Lessons Learned in the Implementation of Referrals in Lesotho

LEARNING BRIEF
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DISCLAIMER

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INTRODUCTION

This document highlights the lessons learned in establishing multi-sector referral processes in Lesotho by Building Local Capacity for Delivery of HIV Services in Southern Africa (BLC) and Livelihoods and Food Security Technical Assistance II (LIFT).\(^1\) In 2012, these two projects, both funded by the United States Agency for International Development (USAID) under the President’s Emergency Plan for AIDS Relief (PEPFAR), recognized their potential synergies and began to evaluate opportunities to integrate Nutrition Assessment, Counseling and Support (NACS) into HIV care and treatment services in Lesotho.

Initial joint activities began in 2013 when LIFT delivered a one-day household economic strengthening (HES) training to 25 community-based organizations (CBOs) in these districts, introducing them to economic strengthening, livelihoods and food security (ES/L/FS) concepts and opportunities. The training prompted the Ministry of Social Development (MOSD) to request similar HES training for a cadre of 15 senior leaders within the ministry, which was organized by BLC and delivered by LIFT that same year. Since then, LIFT has worked with BLC to promote improved health outcomes through HES services in response to the changing HIV and AIDS landscape. In light of the PEPFAR 3.0 strategy,\(^2\) LIFT has paid particular attention to building the capacity of local service providers and facilitating clinic-to-community referrals for people living with HIV and AIDS (PLHIV) in two of the three Partnership for HIV-Free Survival (PHFS) phase one districts—Thaba-Tseka and Mohale’s Hoek—in order to contribute to the growing evidence base on how clinic-to-community linkages can improve client adherence to antiretroviral therapy (ART) and retention in care.\(^3\)

The LIFT-BLC partnership has directly supported health and ES/L/FS service providers, community councils and the leadership of the MOSD and Ministry of Health (MOH) in Lesotho to better integrate referrals into the continuum of care for PLHIV. Focusing on issues associated with HIV care and treatment and the needs of orphans and vulnerable children (OVC), LIFT and BLC have explored the relationship between health interventions and ES/L/FS assistance.

BACKGROUND

In Lesotho, LIFT has worked with BLC to establish two referral networks and provide ongoing technical support for two distinct clinic-to-community referral approaches utilized at both sites:

1. **A Standard of Care** approach which brings together service providers from multiple sectors (health, agriculture, finance, etc.) and trains them to use a standardized set of tools as part of a formal referral network, with the end goal of improved collaboration between and among members in order to best meet the full spectrum of client needs.

2. An accelerated **Clinic-to-VSLA** approach places emphasis on quick and effective brokering of referrals from health facilities to village savings and loan associations (VSLAs), utilizing simplified...
referral tools (mostly paper-based) and, to the greatest extent possible, integrating this process within existing systems and procedures.

KEY LEARNING AND RECOMMENDATIONS

Considering the differences between the two approaches utilized in Lesotho, and recognizing the significance of context in any program implementation, LIFT and BLC have identified some key considerations to inform future work in building capacity and formally linking existing service providers from different sectors.

1. SYSTEMATIZE AND CUSTOMIZE LINKAGES BETWEEN HEALTH AND ES/L/FS

As one of the initial steps to develop an effective and efficient referral system linking HIV care and treatment with ES/L/FS services offered in communities, LIFT, in conjunction with BLC, conducted an organizational network analysis (ONA) in March 2014 to understand the extent of existing collaboration between service providers within each district. The ONA supported stakeholder identification by illustrating relationships between service providers across three metrics:

(1) **funding** sent or received,
(2) **clients** sent or received, and
(3) **information/resources** sent or received

LIFT and BLC used a simple survey loaded on mobile devices to collect this information from organizations at each site. The findings were then used to create data visualizations, such as the sociogram to the right which shows the flow of clients received between members of the Thaba-Tseka referral network. As this example shows, many connections existed among service providers in the sample, yet the role of each circle varied—some received clients (or in other cases, information or funding) from many more network members than they sent clients to (lines with arrowheads pointing towards recipient),

This sociogram is from Thaba-Tseka shows the clients received. Each circle represents a service provider that responded to the ONA survey, and the lines between circles illustrate the relationship between the service providers (arrowheads point towards the recipient). The red circles represent NACS sites, the turquoise circles are organizations that have a direct relationship with the NACS sites, and the gray circles are a step removed from NACS sites. Engaging these gray organizations through referrals yields the greatest benefit to NACS clients by expanding the network of services available to them.
whereas others sent clients more than they received. Additionally, some members may have been very actively collaborative with multiple external entities, while others may only have engaged one or two service providers as part of their normal routine. All in all, sociograms can be useful tools to communicate the power of collective action and coordination to address the many needs of community members.

After ONA completion and analysis of the results, LIFT organized formal stakeholder meetings in each district to discuss prospective referral network development with ONA participants, as well as a variety of stakeholders from the Ministry of Education and Training (MOET), MOSD, MOH, Ministry of Forestry and Land Reclamation (MFL), national and international nonprofit service providers and OVC care and support groups.

Through this process, stakeholders came to understand that although referrals were currently being made among the represented organizations, they were not systematic. It was noted that many of the referrals taking place in their districts were ad hoc and that there was a lack of communication and coordination of effort among service providers. In addition, most referrals were not based on an understanding of client needs nor were referrals tracked to determine whether clients were able to access the service or whether they were provided that service. An acute need existed to connect health and ES/L/FS service providers through a systematic bi-directional referral network.

2. IDENTIFY KEY LOCAL CHANGE AGENTS TO FACILITATE, SCALE AND SUSTAIN REFERRALS

In Lesotho, LIFT and BLC maximized stakeholder meetings to stoke interest in formalizing locally-led, community-owned referral networks. Bearing in mind that there would be opportunities to collectively set priorities and develop plans once a core group of service providers was onboard, initial meetings served as a venue for participants to:

(1) learn more about the service providers working in the districts and the services offered,
(2) gain a better understanding of the benefits of networking and bi-directional referrals for both service providers and clients,
(3) develop a collective identity, and
(4) formalize action plans to build momentum that could be carried through referral system launch.

In Mohale’s Hoek and Thaba-Tseka districts, service providers nominated lead organizations to serve as the coordinators of the networks. These lead organizations were well respected and known in the district, partly due to prior collaboration with BLC. With technical assistance (TA) from LIFT and BLC, these lead organizations were responsible for encouraging active participation and driving forward priority activities identified by the referral network members. In addition to the lead organizations, policymakers and practitioners with relevant health, ES/L/FS, OVC and home-based care experience were also identified and engaged to support the nascent networks and promote institutionalization of the referral processes.

3. BUILD SUSTAINABLE MOMENTUM FOR CHANGE

After initial stakeholder engagement and the selection of a lead organization for each network, it was clear that commitment to the referral network concept was strong among a wide array of service providers in both Mohale’s Hoek and Thaba-Tseka; however, these stakeholders, along with LIFT and BLC, had to be patient and flexible, as political instability delayed referral system launches.
While originally slated for 2014, it was not until May and June of 2015 that community sensitization campaigns were held to raise awareness of and formally launch the referral systems in Mohale’s Hoek and Thaba-Tseka, respectively. The sensitization campaigns included promotional segments on radio talk shows, community dramas to illustrate the referral process, and visits to local high schools to build awareness. Local authorities were invited to speak to their constituents, and they commended the networks for coming together to help address the needs of vulnerable people in Lesotho.

Over time, LIFT and BLC have realized that effective management of referrals requires continued engagement and awareness raising, regular consultations and evidence-based recommendations. Acquiring, adapting and applying referral knowledge is a critical part of the learning process—this is why recurring interaction between referral stakeholders is essential, particularly given the cross-sector nature of the relationships within the district-wide referral networks. In light of this, LIFT and BLC encouraged referral network members to hold monthly meetings coordinated by the lead organizations. While attendance has varied between networks, monthly meetings provide a unique forum for service providers to gather to share challenges and successes, to build their capacity on use of tools and following of processes, and—with a measure of LIFT TA—to review network data, refine tools and provide feedback. Peer-to-peer knowledge exchange between network partners is critical to ensure the sustainability of these referral networks.

Future capacity development should consider change management, the creation of an enabling environment, and coalition building as key building blocks for success. Referral system roll-out should be sequenced to the policymaking process, to the extent possible, and policymakers must be kept aware of the intrinsic value referral systems add to community service delivery so that they can be locally sustained. It is critical that multiple people (i.e., at least two individuals) within each network member service provider are conversant on the purpose of the network, how stakeholders and clients interact within the referral system, and the relevant tools involved in collecting and sharing client data when facilitating referrals. LIFT has learned that while it is important for senior managers or clinicians to be involved in the network to lend legitimacy and help hold staff accountable for referral commitments, the only way clients in need will be effectively reached via referral is by training a cadre of focal persons who have a greater degree of regular interaction with clients, as well as the ability to responsibly incorporate this referral work into their normal routine.
4. UNDERSTAND AND CRITICALLY ANALYZE RESULTS

Often, referral network results are conceptualized in terms of outputs or milestones (e.g., number of service providers engaged, number of referrals made, percent of referrals completed, etc.). These serve an important monitoring function for assessing whether a referral network is being implemented as planned or whether adjustments are needed to achieve objectives. Intensive support and capacity development is needed over time to effectively monitor referral results, strengthen stakeholder ownership of the networks, promote accountability, institutionalize referral processes, enhance efficiencies in referral services and improve network effectiveness.

LIFT has provided TA to lead organizations around data management and reporting, specifically through the creation of Excel-based dashboards to assist lead organizations in compiling and analyzing raw referral network data of interest: referrals made, referrals completed, percentages of referrals completed, HIV+ individuals reached, food security of client households, and poverty of client households. These data have been used to encourage discussion during monthly network meetings for purposes of quality improvement (QI) and to target follow-up by the lead organizations to individual network members who are facing challenges in effectively implementing referrals. Active stakeholder participation in referral activities as well as enhancement of skills and abilities are desirable and warrant tracking and discussion.

KEY LESSONS FROM LESOTHO

The LIFT-BLC partnership in Lesotho has informed LIFT programming at sites in the Democratic Republic of the Congo (DRC), Tanzania and Zambia. In addition, part of LIFT’s global mandate is to contribute to the evidence base on linkage, engagement and retention in HIV care through referrals between clinical and community services. As such, LIFT has worked with BLC to utilize two distinct approaches to understand how resources can be maximized to assist service providers in connecting HIV+ clients to beneficial health, ES/L/FS and social support.

The LIFT-BLC collaboration has highlighted several elements of key importance:

ADVOCACY AND AWARENESS RAISING: Prior to networks launching, it is critical to build-in lead time for referral partners to widely disseminate information about the purpose and perceived benefits of referral participation by clients. These messages must also be shared with local and district government, as they can be valuable champions of the referral work. Awareness raising should not stop after system launch—clients need avenues to understand the purpose of referrals and any expectations or eligibility criteria which must be met in order to receive services. As a part of the referral network launch process, LIFT and BLC supported network partners to implement district-level awareness raising activities through radio, community dramas and events that enhanced the understanding of referrals among local populations.

BUILDING OWNERSHIP: For the sake of sustainability, it is critical to work closely with referral partners and local government to embed referral activities within day-to-day operations of service providers. Helping stakeholders understand that the whole is far stronger than any individual member is vital – no one service provider can effectively

“Lesotho, with its own resources and support from development partners, has made notable progress in responding to the plight of vulnerable orphans and children. These collaborations should be sustained, with collective, long-term investments and partnerships.”

- Her Majesty Queen ‘M’e Masenate Mohato Seeiso
meet all the needs of vulnerable clients. Acting together, referral network partners can much more forcefully and holistically address client needs. The cross-sectoral participation of local clinics, CBOs and ES/L/FS service providers in referral networks has been recognized as a critical response to enhancing the efficiency and cost-effectiveness of in-country programming to address HES and ART adherence and retention in Lesotho. Through their partnership, LIFT and BLC developed innovative clinic-to-community referral networks that engaged approximately 45 local CBOs across the continuum of care to help coordinate service delivery, data collection and reporting processes as well as augment organizational capacity.

PROMOTING LOCAL SERVICE DELIVERY AND INTEGRATION: LIFT and BLC TA was provided simultaneously at the district and community levels. Each level has distinct but mutually reinforcing responsibilities, and the LIFT-BLC partnership’s approach to engaging at these levels has supported greater service integration between social protection, health referrals and HES within Lesotho’s governing structure. This integration should be sought in order to promote increased access to beneficial services for vulnerable clients. It can serve as a platform for understanding gaps in service coverage and how best to prioritize limited resources.

INSTITUTIONALIZING REFERRAL NETWORKS: Referral networks may be comprised of a broad range of public, private and nonprofit participants. LIFT and BLC engaged with networks to instill a clear understanding of member roles and to ensure that they were prepared to commit time and energy to implement a referral process that systematically addresses client health, economic and social needs. Formally documented commitments should be made to referral partners, proper utilization of tools and following a standardized referral process.

SIMPLIFYING TOOLS AND PROCESSES: Referral systems and tools do not need to be complex to demonstrate benefits for vulnerable populations, such as PLHIV. Driven by local lead organizations, the clinic-to-VSLA approach connected interested PLHIV clients at health facilities to VSLAs in Mohale’s Hoek and Thaba-Tseka. The four facilities have successfully connected clients to more than 60 VSLAs, many of which were created following the HES training LIFT provided local partners in 2013. These VSLAs were approached with an opportunity and were willing to amend their by-laws to integrate PLHIV as contributing members of groups.

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<tr>
<th>LIFT/BLC Reach in Lesotho</th>
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<tr>
<td>Referral Focus Districts</td>
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<tr>
<td>Service Providers Reached</td>
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<tr>
<td>NACS Facilities Supported</td>
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<td>Total Clients Referred</td>
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<td>Total Clients Completing Referrals</td>
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<td>Referral Completion Rate</td>
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CONCLUSION

LIFT and BLC’s collaborative efforts in Lesotho around the facilitation of clinic-to-community linkages has not only expanded awareness of and access to services available to health clients, particularly PLHIV and OVC, but also generated considerable learning to share with fellow development practitioners. Referral tools and processes were designed and then adapted based on implementation feedback from local stakeholders with an eye toward increasing efficiency and contextual relevance. This has reduced the level of effort required of referral network participants and helped integrate tools and processes within existing systems, protocols and procedures in clinical and community settings.

Through two clinic-to-community referral approaches, LIFT, BLC and local partners have sought to (1) improve access to ES/L/FS services for PLHIV, (2) strengthen community services as a component of the continuum of care, (3) increase policy influence and advocacy for clinic to community linkages for PLHIV, and (4) increase adherence to ART and retention in clinical care and treatment for PLHIV through referrals and service linkages.

Collaboration between programs like LIFT and BLC can stimulate community mobilization to implement and scale up sustainable referral systems that provide health, economic and social support and that aim to improve HIV care treatment outcomes. The learning gleaned through LIFT and BLC TA in Lesotho can also be applied beyond the projects’ focus areas of PLHIV and OVC to inform program design and implementation of interventions seeking to improve maternal and child health, nutrition and more.