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LIVELIHOODS & FOOD SECURITY  
TECHNICAL ASSISTANCE



# Lessons Learned From Namibia's Clinic-to-Community Referral Networks

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DECEMBER 2014

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## ACRONYMS AND ABBREVIATIONS

ART	Antiretroviral Therapy
CACOC	Constituency AIDS Coordinating Committees
CO	Constituency Office
ES/L/FS	Economic Strengthening, Livelihoods and Food Security
GRN	Government of the Republic of Namibia
HF	Health Facility
LIFT	Livelihoods and Food Security Technical Assistance
MOHSS	Ministry of Health and Social Services
NACS	Nutrition Assessment, Counseling and Support
OHA	USAID Office of HIV and AIDS
ONA	Organizational Network Analysis
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
SG	Support Group
SP	Service Provider
TA	Technical Assistance
USAID	United States Agency for International Development

## INTRODUCTION

### PROJECT BACKGROUND

The five-year Livelihoods and Food Security Technical Assistance II (LIFT) project was awarded to FHI 360 in August 2013. In Namibia and in other supported countries, LIFT II aims to strengthen and expand activities initiated under LIFT I (implemented by FHI 360 from 2009-2013) by systematically linking nutrition assessment, counseling and support (NACS) and other HIV-affected clients with relevant community services in order to improve health and nutrition outcomes, including adherence to treatment and retention in care. LIFT supports Government of the Republic of Namibia (GRN) systems, health facilities as well as community-based service providers (SPs) to establish referral networks that utilize existing services to build the continuum of care for people living with HIV (PLHIV) and other vulnerable households and enhance clinic-to-community linkages. Within the network, LIFT works through existing GRN systems to establish linkages to economic strengthening services along with health/nutrition and other supportive services.

Despite progress made in the provision of antiretroviral therapy (ART) and NACS services, retention in care is a challenge where approximately 50% of clients who enroll in NACS are lost to follow up in addition to a significant number of clients relapsing into clinical treatment after discharge from NACS. The lack of awareness of existing community services, as well as the lack of a functional, systematic clinic-to-community referral system to link HIV affected and NACS clients to complementary care for the maintenance of health gains were noted as key contributors to these challenges by Ministry of Health and Social Services (MOHSS).

Since October 2013, the project has sought to address this gap through the development of formal linkage networks. Through a series of key activities including service mapping, stakeholder coordination, tools development and adaptation, training and capacity building, LIFT has developed an adaptable referral resource kit and supported the establishment and launch of clinic-to-community referral networks in Katutura (Khomas Region) and Engela (Oshana Region).

Working with and through a variety of local stakeholders from multiple sectors, these referral networks were launched between June and July 2014, and they are systematically linking HIV-affected and malnourished clients to appropriate economic strengthening, livelihoods and food security (ES/L/FS) services based on their economic and food security status and needs. Using MOHSS tools and platforms, supplemented with additional referral resources, the networks are able to track clients through the referral process, collect and report on data that can be used to strengthen the network, and capture key pieces of information to measure changes in clients' health and vulnerability over time. Managed with support of constituency offices (COs) and health facilities (HFs), these referral networks are designed to be sustained with local resources.

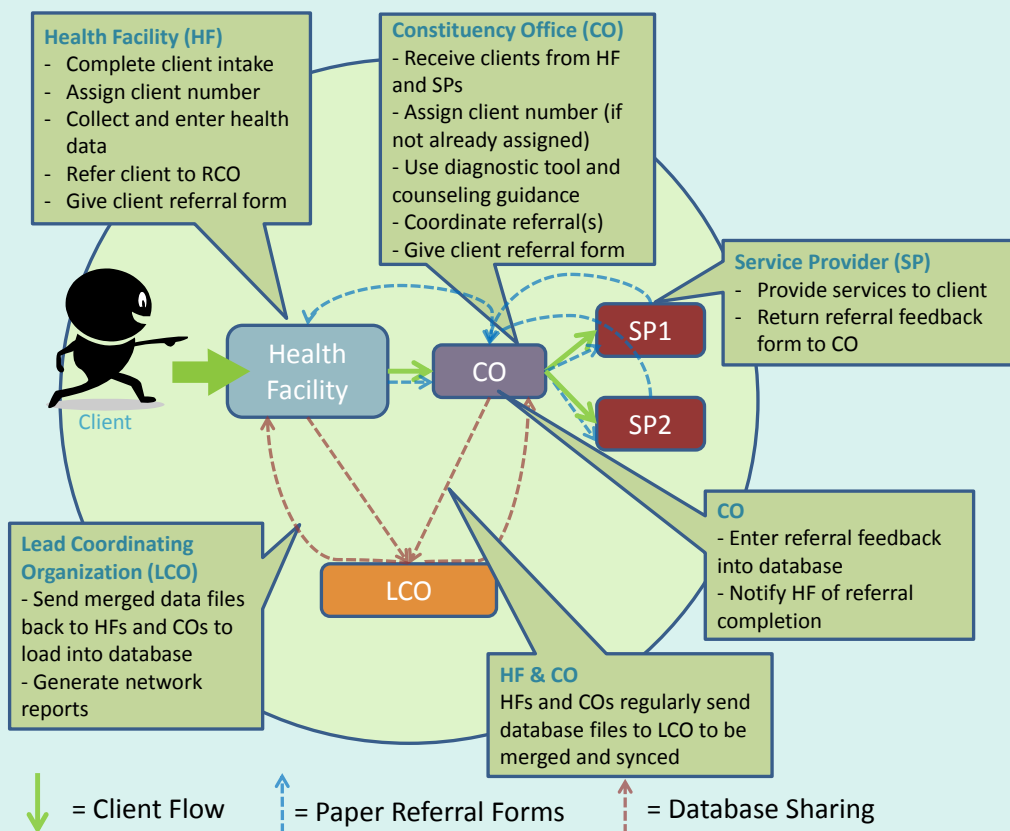
### PURPOSE OF ACTIVITY

To learn from the mission and core investments in Namibia to date, in December 2014, LIFT undertook an assessment of the networks in order to distill lessons learned related to both the process used by LIFT in establishing the networks and the functionality of the system that has been put in place after 4-6 months of implementation. Namibia has been among the first tier of countries in which LIFT has supported the development of these clinic-community referral networks as well as the first country in

which the project is exiting. The assessment was designed to provide valuable lessons and information for USAID/Namibia, MOHSS, LIFT and the broader development community to understand how to establish effective and sustainable referral networks.

### Namibia's Two-Step Referrals Process

In Namibia, LIFT worked with stakeholders to design a two-step client referral process—directing clients through COs as the main hub in the system and the coordinating entity to facilitate referrals to services appropriate for the client's needs. The system was designed in this way for two main purposes—to reduce the burden on HFs and allow them to focus on provision of health services as well as to take advantage of the core coordinating function of COs. The graphic below provides an overview of the process as well as the roles of the different stakeholders.



## METHODOLOGY AND APPROACH

### ASSESSMENT APPROACH

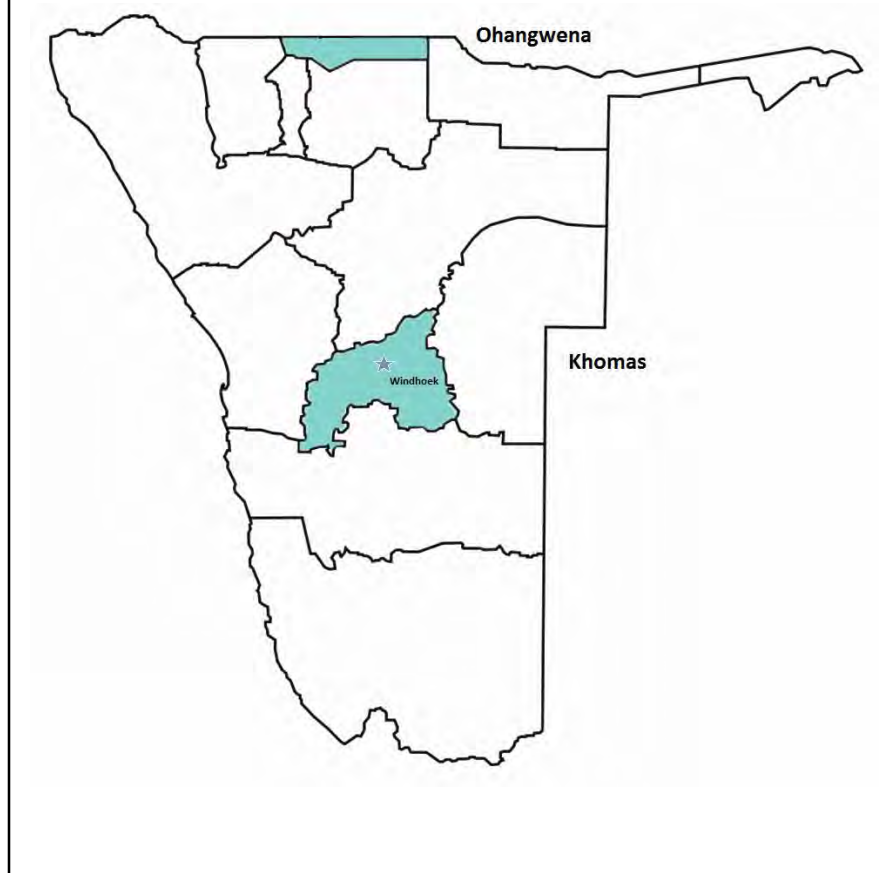
As Namibia represents the first country in which LIFT has implemented its full cycle of support activities, it was critical to implement this activity prior to ending activities in the country. It was most effective to conduct the assessment as close to the project's end in Namibia as possible, allowing for the networks to actively make referrals for several months in order to understand the systems' long-term functionality and gather information on outcomes of interest. In preparation for this activity, LIFT developed a package for review by FHI 360's internal institutional review board, which included a concept note, non-research determination form, verbal consent forms and a detailed interview guide along with tailored guides for each of the four main stakeholder groups slated for interview—a full description of these groups is found in the following Participant Sample section. This package was submitted on November 19, 2014 and returned with a non-research determination on November 25, 2014.

The assessment aimed to gather information and perceptions in the following areas:

1. The **process** used by LIFT to support local organizations to establish the referral networks.  
*Do stakeholders have an appropriate understanding of LIFT's purpose and role? Were the steps taken through the TA process effective in establishing locally-owned, stakeholder-led referral networks?*
2. The **functionality and effectiveness** of the system to date.  
*In what ways are the referral systems working well? What are areas of challenge that can be improved?*
3. Any **changes** seen or experienced as a result of the referral network.  
*What measurable or perceived changes have resulted from the institutionalization of the referral networks and LIFT support?*

The assessment activity was led by LIFT's HQ-based Knowledge Management Officer, who has also provided operational backstopping support for Namibia since late 2012. The KM Officer was supported in country by LIFT's Namibia Technical Specialist who has led the project's activities in country since August 2013. The team traveled to Oshana from November 30 to December 6, 2014 to conduct interviews with members of the Engela Referral Network and then to Khomas from December 5 to 12, 2014 to interview stakeholders from the Katutura Referral Network. The Engela network covers the entire semi-rural Engela District in northern Namibia and is spread through the catchment areas of five health facilities. In contrast, the Katutura network is located in an urban sector of the Khomas region inclusive of Windhoek, the nation's capital, and covers the catchment areas of two health facilities. As seen in Figure 1 displays the locations of both regions in reference to Namibia's capital Windhoek.

**Figure 1:** The Engela network is located in the northern Ohangwena Region while the Katutura network is found in the Khomas Region which also includes the country's capital city of Windhoek.



## PARTICIPANT SAMPLE

LIFT sought to engage a range of stakeholders in this activity to ensure that perspectives and feedback were gathered from all levels—national, sub-national, community and client. Stakeholders contacted for interview came from the following groups:

- **National Ministry of Health and Social Services:** MOHSS represents LIFT's main point of contact within GRN and is also responsible for managing the programming, resourcing and staffing at all state health facilities. At the district level, MOHSS serves as the partner who will assume ownership of the referral networks following the completion of LIFT's TA process.
- **Regional Councils:** Regional Councilors are locally elected to lead their constituencies. Collectively they make up the Regional Council, which is the governing body for the region and advocates for its people. Some Councilors as well as other staff of the Regional Councils provided leadership to the referral networks. While many Councilors were not directly involved in network activities, their



understanding and support of referrals is critical to ensure sustainability and effective network operations.

- **Network Members:** Referral network member organizations include the health facilities, constituency offices, community-based organizations, faith-based organizations, non-governmental organizations and government SPs that make and receive client referrals. The members act as referring and receiving organizations and serve the clients sent through the system to the best of their ability.



*The referral focal persons at each CO play a critical role in the referral system—as the main points of coordination, they receive referred clients, facilitate appropriate referrals to the other network members, and manage the flow of client data.*

- *Health facilities (HFs):* Health facilities, ranging from local community clinics to public state hospitals, represent a main entry point for clients to enter the referral network. Based on LIFT’s global-level mandate, only those health facilities that provide NACS services have been included in the referral networks. As clients visit health facilities for NACS, staff enroll interested, eligible clients into the system by completing client intake procedures and referring them to their respective COs. Health facilities are tasked with entering basic client and referral data into the referral network database.
- *Constituency offices (COs):* Regional Councilors each have a CO, which serve as governing offices and points of coordination for government and other stakeholders to deliver services to their communities. COs were collaboratively designated to fulfill the role of referral coordinating organizations and serve to facilitate referrals from network entry points (i.e., health facilities) and other network members to appropriate services available in the network. Prior to referring a client, COs administer the LIFT economic and food security diagnostic tool to inform appropriate referrals based on the client’s vulnerability level. Additionally COs are also tasked with entering and managing the majority of the client and referral data using the referral network database as well as making regular submissions to the designated lead coordinating organization in each network. COs play a dual role in the system as they also provide services directly to clients, when available.
- *Service providers:* The SPs included in each network were identified for inclusion through a mapping activity (i.e., LIFT’s organizational network analysis [ONA]) which was conducted

between October-December 2013. Network SPs provide a wide array of services, focusing on ES/L/FS. Specific eligibility criteria is captured in the referral network service directories that LIFT developed for each site.

- *Support groups (SGs):* HIV and AIDS support groups have been included into the referral networks in order to help ensure that referrals were being made available to LIFT's target populations of individuals infected and affected by HIV and AIDS. SG leaders underwent sensitization and training around how to refer their members to COs for intake into the system as well as to help set appropriate expectations with the clients themselves.



*Clients active in the referral networks in both Engela and Katutura are majority female, and this was reflected in the sample of clients who participated in both focus groups and individual interviews.*

- Referral Network Clients
  - Focus groups (4-6 individuals)
  - Individual interviews.

LIFT utilized a convenience sample of network members—member organizations were asked to participate based on their role in the network as well as their availability for an interview. LIFT's Namibia Technical Specialist reached out to all network members via email to request availability to participate in the assessment interviews, and based on these initial responses, a final list of interviewees was developed to ensure member feedback from a variety of participatory levels. Since LIFT did not interact directly with referral clients, these participants were recruited by COs. Two COs in each network were contacted with requests to recruit convenience samples of clients—one for a focus group of 4-5 clients, and the other for 2-3 individual client interviews. LIFT provided a script to the COs as the project's due diligence to ensure voluntary participation as well as that the project would not have access to any of the clients' personal identifying information.

Interviewed stakeholders are summarized in the table below:

	<b>Regional Councils</b>	<b>Network Members (organization level)</b>	<b>Referral Clients</b>	<b>MOHSS</b>
<b>Engela</b>	2	11 (3 HFs, 5 COs, 3 SPs)	9	1
<b>Katutura</b>	1	10 (2 HFs, 5 COs, 3 SPs)	6	-
<b>National</b>	N/A	N/A	N/A	1
<b>SUBTOTAL</b>	3	21	15	2
			<b>TOTAL</b>	<b>41</b>

In some instances, more than one individual from a network member (i.e., HF, CO, SP or SG) participated in an interview; thus, a total of 49 individuals from 41 stakeholders were interviewed as participants in this activity.

## FINDINGS

### PERCEPTIONS OF LIFT TA PROCESS

#### Communication of LIFT’s Role and Purpose

As a global technical assistance project, LIFT occupies a much different space than traditional donor projects that bring in resources and implement directly in communities. Given this distinct relationship, LIFT spent a significant amount of time and effort in the early stages of the TA process ensuring that the project’s purpose was clearly communicated to all parties involved and establishing our role in the domains of facilitating local leadership and providing technical support. This particular TA aspect of LIFT’s role required continual emphasis and often had to be reinforced each time the project engaged with stakeholders, especially during the initial phases of the process.

Interviews revealed that most network members possessed a clear and accurate understanding of LIFT’s role in jumpstarting the process of institutionalizing these networks through facilitating communication and collaboration between stakeholders. The majority of network members were able to articulate the role of LIFT as a TA project as opposed to traditional projects that implement directly. Repeated messaging and the use of multiple communication styles—individual visits with stakeholder personnel, group gatherings and trainings, on-site TA from LIFT staff, and group emails—were cited as the main factors that helped instill understanding of LIFT’s support role and encourage stakeholders to realize the need for local ownership of the network from the early stages of its inception. It was noted, however, that network participants who were further removed from direct interaction with LIFT were less clear about the project’s purpose and the types of support that could be provided through this mechanism. This breakdown in messaging is attributed to the simplification of the project’s purpose and role as the information cascaded down to the grassroots level, and as a result, expectations were sometimes misaligned. In particular, some interviewed clients, certain community-based organizations, and SG

leaders mentioned that LIFT should be providing the financial and material resources needed to ensure quality service provision.

From the National MOHSS point of view the communication of the project's purpose was a significant challenge. Initially they struggled to understand the type of TA that was being offered—it was mistakenly expected that direct ES/L/FS support would be provided—as well as how the proposed system really benefited Namibia. These misperceptions proved to be a hurdle in the process of rolling out the networks. During the interview, however, MOHSS cited that their slow uptake was attributed to misunderstandings and their limited capacity to actually support LIFT in its endeavors. Over time, repeated in-person engagement and further clarification has led to strong support for the continuation of the networks after LIFT's departure, and staff expressed positive feedback around the TA provided by the project. On the regional level, MOHSS staff in Engela revealed that they frequently refer to LIFT's TA as an effective approach towards bringing lasting improvements to the community, as opposed to the direct provision of material and financial resources provided under other projects.

*“LIFT is actually one of our example projects, when we are giving examples to actually provide evidence of how things work. The wise thing that LIFT didn't do is provide money to establish [the system] but instead providing technical assistance...this is where we all should be going. At the end of the day, just money does not provide the results.”*

– Regional MOHSS staff

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### Was the Process Used to Establish Referral Networks Effective?

Throughout the entire process—from the initial identification of Engela and Katutura as the referral network sites to the formal network launches—LIFT continuously liaised with USAID, MOHSS and regional as well as community stakeholders and responsively adapted activities based on input from these partners. LIFT's approach to entering communities began with engaging high-level staff who then advise on the appropriate contact points throughout existing structures that can be utilized to flow information down to the community level. Feedback from stakeholders supported the continuation of this tiered engagement approach. This process was designed to **emphasize and generate local ownership** by COs, MOHSS and the networks themselves to **support sustainability**. Activities such as stakeholder meetings, steering committee meetings, group trainings, onsite TA and tools development and upgrading were all framed as **support for stakeholder-led implementation of the networks**. It is worth noting that this type of tailored TA approach that necessitates local ownership and may require a longer timeline for the process to be institutionalized.



All stakeholders interviewed responded positively to the idea of establishing referral networks to enhance and further the reach of existing work, reporting that this concept ultimately benefits the wellbeing of the communities and clients. Network members described the approach used by LIFT introduce the clinic-to-community referral networks as generally positive. Stakeholders who were actively involved from the earliest activities such as the ONA and initial stakeholder meetings described the activities in a way that exhibited a deeper understanding of the rationale behind clinic-community referrals and were more vocally enthusiastic about the need for network activities to not only continue but also expand. Stakeholders who became involved later on (often due to staffing changes), were more likely to express hesitation or apprehension towards taking ownership of the referral systems.



*Group meetings and trainings engage diverse stakeholders in highly participatory activities to facilitate a greater understanding of the rationale for clinic-community referrals as well as providing support to enhance the skills needed to implement client referrals.*

Stakeholders frequently cited group meetings and trainings as the most effective LIFT-supported activity in enhancing their understanding and increasing investment into the system—the continuation of regular meetings and trainings was put forth as an essential element if the system is to continue functioning successfully. These trainings provide a forum for exchanging information, sharing ideas, implementing corrective action, peer learning and boosting network morale as well as allowing for stakeholders to know what fellow network partners exist and the services that they provide.

Participants received two types of trainings throughout the TA process. Operational trainings on the referral system as a whole as well as demonstrations on how to make and receive referrals are fundamental and were provided to all stakeholders. On the other hand, supplemental trainings on specific skills such as data entry/management and counseling were generally more targeted towards the focal persons at each network member organization. Both staff who participated in these secondary trainings as well as personnel who did not reported that it would be helpful to include 2-3 staff from each

stakeholder in order build the capacity of a greater contingent within each member organization. This would generate a broader base of skilled stakeholder staff to implement referrals and would also help ensure that referrals are actually being conducted amidst busy schedules and competing priorities. In health facilities specifically, it was noted that the inclusion of IT and administrative staff as well as data clerks to help with recording referral data would be an effective approach to increase client intake into the system. LIFT has encouraged partners to integrate support staff into referral network operations, and this approach has been working well in Katutura. There have been some challenges with involving data clerks in Engela due to the structure of MOHSS directorates and separation of reporting lines and availability to support the system.



*Throughout the TA process, LIFT's Namibia Technical Specialist maintained regular contact with network members and frequently paid site visits to monitor progress as well as to provide hands-on troubleshooting. This attentive support has been cited by stakeholders as especially helpful in making them feel comfortable to take on the network as their own.*

The on-site TA provided by LIFT's Namibia Technical Specialist was greatly appreciated by stakeholders, particularly at the CO and HF levels. Regular progress checks and follow ups were cited as exceedingly helpful elements of the TA process to support the implementation of referrals as well as to make the stakeholders feel included as vital members of the networks. Competency and unity are important elements that contribute towards local ownership of the networks. Additionally, for those stakeholders who have limited to no capacity in database entry, these visits served as a critical point for the transfer of client referral data, which was entered at other network member sites.

Stakeholders agreed that the correct organizations and individuals were involved, though some stakeholders, such as CACOC coordinators and support group leaders, should be identified as critical players and engaged earlier on in the process. Others, such as Regional Councilors and higher-level health facility administrators and managers, need to be involved more deeply and continually, and these individuals were highlighted as strong candidates to serve as champions and advocates to help motivate progress. Furthermore, additional entities—both at community and district levels—should be brought in as the network grows to ensure that clients are being made aware of and referred to the full breadth of relevant services that can work complementarily to improve wellbeing. While this falls beyond the project’s scope, which is focused primarily on linking to those services that most directly impact economic and food security, LIFT encourages locally-owned expansion of the range of services for more comprehensive coverage as an option that networks can pursue independently as they deem appropriate.

*“All the partners I have seen in the meetings have been diverse...from support groups to community members, all our stakeholders, and government entities...I think it was really a dynamic group drawn from diverse organizations.”*

- Service provider from Engela Referral Network

## SYSTEM FUNCTIONALITY

Overall, stakeholders provided positive feedback around the functionality of the system. Stakeholders recognized that with the institution of any new system or process, time is a critical factor to allow for adaptation and transition before institutionalization is to be expected. Particularly in Engela, which has been operational for slightly longer than Katutura, the stakeholders were enthusiastic about the potential of the referral system, and the present state was described as **useful and beneficial**. In both network sites, stakeholders **agreed with the theory and approach behind establishing the networks**—to create linkages between clients and services that are most appropriate for them based on their assessed needs and interests—though they also identified areas of challenge associated with real implementation.

### What’s Working Well?

Through the institution of these formal referral networks, referrals are being made and clients are getting ES/L/FS and health services that they otherwise would not. The system has demonstrated a certain degree of functionality through **positive levels of client enrollment into the system** as well as about **25% of referrals successfully** completed (i.e., resulting in service delivery). In addition stakeholders generally agree that **collaboration and communication** between network partners—at the local, district and national levels—has resulted in positive change. With the onset of regular referral network meetings, stakeholders now have a platform from which to exchange ideas and learning and to seek support or assistance when facing challenges. LIFT’s TA process has also helped to fill a knowledge gap at the national MOHSS level regarding the service landscape as

*“Our collaboration and coordination with stakeholders has really been strengthened. They know who we are and we know who they are—it is a very good achievement to be able to know what people are doing, who they are, and to have those linkages now and we can continue with that...that is an amazing achievement of this project actually, to have those linkages strengthened.”*

– National MOHSS staff

well as the actual identification of stakeholders and the services they provide.

In Namibia, the system for making and tracking client referrals was designed to harmonize with the existing processes and tools being used nationwide by MOHSS, and feedback around the ease of integration between the two systems was positive. With these tools and resources in hand, referrals that were previously occurring on an informal basis are now able to be logged and client progress can be tracked through the system. Through the TA process, LIFT developed a comprehensive referral toolkit which stakeholders agreed has been lauded as a valuable resource. In particular, the government landscape service directory, local network service directories and the diagnostic tool were most often cited as the most useful tools.

Additionally, while the networks have not yet been operational for a long enough period of time to allow for the observation of significant change backed by referral data, stakeholders recognize the high potential value of the data that will come. Stakeholders assert that network data can and should be used as evidence in making decisions regarding budgets and program planning as well as in advocating for targeting services to close known gaps.

*“Our referrals were done on an ad hoc basis, but now with the forms, it is easier to trace and follow.”*

- Service provider from Engela Referral Network

Feedback from stakeholders revealed that the majority of network members recognize benefits from participating in these networks. Most often, stakeholders indicated that they now possess a greater understanding of who is working in the community as well as what services are available to their clients. Additionally, implementing referrals complements and enhances work that is already happening—by participating in the referral network, partners are furthering the reach and effectiveness of the services they provide. Furthermore, clients themselves are also more aware of the services that are available from



*Gathering stakeholders for network-related activities provides the opportunity for network members to work together in new ways—they now have a greater awareness of who is active in their communities as well as the range of services that are available.*



various network members and can also play a role in sharing this information with their peers at the community level.

Stakeholders also expressed that through participating in the referral network, they have developed an increased understanding of the connections between nutrition and food security as well as the various stages associated with progressing out of poverty. While the institutionalization of these linkages will require more time, it was clear that stakeholders, particularly at the HF and CO level, do possess an understanding of the links between clients' increased ES/L/FS status and adherence and retention in care.

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## Challenge Areas

Based on the team's experience in country as well as ongoing conversations with stakeholders, LIFT was aware of various challenges associated with the **operational environment** in Namibia even before the assessment activity commenced, and these challenges were reinforced through the stakeholder interviews. There are some significant barriers faced by the network members and clients in both the Engela and Katutura networks with regards to the distances between health facilities, constituency offices and SPs as well as the actual location of some of these network members' offices. Transportation presents a challenge in both the availability of public transport options or quality of roads infrastructure as well as the financial costs associated with accessing the options that do exist. In Katutura, there was an added layer of observed cultural norms around transport—while in Engela, walking is a common mode of transportation for even distances of 10 kilometers, in Katutura, people default to hiring taxis for distances as short as 1 kilometer. With the two-step referral process utilized by the networks in Namibia, the financial burden for transportation was especially felt and was mentioned in many interviews a serious hindrance to client participation. COs were assigned to serve as referral coordination points as for the most part, they are centrally located, and given their role as a main community hub, they are regularly accessed by constituents; however, the additional transport needs remain a challenge.

As LIFT instituted a two-step referral process—directing clients through COs as the main hub in the referral system—an important aspect that feeds into proper system functionality lies with the **actual intake of clients into the system itself through both steps of the referral process**. While HFs have been well engaged in completing the client intake process and referring them onward to their respective COs, the number of referrals being made from COs to SPs has been much lower. Interviews revealed that this disparity between referrals made and referrals completed can partially be attributed to CO staff not fully taking advantage of the service directories or understanding the utility of the diagnostic tool to make appropriate referrals. It was also observed that in some cases, CO staff were more cynical towards the ability of SPs to actually provide the necessary services. LIFT recognized this as an issue early on and continually worked to address these areas through working with network members to ensure proper understanding of the tools through onsite visits and demonstrations/role playing activities during network review meetings and refresher trainings.

Additionally related to the two-step system design, some clients has **misaligned expectations** and were confused or discouraged upon arriving at the CO and not receiving direct service provision. One frequent suggestion from stakeholders to facilitate more effective communication included utilizing public radio as a channel to broadcast the benefits of referrals and sensitize the community to adopt this system. Additionally, providing counseling to clients at more points in the referrals process would help reinforce the purpose of this two-step system and help to maintain clear expectations. Finally, the inclusion of community members who interact with the target populations most directly, such as church deacons, traditional leaders and social workers, would enhance sensitization at the community level and could also help alleviate outreach gaps.

*“Some [of the people who are making referrals] do not understand very well what is expected. They are not giving the right information—they just say to go to the constituency office, but when the person comes here, they have very high expectations.”*

- Constituency Office staff from Katutura Referral Network

At all stakeholder levels, **workload** was commonly cited as a challenge in implementing client referrals. Even before the interviews were conducted, staff shortages were observable at constituency offices, health facilities and also MOHSS both at the national and regional levels. For most network partners, these workforce gaps were attributable to funding challenges against hire additional staff as well as limited local availability of trained personnel. Existing staff are tasked with many other responsibilities that lie outside of their formal job descriptions. In the majority of situations, there is only one staff person who has been trained in the implementation of client referrals; as such, referrals are only facilitated through this focal person and are put on hold when he or she is not in the office. It was also noted, however, that for most stakeholders, the integration of referral network activities should not present an arduous burden as service provision to clients is at the core essence of their roles—the institution of the referral networks serves to provide structure for what had previously been happening informally. Suggestions cited by stakeholders to help ease the workload during the integration period include engaging volunteer staff who can ensure proper management of the referrals process as well as providing peer training to additional staff in the office to prevent the responsibility of referrals from landing solely on one person.

The **capacity of SPs to take on additional clients** has also posed a challenge. SPs are often dependent on donor funding, and they do not necessarily have the margin to take on more clients even if the need is presented. In other instances, there is simply limited services/resources available to meet the needs of network clients. A frequently cited example of this resource gap lies in the insufficient availability of food aid. While the purpose of the LIFT diagnostic tool is to begin unraveling root causes to match clients with services to help move them out of extreme poverty, stakeholders cited that the majority of referral network clients they had served to date were faced with immediate food needs. These basic necessities must be met before clients could look to pursue other opportunities that could mitigate hunger in the long term.

It is worth noting that some SPs also indicated that they have services available, though they are not receiving any client referrals from other network partners. Related to this, interviews also revealed that there may be an issue of COs not realizing that they can refer clients to SPs outside of their constituency boundaries—SPs do not possess that particular eligibility criteria—though transport may still prove to be

an access barrier. To mitigate the frustrations of referring clients where services may not be available, some COs are preceding their client referrals with a phone call to the SP to ensure that service can actually be delivered, decreasing the likelihood of having both the client and SP disheartened.

While feedback around the various tools developed and adapted by LIFT were received positively and regarded as beneficial, **some tools were met with mixed feedback in terms of practical usage**. In particular, the Microsoft Access database developed by LIFT was also seen as useful in theory—stakeholders expressed the benefits of using this tool for easy access to client data and for tracking client progression through the system. While most stakeholders see the value of this tool, some network members are still apprehensive about using the database regularly and would benefit from additional training or mentoring on how to use this tool effectively.

In all initiatives that seek to address sensitive issues, **stigma is a significant challenge** that must be recognized. For the Engela and Katutura referral networks, the dual layers of HIV/AIDS and poverty can present challenges around client uptake, as they may not want to reveal their true needs for fear of being perceived as sick or poor. Certain aspects of stigma can be readily addressed through counseling clients on the purpose of referrals. Additional stakeholder training in counseling clients is also warranted, particularly for non-health network members who may not typically deal with client sensitivities that are addressed through the referral system. If the networks effectively refer clients to appropriate ES/L/FS services, it is anticipated that in the long run, stigma may be combatted as clients begin to see and experience the benefits of engaging in these services as related to improved health, nutrition and vulnerability levels. There remains, however, a greater need for continued efforts in community sensitization.

## RESULTS AND OBSERVED CHANGES

### Client Level Changes

Given the short period of full network functionality to date, client feedback and reported change is limited. General feedback from stakeholders who have made referrals include observations that clients are **enthusiastic about participating in the referral process and happy to be served**. Though it is still too early to tell if there are measurable client-level outcomes, **feedback** from stakeholders suggest that awareness around the benefit of referrals as well as availability of services has increased. In addition, support group leaders cited that **SG membership has increased** because of the referral links between the COs and SGs, and **more people are coming together in the community**. Several COs also mentioned that the institution of the **referral networks has created a greater sense of community** as people now have more reasons to visit their CO and on a more regular basis.

*“I’m very happy. I didn’t know about referrals, but my community leader sent me here [at the CO].”*

- Client from Katutura Referral Network

Several anecdotal cases of positive client-level change were shared through the interviews including a client who was referred to a CO in the Engela network and helped through a series of four separate visits. The client, who is HIV positive, was first counseled not to default on treatment, referred back to the HF for additional medication, referred to a SP for food aid, and is now doing well, as observed during

a final follow up visit. Also in the Engela network, a client on ART who had previously dropped off the treatment regime was referred back to the clinic and has since resumed treatment.

### Network Level Changes

The referral network has facilitated considerable change around stakeholder interactions. As a result of gathering for the purpose of LIFT-initiated activities such as review meetings and refresher trainings, **stakeholders have a greater awareness of others in their community**, and there is a **sense of unity fostered amongst the network partners**. Relationships have been formed between network stakeholders because of their communication around the implementation of referrals. In Katutura, one interviewee cited an instance of resource sharing which had grown to become a greater partnership between the organizations outside of the LIFT-facilitated network which now includes the regular donation of agricultural inputs and delivery of youth training programs.



*New relationships have been formed, and existing relationships strengthened, between network members because of their communication around the implementation of referrals.*

Stakeholders report that existing relationships between community entities have also been strengthened through participation in the networks. Many partners highlighted that **COs and health facilities have increased the frequency of communication** as clients enter the network at the hospital or clinic and are referred on to their respective CO.

## LIMITATIONS

From the early stages of development, LIFT was aware of several areas of limitation of this assessment approach. Some of these factors had been identified and discussed prior to the assessment, and others were realized more fully as the activity progressed on the ground.

## SAMPLE OF ASSESSMENT PARTICIPANTS

To gain a broad perspective, LIFT sought participation from network members who were actively engaged in the network as well as those who were less engaged or had experienced challenges in their involvement. However, as participation in this activity was entirely voluntary, those who agreed to be interviewed tended to be the ones who have been more engaged in the process overall and enthusiastic about actively referring and receiving clients. While thoughtful feedback regarding challenges and suggestions for improvement were still openly shared by nearly all stakeholders, the overall perspective may be skewed based on this profile.

Additionally, there was some confusion in communicating the types of clients—those who have at minimum been referred to a SP within the network—that should be recruited by the COs for participation in the individual interviews and focus groups. Unfortunately, all the clients who were interviewed during this activity had either only completed the first step of the referral (i.e., being referred from a HF to the CO) or had come directly to the CO seeking food or material support which was consequently provided. While the feedback collected through these interviews helps to provide more context from the client perspective, none of these interviewees or focus group participants had actually been individuals who had successfully participated the two-step referrals process the way it had been designed.

## LANGUAGE BARRIER

There were select participants who were comfortable communicating purely in English, but the vast majority of LIFT staff's client interaction required double translation—from English to the local language (i.e., Oshiwambo or Afrikaans) and back to English—which was done with the assistance of the CO staff. This meant that in many cases the interviewer was completely reliant on the translator to accurately understand and convey the message on both sides of the translation.

## TIMING

Due to the timeline of LIFT support in Namibia, the 4-6 months of active network operation left limited time to address critical challenges and intensively develop institutional capacity in order to ensure sustainable, efficient operations moving forward. While valuable feedback concerning the TA process employed by the project as well as the actual operations of the network were shared during this activity, LIFT is unable to follow on with support to address this feedback and support the implementation of suggested changes towards creating greater efficiency and uptake. With the limited months of actual network operations at the time that the assessment was conducted, observations of change, particularly at the client level, are limited and often cannot be clearly attributed independently to the network itself. A greater period of implementation is needed before stakeholders are able to determine long-term changes.



Again due to LIFT’s timeline of support, this activity took place adjacent and overlapping with the holiday season in Namibia, thus some key stakeholders were on leave and unavailable to participate in interviews.

## RECOMMENDATIONS

Based on the findings of this assessment, key things to consider in establishing effective, sustainable networks include:

- **Identify key stakeholders (particularly those high-level decision makers) and ensure high-level political support prior to launching the referral system.** Based on the data collected from the two sites in Namibia, it is essential to have strong support from both the regional government entities (i.e., Regional Councilors) as well as the health facilities in the network. It is also critical that these key stakeholders see TA projects such as LIFT as partners and not threats. In the case of Namibia, Regional Councilors hold great influence over their communities and it was clearly observed that those constituencies that had active, supportive leadership around the referral system were functioning much more strongly. Those constituencies whose Councilors were involved minimally (or not at all) struggled both in terms of CO staff engagement in the TA process as well as in actually implementing client referrals. Without support from upper-level management, the time and resources needed to participate in the LIFT-supported network activities were not always readily available; thus, focal persons from these stakeholders were unable to engage to the fullest extent. On the health facility side, identifying and gaining the buy-in of the appropriate senior management staff and district-level supervisors is critically important to ensure an effectively functioning system. Garnering a strong level of support from the health facilities necessitates active backing from program directors and division supervisors who can inspire motivation, monitor implementation and hold nurses/health workers accountable to their responsibilities within the system.
- **Identify appropriate stakeholders/focal persons to serve as champions of the referral system.** In the Engela network, the Engela CO has been serving as the lead coordinating organization, providing peer leadership and coordinating data merges and submission to LIFT for tracking and analysis purposes; in Katutura, the network is still trying to determine the most appropriate network member with the capacity to take on this role as the designated constituency office has been struggling with an ill referral focal person and competing priorities. Through this assessment, there was a marked difference in the system functionality, movement and progress of network activities, and general enthusiasm of the network members. Whether this leadership and coordination comes from a CO, HF, Regional Councilor or other stakeholder, the importance of a champion cannot be understated.

*“If this network was introduced to the community—even the whole country—and people know of what [the network] is doing and who the stakeholders are, I think then we can reach the ultimate goal.”*

- Service provider from Katutura Referral Network

- **Institute a regular schedule of review meetings and refresher trainings.** It is important to ensure an ongoing schedule of regular review meetings, as these gatherings provide a critical platform for stakeholders to share learning, discuss successes and challenges, as well as collectively brainstorm solutions. Refresher trainings on the use of network-specific tools (i.e., database) are also necessary—these skills are still new, and as client flow through the network is slow to start, practice is critical for uptake and essential for retention



*Through participation in network review meetings and refresher trainings, stakeholders have a platform for sharing ideas, peer learning and collectively brainstorming solutions to challenges.*

- **Provide regular on-site TA and mentoring.** Throughout the interviews at all stakeholder levels, it was revealed that the monthly on-site support provided to network partners was critically helpful in moving networks towards effective functionality. This aspect of TA from LIFT took the form of both in site visits and remote support to check on progress, solicit stakeholder feedback on the referral process and resources, and provide troubleshooting. Regular in-person interaction also helped to maintain a strong, positive relationship between the stakeholders and the project which helped network partners to feel well-supported throughout the process.
- **Ensure that each network member has a designated focal person present and available to conduct referrals.** Stakeholder feedback from both networks indicated that without a trained person physically present in the office to make and receive client referrals, action will be severely delayed or may not happen at all. Negative client experiences can result in detrimental consequences against successful adaptation of the network. At any stage of the referral process, clients not being served represents a setback. It is important to ensure that staff—even those who are not directly involved in referral implementation—are aware of the referral network so that clients are not turned away without explanation. Additionally, while it is important to have a focal person within each organization who holds ultimate responsibility for referrals, TA providers should ideally seek to train 2-3

representatives per organization. Staff who are trained in conducting referrals should also be encouraged to train their peers and spread the responsibility apart from just one individual.

## CONCLUSIONS

### SUMMARY OF FINDINGS

#### LIFT's TA Process

Through LIFT's TA process, stakeholders were introduced to the concept of referral networks in relation to expanding the reach of available services to those clients most in need. Overall feedback provided through this assessment indicated positive support for the institution of clinic-community referral networks.

- Despite the newness of LIFT's TA approach, most partners were able to grasp the concept clearly. Support and reinforced messaging is needed for those stakeholders who do not receive direct TA from the project, and it is important to ensure that messaging around the network's purpose remains consistent as the information flows down to the client level.
- Most agree that the process utilized to establish these referral networks was effective and included the appropriate stakeholders, though there are some key influential members who could benefit from being more deeply engaged at an earlier point in the process.
- Stakeholders agree that the progression of activities supported by LIFT was effective to facilitate the institutionalization of the referral networks. Group trainings and stakeholder meetings as well as on-site TA were cited as the most helpful elements of this process.

#### Referral System Functionality and Effectiveness

Through LIFT's TA process, stakeholders were introduced to the concept of referral networks in relation to expanding the reach of available services to those clients most in need. Overall feedback provided through this assessment indicated positive support for the institution of clinic-community referral networks.

- Referrals are being made, and stakeholders reported that clients are being served in appropriate, effective ways.
- The TA provided by LIFT in the form of the referral toolkit and trainings have been critical in supporting the networks to institutionalize these referral processes.
- Challenges exist around the operational context as well as stakeholder capacity in consistently and efficiently conducting referrals as well as providing services; however, the network members themselves are able to act as a resource to each other in helping to prioritize clients being successfully linked to the services they need.

#### Preliminary Changes and Results

Due to LIFT's timeline of support, full network operation prior to this assessment has been limited to 4-6 months, which makes it difficult to assess measurable changes. However, stakeholders are hopeful that



positive results will be seen as the networks move beyond the adaptation phase and towards being fully institutionalized.

- While it is still too early in the life of these networks to determine any measurable client change, overall feedback around the client experience has been supportive, and clients have been become more aware of the services that are available in their communities.
- Collaboration and coordination between the network partners has seen significant positive increase. LIFT has been able to help fill a knowledge gap of the service landscape which has proven beneficial at the national, district and community levels.
- The linkages and relationships between health facilities and community-based service providers has also been strengthened.

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