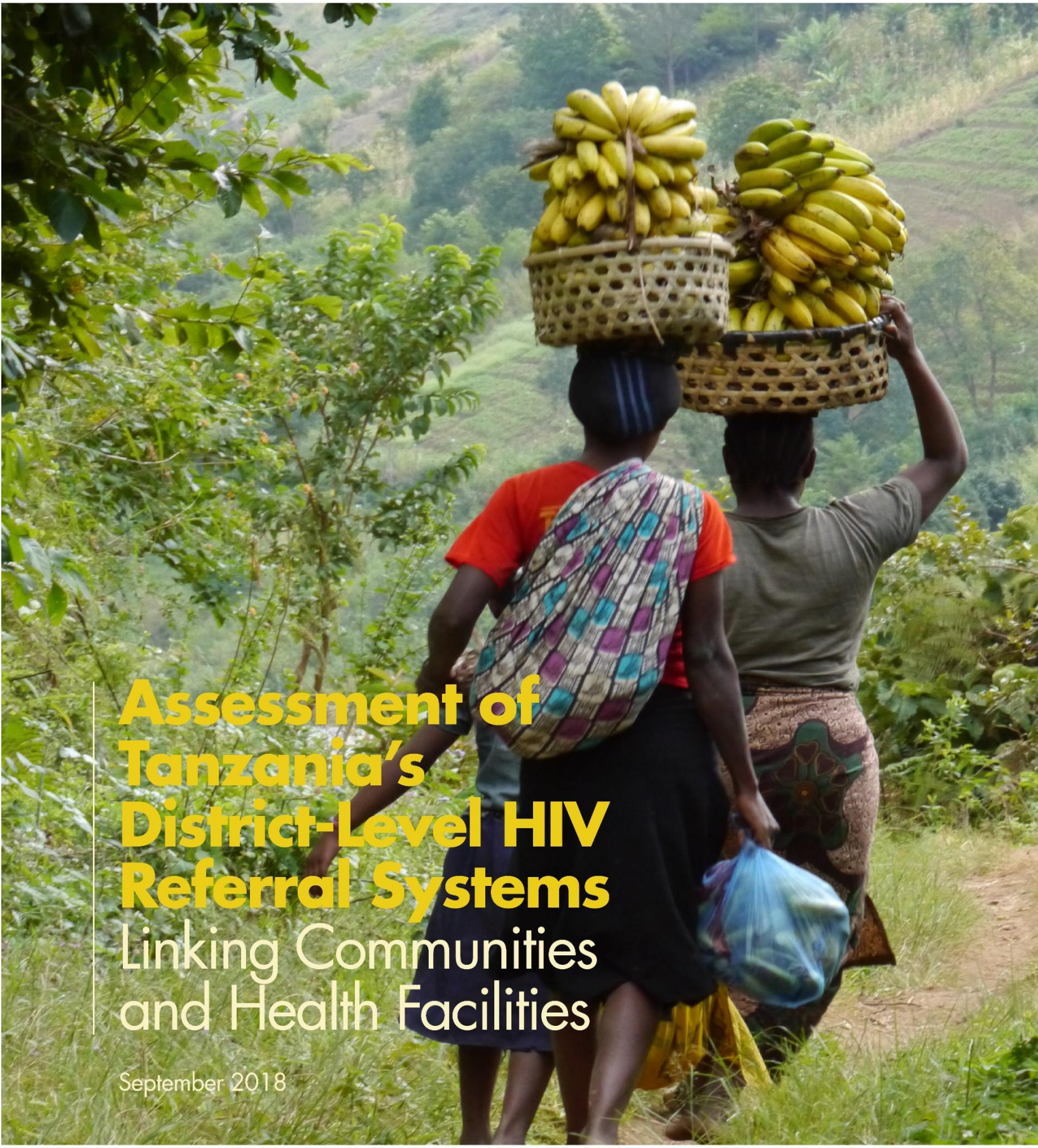


Assessment of Tanzania's District-Level HIV Referral Systems

Linking Communities and Health Facilities

September 2018

USAID FROM THE AMERICAN PEOPLE

PEPFAR

MEASURE Evaluation TZ

Assessment of Tanzania's District-Level HIV Referral Systems

Linking Communities and Health Facilities

Cristina de la Torre, Charles Mushi, Marylad Ntiro, Allison Schmale, Charles Matiko, and Willis Odek

September 2018

MEASURE Evaluation
University of North Carolina at Chapel Hill
123 W. Franklin Street, Suite 330
Chapel Hill, NC 27516 USA
Phone: +1 919-445-9350 | measure@unc.edu
www.measureevaluation.org

This research has been supported by the United States President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation–Tanzania associate award AID-621-LA-14-00001. MEASURE Evaluation–Tanzania is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of PEPFAR, USAID, or the United States government. TR-18-284

USAID FROM THE AMERICAN PEOPLE

PEPFAR

MEASURE Evaluation TZ

ACKNOWLEDGMENTS

We thank the United States Agency for International Development (USAID) for its support of this assessment.

We thank the reviewers from the National AIDS Control Programme and from the United States President's Emergency Plan for AIDS Relief (PEPFAR) for their careful review of the draft report.

A special thanks to FXBT Health for their help with the data collection and analysis. We also want to thank the home-based care (HBC) district coordinators in Kyela, Kinondoni and Waging'ombe for their logistical support with setting up interviews. We are grateful to the many staff from the district health management teams, health clinics, and community-based organizations, and the volunteer community workers who took the time to talk with us about their experiences with the referral system.

Finally, we thank the knowledge management team of MEASURE Evaluation for editorial and production services.

Women carry produce from the villages of the Uluguru Mountains to Morogoro town, Tanzania.

CONTENTS

FIGURES

TABLES

ABBREVIATIONS

ART	antiretroviral therapy
ARV	antiretroviral
CBO	community-based organization
CT	care and treatment
CTC	care and treatment clinic
DACC	District AIDS Control Coordinator
FBO	faith-based organization
GBV	gender-based violence
HBC	home-based care
HTC	HIV testing and counseling
LTFU	lost to follow-up
M&E	monitoring and evaluation
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MOHSW	Ministry of Health and Social Welfare
MVC	most vulnerable children
NGO	nongovernmental organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
RCH	reproductive and child health
RSAM	referral system assessment and monitoring
STI	sexually transmitted infection
TB	tuberculosis

EXECUTIVE SUMMARY

Health systems are increasingly relying on community-based organizations (CBOs) and community workers to provide care and support services to individuals affected by HIV and AIDS. Community health workers can deliver a range of services to improve clients' well-being, provide direct care and treatment, and give support throughout the continuum of care. Additionally, community workers often identify clients in need of services and track them to return them to care.

Strong linkages between community and health facility providers help clients obtain the critical services they need in a timely fashion. Referral systems are an important mechanism for creating strong linkages. Referrals facilitate moving clients through the health care system and exchanging health information between providers. A good referral system helps clients gain access to services, encourages clients to seek care and support, and can also help providers track the services that clients receive and then follow up on client health care needs.

In Tanzania, various national HIV guidelines call for strong referral systems between the community and clinical services to ensure patients receive adequate health care at all levels. To assess the status of referral systems, MEASURE Evaluation conducted an assessment from February to April 2016 in three districts in Tanzania: Kinondoni, Kyela, and Waging'ombe.

Objectives

The purpose of this assessment was to examine how well the HIV referral system between community and facility services is functioning. The focus was on community services offered through the home-based care (HBC) and most vulnerable children (MVC) programs. The results will inform the design and implementation of referral system strengthening interventions to be supported by MEASURE Evaluation.

The assessment had the following specific objectives:

- Document the processes used to refer and counter-refer clients between community and facility service providers
- Determine whether written referral protocols and guidelines exist, and whether they contain sufficient information to direct service providers and program managers in implementing referrals, based on criteria set forth in the Referral System Assessment and Monitoring (RSAM) Toolkit
- Document how referrals are tracked and what data are collected, reported, and used for decision making
- Identify key barriers to referral initiation and referral completion and to tracking referrals between community and facility providers

Methods

The assessment employed a cross-sectional, mixed-methods approach to examine the current functioning of the bidirectional referral system between services providers in the community and at health facilities. The assessment included semi-structured interviews with 35 community workers, 43

facility providers, and 12 HBC focal persons. We conducted group interviews with the district coordinators in each district and with CBO staff at five organizations. As part of the assessment, we reviewed various documents, national guidelines, and monitoring and evaluation (M&E) tools, training curricula and other relevant documents to determine national and subnational-level guidance and explicit procedures on referrals. We also extracted data from community worker registers to estimate number and types of referrals made to facilities.

Data were entered into Epi Info, including numerical and transcribed responses. Responses to some open-ended responses were coded and assigned numerical codes. When appropriate, we ran basic descriptive statistics using STATA, analyzing the data separately by type of respondent. We summarized the transcribed responses and grouped them into categories that described different referral practices. The team then used a data analysis guide to compile responses across respondents and integrate findings from the document review.

Data collection took place in February and March of 2016 in three districts of Tanzania Mainland: Kinondoni (in the Dar es Salaam Region), Kyela (Mbeya Region), and Wanging'ombe (Njombe Region).

Key Findings

This assessment highlights several key findings about the current HIV community and facility referral system.

- Almost 90 percent of community workers reported making referrals to clinical or other community support services, but only 21 percent of HBC community workers and 44 percent of MVC community workers reported making referrals in the previous month. HBC community workers are more likely to refer to health facilities than MVC community workers, who are more likely to refer clients to non-clinical support services. Referrals to health facilities are primarily for HIV testing and counseling and care and treatment services. However, MVC community workers most often referred clients to health facilities for primary care services. The majority of facility providers (72%) indicated they receive referrals from community workers or CBOs.
- Both HBC and MVC community workers typically used referral forms when referring clients. In addition, 76 percent of HBC community workers reported escorting their clients for the referral. Only 43 percent of MVC community workers reported escorting clients during referrals.
- The HBC community workers had access to standardized registers and forms for documenting, tracking and reporting referrals made to the facilities, although 24 percent of HBC community workers were not using these tools. The tools used by MVC community workers were project-specific, not harmonized, and not consistently available. At the time of the study, the Department of Social Welfare was developing new monitoring tools, including referral tools, for the MVC program, but these had not yet been finalized or rolled out.
- Only 28 percent of facility providers reported making referrals to the community, and 16 percent made them in the previous month. These referrals are generally for HBC services and facility providers had limited awareness of other community services available in their district. Most facility providers refer clients orally, claiming they were not given referral forms or tools

for referring to the community. Relatively few community workers (42% for HBC and 19% for MVC) reported having received referrals from facility providers.

- Tracking referral completion is a challenge. Referral slips are only sometimes returned, and service providers are burdened with having to seek out this information by seeking out the client, calling or visiting the receiving provider, or escorting clients. However, not all are proactive in seeking referral completion information.

- The majority (89%) of community workers said they received training on referrals, but less than a third (31%) said they were given written instructions on referral procedures and no copies of these instructions were located for review. In comparison, 12 percent of facility providers said they received trainings on referrals. Various national guidelines for HIV programs, however, explicitly state that referrals to the community are a priority.

- Overall, the study found a lack of specific guidance for service providers on how the referral system should operate. National guidelines provided some guidance on when referrals should be made, but they did not include any instructions on how the referral system should be set up, procedures to follow for making or following up on referrals, and guidance for keeping records about referrals.

- While some HIV and AIDS programs (primarily the HBC, HTC and to a lesser extent the care and treatment programs), document or report on referrals made, the information is not consistently gathered across HIV services. Documentation on referrals to clinical services are included, whereas referrals to community services are not.

- The study found insufficient mechanisms to coordinate referrals and linkages across the spectrum of service providers serving HIV clients. At the district level, district coordinators and CBO staff reported some coordination around the services they provided to HIV clients. Most health facilities had an HBC focal person who could liaise between the facility providers and the community workers and facilitate the sharing of information about referrals. However, respondents reported very few instances of meetings where referrals were discussed. With the exception of the HBC focal persons, facility providers reported little if any contact with community workers.

Key Recommendations

National-level Recommendations

- Harmonize referral procedures by producing a national referral handbook for bidirectional referrals between the community and health facilities that establishes standardized referral processes and tools. The handbook should include the following:
    a. Instructions for service providers on how to make, document, and follow up on referrals. Separate instructions should be developed for community workers, facility service providers, focal persons and district coordinators.
    b. Guidance for how to coordinate community and facility services at the national and subnational levels.

c. Guidance for program managers and district coordinators on overall referral system management.
d. Directions for setting up an effective monitoring system to track referral system functioning.
e. Roles and responsibilities of different actors in the referral system.
f. Tools to be used for referrals, including referral forms, registers, reporting forms, and service directory templates.

- Develop national training package for community-facility referrals and collaboration, based on the referral handbook, which elaborates step-by-step the referral process, which tools are used, and how to use them, how to follow up on referrals made. The training curriculum should also address how to monitor the referral system, what data to collect, and how to analyze and use those data for decision-making.
- Train facility providers to better use the tools that do exist such as the generic MOHCDGEC referral form and patient registers. Make sure that providers are documenting referrals to the community and not just referrals to other clinical services.
- Strengthen the referral system between MVC community services and health facilities in particular, and create (or adapt) standardized national tools for MVC referrals (including referral forms, client registers, and monthly reporting forms), building on the work that MEASURE Evaluation and others have initiated in this area.
- Strengthen the referral monitoring system so that data on referrals made between the community and health facilities are collected and analyzed at the district, regional, and national levels. At a minimum, a monitoring system should collect data on the number of referrals made and the referral completion rate, and it should be disaggregated by program area that initiated the referral (e.g., HBC, MVC, PMTCT, and HTC). The following steps should also be included:
    a. Define indicators and data sources. Review existing referral tools and reporting forms tools to determine if they include the necessary information. Decide whether new tools need to be developed to provide referral data.
    b. Develop a curriculum to train service providers, district coordinators, and CBO staff on how to collect and use referral data.
    c. Determine who should take responsibility for the management of referral data at the district and national levels.
- For tools and registers that currently document referrals (e.g., CTC2 card, HTC register, ART register) create new codes for community services so that these can be explicitly recorded. Assess the feasibility of developing new tools, registers and reporting forms for those program areas that are not documenting referrals at all.
- Undertake an analysis of HBC referral data collected thus far to examine trends and better understand the functioning of the referral system in that program.
- Revise the supportive supervision checklist to include review of referral systems at the facility and community level.
- Develop and ensure that referral tools are available at the community and facility levels at all time

District-level Recommendations

- Assign a district coordinator to assume leadership and coordination of the bidirectional referral system between health facilities and community services. This person should coordinate referrals to and from the community across all program areas.
- Define the roles and responsibilities of various stakeholders (e.g., the district health management teams, NGOs, and service providers) in the referral system. Consider how continuum of care committees and quality improvement committees can support the referral system.
- Instruct district coordinators on the analysis of incoming referral data and discussion of these data during management meetings, including Council Health Management Team and Regional Health Management Team.
- Organize periodic meetings between district coordinators and CBO staff during which referrals are discussed.
- Encourage district coordinators and CBOs to work together to develop district-specific directories of services and make these directories available to all service providers. The directories should capture all services available, providers, contact information, location, and hours of operations. It should be updated at least every two years.
- Increase awareness among facility providers about the services available at the community level and the importance of referring clients to them.
- Ensure that referrals are addressed during supervisory visits at the facility and community levels and encourage joint supervisory visits by MOHCDGEC and CBO staff at the community level.
- Train facility providers to use referral forms and referral feedback forms.
- Advise facility providers to document referrals to community services in existing registers, and CTC2 cards.
- Ensure an adequate supply of referral forms, registers, and reporting forms to be used during the referral process.

Facility-level Recommendations

- Incorporate referrals as a discussion item during facility management meetings.
- Find opportunities for greater exchange between community workers and facility providers and ensure that referrals are a topic of discussion during these exchanges. These can be during formal meetings or community outreach events. Hold periodic meetings between community workers and facility providers to share information on services provided, referral system functioning, and challenges faced.
- Assign HBC supervisor other staff person to act as community-facility officer who will help coordinate referrals to and from the community across all programs.
- Develop and ensure that standard operating procedures for referrals are readily available and staff have been trained
- Ensure referral tools are available at all time

Community-level Recommendations

- Develop standardized tools and procedures for referrals initiated at the community-level and ensure they are available
- Train all community workers in proper referral procedures, including referral follow-up procedures
- Establish mechanisms for monitoring community referrals

INTRODUCTION

Health systems are increasingly relying on community-based organizations (CBOs) and community workers to provide care and support services to individuals affected by HIV and AIDS. Community interventions can have several goals, predominately these three:

1. Deliver support services, such as counseling, nutrition, livelihood, or educational services, aimed at improving the overall well-being of individuals affected by HIV and AIDS and their families.
2. Provide direct care and treatment services to people living with HIV (PLHIV), such as HIV counselling, testing, antiretroviral (ARV) delivery, or home-based care.
3. Support clients in the uptake of clinical services along the HIV care continuum and in the adherence to a treatment plan.

Community actors also play an important role in identifying individuals in need of services and helping them access those services. They are critical to tracking clients lost to follow-up and encouraging them to re-engage in their care.

Establishing strong linkages between the community and health facilities is imperative to ensure that clients can receive the critical, timely services they need. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the World Health Organization (WHO), and the Government of Tanzania have all called for strengthening community-facility linkages (PEPFAR, 2014; WHO, 2015; MOHSW, 2012).

Referral systems are an important mechanism for creating strong linkages. Referrals facilitate moving clients through the healthcare system and exchanging health information between providers. A good referral system helps clients gain access to services, raises awareness of the need for services and their availability, and encourages clients to seek care and support. A well-designed referral system can also help providers track the services that clients receive and then follow up on client health care needs.

In Tanzania, various national HIV guidelines call for strong referral systems between community and clinical services providers. One of the priority strategies listed in the 2013–2017 National Health Sector HIV and AIDS Strategic Plan is to "strengthen effective linkages and referrals between community-based and clinical services to ensure a continuum of comprehensive and integrated services for PLHIV" (NACP, 2013, p.39). In Tanzania, HIV-related community services are through major national programs, including the Home-Based Care (HBC) Programme and the Programme to Support Most Vulnerable Children (MVC). The national HBC guidelines specify that everyone, including district HBC coordinators, nongovernmental organizations (NGOs), and service providers, is responsible for establishing "effective district networking and referral systems so patients benefit from a functional continuum of care at facility, community, and household levels" (NACP, 2010).

Overview of Referral Procedures

A referral is "the process in which a health worker, having insufficient resources (e.g., drugs, equipment, skills) to manage a clinical condition, seeks the assistance of a better or differently resourced provider at the same or higher level to assist in or take over the management of a client's case" (MEASURE Evaluation, 2013).

The following paragraphs list the steps in the referral process.

Referral initiation is the decision to send the client to another service provider and share the information necessary for the referral to be completed. Information sharing needs to happen on two levels:

1. Information is shared with the client. The client needs to know where to go, who to see, and the reasons why he or she is being referred.
2. Information is shared with the provider that will receive the client who is being referred (i.e., the receiving provider). The receiving provider needs to know why the client is being referred, what service is needed, and other relevant details about the client's case and health status.

Referral completion is achieved when the referred client is seen by the receiving provider and obtains the services for which he or she was referred. Referral completion requires the following two conditions:

1. The client is willing and able to access the services for which he or she was referred.
2. The receiving provider is available and able to provide the necessary services and has the necessary resources (e.g., drugs, equipment, skills) to do so.

Referral feedback, also known as counter-referral, is achieved when the receiving provider sends information back to the initiating provider to confirm that the referral was completed, to provide details about the services provided, and to share any other information that the initiating provider may need to continue managing the client's case.

Documentation of referrals is important to their success, although this practice is not always followed. Each of the four referral steps requires some level of documentation. Initiating providers should document outgoing referrals so they can follow up later and ensure that the client obtained the services for which they were referred. Clients need documentation to know where to go and who to see. Receiving providers need documentation from the initiating provider to understand the services being requested. Receiving providers should document the services they provide. Their documentation is used for reporting into the routine health information system and also provides feedback to the initiating provider and confirmation that the referral is complete. Documentation should to be exchanged between providers to clarify the client's needs so that all providers are up to date on the client's status. It is therefore critical to have good referral tools, forms and registers that facilitate this level of documentation.

A strong, formalized network across service providers is an important element of a referral system. Referral networks should include coordination across service providers, defined roles and responsibilities for the various organizations involved, agreed-upon referral procedures, a directory of services, and a unit or individual to oversee the referral system (FHI, 2005; WHO, 2012). Many of the Tanzanian national guidelines we reviewed also highlight the need to have strong collaboration and networking across providers, including providers at the community level.

Background of Referral Systems in Tanzania

A few studies have been conducted in Tanzania to examine referral systems for HIV and AIDS programs. The studies have not focused exclusively on referrals between the community and health facilities, but they highlight common issues and lessons learned on referrals for HIV services in Tanzania. The studies indicate that referrals are not provided consistently, and that referral completion is low (Arreskov, et al., 2010; Mshana, et al., 2006; Nsigaye, et al., 2009; Project SEARCH, 2013). Failure in the referral system can generally be attributed to three areas: (1) barriers to referral initiation and follow-up; (2) barriers to referral completion (i.e., clients obtaining the services for which they were referred); and (3) problems with the overall referral system design.

Barriers to Referral Initiation

The studies conducted in Tanzania note that providers do not consistently refer clients, even when the need is clear (Mshana, et al., 2006; Project SEARCH, 2013; Watson-Jones, et al., 2012). The reasons may be because providers are not sufficiently trained in referral protocols, and, therefore, they lack the knowledge on when to make referrals or what procedures to follow (Project SEARCH, 2013; Watson-Jones, et al., 2012). One study found that ineffective communication between providers and clients led to poor understanding of the services clients had already received and the additional services needed (Watson-Jones, et al., 2012). The study found that providers did not ask clients the right questions to determine whether referrals were needed. To strengthen the referral system, better understanding of provider behaviors and their decision-making process on when and why they make referrals is needed.

Barriers to Referral Completion

In Tanzania, as elsewhere, HIV clients have a low rate of referral completion; that is, clients who are referred never receive the services for which they were referred. This can happen for many different reasons. In Tanzania, studies suggest that the following factors are barriers to referral completion:

- Clients may not seek care because they are asymptomatic and do not perceive the severity of the illness (Rosen & Fox, 2011; Simba, et al., 2008; Watson-Jones, et al., 2012). A lack of understanding of the potential benefits of the services can be an important barrier to care, regardless of health status.
- Clients may not know what to expect of the provider or services, or he or she may have preconceived notions about the quality of care at the facility to which they are being referred (Mshana, 2006; Watson-Jones, et al., 2012).
- Stigma is a common deterrent to seeking HIV-related services at the community or facility level. Individuals who have not disclosed their status have particularly low rates of referral completion (Mshana, et al., 2006; Project SEARCH, 2013).
- Clients may need to travel long distances to services, and they may lack the resources to secure transportation (Mshana, et al., 2006; Project SEARCH, 2013; Watson-Jones, et al., 2012).
- Referral sites may lack the equipment, staff, or drugs needed to fulfill the services for clients who have been referred (Project SEARCH, 2013; Watson-Jones, et al., 2012).

Problems with the Overall Referral System Design

A major issue reported in the design of health referral systems is the inability to track clients across services. Studies from Tanzania note that service providers were unable to confirm whether clients

had received the services for which they were referred (Arreskov, et al., 2010; Colvin, et al., 2014; Mshana, et al., 2006; Project SEARCH, 2013; Shresta & Fatta, 2015; Watson-Jones, et al., 2012). Inadequate referral tools, staff, and poor communication strategies across service providers hinder the ability of the system to track referrals and follow up on them. Another problem is that referral systems are not formal, resulting in poor networks and poor collaboration among providers and a lack of formal procedures for referring clients or exchanging information (Project SEARCH, 2013). Poor documentation and poor recordkeeping for referrals at initiating and receiving health facilities and the inadequate exchange of information are two critical challenges that affect the effectiveness of the referral system.

Some interventions have shown promise in Tanzania for improving referrals between community providers and health facility providers. In Muheza, linkages between the community and clinical services were improved by establishing community teams that supported the HBC volunteers by providing education and sensitization on health issues and encouraging community members to seek care (Shresta & Fatta, 2015). Similarly, a mother-to-mother support group model implemented in five regions of Tanzania led to improved community-facility linkages that facilitated the uptake of PMTCT services (UNICEF, 2016). In Kisesa, a pilot project was successful in increasing referral completion by introducing a new referral form and supporting clients with transportation costs and personal escorts, when needed. The two-part referral form with a matching unique number helped track whether clients completed referrals, and providers could follow up with clients who had not sought care (Nsigaye, et al., 2009). This required a district-level staff person to regularly collect the forms and match them for completion, a process that may be cumbersome at a larger scale of implementation. Improved training of community-level service providers was also an effective way to increase the referral rate (Colvin, et al., 2014).

Justification

This assessment more closely examined the bidirectional referral system between the community and health facilities in three districts to document strengths and weaknesses and identify areas that need improvement. The results can help determine priority interventions for strengthening linkages and referrals between community and facility services.

Objectives

The purpose of this assessment was to examine how well the HIV referral system is functioning between community and facility services, focusing on community services offered through the home-based care (HBC) and most vulnerable children (MVC) programs. The results will inform the design and implementation of referral system strengthening interventions to be supported by MEASURE Evaluation. The assessment was not designed to obtain data that are representative of the national referral practices, nor did it aim to measure point estimates with statistical precision. Rather, the assessment aimed to provide a reasonable picture of the practices and procedures used in referrals in a select group of districts to better understand the overall strengths and weaknesses of the bidirectional community-facility referral system.

The assessment had the following specific objectives:

- Document the processes used to refer and counter-refer clients between community and facility service providers.

- Determine whether written referral protocols and guidelines exist, and whether they contain sufficient information to direct service providers and program managers in implementing referrals, based on criteria set forth in the Referral System Assessment and Monitoring (RSAM) Toolkit.
- Document how referrals are tracked and what data are collected, reported, and used for decision making.
- Identify key barriers to referral initiation and referral completion and to tracking referrals between community and facility providers.

Research Questions

1. What are the primary strengths and weaknesses of a bidirectional referral system linking community and health facilities?
2. Does the current referral system and its tools meet the requirements to monitor referrals and facilitate the necessary exchange of information among health care providers?
3. Are necessary training and guidance to implement effective referrals available to health service providers?

METHODS

The assessment was conducted in three districts of mainland Tanzania:

- Kinondoni District, Dar es Salaam Region
- Kyela District, Mbeya Region
- Wanging'ombe District, Njombe Region

The selection of districts was purposive and sought to include districts that have high HIV prevalence, represented a combination of rural and urban settings, and were supported by different implementing partners. Selection was done in consultation with the Tanzania Ministry of Health, Community Development, Gender, Elderly and Children[1] (MOHCDGEC) and the PEPFAR team in Tanzania.

We used a cross-sectional, mixed-methods approach to examine the current functioning of the bidirectional referral system between services providers in the community and at health facilities. The study includes semi-structured interviews with community and facility providers and other key informants; a review of documents, such as monitoring and evaluation (M&E) tools and national guidelines; and data from registers. The methods and data collection tools were adapted from the RSAM Toolkit, developed by MEASURE Evaluation. Data were collected with the help of FXBT Health, a sub-contracted local organization. Staff from FXBT Health also assisted in the data analysis. Data were collected in February and March 2016.

Key Informant Interviews

We interviewed various stakeholders expected to be knowledgeable about the referral system between community and facility services, with a focus on six categories of respondents: HBC community workers, MVC community workers, facility health care providers, HBC focal persons, district coordinators, and CBO project officers. We used semi-structured questionnaires in the interviews, with a combination of closed and open-ended questions tailored to the type of key informant. We conducted group interviews with the district coordinators in each district and with CBO staff at five organizations. All interviews were conducted in Kiswahili. A research assistant took notes for all interviews, which were later translated to English.

We conducted a pilot test and revised all data collection tools before the interviews started. We also obtained ethical clearance from Tanzania's National Institute of Medical Research and from ICF. All respondents gave written informed consent approval for the interviews.

Respondent Selection

We determined the number of respondents in the assessment based on two criteria: (1) the desire to have heterogeneity among providers and health facilities involved in referrals and (2) the resources available to conduct the assessment. We selected respondents in a two-phase process. First, we

[1] The Tanzania Ministry of Health and Social Welfare (MOHSW) changed its name to the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC). Throughout this document we refer to documents and tools developed under the previous name, MOHSW, rather than the new name. However, in reporting and discussing results, we use MOHSW and MOHCDGEC interchangeably.

selected health facilities in each district, and then we selected a subgroup of community and clinical providers affiliated with those facilities.

Health Facilities

Our approach to selecting facilities was purposeful. We did not aim for a representative sample of facilities, but wanted to include a range of facility types to get a picture of the overall referral system in the target districts.

In each district, we sought to include six health facilities:

- The district hospital
- Two health centers, selected randomly from among all health centers in the district
- Two dispensaries, selected randomly from among all dispensaries in the district
- One private or faith-based facility (FBO) that provides HIV care and treatment services, selected randomly from among private health facilities

We obtained a list of health facilities from district coordinators, sorted them by facility type, and randomly selected six facilities in each district as per the criteria above. To avoid bias, or being potentially steered toward the better performing facilities, we elected to randomly select the facilities within each category. However, we had to adjust our selection on two occasions: one district had only one public health center, so we replaced the second health center with an additional dispensary; in another district, the reference hospital was an FBO, so we included two FBO-owned health facilities instead of just one as planned. This did not affect our analyses since we did not plan to disaggregate by type of facility.

Facility Providers

We sought to interview 42 facility providers, or 14 per district. In each selected facility, providers who offer HIV-related services, including prevention of mother-to-child transmission (PMTCT), HIV testing and counseling (HTC), HIV care and treatment (CT), and tuberculosis (TB) services, were eligible to participate in the interviews. We interviewed four providers from each district hospital and two providers from each dispensary, health center, and private or FBO facility. Facility providers who were present at the time of the visit were eligible to participate. If numerous eligible providers were present, the interviewers created lists and randomly selected the participants.

Community Workers

HBC community workers were identified and invited to participate with assistance from the HBC District Coordinator. At each facility we interviewed one HBC community workers affiliated with that facility. However, one facility did not have any affiliated HBC community workers, so we interviewed two HBC community workers at a different facility. At another facility, the team inadvertently interviewed two rather than one HBC community workers and both were retained for analysis.

The research team had a more difficult time identifying MVC community workers to interview. Few have formal relations with the health care system and are not affiliated with particular health facilities. In the end, we asked the CBOs working in the districts to recruit MVC community workers. We ended up with completed interviews for 19 HBC community workers and 16 MVC community workers. This sample was sufficient for our purpose.

HBC Focal Persons

We invited the HBC focal person affiliated with each selected facility to participate, and we interviewed HBC focal persons at 12 of the 18 health facilities. Four facilities had no HBC focal person, and in two facilities that person was away and unavailable for interview.

District Coordinators

In all three districts, we held a group interview with the district coordinators of HIV programs. The district coordinators were informed before our visit and invited to join a semi-structured group interview. Interviews included 17 district coordinators in various focus areas: care and treatment, HBC, HTC, laboratory, mental health, reproductive and child health (RCH), and TB as well as district medical officers, district AIDS control coordinators (DACC), and district social welfare officers.

CBO Project Officers

We conducted interviews with staff from CBOs that support HBC or MVC programs in the three research districts. With the help of district coordinators, we identified CBOs and notified them of our interest in interviewing project officers who support HIV and AIDS programs. We interviewed staff from one CBO in Kyela, from two CBOs in Kinondoni, and from two CBOs in Wanging'ombe. Table 1 lists the district and types of respondents selected for the key informant interviews.

Table 1. Key informants selected for interviews in three selected districts, by category

District	Type of Respondent					
	Facility Providers	HBC Community Workers	MVC Community Workers	HBC focal Persons	District Coordinators	CBO Project Officers
Kinondoni	14	6	6	6	4	9
Kyela	15	7	3	3	9	5
Wanging'ombe	14	6	7	3	4	10
Total	**43**	**19**	**16**	**12**	**17**	**24**

Document Review

As part of the assessment, we reviewed various documents, national guidelines, and M&E tools to determine national and subnational level guidance and explicit procedures on referrals. Our review included the following categories of documents:

- National HIV guidelines (see Box 1)
- Referral protocols at national or subnational levels
- Training materials on referrals
- Client registers and volunteer notebooks
- Referral forms
- Reporting forms
- Monthly and quarterly reports that include referral information
- Directories of organizations or services
- Other informal tools or registers kept by health providers to track referrals

We used document review checklists with focused questions to guide the extraction of relevant information from the various documents. We examined some documents, such as the national HIV guidelines, as part of a desk review before the field work. We examined other documents, such as client registers and referral forms, during the interviews to determine which tools respondents use, the information they collect, and how well the documents are completed and used in the field.

Box 1: Guidelines and Other Documents Reviewed

- National Guidelines for the Management of HIV and AIDS (2012)
- National Guidelines for HBC Services (2010)
- National Guidelines for Improving Quality of Care, Support, and Protection for MVC in Tanzania (2009)
- National Guidelines for Comprehensive Care Services for Prevention of Mother-to-Child-Transmission of HIV and Keeping Mothers Alive (2013)
- National Guidelines for HIV Testing and Counseling in Clinical Settings (2007)
- National Guidelines for the Management of Tuberculosis in Children (2012)
- Third Health Sector HIV and AIDS Strategic Plan 2013-2017
- Tanzania Elimination of Mother to Child Transmission of HIV Plan 2012–2015
- SOP Manual for HTC
- Management of TB/HIV co-infected patients: Manual for Health Care Workers at TB Clinics and HIV Care & Treatment Centers (2008)
- Appointment Monitoring and Tracking Patients with Missed Visits Reference Guide
- Tanzania National eHealth Strategy

Extraction of Data from Registers and Referral Forms

When interviewing community workers, the survey team asked to inspect client registers and referral forms used in the preceding three months[2] to extract key information on referrals made and received by the community workers. We gathered the following data:

- Number of referrals made to health facilities
- Number of referrals with referral completion information available
- Reasons for referrals to a health facility
- Number of referrals received from health facilities
- Reasons for incoming referrals from health facilities

We recorded data on a register extraction form, with no personal or identifying information about the client. Only six community workers out of 35 (17%) came to the interviews with their registers and documents, however. Most indicated they were not asked to bring their documents to the interview, and others did not want to carry them in the rain for fear of getting them wet. While the number of

[2] Data extraction covered the three-month period from November 2015 to January 2016.

registers reviewed were low, we report findings to illustrate the types and quantity of referrals being made by community workers.

Data Analysis

We collected both quantitative and qualitative data for this assessment and entered the information in Epi Info, including the numerical and transcribed responses. Responses to some open-ended questions, such as the questions about procedures used to make referrals, were coded and assigned numerical codes. We assigned Yes or No values to various referral procedures, based on whether the respondent reported using that procedure. Where appropriate, we ran basic descriptive statistics using STATA, analyzing the data separately by type of respondent. We summarized the transcribed responses and grouped them into categories that described different referral practices.

To compile responses across the various groups of respondents and incorporate findings from the document review, the team developed and used a data analysis guide. The guide includes sections to describe strengths and weaknesses for different dimensions of the referral system, such as the referral networks, outgoing and incoming referral procedures, communication between providers, availability of tools and protocols, training, confidentiality, data flow, referral documentation and reporting, and supervision. Individual team members completed the analysis guide for each of the three districts. Subsequently, we held a workshop to share and compare notes and reach consensus on the findings and recommendations, aggregated across all districts.

Limitations of the Study

The assessment was intended to provide a comprehensive understanding of referral system performance at the community level, and to identify areas that require improvement. It focused on the overall structure of the referral systems and the processes and procedures used to refer clients between community workers and health facilities. The study was not designed to examine clinical aspects or the appropriateness of the referral made.

Due to funding limitations, the study was limited in geographic scope and therefore did not represent a complete national picture of community referral system performance. Similarly, the number of community workers, facility providers and community-based organizations we interviewed was limited. While referral system functioning may vary in other parts of the country, the findings from this assessment may still help identify important challenges and gaps that need to be addressed to improve referrals and linkages between community and facility providers.

RESULTS

Results are organized by the direction of the referral. First, we discuss results for referrals from the community to the facility, and then, we discuss results for referrals from the facility to community services. For each type or direction of referral, we discuss results on referral initiation, referral procedures and tools, documentation and follow-up of outgoing referrals, characteristics of incoming referrals at the receiving end, documentation of incoming referrals, and how feedback is provided to the initiating provider. We also discuss findings on the role of HBC focal persons, CBOs, and district coordinators in support of bidirectional referral systems between health facilities and communities. The findings include the resources available to providers to facilitate referral systems.

We interviewed 35 community workers, 43 facility providers, and 12 HBC focal persons in the three districts. Table 2 lists the characteristics of these providers by district.

Table 2. Position and facility affiliation of respondents by district

	Kyela	Wanging'ombe	Kinondoni	Total
Community Workers				
HBC	7	6	6	19
MVC	3	7	6	16
Facility Providers				
Position				
Doctor	3	3	3	9
Nurse	8	7	7	22
Midwife	2	2	4	8
Other	2	2	0	4
Facility Ownership				
Public	13	8	12	33
Private or FBO	2	6	2	10
Type of Facility				
Hospital	6	4	6	16
Health Center	2	4	4	10
Dispensary	7	6	4	17
HBC Focal Persons				
Position				
Doctor	1	0	0	1
Nurse	1	0	1	2
Midwife	0	0	5	5
Other*	1	3	0	4
Facility Ownership				
Public	2	1	5	8
Private or FBO	1	2	1	4
Type of Facility				
Hospital	2	1	1	4
Health Center	1	1	2	4
Dispensary	0	1	3	4

HBC = home-based care; MVC = most vulnerable children: FBO = faith-based organization.
Note: We do not report facility affiliation for community workers because many were not linked to a specific facility
*These four people identified themselves only as an HBC focal person.

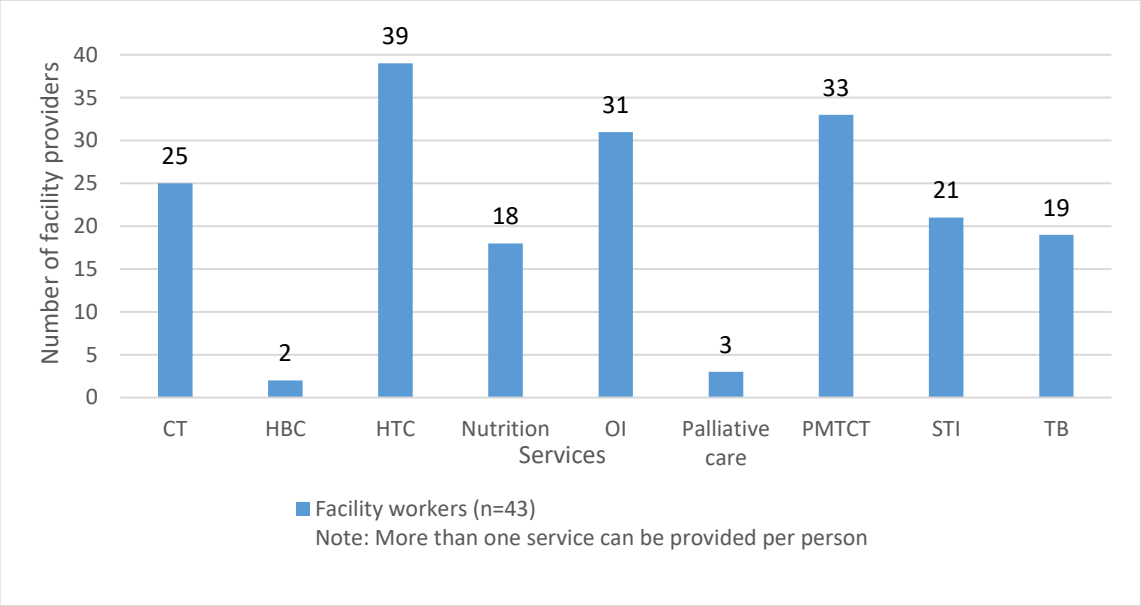
Table 3 lists the services that community worker and CBO respondents reported providing. Figure 1 compares facility provider services.

Table 3. Services provided by community workers and CBOs

HBC Community Workers (n=19)	MVC Community Workers (n=16)	CBOs (n=5)
– Track clients lost to follow-up (2) – Provide nutrition support (2) – Administer first aid (1) – Counsel clients (1) – Refer for opportunistic infections (1) – Advise clients to go to hospital or seek other services (1) – Health education (1) – Weigh children (1) – Oversee village health (1 – Distribute condoms (1) – Distribute water treatment tablets (1) – Provide HIV counseling and testing (1) – Report deaths (1) – Refer gender-based violence (GBV) victims (1) – Provide HIV prevention services (1) – Counsel on antiretroviral therapy (ART) (1) – Provide financial support (1) – Provide PMTCT support (1)	– Provide nutrition support (4) – Provide educational support (4) – Provide financial support (2) – Provide HIV and AIDS education (2) – Follow up on patients' progress (2) – Refer for HIV testing (1) – Provide psychological advice (1) – Provide legal support (1) – Distribute condoms (1) – Counsel clients (1)	– Refer clients (5) – Provide nutrition support (5) – Provide HTC (4) – Provide primary health care (4) – Provide education support (3) – Provide psycho-social support (3) – Assist in obtaining shelter (3) – Provide economic support (3) – Provide HBC services (2) – Counsel clients (3) – Provide HIV prevention education (2) – Track clients lost to follow-up (2) – Support victims of GBV (2) – Provide family planning (2) – Support clients on ART adherence (2) – Provide legal support (2) – Treat pain (1) – Provide palliative care (1) – Distribute condoms (1)

Notes: The number of respondents reporting they provide the service appears in parentheses. Respondents could report multiple services, and therefore, the total number of services provided could exceed the number of respondents.

Figure 1. Number of facility providers offering various clinical services



Referrals from Community to Facility

Referral Initiation by Community Workers

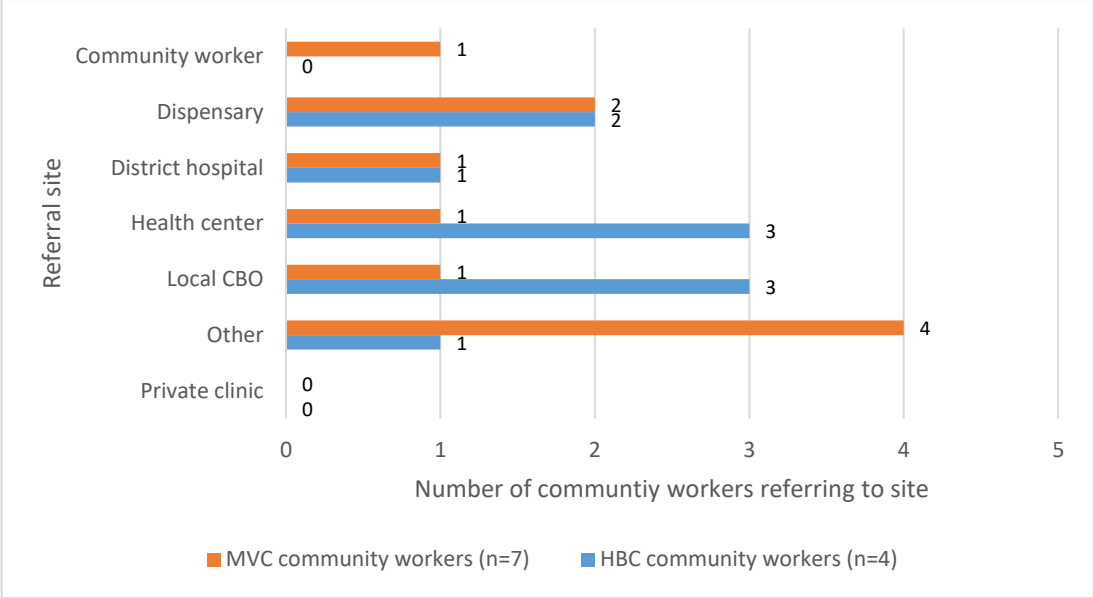
The majority of community workers reported that they referred clients to other clinical or support services; however, only 21 percent of HBC community workers and 44 percent of MVC community workers said they have made referrals in the past month (Table 4). The number of referrals to clinical or support services made in the past month ranged from 0 to 4 for HBC workers, and from 0 to 14 for MVC workers.

Table 4. Self-reported referral initiation practices among community workers

Referrals	HBC Community Workers (n=19)	MVC Community Workers (n=16)
Make referrals as part of their job	89% (17)	88% (14)
Made referrals in past month	21% (4)	44% (7)
Mean number of referrals made in past month, among those making referrals	2	6.4

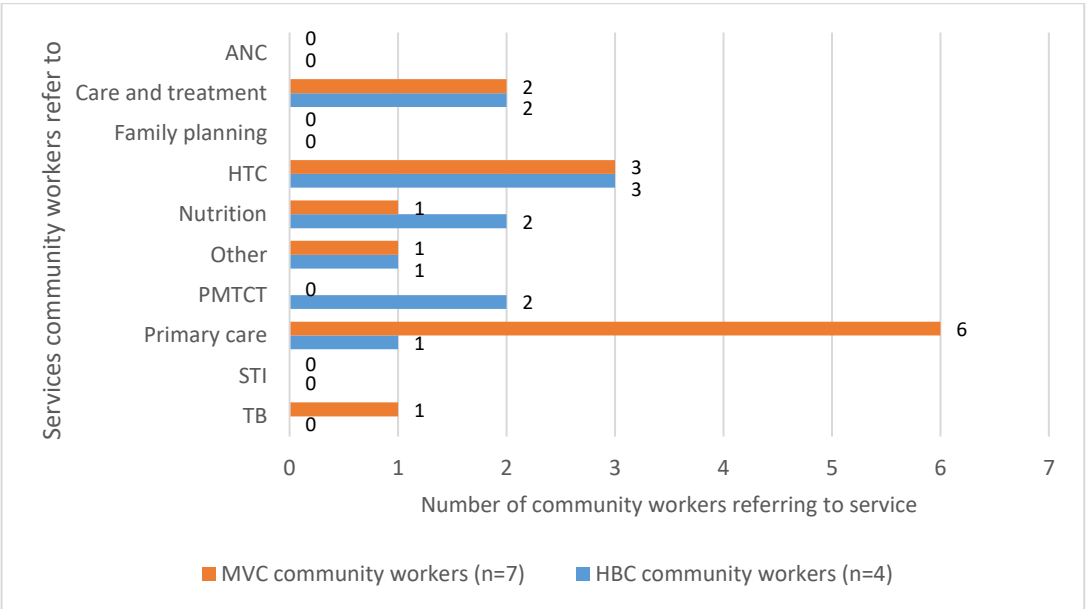
The results show that HBC community workers who made referrals in the past month tend to refer clients to dispensaries, health centers, and CBOs; MVC community workers tend to refer clients to nonclinical sites, such as ward offices for gender-based violence (GBV) cases, village government offices, organizations that provide spiritual counseling or vocational training, and to HBC community workers. None of the community workers reported sending clients to private health facilities (Figure 2).

Figure 2. Number of community workers that made referrals in the past month to different service delivery sites



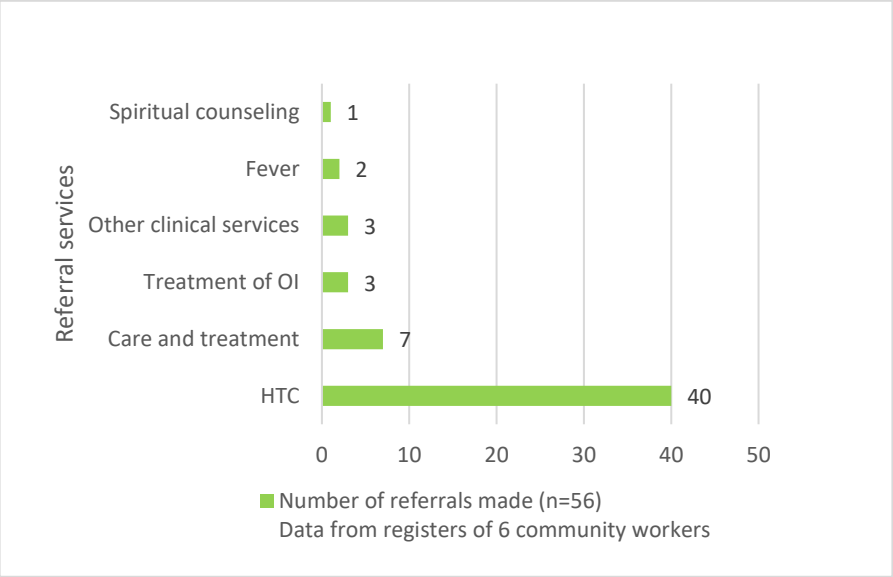
The types of clinical services to which community workers referred clients varied by the type of community worker. HBC workers are more likely to refer clients to nutrition and PMTCT services and MVC community workers are more likely to refer clients to primary care services. Both HBC and MVC workers referred clients to care and treatment and to HTC in equal numbers (Figure 3).

Figure 3. Comparison of types of clinical services that community workers report referring clients to in the past month



For six community workers we were able to verify referral data from their registers. These six community workers recorded a total of 56 referrals in the three-month period form November 2015 to January 2016. Of these, 55 referrals were confirmed as having been completed. The majority of these referrals were to HTC services (Figure 4).

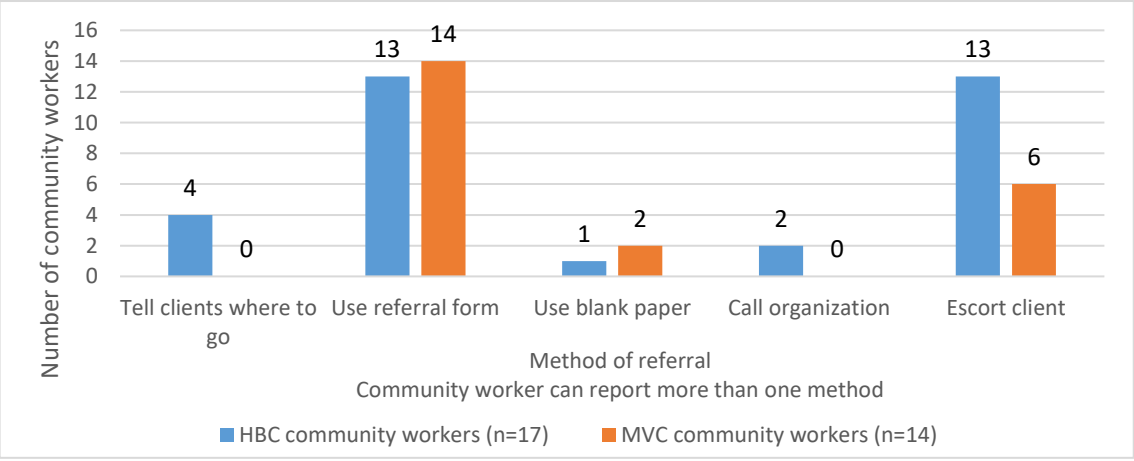
Figure 4. Types of services that community workers referred clients to in the past three months, based on data extracted from community worker registers



Processes for Making Referrals

Most HBC community workers (13 of 17) reported that when they make referrals, they use referral forms, and an equal number escort clients to the facility. Fewer HBC community workers used oral referrals without supporting documentation, calling the organization, or writing a referral note on blank paper (Figure 5). Among MVC community workers making referrals, all but one used referral forms, and almost half said that they escort their clients.

Figure 5. Comparison of referral methods community workers use.



Tools and Forms Community Workers Use

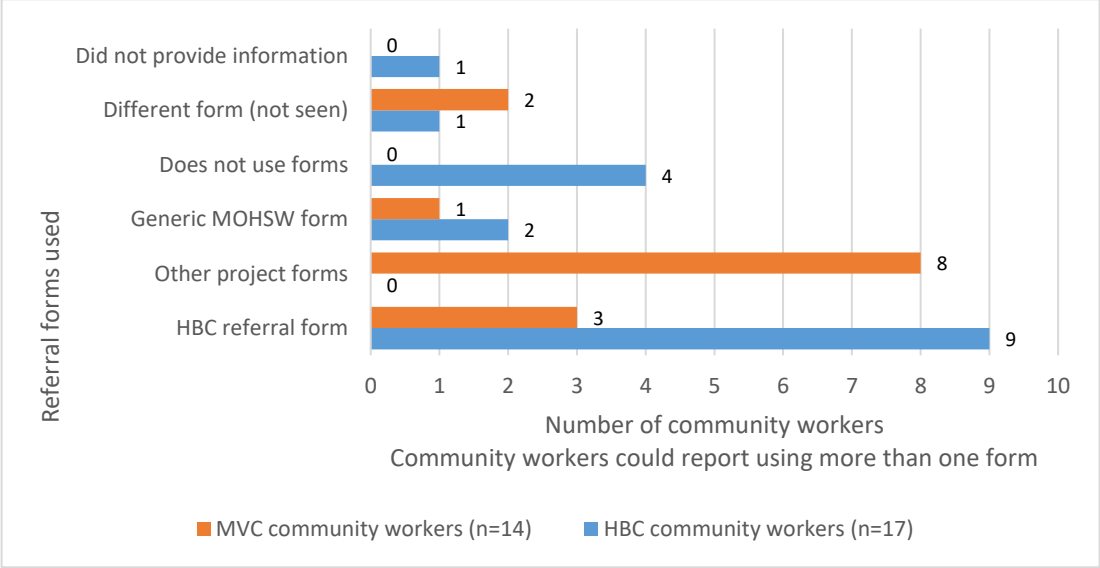
The document review revealed that MOHCDGEC has developed two standard referral forms:

- A generic referral form that is not affiliated with a particular program
- A referral form developed specifically for the HBC program and used by HBC community workers

Of the 35 community workers interviewed, 26 reported that they use referral forms. Of the 17 HBC community workers that made referrals, nine reported using the HBC referral form and two reported using the generic MOHCDGEC form. The remainder used a different form or no referral form (Figure 6).

MVC community workers relied mostly on project-specific tools. Of the 14 MVC community workers that made referrals, seven reported using a form from the Pamoja Tuwalee Project and one reported using a form from a Walter Reed Project. Few used standard MOHCDGEC referral forms.

Figure 6. Comparison of referral forms community workers use to make referrals



The community workers who do not use forms gave the following reasons for not using referral forms (multiple responses were allowed):

- They were not given referral forms (3)
- They thought clients do not always need a referral form (3)
- They did not always carry the referral forms on client visits (2)
- They had not received training on using the forms (1)
- They called the HBC supervisor instead of using a form (1)
- They were too busy to fill out a form (1)
- They forgot to use the form (1)
- Clients said that they did not want their HIV status documented on the form (1)

Documentation of Outgoing Referrals by Community Workers

Almost all community workers who made referrals indicated that they keep some type of record of the referrals, such as in a blank notebook or in the HBC volunteer notebook when available, or by keeping carbon copies of the referral forms (Table 5). More than half of the HBC community workers reported they use the HBC volunteer notebook to record and track the referrals they have made. MOHCDGEC developed the HBC volunteer notebook for HBC community workers to record services provided to community members. It includes two columns, one to document referrals made and one to document referrals completed.

Most MVC community workers reported keeping copies of referral forms and using blank, nonstandardized notebooks to document referrals. Only two indicated they had a standardized register, and they reported that they used the HBC volunteer notebook.

Table 5. Tools community workers use to record referrals made

Tools for Recording Referrals	HBC Community Workers (n=17)	MVC Community Workers (n=14)
HBC volunteer notebook	10	2
Copies of referral form	6	7
Blank notebook	2	6
No referral records kept	2	0

Note: Respondents could report more using than one tool, and therefore the number of tools may exceed the number of workers.

Follow-Up of Referral by Community Workers

Approximately half of the community workers said that they always obtain feedback on the referrals they make to health facilities (Table 6).

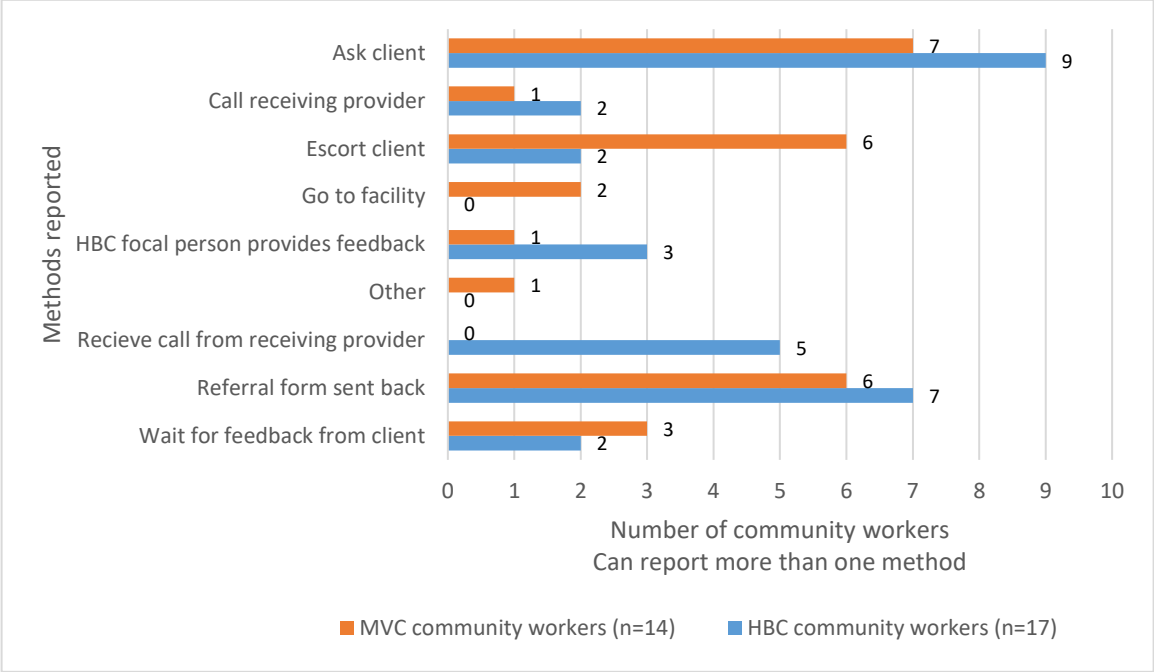
Table 6. Number of community workers that receive referral feedback

Receive feedback	HBC (n=17)	MVC (n=14)
Always	8	7
Sometimes	8	7
Never	1	-

When asked how they confirm that clients have completed the referrals, the majority of HBC community workers said that they follow up directly with the client or receive a referral feedback slip from the facility. Others noted that they receive calls directly from facility providers. Only three said that they receive feedback from the HBC focal person (Figure 7).

MVC community workers said that they get feedback by escorting clients to the referral, following up with clients later, or having referral slips returned. None reported receiving calls directly from facility providers.

Figure 7. Comparison of methods community workers use to follow up on referrals made



Health Facilities Receiving Referrals from Community Providers

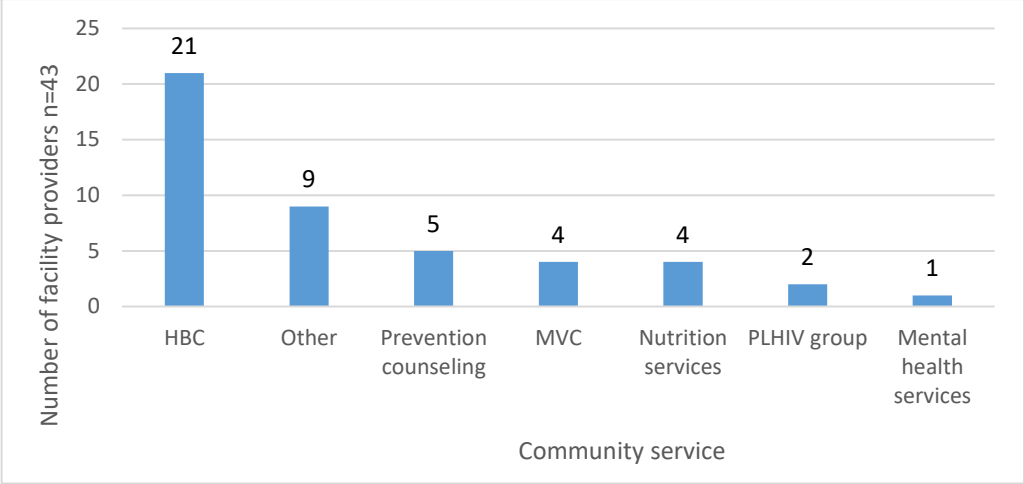
Thirty-one of the 43 (72%) facility providers interviewed stated that clients are referred to them from the community, and 20 of them (47%) reported receiving referrals from the community in the past month (Table 7). Among the providers that received referrals from the community in the past month, the number of incoming referrals ranged from 1 to 16, with a mean of 4.8 referrals per provider.

Table 7. Percentage of facility providers that reported incoming referrals and the mean number received

Referrals Received	Number
Referrals received from community (n=43)	72% (31)
Referrals received in past month (n=43)	47% (20)
Mean number of referrals received in the past month, among those receiving referrals (n=20)	4.8

Of the 43 facility providers interviewed that provide HIV and AIDS-related services, almost half indicated that they receive clients referred by HBC community workers (Figure 8). Only four providers said that they received referrals from MVC workers. The number of facility providers that reported receiving referrals from other types of community services, such as maternal health programs, support groups, peer educators, project officers, and other community workers, was low.

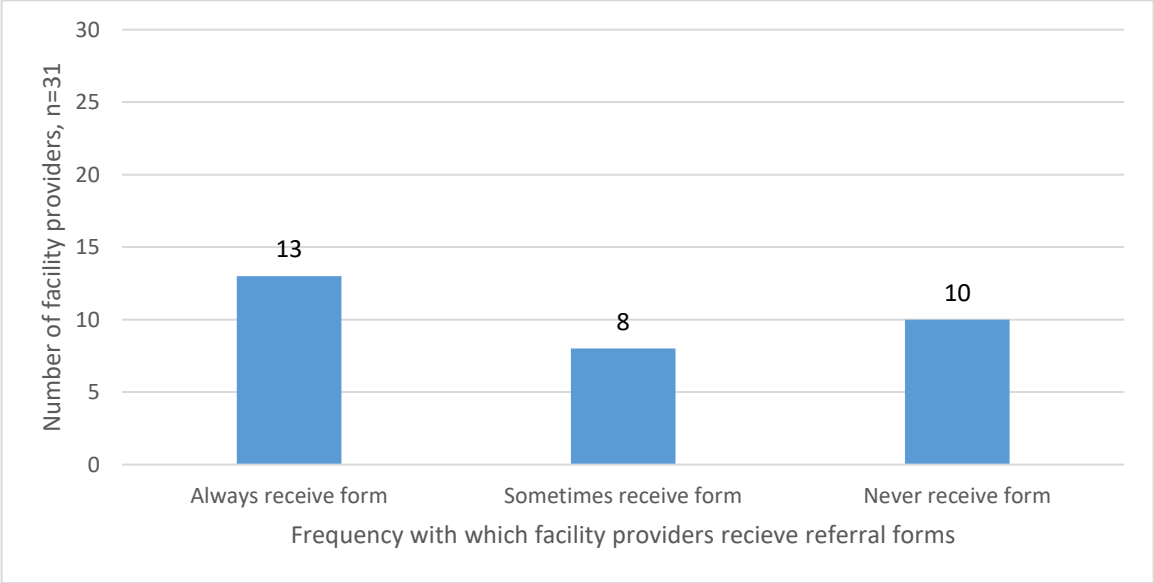
Figure 8. Number of facility providers that reported incoming referrals, by type of service clients were referred from



Incoming Referral Documentation

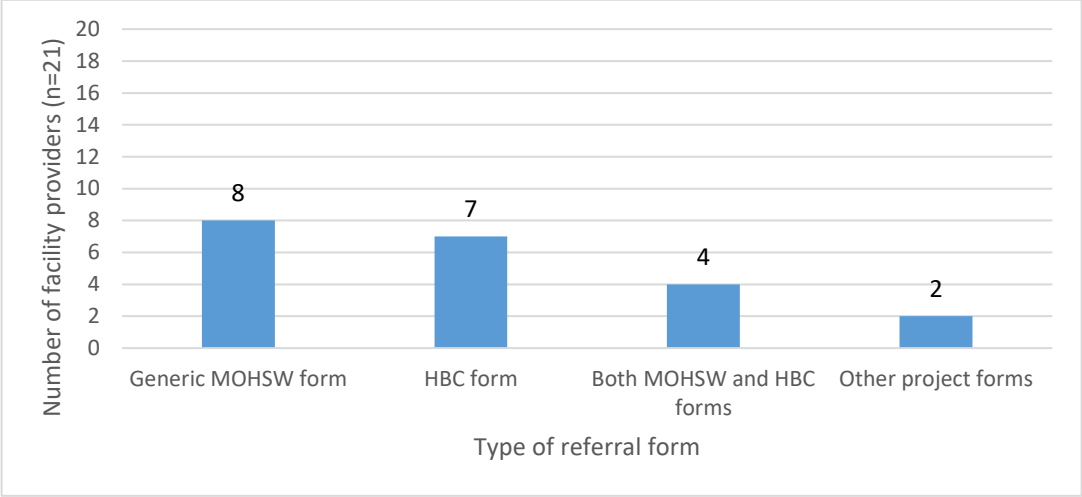
Facility providers said that they receive oral referrals, referral forms, written notes, escorted clients, and phone calls from community workers when clients are referred to them from the community. Two-thirds of facility providers that receive referrals said that they always or sometimes get a referral form from clients from the community, and one-third said that they never receive a referral form (Figure 9).

Figure 9. Number of facility providers that receive referral forms from community workers



Of the facility providers that receive referral forms, 19 said that they receive a standard MOHCDGEC referral form with community referrals (Figure 10).

Figure 10. Referral forms that facility providers receive

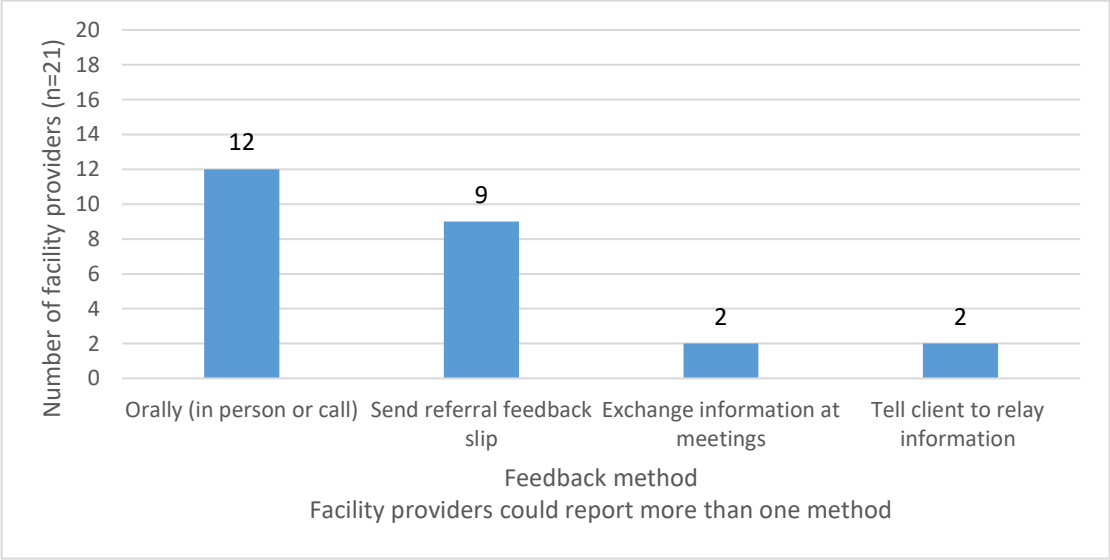


Of the 20 facility providers who said that they keep records of incoming referrals, 16 said that they always keep records, and four said that they sometimes keep records. Sixteen facility providers keep copies of the incoming referral forms, 1 keeps records in a notebook, and the remainder did not specify how they keep records of incoming referrals. No facility provider mentioned recording incoming referrals in patient registers.

Feedback to Community Workers on Referrals

Less than two-thirds (13 of 21) of facility providers said they always send feedback to the community workers on all referrals, eight said that they sometimes send feedback, and 10 said that they do not send feedback to community workers. Figure 11 compares the different methods facility providers reported using to provide feedback.

Figure 11. Methods facility providers use to give referral feedback to community workers



Referrals from Facility to Community

Referral Initiation by Facility Providers

Most facility providers reported that their facility has linkages to community interventions. Linkages to the community HBC services were the most commonly reported, but other community interventions, such as mother support groups and income-generating activities, were also mentioned (Table 8). A few facility providers in Kyela noted that they have linkages to CBOs, but they did not specify a particular intervention.

Table 8. Number of facility providers that are aware of linkages to community interventions, by type of intervention

Community Intervention	Kyela District (n=15)	Wanging'ombe District (n=14)	Kinondoni District (n=14)
HBC	13	14	14
Mother support groups	6	1	3
MVC	7	1	2
Income-generating activities	0	2	4
Other*	0	2	2

*Other interventions include linkages to palliative care and to community workers.

Only 28 percent of facility providers reported making referrals to the community and 16 percent reported making referrals in the past month. Of the facility providers that reported referring clients to the community in the past month, the number of referrals made ranged from 2 to 20, with a mean of 9.2 referrals per provider (Table 9).

Table 9. Self-reported referral initiation practices among facility providers

Referral Initiation	Facility Provider (n=43)
Make referrals	28% (12)
Made referrals in past month	16% (7)
Mean number of referrals made in past month, among those making referrals	9.2*

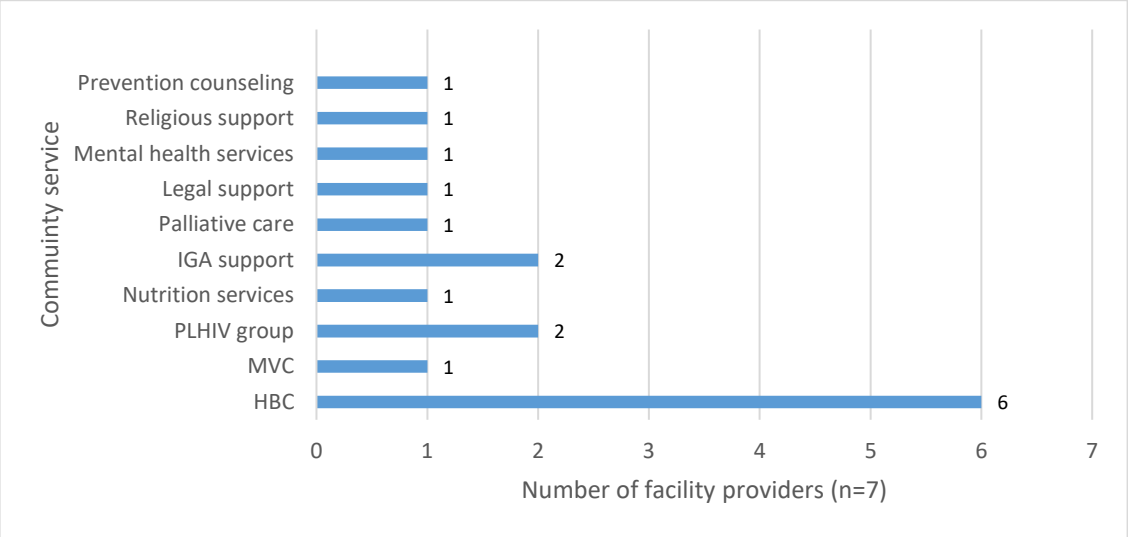
*One provider reported making 20 referrals in the past month; the remainder reported making 10 or fewer.

When asked where in the community they referred clients to, facility providers listed the following sites:

- CBOs
- HBC community workers
- Support groups
- Income-generating activity groups
- Ward developmental officers
- Village government office

Figure 12 compares the number of different community services where facility providers reported referring clients in the past month. Of the seven facility providers that reported making referrals in the past month, six referred clients to an HBC community worker. Few providers reported referring clients to other community services in the past month.

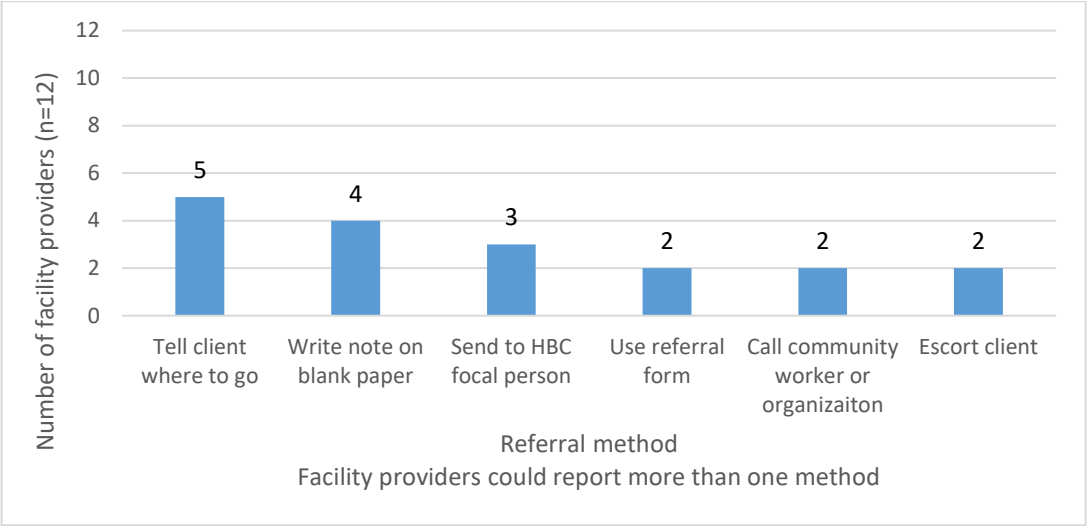
Figure 12. Number of facility providers that report referring clients to community services in the past month, by type of community service



Processes for Making Referrals

Facility providers made referrals to community services through various means (Figure 13). Five facility providers used oral referrals to tell clients where to go and four provided handwritten notes. Only two facility providers said they used referral forms. Two facility providers said that they called or personally discussed the referrals with the receiving community provider, either the HBC focal person or the community worker. Some facility providers indicated that referrals to community services were made through the HBC focal person. Those who escort clients most likely escort them to the HBC focal person or other community liaison (e.g., mother-to-mother support group) at the facility.

Figure 13. Referral methods facility providers use to refer clients to community services



Tools and Forms Facility Providers Use

Only two facility providers reported using official referral forms when they refer clients to community services. One used the generic MOHCDGEC form and the other used the HBC referral form. Only one of these providers reported using a referral form every time a referral was made to community services.

Table 10 lists reasons facility providers gave for not using referral forms. The majority of facility providers said they do not have referral forms for community referrals, and one said that it is not official practice to use referral forms to refer client to community services.

One facility provider noted that clients might not accept a referral form, saying "Sometimes the client is not ready to carry a referral form, so we continue to counsel them. If you give it to them before they are ready, they will just go and throw it away."

Table 10. Reasons facility providers give for not consistently using referral forms

Reason Stated	Number of Facility Providers (n=11)*
Do not have referral forms	7
Use of a referral forms is not official	1
Client is not ready for a referral form	1
No explanation given	2

*Only facility providers that make referrals and do not use forms consistently were asked this question.

Documentation of Outgoing Referrals by Facility Providers

Of the 12 facility providers that made referrals to community services, six reported keeping records of the referrals made (Table 11). The methods reported for keeping records varied by provider. Most facility providers (6) did not document referrals. Only two providers mention recording referrals on care and treatment clinic client cards (CTC1 and CTC2). None of the providers reported documenting referrals to community services in any of the standard patient registers available at the facility, although some of the registers included columns for referrals made, such as the HTC and ART registers.

Table 11. Tools facility providers use to record referrals made

Tools Used	Number of Facility Providers (n=12)
Keep copies of referral forms and record in HBC notebook	2
Blank notebook	1
CTC1 card	1
Keep copy of note and record referral in CTC2 card	1
No records kept	6

CTC=Care and treatment clinic
Note: One provider did not give details on how records were kept.

Follow-Up of Referrals by Facility Providers

Four of the facility providers said they always obtain feedback on referrals made to the community, and the remainder said that they get feedback on some referrals. The most cited means of getting feedback were to follow up directly with the client or to wait for the community provider or the HBC focal person to provide the information (Table 12). For referrals to HBC services, two providers said that they know a referral had been completed when client CTC1 cards included an HBC number. Only one facility provider reported that feedback slips from referral forms were received from the community.

Table 12. Methods facility providers use for follow-up on client referrals

Referral Feedback Methods	Number of Facility Providers (n=12)
Seek information from the client by calling or in person at the next client visit	4
Receive a phone call or visit from community providers	4
Look for HBC number on CTC1 card	2
Receive feedback slip from client's referral form	1
Receive feedback from HBC focal person	1
Call community provider to get feedback	1

Three facility providers reported that the HBC focal person is responsible for following up on referrals to the community. Other facility providers reported that a different health care worker, nurse, doctor, or individual in the palliative care unit does follow-up.

Community Providers Receiving Referrals from Facility Providers

We asked community workers and CBO project officers how often they received referrals from facility providers. Fewer than half (8 out of 19) of the HBC community workers reported sometimes receiving referrals from health facilities. Of these eight, only three had received any referrals in the past month. Among the MVC community workers, three out of 16 said that they received referrals from the facility, but only one reported receiving referrals in the past month.

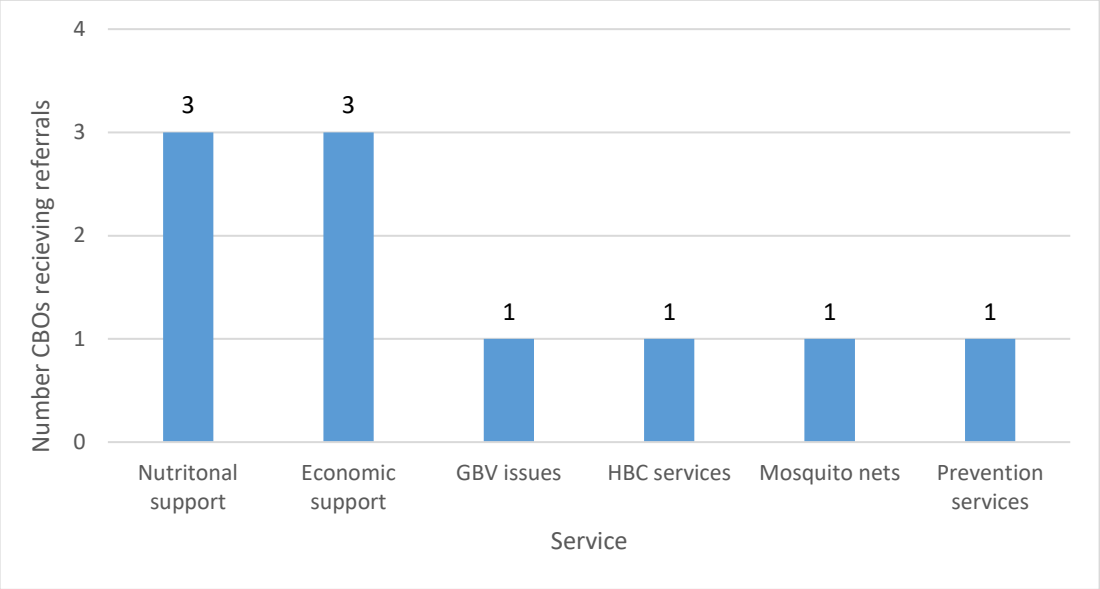
Table 13. Percentage of community workers that reported incoming referrals from facility providers and the mean number received

Referrals Received	HBC (n=19)	MVC (n=16)
Receive referrals from facility	42% (8)	19% (3)
Referrals from facility received in past month	16% (3)	6% (1)
Mean number of referrals received from facility in past month, among those receiving referrals	3.3 (n=3)	10 (n=1)

Four of the five CBOs reported receiving incoming referrals from facility providers. Of the four organizations receiving incoming referrals, two reported that clients are referred directly to the community workers, and two reported that clients are referred to the project office.

Figure 14 lists reasons for incoming referrals to CBOs from the facility providers.

Figure 14. Reasons for which clients are referred from facility providers to CBOs



Incoming Referral Documentation

Four HBC community workers reported receiving referral forms from the facility (Table 14). Three of the HBC community workers received the HBC referral form, and one received the generic MOHCDGEC form. Only one of MVC community workers reported receiving referral forms with incoming referrals from the health facilities. This individual also reported receiving the HBC referral form.

Four of the eight HBC community workers who receive incoming referrals keep records on these referrals, and one of the MVC community workers who receives incoming referrals keeps records. Table 14 shows the different ways that community workers keep records of incoming referrals.

Table 14. Documentation received and records kept by community workers for incoming referrals from the facility

Documentation Tools	HBC (n=8)	MVC (n=3)
Receive referral forms from the facility	4	1
Keep copies of referral forms	1	1
Use HBC Volunteer Notebook	1	0
Use blank notebook	2	0
Do not keep records	4	2

Feedback to Facility Providers on Referrals

Five of the eight HBC community workers who receive incoming referrals reported providing feedback on referrals back to the facility; four of these reported always sending feedback, and one reported sometimes sending feedback.

Methods for providing feedback to facility providers included:

- Sending the feedback portion of the referral form (2)

- Providing feedback during monthly meetings with facility staff (2)
- Sending activity reports to the facility (1)

Two of the three MVC community workers who receive referrals stated that they provide feedback on referrals made to them by filling out the feedback portion of the referral form.

Role of HBC Focal Persons in the Referral Process

Community workers, facility providers, and other CBO staff members reported that HBC focal persons have an important role in the referral system between health facilities and community services. Several facility workers reported that HBC focal persons act as intermediaries in the referral process. The facility workers will send the client to the HBC focal person, who will then make referrals or linkages to other community services. CBO staff members stated that the HBC focal persons help follow up and track patients who are referred or are lost to follow-up. The HBC focal persons also coordinate meetings with community workers and participate in CTC meetings at health facilities.

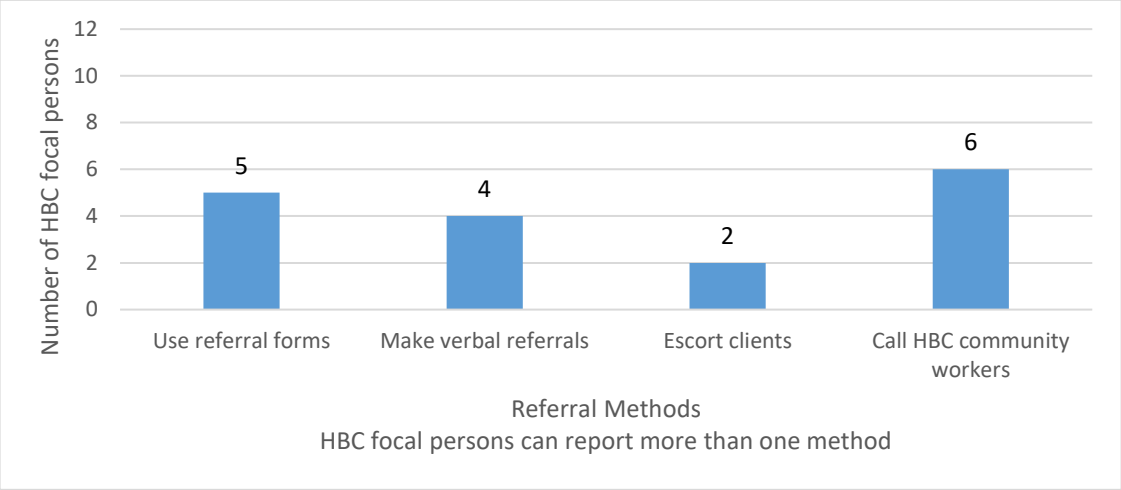
According to the National HBC Guidelines, the role of HBC focal persons is to mentor and provide services to HBC community workers, patients and families receiving HBC services, and communities in the catchment area of the facility (NACP, 2010). One of their responsibilities is to assist community workers with the follow up of patients discharged from health facilities. At health facilities where CTC is provided, they facilitate referrals and linkages to community HBC services, follow up on defaulters or missed appointments, keep a directory of services, and work with the CTC team at the facility. At the community level, HBC focal persons help increase community awareness of HIV and AIDS, coordinate HIV and AIDS prevention programs, and help decrease stigma (NACP, 2010).

All HBC focal persons interviewed reported that their main role regarding referrals is to ensure that clients get the services they need. They do so by referring clients to community or facility services and by following up with clients referred by other providers. Some HBC focal persons specified that they make home visits and provide counseling to clients who do not complete referrals or miss appointments.

Of the 12 HBC focal persons interviewed, 10 said that clients are regularly referred to the community. Two HBC focal persons, one from Kyela and one from Kinondoni, reported that they do not make referrals to community services. The HBC focal persons who make referrals indicated that they refer clients to community providers for HBC care and support, nutrition services, spiritual counseling, financial services, GBV support, and legal services.

Methods that HBC focal persons use to refer patients are presented in Figure 15.

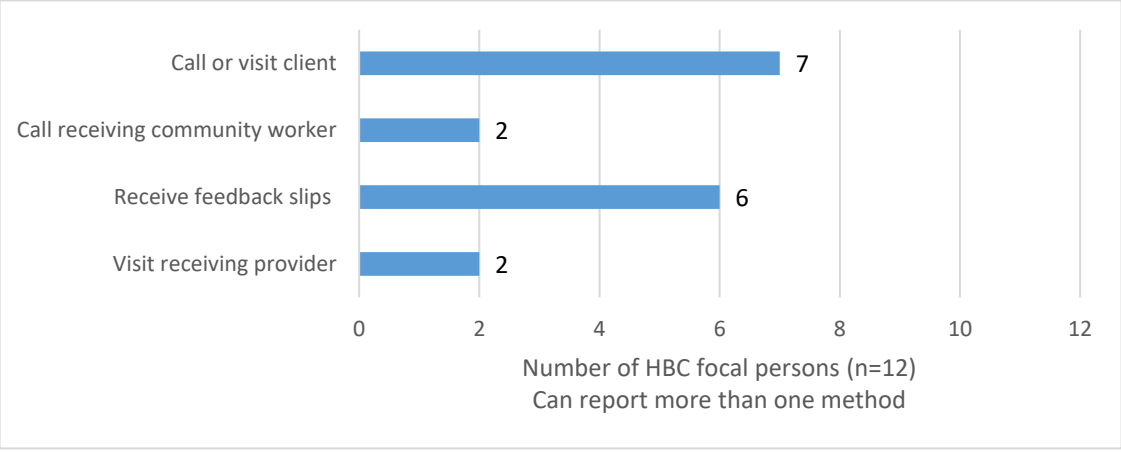
Figure15. Referral procedures used by HBC focal persons



All HBC focal persons interviewed reported having a process for following up with clients who are referred between health facilities and the community. The HBC focal persons are primarily responsible for follow-up, although five HBC focal persons indicated that clinical providers are sometimes also involved in the follow-up of client referrals. Community workers, however, are more active in the referral process than facility providers; according to the HBC focal persons, community workers often escort clients to the facility for different services or come to the facility at a later date to verify referral completion.

HBC focal persons also obtain information on completed referrals by receiving referral slips, making phone calls, meeting with the HBC community workers, going to the facility where the client was referred, and following up with the client directly (Figure 16).

Figure 16. Methods HBC focal persons use for confirming referral completion



All HBC focal persons reported that they documented referrals to facilitate tracking of referred clients. The tools used for documenting the referrals varied (Table 15). The HBC focal persons also stated that they receive information on completed referrals by receiving the referral form sent with the client.

Table 15. Tools used by HBC focal persons for documenting referrals they make

Tools for Documenting Referrals	Number of HBC Focal Persons (n=12)
HBC supervisor report book	4
An unspecified register or form	4
Copies of referral forms	3
Pre-ART register	1
Appointment register	1
Blank notebook to write age, sex, and date of referral initiation	1
Monthly report sent by HBC community workers	1

Note: More than one tool can be reported

Role of CBOs in the Referral Process

CBOs work in many districts to support HIV and AIDS programs, including the HBC and MVC programs that provide HIV-related health and support services at the community level. These CBOs are usually responsible for coordinating the delivery of services and supervising the work carried out by the community workers.

Program coordinators and focal persons from all five CBOs included in this study reported that making referrals is an important part of their work. CBO staff indicated that referrals were primarily done by the community workers affiliated with the CBO, but four of the five reported that other organization staff members, such as HBC coordinators, focal persons, supervisors, and peer educators, also make referrals.

Program coordinators and focal persons at the CBOs were asked about their role in the referral system. At all five CBOs, program coordinators and focal persons said that their role involved tracking the referrals made to verify whether clients went to the facility and what services they received. They also noted that they were responsible for getting feedback on the referrals from volunteers and ensuring that the referral forms are completed and used correctly. Coordinators from two CBOs also stated that their role is to create relationships between clients and community workers, and two other coordinators stated that they are responsible for creating relationships between community workers and facility providers. The following roles were each reported by one CBO coordinator:

- Investigating problems in the referral system
- Following up with clients lost to follow-up
- Maintaining confidentiality
- Conducting meetings with community workers or district coordinators
- Counseling clients
- Ensuring the availability of tools
- Escorting clients
- Conducting client needs assessments
- Assisting and mentoring community workers in making health facility referrals

- Collecting and compiling referral data
- Creating referral tracking records
- Ensuring proper recording and paper documentation of referral information

Referral Tools

All five CBOs noted that they (staff and community workers) use referral forms when referring clients to health facilities. They also noted that escorting clients is commonly practiced. In some CBOs, the referral forms used varied by program area; MVC, HBC, HTC, and prevention programs may each have their own versions. Other than HBC forms, the referral forms were often developed specifically for the project.

Referral Records Kept

All five CBOs have a recordkeeping system to document referrals made between the community and facility and help track which referrals need follow-up. These systems primarily deal with outgoing referrals from community providers to the health facilities.

Four of the CBOs reported filing the carbon copies of referral forms and received feedback slips to keep records on referrals for clients.

One CBO used Excel databases for their HBC and MVC programs. The HBC program database was not referral-specific but included information on referrals made. The database for the MVC program collected information on the number of referrals made and received, type of service for which the client was referred, and the direction of the referral (to community or to facility).

Another CBO had developed a referral register in a blank notebook to note all referrals made, copying key information from referral slips and indicating referral completion dates captured from feedback slips. The notebook, however, was not up to date when the research team examined it due to the high volume of clients and referrals.

Confirming Referral Completion

CBO staff members were asked how they obtained information about referral completions. All organizations reported that they relied on returned feedback slips and on community workers following up directly with clients; other methods of verifying referral completion are listed in Table 16.

Table 16. Methods used by CBOs to verify referral completion

Method Used	Number of CBO * (n=5)
Receive referral feedback slips	5
Community workers communicate with client	5
Hold monthly meetings with community workers to gather information on clients	3
Visit client	3
Community workers communicate with facility workers	2
Escort client	2
Review client file	1
Obtain feedback from HBC focal person at each facility	1
Organize club meetings and get information about other clients from club members	1
Check prescriptions from medical provider	1

*Note: Each CBO can have multiple responses.

Role of District Coordinators

District coordinators for HIV programs were asked how they support the referral system in their district. Several reported that their role was to advise facility and community providers on how to make referrals (Table 17). District coordinators also noted that they were responsible for ensuring that providers have referral tools, lists of community workers, and the equipment needed to provide their services. A small number of district coordinators also cited providing supervision and reviewing referral forms and monthly reports as key responsibilities.

Only one district coordinator mentioned coordinating with CBOs as a key responsibility. However, when asked directly about what type of coordination existed with CBO, many district coordinators in all three districts reported collaborating with CBOs, mostly through meetings. The district coordinators who reported collaborating with CBOs included HBC, social welfare, and TB coordinators. For the PMTCT and HTC programs, specific instances of collaboration with CBOs were only noted in one district, respectively.

Table 17. Self-reported responsibilities of district coordinators in the referral system

Type of District Coordinator	Reported Responsibilities (responses from all districts are included, so some answers may appear more than once)
HBC coordinator	-Provide a list of providers at each facility -Collaborate with CBOs to link providers to health facilities
Social welfare coordinator	-Instruct providers (orally) -Give contacts to volunteers so they can easily communicate
HTC coordinator	-Make sure resources are available
RCH coordinator	-Orient facility providers on referrals and linkages -Mentor and coach service providers -Provide supervision
District AIDS control coordinator	-Ensure availability of referral tools -Conduct supervision at the community level -Supply referral tools to health facilities -Supply health equipment -Review reports on referrals -Instruct both facility and community providers to follow up on referrals made
TB and HIV coordinator	-Write referrals -Give instructions on how to reach the facility -Support clients (e.g., providing transport fee, airtime voucher) -Make sure that referral tools are available to health personnel -Review referral tools
Mental health coordinator	-Communicate with the community organizations

District coordinators also described the strengths and weaknesses of each program (Table 18).

Table 18. Strengths and weaknesses of linkages with community programs as reported by district coordinators

Program areas	Strengths	Weaknesses
HBC	-Strong linkage with health facilities -Strong linkage with MVC program -Availability and usage of referral forms -Meetings between providers and supervisors -Referral of clients to HBC services	-Transportation: difficulty getting to facility for follow-up -Clinicians do not prioritize community referrals -Facility workers unaware of community referrals -Not enough referral tools -No feedback on referrals
MVC	-Referral of clients to health facilities (orally) -Receive clients from pediatric clubs -Availability of health services -Recognizing clients when getting services -Availability of referral tools -Use of referral forms	-Most referrals oral -No standard referral tool -Referral forms not available -Lack of follow-up for feedback -Poor participation from volunteers -Community workers not known to facility providers -No feedback received -Reports from NGOs not received

Program areas	Strengths	Weaknesses
RCH and PMTCT	-Partner involvement facilitates referral for mothers who test positive -Social groups increase linkage between HBC and other community projects	-No standard referral tool across all service providers -Facility providers do not refer to community -Mainly oral referrals -Providers have poor knowledge of referral system -Lack of follow-up system to get feedback on referrals
Care and treatment	-Collaborate with CBOs that provide services at the facility and community level -List of volunteers and services available -Good relationship between CTC and volunteers -Availability and usage of referral forms -Feedback, i.e., referral slips, returned to show that a client has received the services	-No mobile CTC to assist with outreach to harder to reach areas -No referral forms available -Clients not always enrolled in HBC services -Volunteers only follow up on clients who miss appointments -No monitoring of the referral system -Care and treatment do not refer clients to community
TB and HIV	-Use referral forms for TB clients -Volunteers track LTFU clients -Registers and reports available -Clients educated on TB -Escort client to health facility	-Volunteers lack education -No referral tool for community referrals -Health facilities do not refer to community -Clients do not know location of facility
HTC	-Use referral forms -Refer clients to community services	-Distance to health facility makes it difficult for clients to access services and increases the number lost to follow up

Coordination around Referrals

Coordination with Community Workers

Thirteen of 35 community workers (37%) reported exchanging information with facility providers when they escort clients, when they visit the facility to follow up on referrals made, and in a few cases by phone. However, not all community workers had regular or direct communication with facility providers, and very few facility providers indicated engaging directly with community workers. Nine community workers indicated that communication with facility providers was through feedback slips of the referral forms, and six community workers stated that CBOs and facility providers do not help them get information at all.

A few community workers mentioned that they were not always well received or respected by facility providers, and some shared experiences where facility providers had ignored or rejected their referral forms. Both community workers and facility providers suggested that improving the relations between them was important for strengthening referral systems and linkages.

HBC community workers generally reported interacting and sharing information with HBC focal persons, primarily when they turn in monthly reports. However, only one HBC focal person reported having formal meetings with community workers where referrals were discussed.

Coordination between Health Facilities and CBOs

Eight of the 43 facility providers (18%) attended facility management meetings in the previous six months where referrals were discussed, and three of the facility providers (7%) reported attending a meeting in the past six months with CBOs or community workers where referrals were addressed. Issues discussed at these meetings included adherence to ART, processes of starting a referral system and linkages, clients lost to follow-up, and processes to follow up on referrals made.

Three of the five CBOs reported that they participated in meetings within the past six months with other stakeholders, including facility providers, where referrals had been discussed. These meetings included the following:

- A meeting between CBO HBC program staff and district coordinators
- A meeting for the MVC program organized by the regional social welfare office
- Meetings with HIV care and treatment stakeholders
- A meeting with another CBO to coordinate referral systems

The district coordinators all reported that they attend monthly meetings, including meetings with care and treatment staff at the facility, meetings with the district medical officer, and council health management meetings. However, only one district coordinator reported discussing referrals at one of the meetings in the previous year.

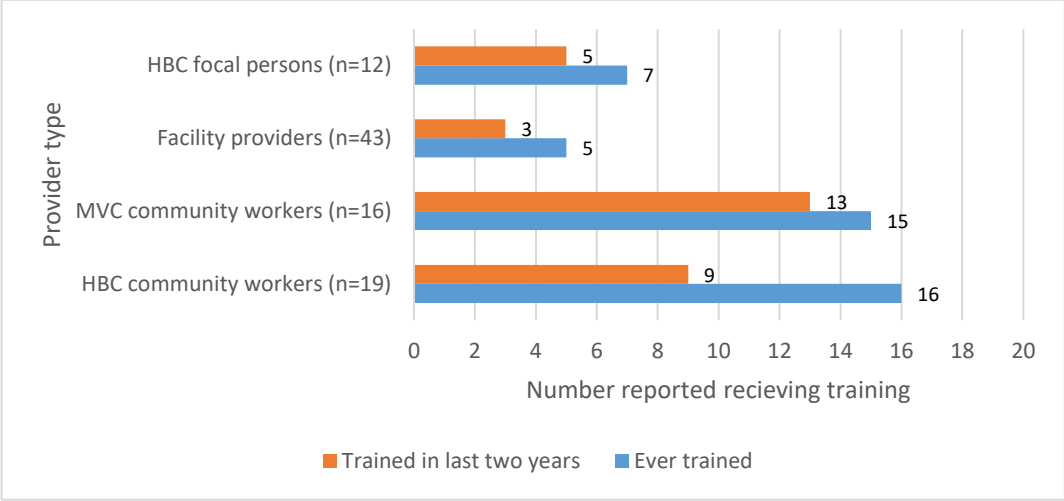
The districts coordinators reported that there are no Continuum of Care Boards in two of the districts: Kyela and Wanging'ombe. In Kinondoni, a district coordinator stated that there are health committees for the HBC program in each ward, which include religious leaders, CBOs, NGOs, and health experts. These health committees have discussions on clients lost to follow-up but not on referrals more broadly. In Kinondoni, district coordinators reported that there are MVC committees which have quarterly meetings that discuss linkage and referral issues.

Resources Available to Support Referrals

Trainings

Community workers and HBC focal persons reported having received training around referrals more frequently than facility providers (Figure 17). Almost all the community workers (31 of 35) had received some type of training about referrals, and about half of the HBC community workers had received referral training in the two years before the study. Only five of the 43 facility providers and half of the HBC focal persons indicated having received training related to referrals.

Figure 17. Community and facility providers who report receiving referral trainings



According to the respondents, the trainings on referrals were included in broader service delivery trainings. When asked what referral topics were covered in the trainings, 11 community workers reported that they were trained on how to make referrals, and 13 stated that they were instructed on how to fill out referral forms (more than one answer was possible). In addition, one community worker provided each of the following responses: how to give feedback, how to counsel clients on referrals, how to follow up on referrals made, how to retain copies of referral forms, the importance of making referrals, how to tell clients to return the feedback, and confidentiality. Seven community workers reported training topics that did not directly address referrals.

Facility providers reported receiving training on the following topics: referrals from HTC, collaboration with the community for referrals; and linkages between the community and facility. Four of the HBC focal persons reported that trainings included information on how to make referrals to the community.

The research team reviewed available training curricula[3] for community workers and facility providers to determine the extent to which referrals are addressed. Two training curricula for community workers were brought to our attention:

- The **Tanzania Para Social Worker Training Manual and Curriculum** (no date found), developed by the American International Health Alliance with the Tanzania Institute of Social Work and others, is used to train MVC community workers nationally. The training materials stress that referrals and linkages to services are a key part of the community workers' jobs. Some guidance is given on when and where to refer clients under specific circumstances (such as in cases of abandonment or abuse). However, the curriculum does provide specific instructions on the processes to make and track referrals.
- The HBC program has a **standard training curriculum for community workers and for HBC focal persons.** We were not able to locate this curriculum for review, however.

We located the following training materials for facility providers:

[3] The training curricula described here are the ones we were able to locate from an internet search.

- The **National Training Package: Services for Comprehensive Care and Prevention of Mother-to-Child Transmission of HIV (2012)** contains clear instructions on how to refer clients, including how to use forms and document referrals, and includes tools to be used for referrals and tracking clients. It states that referrals must include referrals to the community.
- The **National Training on Tuberculosis and HIV for Healthcare Workers: Participant Manual for Health Workers** (no date found) emphasizes the importance of referrals, including referrals to community services. The participant manual specifies that referral tools should be used to aid clients in accessing care, including tools such as unit TB registers, TB and HIV referral forms, and referral directories, and it describes steps that need to be taken when making referrals, including follow-up with clients. The manual also notes that the provider is responsible for networking with community service providers and CBOs to strengthen linkages.

Written Referral Protocols and Guidelines

Community workers, facility providers, HBC focal persons, CBO staff, and district coordinators were all asked if they had seen written referral protocols. Of the 35 community workers interviewed, eight HBC community workers and three MVC community workers indicated that they had received written instructions on how to make referrals; however, copies of these tools were not available to verify the existence of these documents or review their content.

Two facility providers reporting having seen written guidelines for referrals. One cited national guidelines and one cited a project-specific guideline, but neither could locate these documents at the facility.

When asked if they had seen written referral guidelines or protocols, staff at five CBOs reported that they had, as did various district coordinators in the three districts surveyed. When asked to specify the guidelines or protocols they had seen, all cited national guidelines for HIV programs, including national guidelines for the HTC, HBC, MVC, PMTCT, care and treatment, and TB programs. One district coordinator also mentioned having seen standard operating procedures for referrals.

Our document review did not identify any written referral protocols that provided specific instructions on the procedures to follow to make referrals.

The research team reviewed the national guidelines for care and treatment, HBC, HTC, MVC, PMTCT, TB, and tracking patients lost to follow-up (listed in Box 1 of the Methods Section). While all guidelines emphasize the need for referrals, there were few concrete procedures or actions laid out to guide providers and health care workers on how to set up and implement effective referral systems. The need for referrals is noted consistently throughout the guidelines, indicating that they are necessary for comprehensive care to HIV patients. Most guidelines also state the need for up-to-date directories, meetings, and follow-up procedures to facilitate and ensure that referrals are taking place (NACP, 2010).

The HBC guidelines describe some roles and responsibilities regarding implementing referrals and note that the national referral form should be used. However, the guidelines contain limited guidance as to how these referral systems should be configured and organized (MOHSW, 2010).

Likewise, the MVC and PMTCT guidelines (MOHSW, 2009; MOHSW, 2013) make several mentions of the need to refer clients between community and clinical providers under specific circumstances and the need to keep records of referrals made, but they lack specificity about referral procedures and clear instructions for providers.[4]

We also reviewed the Standard Operating Procedures Manual for HTC, which specified when to make referrals depending on the type of client and where HTC services are provided. It included statements such as "provide referral and link the infant to pediatric HIV and AIDS care as appropriate." The manual provided no further instruction on how to make referrals, what documentation to keep about referrals, and how to follow up.

The Appointment Monitoring and Tracking Patients with Missed Visits Reference Guide included instructions on how to track clients, but this guide focused on clients with pre-determined care and treatment appointments at a facility. It did not include guidance on tracking referrals more broadly.

For the most part, the national guidelines indicate that districts, health workers, and implementing partners should be responsible for establishing and reinforcing referral systems (MOHSW, 2009; NACP 2010; MOHSW, 2012). Thus, the implementation of referral systems varies depending on the different approaches chosen by various implementing partners and local organizations that support HIV programs and community service provision at the district level.

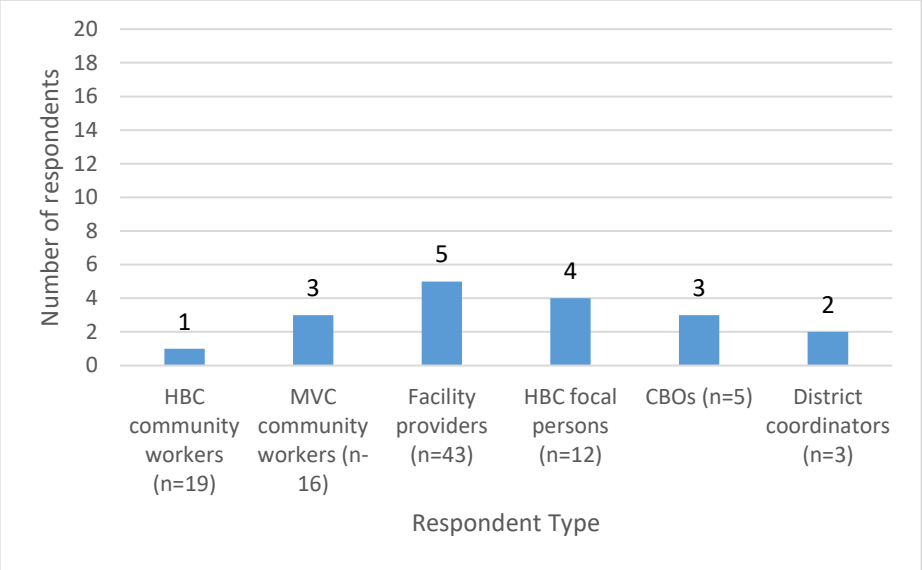
All of the guidelines stated that it the HBC and MVC community worker as well as the facility providers are responsible for making appropriate referrals for services that clients need (NACP, 2010; MOHSW, 2009; MOHSW 2012; MOHSW, 2013). The HBC guidelines also stated that the facility providers and community workers are responsible for providing feedback on the clients they receive (NACP, 2010).

Service Directories

Few facility and community workers reported having access to a service directory, while CBOs and district coordinators were more likely to report that service directories were available (Figure 18). In several cases, the directories reported were lists of community workers with phone numbers, rather than a comprehensive service directory that lists all providers and service delivery points in the area. One CBO had a good example of a directory in poster form, but none of the community workers in the district were aware of it.

[4] Of note, the most vulnerable children program developed referral forms and guidance in 2015 to standardize how referrals are made between community workers and clinical facilities. The new tools are in the early stages of being rolled out and have not been fully implemented.

Figure 18. Number of respondents reporting service directories were available



Tools for Making and Monitoring Referrals

The HBC program has a series of well-designed tools that facilitate making referrals and monitoring referrals made from the community to the facility. These tools include the following:

- **The HBC Referral Form** contains adequate fields to communicate information to the client on where to go, and to communicate to the receiving provider about client needs. It also includes a feedback slip to facilitate the return of information to the initiating provider. The forms are available with carbon copies so referring providers have a means of tracking the referrals they make.
- **The HBC Volunteer Notebook** contains columns to document referrals made and whether the referrals were completed. This provides HBC community workers an easy means to check for referrals that need follow-up.

For the MVC program, referral forms were not standardized and were primarily developed by the projects operating in a given district. Various NGOs and FBOs have also developed their own referral forms. The research team encountered nine different referral forms being used at the community level.

Client registers and community volunteer services forms for the MVC program were also project specific. Only one of the MVC services forms that we reviewed did include space to document referrals made to health facilities and referrals made to children's groups for psychological support.

At the facility level, referral forms were generally not available for making referrals to the community, although the MOHCDGEC has developed generic referral forms to be used by all providers.

Some client registers, such as the ART and HTC registers, did include space for documenting referrals (Table 19). The CTC2 Patient Record Card also collects information on where clients are referred. In these notebooks, registers, and patient cards, referrals can be categorized by the type of service where clients are referred (e.g., CTC, HTC, PMTCT). The focus is on referrals for clinical services, although some include referrals to support groups, HBC, and an "other" option that could include any referral

to the community. None of the facility-level client registers had space to document whether the referral was successfully completed.

Table 19. Patient registers used and data collected about referrals

Register Reviewed	Referral Data Collected
ART register	• Referral made • to which service Only allows provider to record one instance of a referral even though the register tracks a client over 72 months

HBC volunteer notebook	• Referral made
	  • to which service
	  • date service (and referral) was provided
	• Successful (completed) referral

HTC register	• Referral made • to which service
PMTCT register	No referral information collected

CTC2 form	• Patient referred from
	(only initial referral into CTC is noted)
	• Referral made:
	  • to which service
	  • date that service (and referral) was provided
	For each visit to CTC, includes an option to note referrals made (and service referred to)

Reporting Referrals

Community Workers

Both HBC and MVC volunteers send monthly reports on their activities. Seventeen of the 19 HBC volunteers and 13 of the 17 MVC volunteers stated that their monthly reports include referral data. These reports are sent to local CBOs and health facilities.

The HBC program has national standardized tools for reporting data about services provided at the community level. The monthly summary reports sent by HBC community workers include information on the referrals they make to health facilities for HTC, CTC, opportunistic infections, TB clinic, PMTCT, and other services. It is used, when aggregated with other such reports, to populate the Monthly Summary Report for the Facility Level. Data reported include the number of referrals made and the number of referrals that were completed, disaggregated by the type of services to which clients were referred.

Only four MVC community workers interviewed had reporting forms available for review by the research team, and all reported using a different tool for reporting data.

Facility Providers

Of the 43 facility providers interviewed, 11 (26%) said that they report referral data to the MOHCDGEC, 20 (47%) said that they do not report any referral data, and 12 (28%) did not know whether referral data are reported. Two facility providers also reported that they send referral information to partner NGOs.

Of the facility providers that send referral data, some of them stated that they use the HBC Monthly Summary Reporting Form to do so. The research team verified that the HTC reporting form also collects information on the number of referrals made and where clients are referred, which can be listed as HIV care and treatment, TB clinic, laboratory for sputum testing, PMTCT services, family planning services, STI services, and other services. Referrals to the community are not explicitly reported through this form. The ART reporting form did not collect information on referrals. We were not able to verify other reporting forms from programs such as PMTCT or TB.

HBC Focal Persons

Ten of the 12 HBC focal persons stated that they report referral data to the MOHCDGEC using the HBC Volunteer Monthly Summary Form, which is used at the facility level. Five HBC focal persons also stated that they report referral data to a partner organization. The Volunteer Monthly Summary Form aggregates data sent by community workers and captures information on the number of referrals made from the community to health facilities and the number of referrals completed by type of service. The services specified include HTC, CTC, opportunistic infections, TB clinics, PMTCT, and other services. The report does not include information on number of clients referred to community services from health facilities.

CBOs

Of the five CBOs sampled, four report data to the MOHCDGEC and partner NGOs, and one said it reports data to the partner NGO only. One CBO reports data for the HBC and HTC programs but not for the MVC program. Most of the reported data were specific to HBC clients.

District Coordinators

According to the district coordinators, HBC, HTC, and TB programs are collecting and reporting data about referrals. The data are sent by facility focal persons to the district where the coordinators for those programs compile the data. In one district, the DACC also reported receiving and reviewing data about referrals. The district coordinators did not provide information about data collection and reporting in the MVC program.

Each district reported using referral data differently in their programs:

- In Kyela, the HBC coordinator used referral data for reporting and planning purposes, as well as to understand the problems clients face, the provider's roles and responsibilities, and which partners are effective.
- In Wanging'ombe, the HTC program stated that they used referral data to track clients lost to follow-up and bring them back to care.
- In Kinondoni, the HTC district coordinator reported using data to address challenges in the referral systems, assess the number of clients needing health services, and follow up with clients who have been referred. The TB district coordinator reported that referral data were used to look at the success of services provided, the number of clients receiving services, and client progress.

In Kyela and Kinondoni, reports for HBC data have been prepared in the past six months; in Wanging'ombe, district coordinators indicated that they had not prepared reports because the data collected "were not clear." At the district-level, there is little if any discussion about referrals and

linkages during management meetings. The district coordinators all reported that they attend monthly meetings, such as council health management team meetings, meetings with care and treatment staff at the facility, and meetings organized by the district medical officer; however, only one district coordinator reported any discussion about referrals during one meeting in the previous year.

Confidentiality During the Referral Process

Facility providers reported various methods to ensure patient confidentiality during the referral process. Methods include keeping patient records in secure files (mentioned by 21 facility providers), ensuring private conversations with clients (13), using identification numbers instead of names on registers and referrals forms (8), obtaining client consent before disclosing information to relatives or community workers (6), and not sharing client information with others (6). A few facility providers also mentioned handing referral forms directly to clients for them to deliver to the community worker of their choosing. Others noted that they provide the referral forms in sealed envelopes.

Nevertheless, various facility providers remained concerned that health facilities lack sufficient rooms to ensure privacy and confidentiality or do not have adequate storage for client files. Several noted that providers at the facility and community levels should be reminded about proper measures to ensure confidentiality. Community workers were not asked directly how they maintain client confidentiality, but most reported keeping records in a secure location at home or a local organization or government office to protect client confidentiality.

Most HBC focal persons stated that they obtain clients' permission before sharing their information and HIV status with anyone, including HBC community workers. A few also noted that they ask permission before visiting clients or before filling out a written referral form to clinical services. CBO program coordinators also reported that they obtain consent from clients before following up on referrals with the receiving providers.

In all districts, district coordinators reported that they train both facility providers and community workers on confidentiality. In Kinondoni and Wanging'ombe districts, district coordinators also reported that they use identification numbers and not client names.

CONCLUSIONS

Referrals between the community and health facilities occur in both directions, although most are from the community to the facility. The HBC program has a more formalized referral system in place compared with the MVC program. PMTCT program community-facility referrals were not reported in the study area. Referral practices and procedures differ by type of program and type of provider, in part due to a lack of clear guidance on how a referral system should be structured and implemented.

Referrals from the Community to Health Facilities

Strengths

The majority of community workers are referring clients to health facilities. HBC community workers are more likely to refer to health facilities than MVC community workers, who are more likely to refer clients to non-clinical support services. The records that the research team reviewed indicated that most referrals to health facilities are for HIV testing and counseling, with fewer referrals to care and treatment or other clinical services. MVC workers are more likely to make referrals to primary care services than specialized HIV services. Referrals are not very frequent, and many community workers reported not having made any referrals in the previous month.

The majority of community workers are using appropriate referral forms to make referrals, and many were also escorting clients to ensure that they received the services for which they were referred. Community workers often reported being actively engaged in following up on referrals made, by calling or visiting the client or going to the facility to get information. The HBC community workers had access to volunteer notebooks that facilitate documentation and follow-up of referrals, even oral referrals. HBC focal persons supported community workers in obtaining information about referrals.

The HBC program has set up formal systems for linking community and facility services. The program has appropriate tools for making and tracking referrals and has assigned HBC focal persons at the district and facility levels to oversee these linkages. Most of the CBOs included in the study had established systems for documenting and tracking referrals made between the community and the facility.

Weaknesses

Not all districts we visited had functional MVC programs. For those that did, MVC community workers tended to have stronger linkages with non-clinical support services and infrequently referred clients to health facilities. MVC community workers used forms that tended to be project-specific and were not always given due respect by facility workers. The MVC programs also lacked a focal person at the facility to liaise with community workers and provide feedback on referrals.

Several community workers indicated that they do not carry forms or registers with them because they are worried these items will get ruined if they get wet. This limits their ability to keep accurate records and use referral forms consistently. Thus, many referrals from the community are still being made orally. Without proper written documentation, it may be more difficult for clients to know where to go or to ask for the specific type of service they need. It may also be more difficult for clients to obtain services if they do not have referral forms (Nsigaye, 2009; Liambilia, 2011).

Some community workers reported that feedback slips were not frequently returned from the facility, forcing them to track down clients or providers to get the information. This placed a financial burden on community workers who not receive a stipend for calls or travel.

Not all facilities had an HBC focal persons to liaise with the community and support community workers in tracking referrals. The MVC program did not have anyone (like a focal person) at the facility to help strengthen relations with the community. The linkages between facilities and MVC program were therefore notably weaker than in the HBC program.

Referrals from the Facility to the Community

Strengths

HBC focal persons are present in most health facilities, and many were active in referring clients to the community for HBC services. HBC focal persons communicate regularly with community workers about referrals made to the community, either by phone or when community workers came to the facility.

Weaknesses

Less than a third of facility providers reported having made referrals to the community. Facility providers have limited knowledge of the services available at the community or where to send clients. Many did not think it was their role to do so, and they reported that making referrals was not official practice or that they had no referral forms for this purpose. Various national guidelines, however, do instruct facility providers to make referrals to the community.

Linkages between the facility and MVC programs were particularly weak. For the most part, facility providers were unaware of MVC services in their districts. The MVC program did not have focal persons at the facility to serve as a liaison, and clients are rarely referred for these types of services.

When referrals are made to the community, they are generally made orally without a referral form or documentation. There are no procedures for following up with clients referred directly to the community. Unless referrals to the community are made via the HBC focal persons, they are not documented, and records are not kept.

Facility providers have not been trained in making referrals to the community.

Referral Tools

Strengths

MOHDCGEC and project-specific referral forms exist and are generally used by community workers. The forms we reviewed contain the necessary level of detail to inform clients where to go and provide information to receiving providers about what services are required and why. All the referral forms also include a feedback portion that can be completed by the receiving provider to inform the referring provider that the referral was completed and describe the services rendered. Many referral forms have carbon copies, which allows the referring provider to keep track of referrals made and facilitates follow-up.

The HBC program has developed standardized tools that include referral forms and registers used by community workers to record referrals. These tools were widely available to community workers, and only a couple reported not having them. Facility staff were also aware of the standardized tools.

Weaknesses

The study identified nine different referral forms being used in three districts. For the most part the information contained was similar, but the format was different and some information varied. These forms are used primarily by community workers.

The MVC program lacks standardized tools. Formal registers that included documentation of referrals were only available to some MVC community workers because MVC tools were project-specific. Many MVC community workers reported using blank notebooks to track the services they provided, which in some cases included referrals made. The lack of standardized tools can lead to omissions in the information that community workers are tracking, and inconsistent data elements make it difficult to set up reporting and monitoring systems.

Facility providers said that they do not have referral forms to make referrals to the community. They did not think to use the generic MOHCDGEC referral forms for this purpose. A few registers, such as the ART and HTC registers, have space for documenting referrals made, but facility providers did not use the registers to document referrals to the community. Only one facility provider said they made note of referrals in the patients CTC2 card, even though there is a column on the card for documenting referrals at each visit.

Nature of the Referral Network

Strengths

At the district level, district coordinators and CBO staff reported some coordination around the services they provided to HIV clients. There was coordination around trainings, and in some instances they reported joint supervisory visits.

Most health facilities had an HBC focal person who could liaise between the facility providers and the community workers and facilitate the sharing of information about referrals. Facility workers knew of the existence of HBC program and of the HBC focal person at the facility.

Weaknesses

This study found that there was little coordination around referrals among providers and organizations involved in service delivery. Respondents reported very few instances of meetings where referrals were discussed. These meetings are important for identifying potential problems with the referral system and better understanding the resources and services that different stakeholders have to offer (FHI, 2005).

Community workers engaged with facility workers, mainly the HBC focal persons, to follow up on referrals on a case by case basis, but they did not have any ongoing discussion about the overall functioning of the referral system. With the exception of the HBC focal persons, facility providers reported little if any contact with community workers and had limited familiarity with the breadth of services offered at the community level. They were unaware that they could or should refer clients to community services.

Some community workers felt that they were not regarded by facility providers as being important service providers for clients with HIV. An effective community-facility referral system requires community workers to be well integrated into the system and seen as partners in the provision of the full continuum of care to clients (Sips et al., 2014).

CBOs and HBC focal persons reported having lists of and contact information for HBC community workers. However, comprehensive service directories that list all HIV-related services offered in the district were lacking. Service directories are an important tool during the referral process, as they help providers know what services are available and where to send clients for specific services.

Referral Protocols and Instructions

Strengths

At the national level, as per the various national guidelines we reviewed, it is recognized that referrals to community services are an integral part of service delivery for HIV clients. Referrals to and from community services are highlighted in all national guidelines for HIV programs that the research team reviewed.

Weaknesses

Overall, the study found a lack of specific guidance for service providers on how the referral system should operate. National guidelines provided some guidance on when referrals should be made, but they did not include any instructions on how the referral system should be set up, procedures to follow for making or following up on referrals, and guidance for keeping records about referrals. The guidelines specified vaguely that district coordinators and other stakeholders are in charge of overseeing and coordinating the referral system at the district level, but provided no guidance on how to set up such a system.

Community workers indicated that they had received training around referrals and specifically on how to fill out referral forms, but none reported having seen written instructions. Only a few of the training materials reviewed for the study had more in-depth instructions for providers, and some of these trainings targeted facility providers specifically. However, the facility providers were the least likely to be making referrals to the community.

Referral Reporting and Monitoring System

Strengths

The HBC program has registers and reporting tools that permit the collection of data about referrals made from the community to health facilities. These registers and tools collect data on the number of referrals made, number of referrals completed, and the types of clinical services to which clients are referred. The data collected allow for adequate monitoring of the referral system (MEASURE Evaluation, 2013).

A few HBC focal persons and district coordinators indicated that they use these data to monitor referral system functioning, facilitate planning by knowing approximately how many referrals are made, and better understand client needs.

Some MVC community workers use project specific monthly summary reporting forms.

Weaknesses

The research team did not come across any standard data collection tools that track clients referred from health facilities to the community for HBC or any other type of service. The reporting and monitoring of HBC referrals is for referrals made in one direction only, toward the facility. Thus, it is not possible to obtain a clear picture of the number or nature of referrals to the community, which health facilities are successfully making referrals, and where blockages may exist.

The MVC program lacks standardized tools and systems for collecting data about referrals. In some district-level MVC programs, community workers record data on referrals made to health facilities, but they are not systematically collecting data about these referrals for reporting or monitoring purposes. Only one MVC program was collecting monthly referral data and reporting them to the project, but it did not report these data to the MOHCDGEC.

Even when data are collected, data use for decision-making is limited. Data are not discussed at meetings, and there are no clear guidelines for how the data can help programs improve service delivery.

RECOMMENDATIONS

National-level Recommendations

- Harmonize referral procedures by producing a national referral handbook for bidirectional referrals between the community and health facilities that establishes standardized referral processes and tools. The handbook should include the following:
    1) Instructions for service providers on how to make, document, and follow up on referrals. Separate instructions should be developed for community workers, facility service providers, focal persons and district coordinators.
    2) Guidance for how to coordinate community and facility services at the national and subnational levels.
    3) Guidance for program managers and district coordinators on overall referral system management.
    4) Directions for setting up an effective monitoring system to track referral system functioning.
    5) Roles and responsibilities of different actors in the referral system.
    6) Tools to be used for referrals, including referral forms, registers, reporting forms, and service directory templates.
- Develop national training package for community-facility referrals and collaboration, based on the referral handbook, which elaborates step-by-step the referral process, which tools are used, and how to use them, how to follow up on referrals made. The training curriculum should also address how to monitor the referral system, what data to collect, and how to analyze and use those data for decision-making.
- Train facility providers to better use the tools that do exist such as the generic MOHCDGEC referral form and patient registers. Make sure that providers are documenting referrals to the community and not just referrals to other clinical services.
- Strengthen the referral system between MVC community services and health facilities in particular, and create (or adapt) standardized national tools for MVC referrals (including referral forms, client registers, and monthly reporting forms), building on the work that MEASURE Evaluation and others have initiated in this area.
- Strengthen the referral monitoring system so that data on referrals made between the community and health facilities are collected and analyzed at the district, regional, and national levels. At a minimum, a monitoring system should collect data on the number of referrals made and the referral completion rate, and it should be disaggregated by program area that initiated the referral (e.g., HBC, MVC, PMTCT, and HTC). The following steps should also be included:
    1) Define indicators and data sources. Review existing referral tools and reporting forms tools to determine if they include the necessary information. Decide whether new tools need to be developed to provide referral data.
    2) Develop a curriculum to train service providers, district coordinators, and CBO staff on how to collect and use referral data.
    3) Determine who should take responsibility for the management of referral data at the district and national levels.

- For tools and registers that currently document referrals (e.g., CTC2 card, HTC register, ART register) create new codes for community services so that these can be explicitly recorded. Assess the feasibility of developing new tools, registers and reporting forms for those program areas that are not documenting referrals at all.
- Undertake an analysis of HBC referral data collected thus far to examine trends and better understand the functioning of the referral system in that program.
- Revise the supportive supervision checklist to include review of referral systems at the facility and community level.
- Develop and ensure that referral tools are available at the community and facility levels at all time

District-level Recommendations

- Assign a district coordinator to assume leadership and coordination of the bidirectional referral system between health facilities and community services. This person should coordinate referrals to and from the community across all program areas.
- Define the roles and responsibilities of various stakeholders (e.g., the district health management teams, NGOs, and service providers) in the referral system. Consider how continuum of care committees and quality improvement committees can support the referral system.
- Instruct district coordinators on the analysis of incoming referral data and discussion of these data during management meetings, including Council Health Management Team and Regional Health Management Team.
- Organize periodic meetings between district coordinators and CBO staff during which referrals are discussed.
- Encourage district coordinators and CBOs to work together to develop district-specific directories of services and make these directories available to all service providers. The directories should capture all services available, providers, contact information, location, and hours of operations. It should be updated at least every two years.
- Increase awareness among facility providers about the services available at the community level and the importance of referring clients to them.
- Ensure that referrals are addressed during supervisory visits at the facility and community levels and encourage joint supervisory visits by MOHCDGEC and CBO staff at the community level.
- Train facility providers to use referral forms and referral feedback forms.
- Advise facility providers to document referrals to community services in existing registers, and CTC2 cards.
- Ensure an adequate supply of referral forms, registers, and reporting forms to be used during the referral process.

Facility-level Recommendations

- Incorporate referrals as a discussion item during facility management meetings.
- Find opportunities for greater exchange between community workers and facility providers and ensure that referrals are a topic of discussion during these exchanges. These can be during formal meetings or community outreach events. Hold periodic meetings between community

workers and facility providers to share information on services provided, referral system functioning, and challenges faced.

- Assign HBC supervisor other staff person to act as community-facility officer who will help coordinate referrals to and from the community across all programs.
- Develop and ensure that standard operating procedures for referrals are readily available and staff have been trained
- Ensure referral tools are available at all time

Community-level Recommendations

- Develop standardized tools and procedures for referrals initiated at the community-level and ensure they are available
- Train all community workers in proper referral procedures, including referral follow-up procedures
- Establish mechanisms for monitoring community referrals

REFERENCES

1. Arreskov, A., Minja, E., Theilgaard, Z., Mandara, C., Gerstoft, J., Lemnge, M., & Katzenstein, T. L. (2010). Referral success among HIV-infected women and HIV-exposed children referred from monitoring and treatment in Tanga, Tanzania. *International Health*. 2(1): 36-41.
2. Colvin, C., Mugyabuso, J., Munuo, G., Lyimo, J., Oren, E., Mkomwa, Z., Makame, M., Mwangomale, A., Mahamba, V., Mueller, L., & Richardson, D. (2014). Evaluation of community-based interventions to improve TB case detection in a rural district of Tanzania. *Global Health: Science and Practice*. 2(2): 219-225.
3. FHI 360. (2013). Designing effective clinic-to-community referral systems: Analysis of best practices to inform LIFT technical assistance. LIFT. USAID. http://theliftproject.org/wp-content/uploads/2013/12/Referral-Literature-Review-and-Technical-Brief-FINAL.pdf Accessed on March 29, 2016.
4. Family Health International. (2005). Establishing referral networks for comprehensive HIV care in low-resource settings. Durham, NC: FHI http://pdf.usaid.gov/pdf_docs/Pnadf677.pdf Accessed on March 22, 2016.
5. Hatcher A., Turan, J., Turan, J. M., Leslie, H. H., Kanya, L. W., Kwena, Z., Johnson, M. O., Shade, S. B., Bukusi, E. A., Doyen, A., & Cohen, C. R. (2012). Predictors of linkage to care following community-based HIV counseling and testing in rural Kenya. *AIDS Behavior*. July; 16(5): 1295–1307.
6. Kamanga, J., Nyangu, S., Maluza, A., Rakhmanova, N., Dirks, R., & Bouchet, B. (2012). Improving the referral system for HIV clients in the Livingstone and Kazungula Districts of Zambia. Quality improvement stories. COH III Project. Durham, NC: FHI 360. http://www.fhi360.org/resource/quality-improvement-stories-improving-referral-system-hiv-clients-livingstone-and-kazungula Accessed on March 30, 2016.
7. Liambilia, W., Obare, F., Birungi, H., Wayua Muia, R., Maina, J. W., Maina, M. N., Awuor, C., & Mohammed, I. (2011). Linking HIV–positive family planning clients to treatment and care services in Kenya. Nairobi, Kenya: APHIA II.
8. Ministry of Health and Social Welfare, Department of Social Welfare (DSW). (2009). National guidelines for improving quality of care, support, and protection for most vulnerable children in Tanzania. Dar es Salaam, Tanzania: MOHSW, DSW.
9. Ministry of Health and Social Welfare. (2012). National AIDS management guidelines, 2012. Dar es Salaam, Tanzania: MOHSW.
10. Ministry of Health and Social Welfare. (2013). National guidelines from comprehensive care services for prevention of mother-to-child transmission and keeping mothers alive. Dar es Salaam, Tanzania: MOHSW.
11. Ministry of Health and Social Welfare. (2008). Management of TB/HIV co-infected patients: Manual for health care workers at TB clinics and HIV care and treatment centers. Dar es Salaam, Tanzania: MOHSW.
12. Ministry of Health and Social Welfare. (2007). Guidelines for HIV testing and counselling in clinical settings. Dar es Salaam, Tanzania: MOHSW.
13. Ministry of Health and Social Welfare. (2012). National guidelines for the management of tuberculosis in children. Dar es Salaam, Tanzania: MOHSW.

14. Ministry of Health and Social Welfare. National training on TB/HIV for healthcare workers: Participant manual for health workers. Dar es Salaam, Tanzania: MOHSW.
15. Ministry of Health and Social Welfare. National training package: Services for comprehensive care and prevention of mother-to-child transmission of HIV: Trainer manual. 3rd Edition. Draft. Dar es Salaam, Tanzania: MOHSW.
16. Ministry of Health and Social Welfare. National HIV care and treatment programme: Appointment monitoring and tracking patients with missed visits reference guide. Dar es Salaam, Tanzania: MOHSW.
17. Mshana, G. H., Wamoyi, J., Busza, J., Zaba, B., Changalucha, J., & Urassa, M. (2006). Barriers to accessing antiretroviral therapy in Kisesa, Tanzania: A qualitative study of early rural referrals to the national program. *AIDS Patient Care and STDS*. 20(9): 649-57.
18. National AIDS Control Programme, Ministry of Health and Social Welfare. (2013). Third health sector HIV and AIDS strategic plan (HSHSP-III) 2013-2017. Dar es Salaam, Tanzania: MOHSW.
19. National AIDS Control Programme, Ministry of Health and Social Welfare (MOHSW). (2012). National guidelines for the management of HIV and AIDS, 4th edition. Dar es Salaam, Tanzania: NACP, MOHSW.
20. National AIDS Control Program, Ministry of Health and Social Welfare (MOHSW). (2010). National guidelines for home-based care services. Dar es Salaam, Tanzania: NACP, MOHSW.
21. Nsigaye, R., Wringe, A., Roura, M., Kalluvya, S., Urassa, M., Busza, J., & Zaba, B. (2009). From HIV diagnosis to treatment: Evaluation of a referral system to promote and monitor access to antiretroviral therapy in rural Tanzania. *Journal of the International AIDS Society*. 12(31).
22. Office of the U.S. Global AIDS Coordinator (OGAC). (2014). PEPFAR 3.0 controlling the epidemic: Delivering on the promise of an AIDS-free generation. Washington, DC: OGAC.
23. Project SEARCH. (2013). Strategic assessment to define a comprehensive response to HIV in Iringa, Tanzania. Research brief, linkages to care. http://www.jhsph.edu/research/centers-and-institutes/research-to-prevention/publications/iringa/testing-counseling-final.pdf Accessed October 25, 2015.
24. Ricca, G., & Negroustoueva, S. (2009). Development of a monitoring framework for referral within a network of HIV/AIDS service providers. Chapel Hill, NC: MEASURE Evaluation. https://www.measureevaluation.org/resources/publications/sr-09-58a. Accessed March 22, 2016.
25. Rosen, S., & Fox, M. (2011). Retention in HIV care between testing and treatment in sub-Saharan Africa: A systematic review. *PLoS Med.* 8(7): e1001056.
26. Shrestha, R., Fatta, K. (2015). Case study: Improving linkages between health facilities and communities in Muheza, Tanzania. Chevy Chase, MD: USAID ASSIST Project. https://www.usaidassist.org/sites/assist/files/tanzania_community_linkages_jan2015_usletter_ada.pdf Accessed October 25, 2015.
27. Simba, D. O., Mbembati, N. A. A., Museru, L. A., Lema, L. E. K. (2008). Referral pattern of patients received at the national referral hospital: Challenges in low income countries. *East African. Journal of Public Health*. 5(1): 6-9.
28. Sips, I., Mazanderani, A. H., Schneider, H., Greeff, M., Barten, F., & Moshabela, M. (2014). Community care workers, poor referral networks and consumption of personal resources in rural South Africa. *PLoS One*. 9(4): e95324.

29. The American International Health Alliance (date not found). Tanzania para social worker training program manual and curriculum. http://www.aiha.com/tanzania-para-social-work-training-program-curriculum/ Accessed May 26, 2016.
30. Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF International. (2013). Tanzania HIV/AIDS and malaria indicator survey 2011-12: Key findings. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and ICF International.
31. UNICEF Tanzania. (2016). End-evaluation of mother mentors and mother support groups for improving uptake of PMTCT services. Dar es Salaam, Tanzania
32. Watson-Jones, D., Balira, R., Ross, D. A., Weiss, H. A., & Mabey, D. (2012). Missed opportunities: Poor linkage into ongoing care for HIV-positive women in Mwanza, Tanzania. *PLoS One.* 7(7): e40091.
33. WHO. (2015). Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: What's new. Geneva, Switzerland: WHO.
34. WHO. (2012). Planning, implementing, and monitoring, home-based HIV testing and counselling. Geneva, Switzerland: WHO. http://www.who.int/hiv/pub/vct/home_based_care/en/ Accessed March 29, 2016

MEASURE Evaluation
University of North Carolina at Chapel Hill
123 W. Franklin Street, Suite 330
Chapel Hill, NC 27516 USA
Phone: +1 919-445-9350 | measure@unc.edu
www.measureevaluation.org

This research has been supported by the United States President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation–Tanzania associate award AID-621-LA-14-00001. MEASURE Evaluation–Tanzania is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of PEPFAR, USAID, or the United States government. TR-18-284

USAID FROM THE AMERICAN PEOPLE

PEPFAR

Tanzania

MEASURE Evaluation TZ