settled.
- ***Additional Provisions*** or information to be contained under the MOU.
- ***Notices***, which clarifies the primary point of contact for each organization, who should be contacted in the case of any changes, extensions, termination, questions, and other administrative matters related to the MOU.
- ***Signatures*** of the primary points of contact for each organization, affirming their agreement to the terms of the MOU.

All organizations who are party to the MOU should retain an original counter-signed copy of the MOU for their records.

Annex X Counseling Guidance

Counseling sessions should be carried out by network members before they complete the **client referral form**. These sessions should use some key probing questions and the **referral directory** to narrow down the range of options that is most appropriate for the client.

Counseling based on key probing questions AND on the services available in the catchment area can help ensure that the referrals take into consideration key factors and barriers that affect clients' ability to act on referrals made. These counseling sessions will be somewhat context specific, but all should address important issues such as those listed below before a referral(s) is made:

The following questions can help to classify the household and what type of service might be most beneficial:

1) Do you have employment? If so, what kind/profession?
2) Are there other source(s) of income to the household?
3) How many people live in your household?
4) Are all school aged children in your household currently attending school?
5) What is the main type of energy that your household uses for cooking?

The following questions can help to determine which specific services and/or service providers would be a good fit for the client/household:

6) What is your area of residence?
7) Do you have an interest in a particular service?
8) What relevant skills, experience and/or education do you have?
9) How far are you able to travel to access services? How frequently?
10) Are there government grants that the client is eligible for and can be linked to?

Once a service has been selected confirm the following:

11) Does the client meet eligibility criteria for certain services?
12) Is the client willing and able to commit time to participate?
    - Will time spent on an activity/service detract from other productive activities (child care, other employment, etc.) to the extent that it will have a negative impact on the household?
13) Can the client meet the physical demands of various services/activities?
14) Can the client pay fees towards receipt of a service (if fees are required)?

What possible barriers did the client state that might prevent them from acting on the referral(s) made *(check all that apply)?*

☐ Time
☐ Distance
☐ Money
☐Family responsibilities
☐Low interest in available service(s)
☐ None
☐ Other (specify) _____

Annex XI Quality Improvement (QI) Guidance

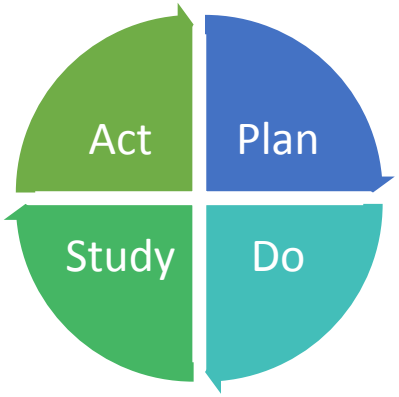
QI is an approach to the analysis of performance, and systematic efforts to improve it. QI principles can be very effective in helping to improve the operation of referral networks. The LIFT project has implemented QI activities within several of the networks which it supports to assist referral network members in identifying and implementing procedural changes to improve their network's operations and overall performance. A detailed QI Practitioner Guide will be prepared and released by LIFT during FY2017. The information below is a brief primer to the material which will be included in this guide.

QI Overview

The QI Model has three fundamental questions:

- **The Aims**: What are we trying to accomplish? How good do we want the system to be and by when? What are our targets?
- **The Measures**: How will we be able to tell whether a change or series of changes lead to an improvement?
- **The Changes:** How will we know which specific change or series of changes to make to our system to result in the desired improvement?

The ***Plan Do Study Act (PDSA) Cycle*** can be a useful tool in thinking about and implementing QI activities.



In the ***Plan*** phase, it is important to think about what you want to improve, what change(s) you should make, and what outcome you expect.

During the ***Do*** phase, you carry out the process changes you had planned, and document outcomes of this change.

The ***Study*** phase involves evaluating the extent to which the changes made led to the desired process improvements. At this point you should also determine whether any alterations to your plan need to be made in order to achieve the overall QI goal.

The ***Act*** phase allows you to decide how to respond to the results of the earlier phases. Will you adopt the process changes on a larger scale? Adapt the process changes based on results? Or abandon the change entirely and try a different strategy to achieve the desired goal?

QI Core Components

There are three core components of QI activities, which include the following:

QI Aims

QI aims are the targets or goals of the QI activity. They are a clear statement of what you are trying to achieve, by making specific changes. QI aims must also be important to individuals involved in the referral network, or else people will not expend the effort required to work toward the aim and the activity will be unsuccessful.

Good QI aims should be SMART:

Specific

Measurable

Achievable

Relevant

Time-bound

For example, a SMART QI aim might be: By June 2017, the % of completed referrals will increase to 100%, from the June 2016 baseline of 65%.

QI Teams

QI is a collaborative effort and QI teams are groups that take ownership of, and work on, specific QI efforts. QI teams should be comprised of diverse individuals who can each provide an informed perspective on the QI effort, with one member designated as the "champion" or team leader. This individual is crucial in ensuring that the QI team maintains focus and commitment to implementing their process improvement(s).

QI teams should meet regularly to review performance data, plan how best to work together with other QI team members to help the wider network achieve their QI aim, and delegate specific responsibilities to one another when implementing the agreed plan. Teams might consider using the discussion points below for each QI team meeting to discuss progress on its QI aim(s) and the strengths and weaknesses of the change package(s):

What part(s) of the change package are working well?

Is there a way those changes can be improved further?

What part(s) of the change package are not working well?

Why are these changes not working?

How can they be improved to help reach the aim?

Are there other gaps or weaknesses in the referral processes we should address to reach our QI aim that are not in the current change package?

If yes, discuss new change(s) that should be added to the change package. These gaps and suggested changes should be proposed to the referral network at the next monthly referral network meeting.

QI Change Packages

We may need to make several changes in order to achieve our QI aim and see actual improvement. This set of changes is also known as a "change package". Some basic techniques to identify possible changes to include in the larger change package may be:

- Critical thinking – use flow charts and fishbone diagrams to "visualize" the system
- Creative thinking – Put yourself in your client's shoes! What would you want to see done differently?
- Benchmarking – Identify and assess best practices from a similar system somewhere else

Some typical "change concepts" the you might consider for your change packages are:

- Eliminating waste – do you have things that don't add value?
- Streamlining workflows – are there bottlenecks or unnecessary process loops within your network?
- Optimizing inventory – are resources disorganized?
- Adapting work environments – does the existing work culture impede change?
- Managing time – can tasks be distributed more efficiently?
- Checking for errors – are there ways you could implement quality control to reduce the frequency of mistakes?

Data Collection

Data collection is critical to test whether a change successfully improves your system – QI will not be effective if you do not know whether the changes you are making are leading to the desired outcomes!

There are three types of QI measures:

- Outcome – Where are we going? Are the changes we are testing actually resulting in improvement?
- Process – Are we doing the right things to get there?
- Balancing – Are changes we've made to one part of our system causing problems in another part of the system?

However, it is not enough to simply collect data. The data must then be analyzed and discussed within the QI teams and the larger referral network so that everyone understands the rational for making changes, the effect the changes are having, and what future developments need to be made. Run charts can be an effective way to present this data so that progress can be visualized against the overall target.

Annex XII Illustrative Referral Process and Outcome Indicators

In general LIFT tracks process indicators monthly whereas outcome indicators require supplemental data collection)

Process		Outcome	
Referral Coordination	Referral Activities (disaggregated by sex and age, if necessary)	RN Outcomes	Client Outcomes (disaggregated by sex and age, if necessary)
Numbers of meetings held by the network	Number of clients referred	% of RN members benefiting from trainings	Number of ARV doses/Rx missed or gone uncollected since initiating treatment
Number of participants in the meeting (disaggregated by sex)	Number of HIV+ clients referred	% of RN members with increased demand for services as a result of RN membership	Number of clients referred to a health facility who test HIV+
Number of organizations participating in the meeting (disaggregated by type of service provider)	Number OVC or OVC caregivers referred	% of RN members completing forms correctly and completely	Number of clients who test HIV+ and initiate ART after being referred to a facility
Number of trainings held by the network and names	Number RN members making and/or receiving referrals for clients	% of RN members submitting forms on-time to RC for data aggregation	Number of previously LTFU clients reengaged in clinical care
Number of participants trained (disaggregated by sex)	Number of clients receiving services		Number of clients with improved food security after referral participation
	Number of HIV+ clients receiving services		Number of clients with reduced poverty/vulnerability after referral participation
	Number OVC or OVC caregivers receiving services		
	% of clients referred who complete their referral (disaggregated by type of client: OVC, PLHIV, M/F)		

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