Improving Health and Social Outcomes for People Living with HIV:
Clinic-to-Community Referral Systems

STATE OF THE PRACTICE: ESSENTIAL ELEMENTS OF EFFECTIVE REFERRAL SYSTEMS

While referral systems have existed in the health sector for some time, there has been limited evaluation of bi-directional systems that link patients between health clinics and a range of community-based support, such as home-based care, food aid, livelihood opportunities, or psychosocial support. A thorough review of referral system literature and practices established the 'essential elements' that need to be in place for referral systems to be operationally effective and optimize outcomes for clients and their households:[3]

1. A **group of organizations** that, in the aggregate, provide comprehensive services to meet the needs of people living with HIV, their caregivers, and their families within a defined geographic area
2. A **lead unit or organization** that coordinates and oversees the functionality of the whole referral network
3. **Periodic meetings** of network providers
4. Designated **referral persons** at each organization in the network
5. A **directory of services** and organizations within a defined catchment area
6. A **standardized referral form** used by all network members
7. A **feedback loop** to track referral completion and follow up with clients
8. A **documentation and data management system** for referrals

More information on these essential elements can be found in our report, *Designing Effective Clinic-to-Community Referral Systems*, available on our website: http://theliftproject.org/designing-effective-clinic-community-referral-systems/

INTRODUCTION

Over the last decade, exceptional progress has been made globally in the provision of HIV care and life-saving antiretroviral treatment (ART). Due to these advances, even in developing countries HIV has transitioned from an acute to a chronic illness—a transition which impacts the health, cultural and economic responses to the disease and requires ongoing care and support to maintain health gains and improve the quality of life for people living with HIV. To support these long-term needs, linkage, engagement, and retention (LER) in care are playing an increasingly critical role in improving client health outcomes. PEPFAR's LER Strategy highlights the need for effective linkages between services along the continuum of HIV service delivery and seamless transitions between facility- and community-based care and support platforms.[1] Through the Treatment 2.0 Framework, WHO and UNAIDS underscore the need for clinical HIV services to better integrate with and link to diverse community services in order to address barriers to retention in care, such as poverty and stigma—resulting in increased access, adherence, and retention in care for people living with HIV.[2]

The Livelihoods and Food Security Technical Assistance II (LIFT II) project connects clients accessing clinical HIV and nutrition services to a continuum of care and support, focusing on links to economic strengthening, livelihood, and food security opportunities that can improve their overall health and social outcomes. The creation of a viable continuum of HIV care requires that functional, systematic referrals are established between health facilities and community-based services. LIFT II supports government systems, health facilities, and community-based service providers to establish effective clinic-to-community referral systems that utilize existing services to improve LER, address underlying causes of illness and malnutrition, and strengthen client tracking and follow up.

Local Network Activity: At a LIFT II stakeholder meeting in Namibia, participants used string to make connections to represent that their organizations had a working relationship, such as sharing clients, joint programming, shared funding, and/or ongoing collaboration. This activity demonstrated the current state of the network and the existing connections to build on. This led to a discussion on the wide variation in type and quality of the organizational relationships represented by the strings.

[1]PEPFAR FY 2014 Country Operational Plan (COP) Guidance. (2013). http://www.pepfar.gov/documents/organization/217765.pdf

[2]Stricker, S.M., Fox, K.A., Baggaley, R., Negussie, E., de Pee, S., Grede, N., & Bloem, M. (2013). Retention in Care and Adherence to ART are Critical Elements of HIV Care Interventions. AIDS and Behavior. http://link.springer.com/article/10.1007%2Fs10461-013-0598-6

[3]Designing Effective Clinic-to-Community Referral Systems: An Analysis of Best Practices to Inform LIFT Technical Assistance. (2013). FHI 360. http://theliftproject.org/wp-content/uploads/2013/12/Referral-Literature-Review-and-Technical-Brief-FINAL.pdf

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REFERRAL TOOLKITS

LIFT II works with networks to develop customized referral toolkits with all the essential materials, tools and processes to support network members in the implementation of a referral system:

- → Referral network operations manuals and standard operating procedures
- → Local referral service directories
- → Poverty and food security 'diagnostic' tools
- → Referral forms and templates
- → Referral feedback mechanisms for client tracking and follow up
- → Databases and data tracking systems
- → Memoranda of understanding (MOUs)

SUSTAINABILITY OF REFERRAL NETWORKS

An essential part of donor-supported programming is planning for this transition by building sustainable approaches and exit strategies into project design and implementation from the very beginning. LIFT II utilizes a sustainability framework that outlines four components of sustainability:

1. **Technical**
2. **Programmatic**
3. **Social**
4. **Financial**

The framework supports the design of sustainable referral systems that can be transitioned to local management beyond LIFT II support.[4] More information on LIFT II's approach to optimizing operational sustainability can be found in our report, *Optimizing Sustainability of Referral Networks*, available online at: http://theliftproject.org/optimizing-sustainability/

[4] Torpey K, Mwenda L, Thompson C, Wamuwi E, van Damme W. From project aid to sustainable HIV services: a case study from Zambia. Journal of the International AIDS Society 2010, 13:19. http://www.jiasociety.org/index.php/jias/article/view/17505

LIFT II APPROACH TO STRENGTHENING CLINIC-TO-COMMUNITY REFERRAL SYSTEMS

Given the multi-sectoral nature of the referral networks that LIFT II supports, many of the institutions within these networks do not regularly interact with one another in other contexts, may not have prior experience with referrals, and often do not have the technical understanding of the other sectors and services available within the network in order to make informed referrals. These factors amplify the importance of effective and standardized tools, processes, and systems. LIFT II follows the steps below to facilitate the creation of locally led and owned referral networks composed of health facility, community-based, and government service providers:

1. Map service providers in the area, understand existing services and related eligibility criteria
2. Bring the identified service providers together to define collective priorities, action steps, and build a shared identity
3. Assist in establishing referral standards and creating effective and uniform referral tools (see sidebar) and processes (strengthening existing systems and platforms, when needed)
4. Provide training, capacity building, and mentoring in the effective implementation of referral tools, standards, and processes, and in the use of referral data for decision making

TRACKING REFERRALS AND CLIENT OUTCOMES

Effective referral systems are able to track clients through the referral process to ensure they receive needed services. Tracking client access to services as well as client or household level outcomes over time can also demonstrate the effectiveness of the referral system in improving desired results such as adherence and retention in care. LIFT II is working in six countries to support the design of both mobile and paper-based referral and data management systems, which are set up to simplify the process of making referrals to existing services provided by government, civil society, and the private sector. In some settings, LIFT II supports an 'accelerated package' whereby clients are referred to either group savings or food aid services and the referral tracking and data collection burden is minimized.

In other settings, LIFT II supports a 'standard of care package' which includes an assessment of household poverty and food security to inform referrals to a wide range of possible services. In this context, LIFT II utilizes a quasi-case management approach whereby clients are followed-up to encourage uptake of referred services and track referral completion, as well as to measure outcomes over time, including household level changes in poverty and food security scores, and client level outcomes such as adherence to ART and retention in health care.

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For more information on LIFT II, please visit our website: www.theliftproject.org

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