REFERRAL SYSTEMS ASSESSMENT AND MONITORING TOOLKIT

MEASURE Evaluation

2013

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The Referral Systems Assessment and Monitoring (RSAM) Toolkit was originally conceived as a tool for use among HIV/AIDS service providers. Jim Ricca, Svetlana Negroustoueva, and Ilona Varallyay of ICF International developed the original version, called the Rapid-Monitoring of AIDS Referral Systems (R-MARS) Toolkit, which was piloted in Kenya and Thailand. Based on findings from the pilot, the final RSAM Toolkit was developed by Svetlana Negroustoueva and Cristina de la Torre, with support from Ani Hyslop. The pilot was conducted by MEASURE Evaluation teams in Kenya (Akaco Ekirapa, Edward Kunyanga, Catherine Mbaire, and Samwel Wakibi) and in Thailand (Simon Baker). The MEASURE Evaluation team wishes to acknowledge the support of the district and community unit health teams in Nyandurahu South and North in Kenya and the staff at Poz House and Thai Red Cross in Thailand for their participation in piloting the toolkit. The team would like to thank the USAID Missions in Kenya and Thailand and their implementing partners (APHIA*plus* in Kenya and PSI, Pact, and FHI360 in Thailand) for their support in the pilot activity. Finally, the team wishes to acknowledge Family Health International for developing various referral standards upon which this work was built.

ACRONYMS

ART	Antiretroviral therapy
CBO	Community-based organization
CHW	Community health worker
IEC	Information, education, and communication
MOH	Ministry of Health
MSM	Men who have sex with men
NGO	Nongovernmental organization
OVC	Orphans and vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHA	Persons living with HIV/AIDS
PMTCT	Prevention of mother to child transmission
RSM	Referral System Monitoring
RSA	Referral System Assessment
RSAM	Referral Systems Assessment and Monitoring
STI	Sexually transmitted infection
TB	Tuberculosis
VCT	Voluntary counseling and testing

Definitions of Key Terms

Integration: Combining different services or operational programs to offer comprehensive services to maximize collective outcomes. A referral system is one method of service integration.

Linkages: The bidirectional synergies in policy, programs, services, and advocacy among various program areas. Linkages refer to a broader human rights–based approach, of which service integration is a subset.

Referral: A process in which a health worker at a one level of the health system, having insufficient resources (e.g., drugs, equipment, skills) to manage a clinical condition, seeks the assistance of a better or differently resourced facility at the same or higher level to assist in or take over the management of a client's case.

Initiating facility (or referring facility): The facility (e.g., organization, clinic) that starts the referral process. This is the point in the referral process where an outward referral is prepared to communicate the client's condition and status.

Receiving facility: The facility (e.g., organization, clinic) that accepts the referred client's case and provides needed services.

Initiating service (or referring service): The type of service from which the referral was initiated (e.g., family planning, antenatal care, or general primary care).

Receiving service: The type of service to which the client is referred (e.g., family planning, antenatal care, or HIV testing and counseling).

Counter-referral: The process by which the receiving facility sends the client back to the initiating facility with information about services provided there and any needed follow-up. This completes the referral loop between the two facilities.

Referral network: The interconnected group of service providers among which referrals are made. Referral systems are used to integrate networks of service providers.

Geographic unit: The geographic area within which a referral network operates (i.e., an area that contains the services that a given client is reasonably able to access). Often the geographic unit is a district or a section of a city. However, it can be defined differently based on the configuration of the project.

Directory of network services: List of all organizations and facilities providing care within a geographic unit. Such a directory can facilitate the search for the most appropriate service provider for a particular referral. Where such a directory is used, it is important that the contact information is kept up to date.

Monitoring unit: The unit or team designated as a central focal point for the referral network and responsible for monitoring the network's performance.

EXECUTIVE SUMMARY

The Referral Systems Assessment and Monitoring (RSAM) Toolkit was developed to assist health and program managers in obtaining and using information regarding the performance of referral systems. These systems play an increasingly important role in the health systems of developing countries as result of the recent impetus toward service integration. Regular assessment and monitoring of referral systems should aim to assure that the underlying processes are functioning properly, that providers are linking clients to the services they need, and that clients are able to access a comprehensive package of health and related services.

The RSAM Toolkit was developed to provide program managers with the tools, guidance, and skills needed to effectively assess and monitor referral systems. The RSAM Toolkit contains two main components:

1. Referral System Assessment (RSA) to obtain an in-depth examination of how well referral processes and mechanisms are functioning at a given point in time
2. Referral System Monitoring (RSM) to generate routine data on the frequency and completion of referrals across services

The RSA examines how the referral system is structured, how networks are formed, whether appropriate written referral protocols and guidelines exist, the processes providers follow to refer and counter-refer clients, how well referrals are tracked and followed up, and barriers to referral initiation and referral completion. The assessment can also be used to evaluate interventions when applied repeatedly.

RSM on the other hand, allows program managers to track how often referrals are made to different services, the types of services to which clients are most often referred, whether clients are able to take advantage of the referrals, and whether adequate follow-up is provided after the fact. Monitoring can assist in identifying problems in the system, such as providers who are not referring patients, services that are being under- or overutilized, or linkages between services that are not sufficiently established.

The tools and forms included in this toolkit were originally designed to assess and monitor HIV/AIDS referral systems. However, they can be used for any type of referral system, regardless of the types of services provided or the configuration of the referral network.

The RSAM Toolkit consists of a series of tools that can be used as is or adapted to the specific design and purpose of the referral system in question. The toolkit provides clear, step-by-step instructions to assist managers in deciding which component to implement; which tools to use; how to adapt the tools; how to use the tools for data collection; and how to analyze, interpret, and use the information generated.

BACKGROUND

Integrating health services (clinical and community-based) is important to making service delivery more efficient for the health system and more accessible for clients, as well as for improving individual and family outcomes. Integration of clinical services has centered on facilitating and promoting access to a comprehensive package of services, rather than waiting for clients to seek out the individual services on their own. Recently, integration of clinical services with services that traditionally are outside of the health system (e.g., educational services, social services, community-based services) has been of interest because of the emerging multisectoral approach to addressing health problems. This has been particularly true for HIV/AIDS programs, which recognize that a broad scope of intervention is needed for HIV prevention and mitigation. While there are many context-specific models for integrating services, approaches can be grouped into three main categories:

1. Services provided by a single provider trained in multiple services
2. Services offered in the same facility by different providers using an intrafacility referral system
3. Services offered by providers in different facilities or sites using an interagency referral system

The first approach raises concerns about feasibility and cost, centering on needs to reconfigure personnel profiles, training and supervision systems, and infrastructure. The referral systems of the second and third approaches may be more appropriate for integration of a wide range of specialized services, such as those needed in HIV/AIDS programming. However, these approaches depend on a well-functioning referral system.

Assessing and monitoring the performance of the referral system should aim to ensure that the system is functioning properly, that referral processes are appropriate and efficient, and that people are getting the referral services that they need. Monitoring referrals between service providers demonstrates the accomplishments of collective efforts, the balanced use of resources and capabilities through efficient use of network members, and the avoidance of duplication of efforts.

Developing the RSAM Toolkit

To inform the content of the RSAM Toolkit, literature on referral system practice was reviewed and a sample of existing HIV/AIDS referral systems was examined to determine how performance was being monitored. A convenience sample of four referral systems (described in Table 1) were examined for the following:

- The context for referrals within a network, including strategies for strengthening the service network
- Indicators being used to monitor referral system performance
- Mechanisms for capturing the data elements needed to construct the referral system performance indicators (e.g., referral forms, registers, tracking slips, periodic reports)
- Suggestions for capturing and analyzing referral monitoring information

Table 1: HIV/AIDS Referral Systems Examined, 2009

Country, Geographic Scope, and Organization/ Project	HIV/AIDS Services Examined	Methods of Study
Swaziland; national; Ministry of Health (MOH)	All services	• Review of recent referral study • Offsite interview of study author
Kenya; Central and Western Provinces; AIDS, Population, and Health Integrated Assistance (APHIA II)	• Community health worker (CHW) (community) referral to testing and treatment services (facility) • Comprehensive care centers (facility) referrals to support groups and home-based care (community)	• Initial offsite interviews • Country visit: o Interviews with key staff o Record reviews o Site visits to facilities and community groups
Zambia; Kabwe, Samfya, and Mkushi Districts; Zambia Prevention, Care and Treatment Partnership (ZPCT)	All services	Offsite interviews and record reviews
Nigeria; Osun, Edo, Nasarawa, Bornu, Kebbi, Adamawa; NELA Consortium	Care and prevention	Offsite interviews and record reviews

Observations based on the examination of these referral systems highlighted the need for the following:

- Accommodation of **different types** of services, different systems of care, and difference in the relationships between referring agencies (i.e., intrafacility, facility-facility, community-facility, facility-community, and community-community)
- Establishment of **data quality mechanisms** with norms and protocols, initial provider training, supervision on the use of the system, and periodic data checks and on-the-job training
- Consideration for **client confidentiality** through provider training and secure client registers with access only by authorized staff
- Limits to **provider burden** by minimizing the number of data elements collected and analyses done
- Standard **referral indicators** that give an adequate sense of referral system performance
- Guidance on how to **use data for programmatic decisions**

The RSAM Toolkit was developed in response to the findings of the literature review and referral system examination. A preliminary version was piloted in Kenya and Thailand to determine the feasibility of using the toolkit and its respective instruments and to assess the utility and quality of the monitoring information produced. Findings from this pilot were used to refine the RSAM Toolkit and produce the current version. The purpose of the toolkit is to provide an assessment and monitoring framework for referral system performance that includes indicators for performance monitoring, mechanisms (such as referral tools and registers) to capture the information, and systems to ensure the quality of the information and facilitate its use. By using the RSAM Toolkit, referral system managers and stakeholders will be able to generate performance data and to use that data to strengthen the referral system.

INTRODUCTION TO THE RSAM TOOLKIT

The Referral Systems Assessment and Monitoring (RSAM) Toolkit provides tools and guidance to those who wish to assess and monitor the performance of a referral system. The toolkit consists of two main components:

1. Referral System Assessment (RSA). The RSA consists of generic tools and instructions for assessing the current status of a referral system, evaluating the processes used to document referrals, and identifying areas that require improvement. The assessment tool examines the various facets of a referral system, such as the following:
   - How formally the referral network is organized
   - The existence and application of written protocols and guidelines
   - The mechanisms used for making and tracking referrals

   The RSA focuses on the systems and processes that need to be in place for a referral system to be effective. The assessment is not intended to examine the clinical appropriateness of referrals made, although a section can be added easily to look at those particular issues, if desired.

   The RSA provides an in-depth look at referral system functioning at a single point in time. When implemented periodically, the assessment tool can be used to evaluate improvements in the referral system over time (e.g., in response to specific interventions).

2. Referral System Monitoring (RSM). Routine monitoring of referral system performance consists of guidance and forms for establishing a monitoring system to track the performance of a referral system over time. Referral system monitoring entails the regular gathering of data to track the flow of clients across services. Specifically, RSM whether or not referrals are being made and completed, whether specialized services are referring clients back to the referring service (i.e., counter-referring), and the level of client satisfaction with the referral process. Monitoring provides assurance that referrals occur as intended, by allowing decision makers to rapidly identify problems or blockages in the system and make adjustments as needed.

These two components, assessment and monitoring, can be used together or independently, although an assessment of the referral system is necessary before establishing a monitoring system. Each component is described in greater detail in the sections that follow.

Objectives and Uses of the RSAM Toolkit

The RSAM Toolkit is intended to help managers and implementers learn how well their referral system is performing and what to do to make it work better, thus contributing to health system strengthening and better health outcomes.

This toolkit, in its entirety or as separate components, can be used to do the following:

- ✓ Identify referral processes that work well and those that need improvement
- ✓ Establish RSM into a functioning referral system
- ✓ Examine the strength and functionality of a referral network
- ✓ Determine how well integrated the various services are by tracking the flow of clients
- ✓ Determine whether referrals are provided in an equitable fashion across gender, age groups, regions, or other categories of interest
- ✓ Evaluate the success of interventions aimed at improving referrals or service integration
- ✓ Guide decision makers on how to interpret referral data and make programmatic recommendations based on these data
- ✓ Develop evidence-based strategies and action plans to strengthen the referral systems

How to Use the RSAM Toolkit

The toolkit consists of a series of tools that can be used as is or adapted to the specific configuration and purpose of the referral system in question. The toolkit provides clear, step-by-step instructions to assist managers in deciding which component to implement; which tools to use; how to adapt the tools; how to use the tools for data collection; and how to analyze, interpret, and use the information generated.

The tools and forms included in this toolkit were originally designed to assess and monitor HIV/AIDS referral systems. However, they can be used for any type of referral system, regardless of the types of services provided or the nature of the network or providers involved. For illustrative purposes, references to HIV-related services have been left on these tools and forms; adapting them primarily involves altering the list of services provided at the referring or receiving sites to match those offered in the particular referral system under study.

INTENDED AUDIENCE FOR THE RSAM TOOLKIT

Persons involved in coordinating efforts to strengthen the referral systems—namely, health workers and managers who work to improve the delivery of health services in their various jurisdictions—are the intended audience for the RSAM Toolkit. Depending on the context-specific rationale for toolkit use, users may include

- doctors and senior medical officers involved in referrals,
- monitoring and evaluation (M&E) staff members,
- case managers,
- chiefs of party and/or designated knowledgeable staff members of implementing partners.

GETTING STARTED

Referral Systems

Whether the objective is to assess or monitor a referral system, a clear definition of the breadth and members of the referral system are needed. Prior to undertaking an examination of the referral system, it is necessary to determine the following key elements:

1. The nature of referral system to be studied. The coverage of the referral system needs to be defined, including the type of program or health area that the referral system is designed to address, the scope of the referral system (national versus local), and the types of organizations involved in the referral system. Table 2 shows the range of coverage that a referral system may have.

Table 2: Dimensions of Referral System Coverage

Coverage Type	Broad Scope	Focused Scope
Programmatic coverage	Across the health sector (e.g., to study the integration of programs)	Program or disease-specific referrals (e.g., HIV/AIDS, obstetric care)
Geographic coverage	National health system	More localized (e.g., specific city or region, within the margins of a project, within refugee camps)
Organizational coverage	Array of governmental and nongovernmental providers	Government facilities only

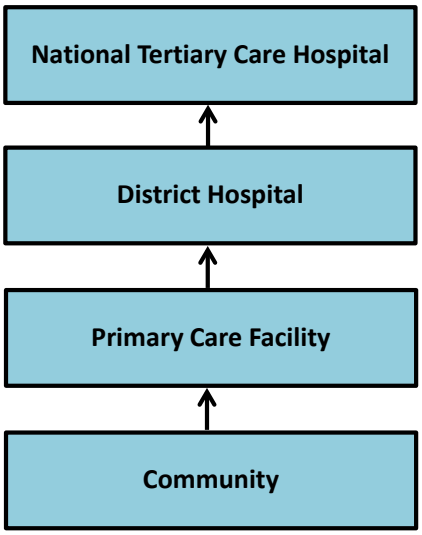
2. The range of services offered (or ideally offered) through the referral system in question. Make a list of all existing or possible services offered through the program, even if these services are not offered in all locations.

3. The expected or logical referral pathways. Which services refer, or should refer, to which other services.

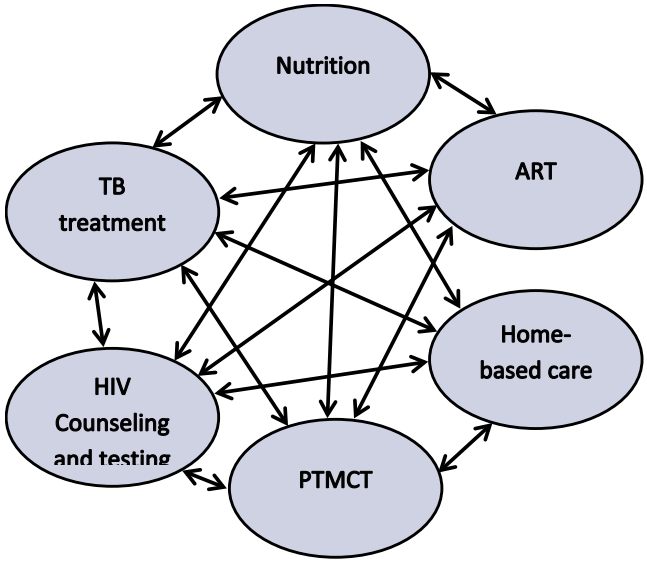
Another recommendation is to gather and review national or project referral protocols and other supporting documentation to obtain information about the referral system in question. Refer to the section entitled **Document Review** (p. 16) for additional information.

Referral systems are configured differently in different settings. Often, they involve the movement of patients from primary care to increasingly specialized levels of care. Referrals, however, can also involve the movement of patients across services within a same facility (e.g., from tuberculosis [TB] treatment to HIV testing services within a same clinic). A more complex referral system can include a number of private and public service providers that refer across a range of services, as illustrated in Figure 1.

Figure 1: Different Types of Referral Networks



Example of linear referral system. May be used for referring obstetric cases, for example.



Example of a more complex referral system. Here referrals are made across a range of services in both directions. May be used for linking HIV positive patients to a number of related services.

This toolkit can be adapted to any of these scenarios. They key is to define the geographic range of the network, the range of services provided within the referral network, and the full list of service providers that belong to the network.

Defining Referral Networks

While a referral system may exist at the national level, referral networks tend to be contained within smaller geographical areas, such as districts. Referral networks consist of a group of service providers that refer clients to one another. Referral networks operate in smaller geographic areas so that clients can readily access the network's services; thus, a national referral system usually comprises various district-level networks. The assessment and monitoring of referral systems focus primarily on these contained (e.g., district-level) networks because of the linkages of services that are being studied. Information can be aggregated across districts to draw larger conclusions regarding the functioning of the referral system as a whole.

Occasionally, a referral network may include facilities or service providers in faraway locations (e.g., a tertiary-care hospital in a large city). The program managers will need to decide whether it is necessary and realistic (logistically and financially) to include these remote services and facilities for the purposes of referral system assessment and monitoring.

Often, a referral system or network is already established, so identifying the various providers or facilities belonging to the network is straightforward. When the referral network is not clearly defined, perhaps because it relies on informal linkages between providers, then creating a directory of referral services in the network is recommended.

Directory of Network Services

A directory of network services lists all facilities and projects that provide related services within a predetermined geographical area, or network. For each facility or organization listed, the directory should specify all services provided the address or location, contact information, and hours and days of operations. The directory should be published and made available to all providers. An example of such a directory can be found in Appendix 1A.

Stakeholder Engagement

Since assessing and monitoring the performance of a referral system involves collecting data from and about the health facilities, community-based organizations (CBOs), and other service providers, engaging key stakeholders is essential. Stakeholders consist of groups or individuals who have an interest in the services provided through the referral network. They may be donors, MOH officers, program implementers, service providers, clients, and client advocates.

Engaging stakeholders in planning and in adapting the tools helps to assure that they will value the information and that the information is responsive to their needs. Stakeholder involvement will also help to expedite approvals, aid in gathering of pertinent information and documents, and assure that the tools are adapted satisfactorily to the particular context.

Stakeholders ought to be involved in the following aspects of assessment:

- Determining the types of services to assess
- Selecting the geographic areas and the facilities and service providers to include in the study
- Adapting the tools
- Identifying respondents
- Identifying individuals to assist with the data collection in each geographic unit
- Analyzing data (interpreting findings and formulating recommendations)
- Disseminating findings
- Developing work plans based on findings from the assessment and associated decision calendar
- Identifying funding for referral system improvements

Results from the toolkit pilot study indicated that stakeholder participation in the assessment, in particular, raises awareness about the importance of referrals, motivates reflection, and generates interest in strengthening the referral system.

COMPONENT 1: REFERRAL SYSTEM ASSESSMENT

Overview of Referral System Assessment

Purpose

An RSA is intended to provide an overview of the structure and functionality of a referral system at a given point in time. The assessment is not designed to examine the clinical aspects or appropriateness of referrals made; rather, it should focus on the systems and processes that need to be in place for a referral system to be effective. More specifically, the assessment should examine how the referral system is structured, how networks are formed, whether appropriate written referral protocols and guidelines exist, the processes used to refer and counter-refer clients, how well referrals are tracked and followed up, and barriers to referral initiation and referral completion.

A significant objective of the assessment is to gauge how effectively referral data are being captured, whether referral data are being used to improve the referral system, and whether mechanisms exist to exchange information among providers regarding referral system functioning.

When to Conduct an Assessment

The assessment was developed to take the pulse of the existing referral system. It can be conducted in various situations and for various purposes, including the following:

- To identify aspects of the referral system that need to be improved
- Before establishing RSM (as described in Component 2)
- To develop or strengthen capacity in following referral protocols
- Before expanding referrals as part of service integration efforts
- To establish or formalize the network of service providers

A series of assessments over time can be used to do the following:

- Examine improvements in efficiency and specific processes over time
- Evaluate the effect of specific interventions on referral system performance

Implementing an assessment before establishing RSM is needed to determine whether the necessary data elements for indicator construction are available through existing registers and how data are reported. This information is used to adapt the monitoring forms presented in Component 2 of the RSAM Toolkit.

Implementing the Referral System Assessment

The referral system assessment involves two parts:

1. Interviewing key service providers involved in the referral system
2. Reviewing relevant documents

To undertake an assessment, the following are required:

- The **Referral System Assessment (RSA) Instrument** (Appendix 1B), adapted as needed for the type of program (e.g., HIV/AIDS, sexual and reproductive health, maternal and child health).
- The **Document Review Checklist** (Appendix 1C).
- A team to coordinate and carry out the assessment. One individual can conduct an assessment within a manageable geographic area, such as a district, or within a small number of sampled facilities. A larger team is needed if wider coverage is desired.
- A list of services and providers in each geographical unit.
- Resources for travel, communication, and printing.
- Resources for an analysis workshop and for results dissemination.
- Approval from the institutions and organizations involved and from an ethics review board.
- Tape recorders (if interview recording and transcriptions are desired).

Assessment Team

The assessment is conducted by a team of persons and requires, at a minimum, the following:

1. Assessment coordinator: This person oversees implementation, obtains necessary approvals, and facilitates stakeholder participation. The coordinator leads the analysis and interpretation of findings through participatory processes. The coordinator should be knowledgeable about the program and the referral system.

2. Supervisor: This person trains and supervises data collectors. (This can be done by the coordinator if the assessment covers a small number of districts with a small team.)

3. Data collectors: These team members conduct interviews and document reviews. One individual can conduct an assessment within a manageable geographic area or within a small number of sampled facilities. A team is recommended, however, if various geographic units are included in the assessment. Ideally, the data collectors will be familiar with service providers and stakeholders in the geographic unit to facilitate their participation in the process.

4. Analyst(s): A qualitative analyst helps to guide analysis within and across geographic units.

5. Stakeholders: Stakeholders facilitate the process and aid in the interpretation of results and formulation of recommendations. Since conducting assessments involves collecting data from health service providers, maximizing the impact of that data for their benefit is essential.

Selection of Organizations and Service Providers to Participate in Assessment

The number of geographic units selected will depend on the coverage of the health program, the purpose of the assessment, and the budget available for this activity. It is not necessary to be exhaustive. A small number of geographic units can give an adequate impression of the functioning of the broader system. However, the geographic units selected should be representative or similar to other units that participate in the program being studied. If the intent is to draw conclusions at the national level, it is better to include more regions rather than many districts in a single region.

Depending on the purpose of the assessment and availability of financial and human resources, selection of the facilities within a network or district will vary. However, the following general guidelines apply:

- It is not necessary to include all the service providers in the network (or geographic unit). However, attempts should be made to
  - include all of the types of services available,
  - include service providers at different levels of the referral network (e.g., example, from CBOs to tertiary hospitals),
  - include service providers that **refer** and that **receive** patients.

- At each selected facility or organization, at least one service provider should be interviewed. In facilities that offer a wide range of services, efforts should be made to interview more people. Interviewees should be persons who provide services directly to clients, as well as members of the M&E staff.

- If the assessment is conducted as part of an evaluation, selection of geographic units and facilities will need to be considered carefully so that more rigorous research standards will be met. The evaluation design may, for example, require random selection of geographic units, or the inclusion of geographical units that do and do not receive a particular intervention.

Referral System Assessment (RSA) Instrument

The RSA Instrument is designed to collect information from health project managers and service providers about the functioning of the referral system. The instrument consists of the five sections shown in the box below. Most questions are open ended to allow respondents to describe the system and its strengths and weaknesses, in their own words. An RSA takes approximately 90 minutes to complete.

RSA Instrument Contents

Section 1: Background characteristics of facility or organization
Section 2: Characteristics of the referral network
Section 3: Referral system monitoring
Section 4: Referral system processes:
- Referral protocols
- Data quality and use
- Client confidentiality and satisfaction

Section 5: Respondent recommendations

Detailed instructions on how to administer the instrument are included with the instrument itself in Appendix 1B.

Adapting the RSA Instrument

The RSA Instrument needs to be tailored to the specific program and network. Before adapting the instrument, the coordinator will need to know the range of services provided through the program and referral system in question.

The following must be changed throughout the instrument:

- Specify the program or referral system in question (currently all references are to HIV/AIDS programs). Change the term "HIV/AIDS" to the appropriate health area. If various health areas are considered (e.g., when various programs are integrated), then interviewers should refer to the health system rather than to a specific program.
- Adapt response categories. Types of service providers, types of services, and target populations will need to be changed throughout the RSA Instrument.
- Adapt sections on data quality and client confidentiality as necessary.

Sections can easily be added to this assessment. Additional questions can be included (e.g., to assess provider knowledge of project-specific referral guidelines) or modules can be added to examine the appropriateness of disease-specific referrals (e.g., through review of medical record reviews). If the assessment is used to evaluate a specific intervention, sections or modules can be added to ask about intervention processes and impacts.

Document Review

Various documents are reviewed as part of the RSA. Most of these documents are gathered during the interview process.

Table 3 lists the documents to be reviewed and describes the purpose of examining each one. The **Document Review Checklist** (Appendix 1C) is used to extract relevant information from each of the documents obtained during RSA interviews with facility staff members. Specific instructions on how to fill out the checklist are also included in Appendix 1C. The information should then be compiled across facilities in the network to help answer the broader questions presented in Table 3.

Some aspects presented in Table 3 will require more in-depth examination of the documents than what is specified in the Document Review Checklist. For example, questions may need to be added to determine whether the referral protocols are clinically appropriate. This can be done centrally and need not be examined at each facility. The criteria for determining whether the protocols are clinically appropriate, or in line with national policies, also will need to be determined before the review.

Table 3: Document Review for Referral System Assessment

Aspect	Document	During review, determine that the following apply
Characteristics of referral network and system	Referral protocols Referral guidelines	-Referral protocols exist -Protocols are widely available to service providers within the network (i.e., at each facility or organization) -Protocols are clinically appropriate -Protocols cover the full range of relevant services -Protocols describe how to track and document referrals - Protocols ensure client confidentiality
	Directory of Network Services (listing of organizations providing related services in the geographic unit)	-Directories exist in most geographic areas or districts -Directories are complete and up to date -Directories include current contact information, location, and hours of operation -The full range of services is available in geographic unit (districts)
	Formal agreement between referring and receiving institutions (for each organization and referring pathway)	-Referral networks are formally linked (i.e., formal agreements exist across services) -Agreements cover the full range of relevant services -Agreements specify processes for initiating referrals and counter-referrals -Agreements contain information regarding documentation of referrals - Agreements coincide with program or national referral protocols
	Agenda or minutes from a referral network meeting	-Mechanisms exist to exchange information across service providers -Exchanges are held regularly

Aspect	Document	During review, determine that the following apply
Systems for monitoring and tracking referrals	Examples of registers, referral forms or tools used	-The necessary data elements are being collected by all facilities and organizations involved -There is consistency across providers on the type of information collected -Client confidentiality is maintained
	Report with compiled or analyzed referral data	-Data are being collected and analyzed -Recommendations for improvement are proposed -Referral-related information is written and disseminated to stakeholders -Reports and findings are available at facility or organizational level
	Client satisfaction surveys	-Data on client satisfaction is collected, analyzed and considered
	Reports of data quality audits (DQA) of referral system data	-Data quality checks are conducted routinely -Identify main data quality problems
Other	Report on evaluation of referral system	-An evaluation of the referral system has been conducted and when -Key findings of evaluation
	Evidence of training of service providers on referrals protocol	-Service providers received training on the referral protocols -Training materials are available at the facility level -Trainings included discussion of client confidentiality -Trainings included information on documenting referrals, use of registers, and referral forms

Collecting Documents

Some documents, such as written referral protocols, evaluation reports, or formal institutional agreements, should be obtained before initiating the RSA interviews. These documents will contain information that will be of use to researchers in designing and adapting the assessment.

To make sure the documents are available at the facility level, they should still be requested during the assessment interviews. Information should be extracted as indicated on the Document Review Checklist.

Adapting the Document Review Checklist

The Document Review Checklist should require little adaptation. Ideally, the documents listed for review should exist for all referral systems and the information contained should be similar. If they do not exist in a given program or country, it is important to note this. Additional documents specific to the program can be added (a national referral strategy, for example). The response categories can be expanded if specific aspects of the document are to be further examined.

Analysis and Interpretation of the Referral System Assessment

The analysis of the referral system assessment is best done in steps.

First, data collectors should review their notes, from the interviews and document review, and synthesize the information for each geographic unit. Since the objective is to study a referral network (the interactions of service providers in a predefined geographic area), the response of all providers in the area should be consolidated.

It is helpful to classify aspects of the referral system into two categories: (1) what is working well and (2) what is in need of improvement or lacking entirely. Several questions in the RSA Instrument ask respondents for their opinion of the referral processes. Their answers shed light on strengths and weaknesses of the system. However, analysis of other responses can be equally important.

Table 4 can help to guide the analysis. It indicates different areas to consider when reviewing materials and provides space to list the strengths and weakness of the referral system.

Table 4: RSA Analysis Guide

Elements of the Referral System to Analyze	Strengths	Weaknesses
Nature of the network connections: -Agreements -Directories -Familiarity with other services -Meetings or consortiums -Exchange of information across service providers		
Referral protocols: -Available -Appropriate -Up to date -Staff trained		
Outgoing referrals -Occurring as needed -Proper documentation/ registration -Information exchange between providers -Processes to facilitate referral completion		

Elements of the Referral System to Analyze	Strengths	Weaknesses
Incoming referrals -Referral completion -Proper documentation/ registration -Information exchange between providers -Processes to facilitate counter-referral completion		
Counter-referrals -Proper documentation/registration -Information exchange between providers -Processes to follow-up with clients		
Referral documentation: -Data collection systems -Data quality -Confidentiality		
Data collection tools: -compatibility of tools across service providers in the network -data elements are the same and similarly defined		
Use of referral data for decision making: -Referral data analyzed -Recommendations made -Facilities informed of results -Evaluations conducted and disseminated -Recommendations from network consortiums Actions taken to improve referral system		

This categorization can be done for each respondent and then across a geographic unit, searching for patterns in responses. Poor documentation of referrals, or certain types of services that are not well linked to the network, or good counter-referral practices are examples of patterns that can be described. The idea is to study the dynamics across the network, rather than detailed analysis of the practices of individual organizations.

Finally, assessment findings can be summarized across geographic units, if the intention is to have an impression of the referral system at a broader or national level. In that case, it is advisable to work in a participatory manner and involve everyone who conducted the data collection. Analysis can occur in a workshop-type environment, with active exchanges about all sections of the RSA Instrument, the Document Review Checklist, and the RSA Analysis Guide. Consensus regarding the referral system's main strengths and weaknesses in each area should

emerge from these discussions. A list of key aspects requiring improvement should be generated.

A participatory process with data collectors and stakeholders allows richer analysis and greater reflection of the data collected. When such a participatory process is not feasible, however, the interviewer notes, and strength and weaknesses analysis from each geographic unit can be compiled and examined for similar patterns as those described above. This requires a central analysis team.

Stakeholders should be involved in reviewing the findings and contributing to the interpretation and possible explanation of the findings.

If the assessment is implemented in anticipation of establishing RSM (as described in Component 2), the registers and other referral data collection forms need to be examined for the following: Are data elements recorded and reported that are necessary for construction of core referral indicators (i.e., utilization rate at receiving institution, referral rate from referring institution, referral completion rate, counter-referral success rate, and client satisfaction)?

The descriptions of the elements needed for these indicators can be found in Table 6

Also, referral forms and registers should be compared across service providers in a referral network to determine how comparable they are. It is important to determine whether data elements are the same and similarly defined. The tool design need not be identical across partners, but the data collected should be the same. Note whether service providers are able to obtain from each other the data they need about referrals.

Data Use of Assessment Findings

During the RSA, interview respondents and those conducting the assessment will make recommendations on areas of the referral system that need improvement. These recommendations need to be clearly discussed in the assessment report. The findings and recommendations should be presented and discussed with key referral system stakeholders (both at the geographic unit and national levels), and with persons who have the authority to make decisions about the referral system's functioning. Involving stakeholders in the analysis process will increase their familiarity with these issues.

Prioritizing recommendations and defining concrete actions to improve the referral system are important steps in the analysis and decision-making process. The **Decision Calendar** is a helpful tool to facilitate these crucial activities. The calendar helps to prioritize actions aimed at improving the system and plan what is required to implement each action.

A copy of the Decision Calendar tool can be found in Appendix 1D, along with a brief explanation of its various columns. A full description of this tool is available on the MEASURE Evaluation Web site.[1]

1 The Decision Calendar was developed by MEASURE Evaluation. The full tool can be found on the project Web site, under Tools, at http://www.cpc.unc.edu/measure/tools/data-demand-use/ddu-decision-calendar

COMPONENT 2: MONITORING OF REFERRAL SYSTEM PERFORMANCE

Overview of Referral System Monitoring

Purpose of Referral System Monitoring

To determine whether a referral system is functioning as intended, regular monitoring of referrals is required. The objective of referral monitoring is to provide routine information regarding the flow of clients through a network of providers. A good monitoring system will allow decision makers to track how often referrals are being provided to the different facilities and services, the types of services clients are most often referred to, whether clients are able to take advantage of the referrals, and whether adequate follow-up is provided after the fact. Referral monitoring allows managers to determine whether services are integrated successfully, whether clients are receiving comprehensive care, and whether clients are able to access a wide range of services.

A few core indicators are sufficient to assess the overall functioning of the referral system.[2] These indicators are listed below. A more thorough description is contained in the indicator reference sheets presented later in this document.

1. **Referral Initiation:** Proportion of clients seen that is referred to another service.
2. **Referral Completion:** Proportion of referred clients that completed the referral.
3. **Counter-Referral Completion:** Proportion of referred clients seen at receiving service that is seen back at referring service with complete counter-referral information.

The core indicators in this toolkit were selected to be applicable to any type of referral system, regardless of the nature of the network, the types of services provided, or the level of service delivery. The core indicators can assist in identifying problems in the system, such as providers who are not referring patients, services that are being underutilized, or linkages between services that are not sufficiently established. Once such issues are identified, further investigation will likely be required to comprehend the cause and identify solutions. Of note, performance monitoring is not intended to evaluate the referral system or the quality of care provided.

[2] These indicators were selected and validated through prior research undertaken by MEASURE Evaluation, including a series of cases studies and a pilot of this toolkit. For more information see Ricca, J. G., & Negroustoueva, S. (2009). *Development of a monitoring framework for referral within a network of HIV/AIDS service providers: Final report based on four case studies.* Washington, DC: U.S. Agency for International Development and MEASURE Evaluation. Available at http://www.cpc.unc.edu/measure/publications/sr-09-58a See also the MEASURE Evaluation 2012 presentation on results of the piloting of the Rapid-Monitoring of AIDS Referral System (R-MARS) Toolkit.

Elements of a Monitoring System for Referrals

The RSAMRSAM Toolkit proposes a system for monitoring referrals that meets the following requirements:

- Captures the information that is needed to construct the monitoring indicators
- Ensures the quality of that information
- Protects the confidentiality of the patient
- Is of low burden to service providers
- Facilitates the use of the information for improvement of the referral system

The following are the elements needed to implement this monitoring system:

1. Buy-in from health authorities, service providers, and M&E officers to undertake routine data collection and use the data (see discussion on stakeholder engagement on p. 10).
2. **Referral Registers** at the facility level that properly document outgoing and incoming referrals (see Appendices 2B and 2C for examples).
3. **Referral Reporting Forms**, where referral data are summarized and aggregated for reporting purposes (see Appendix 2D).
4. **Indicator Reporting Forms** (see Appendix 2E) to document the indicators that are calculated using the Referral Reporting Forms.
5. Trained staff members at the facility level who understand how to document referrals and the importance of data quality.
6. **Referral monitoring or coordinating unit**: Persons at the district and/or central level who are responsible for compiling referral data, checking quality, entering data into a database, analyzing data, and preparing periodic reports. These persons should have previous M&E experience and additional training on referral monitoring.
7. Database for entering and analyzing referral data.
8. Periodic client satisfaction surveys.

Preliminary Assessment of the Referral System

Prior to establishing a monitoring system, an assessment of the current referral system must be undertaken as described in Component 1 of this toolkit. The purpose of the assessment is to clearly understand how the referral system is configured; determine who is involved in the referral network; and determine what data are already collected, how they are collected, and how they are used. With regard to establishing a monitoring system, the rapid assessment is needed to do the following:

- Verify whether the data needed to calculate the three core referral indicators are being collected by all service providers in the network (see Table 6 for the list of data elements required)
- Determine what forms are being used to collect data by the different providers in the referral network
- Define how data can be disaggregated based on the client characteristics (e.g., age groups) collected by different service providers

- Obtain information needed to adapt the referral monitoring forms to the specific program and services offered through the referral system
- Ascertain to what extent the following referral system requirements are met:
  - client confidentiality measures are in place
  - data quality controls are in place
  - referral monitoring is of low burden to service providers
  - the referral data are used to facilitate improvements of the referral system

Indicators for Monitoring Referral Systems

The three core indicators recommended for monitoring the performance of the referral system are summarized in Table 5 and described in detail in the indicator reference sheets that follow.

Table 5: Core Indicators for *Referral* System Monitoring

Indicator Name	Description	Numerator/Denominator
1. Referral Initiation	Proportion of clients referred from initiating service	Number of clients referred from initiating service
		Number of clients seen at initiating service
2. Referral Completion	Proportion of referred clients that complete referral at receiving service	Number of referred clients seen at receiving service
		Number of clients referred from initiating service
3. Counter-Referral Completion	Proportion of referred clients seen at receiving service that is seen back at referring service for counter-referral	Number of clients seen at initiating service after being counter-referred
		Number of referred clients seen at receiving service

Indicator 1	**Referral Initiation:** Proportion of clients referred from initiating service
Numerator:	Number of clients referred from initiating service.
Denominator:	Number of clients seen at initiating service.
Disaggregation by:	• Initiating service (e.g., family planning, VCT, community health visit) • Type of service to which the client was referred (e.g., comprehensive care clinic, HIV testing and counseling, PMTCT) • Client characteristics (i.e., gender, age) Further disaggregation can be done if the data are of particular interest and the referral system has a mechanism for collecting the additional data. For example, data can be disaggregated by eligibility factors: • Eligibility characteristics (e.g., HIV status, pregnancy status, other medical or social conditions) *Note: These additional data elements are not included in the reporting forms contained in the toolkit. They can be added as needed.*
Purpose:	This indicator captures the extent to which clients are being referred from one service to another. The numerator and denominators also indicate the volume of clients using various services and the potential client burden for the receiving service.
Data collection and reporting frequency:	Continuous collection at initiating service. As clients are seen, the data are collected in the **Initiating Service Referral Registers** or client databases. The information is aggregated monthly or quarterly, depending on a program's monitoring needs and national reporting standards.
Data source:	A **Client Referral Form** that the patient carries between the referring and receiving services captures all the relevant information, which is then recorded in the **Initiating Service Referral Register** or client databases with columns or data fields that indicate client characteristics, receiving service, and referral eligibility status if available. (See illustrative referral register in Appendix 2B.) *Note: Registers specific to referrals will only provide numerator information. If referral-specific registers are used, a general client register will be needed to calculate the denominator.*
Measurement method:	Numerator: Count the number of clients who were provided with a referral during the reporting period. Counts will be done separately for each type of initiating and receiving service, and by age and sex as needed. For example, count the total number of (male and female) clients referred to VCT and note the totals on reporting form. Next, count the total number of (male and female) clients referred to family planning and note the totals on the reporting form. The numerator should specify "number of unique individuals" if Unique Identifier Codes (UIC) are used. Denominator: All clients seen at the referring service during the reporting period. For reporting purposes, the numerator, denominator, and proportion should be reported. In order to aggregate data from multiple referring services, the actual denominators and numerators are needed.
Interpretation:	The Referral Initiation Indicator is used to monitor the volume of referrals from initiating services. Benchmarks should be established for the indicator, and interpretation would be based on the deviation from the benchmark. A high proportion (close to 100% or the benchmark) may indicate good referral practices but should be verified occasionally to make sure that only persons requiring referrals are being referred, and that eligibility is correctly ascertained. A low proportion may reflect the referring service's perception of poor quality of care at the receiving site or of the clients' ability to access the receiving service.

Additional information on eligibility:	If the referral registers are able to differentiate which clients are eligible for particular referral services and which are not, it is recommended that the denominator be limited to eligible clients. Numerator: Number of clients referred to a specific service Denominator: Total number of clients eligible for a specific service who were seen at the initiating service Counting only eligible clients allows a more precise assessment of the referral system's functioning and makes this indicator easier to interpret. In general, the proportion of eligible clients that is referred should be 100%. Specifying eligibility has not automatically been included in the indicator definition since most referral monitoring systems are not adequately tracking client eligibility for all types of services. The process of determining whether or not the client is eligible for a service will be specific to each type of service. It requires providers to note for each client whether he or she is eligible for each of the various referral services available.

Indicator 2	**Referral Completion:** Proportion of referred clients that completes referral at receiving service
Numerator:	Number of referred clients seen at receiving service.
Denominator:	Number of clients referred from initiating service.
Disaggregation by:	• Initiating service (e.g., family planning, VCT, community health visit) • Type of service to which the client was referred (e.g., comprehensive care clinic, HIV testing and counseling, PMTCT) • Client characteristics (i.e., gender, age) Further disaggregation can be done if the data are of particular interest and the referral system has a mechanism for collecting the additional data. For example, data can be disaggregated by eligibility factors: • Eligibility characteristics (e.g., HIV status, pregnancy status, other medical or social conditions) *Note: These additional data elements are not included in the reporting forms contained in the toolkit. They can be added as needed.*
Purpose:	To assess utilization of the referral system and measure referral success. This indicator captures most directly the effectiveness of the referral system.
Data collection and reporting frequency:	As clients are seen, the data are collected continuously in the initiating and receiving services registers or client databases. The information is aggregated monthly or quarterly, depending on program monitoring needs and national reporting standards.
Data source:	This indicator requires data from registers at both the initiating service and receiving service. The numerator is collected at the receiving service. The denominator comes from initiating service records. A **Client Referral Form** that the patient carries between the referring and receiving services captures all the relevant information, which is then recorded in the **Initiating and Receiving Service Referral Registers** or client databases. The receiving service needs: • To actively identify which clients have been referred and obtain referral information from them (including the type of service from which they were referred). A **Client Referral Form** should be used to capture and input all the relevant information into the Receiving Service Register. • A method to report the number of referred clients seen from each initiating service. Ideally, the **Receiving Service Referral Register** or client database includes columns or data fields that indicate the initiating service and when the referral was completed. (See illustrative referral registers in Appendices 2B and 2C.) The **Initiating Service Referral Register** provides information regarding the number of patients referred to each receiving service.
Method of measurement:	Numerator: Count the number of clients for whom there is evidence of a completed referral, based on records at the receiving service. Denominator: Count the number of clients who were provided with a referral during the reporting period (same as numerator for Referral Initiation Indicator). For reporting purposes, separate counts should be done for each type of service. The numerator, denominator, and proportion should each be reported. The proportion will be used to monitor individual referring services and make comparisons between them. The actual denominators and numerators are needed to aggregate data from multiple referring services.

Interpretation:	This indicator measures whether or not clients complete referrals. It serves as an indication of how effectively the referral system provides clients with the services they need. (A literature review[3] found that a realistic benchmark for this indicator to be at least 80%.) If the proportion of clients who complete a referral is high, the system is performing well and the majority of referrals made are completed. If this proportion is low, this indicates problems with the system that require further investigation to understand barriers to uptake of referrals. These problems could be related to cost, distance, stigma, locus of control, perception of low disease severity, perception of low-quality services provided at the receiving site, and so forth.

[3] Ricca & Negroustoueva, 2009. Op. cit. See also Villaume, M. L., Ezzat, M., & Gaumer, G. (2000). *Study of Hospital Referrals in the Pilot Program in Alexandria, Egypt* (Report to Partnerships for Health Reform). Bethesda, MD: Abt Associates Inc.

Indicator 3	**Counter-Referral Completion:** Proportion of referred clients seen at receiving service that is seen back at referring service for counter-referral information
Numerator:	Number of clients with complete counter-referral information seen back at initiating service. These are clients who were referred, received the service for which they were referred, and attended a follow-up visit at the service of origin (initiating service) with information on referral completion.
Denominator:	Number of referred clients seen at receiving service.
Disaggregation by:	• Initiating service (e.g., family planning, VCT, community health visit) • Type of service to which the client was referred (e.g., comprehensive care clinic, HIV testing and counseling, PMTCT) • Client characteristics (i.e., gender, age) Further disaggregation can be done if the data are of particular interest and the referral system has a mechanism for collecting the additional data. For example, data can be disaggregated by eligibility factors: • Eligibility characteristics (e.g., HIV status, pregnancy status, other medical or social conditions) *Note: These additional data elements are not included in the reporting forms contained in the toolkit. They can be added as needed.*
Purpose:	To assess the completion of the referral process. Clients not only receive the referred service, but are also referred back to the original referring service for follow-up.
Data collection and reporting frequency:	As clients are seen, the data are collected continuously in the initiating and receiving services registers or client databases. The information is aggregated monthly or quarterly, depending on program monitoring needs and national reporting standards.
Data source:	This indicator requires data from registers at both the initiating service and receiving service. The numerator is collected at the initiating service. The denominator comes from receiving service records. A **Client Referral Form** that the patient carries between the initiating and receiving services captures all the relevant information, which is then recorded in the **Initiating and Receiving Service Referral Registers** or client databases. The receiving service needs: • To actively identify which clients have been referred and obtain referral information from them (including the type of service from which they were referred). A **Client Referral Form** should be used to capture and input all the relevant information into the Receiving Service Register. • A method to report the number of referred clients seen from each initiating service. Ideally, the **Receiving Service Referral Register** or client database includes columns or data fields that indicate the initiating service and when the referral was completed. (See illustrative tools in Appendix 2C). The initiating service needs: • To actively identify and document clients who are counter-referred, noting the type of service the client obtained at the receiving service.
Method of measurement:	Numerator: Count the number of clients who come back to the original referring service with complete counter-referral information, including evidence of services provided and need for follow-up. Denominator: Count the number of clients for whom there is evidence of a completed referral, based on records at the receiving service (same as numerator for Referral Completion Indicator).

Interpretation:	This is most applicable for between different levels of facilities. Counter-referrals provide information to initiating service on client's follow-up care needs, improve continuity of care, and measure linkages in service delivery. This indicator reflects the health workers' compliance with counter-referral practices and their adherence to good practice; it also reflects clients' adherence to counter-referrals, when applicable. If this proportion is high, the health workers are highly compliant with counter-referral practices and clients adhere to the counter-referrals. If this proportion is low, either the health workers are not carrying out the counter-referrals or the clients are not responsive to the counter-referrals. Not much information is available on benchmarking for this indicator. On the basis of related indicators, the value should also be at least 80% (as with referral completion); in most settings, however, it is much lower.

As noted earlier, these core indicators can provide key information regarding the system's functioning. Some countries, however, may decide to add additional indicators to this list in order to obtain deeper information on specific characteristics or dimensions of the referral system (for example, client satisfaction with referrals processes or monitoring health outcomes after referrals). It should be noted that additional indicators imply added reporting burden and added cost, in terms of the time needed to train people in its use and to collect and analyze the data. The programs should weigh whether the added information is important enough to warrant these costs.

Data Collection and Reporting Tools for Referral System Monitoring

A series of tools is required for collecting, reporting, and aggregating the data for the core indicators. The tools include the following:

1. Client Referral Form
2. Service Registers from referring and receiving services
3. Referral Reporting Forms for referring and receiving services (Appendix 2D)
4. Aggregate Referral Reporting Form
5. Indicator Reporting Form

Client Referral Form

A Client Referral Form assures that different service providers have accurate information regarding a client's health care needs. These forms accompany clients through the referral process, and service providers enter relevant information at each referring and receiving service.

For RSM, which depends on accurate documentation in all registers, the Client Referral Form is indispensable for accurately completing the registers at both referring and receiving facilities. A well-designed Client Referral Form should contain details regarding the client, reasons for referrals, services rendered, and contact information for both referring and receiving services.

Referral Registers

Referral registers are needed at each referring and receiving facility to record all outgoing and incoming referrals. The minimum data elements required in these registers are listed in Table 6. If the essential elements are available on existing registers, it is not necessary to introduce new ones. Appendices 2B and 2C include illustrative registers that can be adapted to a specific program.

Table 6: Data Elements Needed to Collect RSAM Indicator Data

Form	Minimum Data Elements*
Client Referral Form	• Client characteristics: Sex and age (characteristics will vary by how data are to be disaggregated) • Name of referring organization • Type of service initiating the referral • Date of referral initiation • Type of service referred to (reason for referral) • Name of receiving facility • Date client seen at receiving service • Description of services rendered at receiving facility • Date seen at referring service for counter-referral
Referring and Receiving Service Registers	Referring service: Record of total number of clients seen for each type of service offered at the facility • Client ID • Client characteristics: Sex and age (characteristics will vary by how data intend to be disaggregated) • Type of service initiating the referral • Date of referral initiation • Type of service referred to (reason for referral) • Date client seen at receiving service • Description of services rendered at receiving facility • Date client seen back at initiating facility for counter-referral (counter-referral received)
	Receiving service: • Client ID • Client characteristics: Sex and age (characteristics will vary by how data are to be disaggregated) • Type of service initiating the referral • Date of referral initiation • Type of service referred to (reason for referral) • Date client seen at receiving service • Description of services rendered at receiving facility • Date client seen back at initiating facility for counter-referral (counter-referral received)

* These elements are only those required for calculating in the RSAM indicators. Additional information needed for clinical purposes should be included in these forms and registers. A full list of recommended data elements for each form and register is included in the Document Review Checklist (Appendix 1C).

Reporting Forms

Appendix 2D contains reporting forms that can be used to gather referral data needed to calculate the three core indicators. The reporting forms contain three tables that are used to record (1) the number of referral made to other services, (2) number of clients seen back at initiating facility with a counter-referral, and (3) the number of referrals seen at receiving facility. The first two tables are to be filled in by facilities that refer clients to other services; the third table is to be filled in by facilities that receive referrals. Often, a facility will have to fill out all three tables if it both refers clients out and receives clients from other services.

Each table allows for disaggregation of the data by the type of service initiating the referral and by the type of service receiving the referral. The forms also allow disaggregation by age, sex, or other relevant characteristics, depending on program needs. Detailed instructions for filling out the forms are included in Appendix 2D.

Aggregating Form

The same Referral Reporting Forms used by individual facilities can be used to aggregate data across a geographic unit, or at the regional or national level. All that is required is to sum each cell in the table across facilities. To facilitate aggregation of data, a system can be set up in Microsoft Excel that will automatically sum across facilities as data are entered.

Indicator Reporting Form

The Indicator Reporting Form is located in Appendix 2F. This form is to be filled out at the geographic level after data from all facilities have been aggregated. The indicators are calculated and reported separately for each initiating and receiving service linkage. The same form can be used to report indicators for the regional or national level. Instructions for calculating the indicators are described in a separate section below.

Adapting Referral Monitoring Tools

Registers

It may not be necessary to introduce new registers to the referral system in order to establish a monitoring system. Often, referrals are already being documented and existing registers contain the required information. Table 6 indicates the minimum data elements that need to be on the registers for the RSAM indicators to be calculated.

If some information is missing, the tools could be adapted by adding relevant columns in registers, including services categories in existing forms, or by adding relevant disaggregation. If the exiting registers and Client Referral Forms are not suitable for collecting the needed referral monitoring data and cannot be changed easily to add missing information, then it will be necessary to introduce new tools. Appendices 2A–2C provide examples of what these registers and forms may look like. For illustrative purposes, the forms list HIV/AIDS–related services that may exist in a referral network. The exact format of the tools is not important, as long as the key data points listed in Table 6 are included.

Mapping Indicator Data Elements to Data Collection Forms

For training purposes, it is important to clearly indicate which data points to pull from the registers and referral forms for reporting. If forms are not standardized across service providers in the network, this exercise will have to be conducted individually with each facility or organization reporting referral data.

Reporting Forms

1. Types of services offered through the program. The Referral Reporting Form and Indicator Reporting Form will need to be adapted to specify the exact services included in the referral system. The referring and receiving services will need to be listed (i.e., replace the current labels "service 1," "service 2," and so forth). In addition, the linkages across services will need to be considered. If referrals only occur in one direction, or if it is impossible for a specific service to refer to another, then the box that intersects those services should be blacked out on the Referral Reporting Form.

2. Level of disaggregation. The reporting forms include space above the tables to specify age and sex, so that data can be disaggregated by these characteristics. Depending on the program, it may be desirable to disaggregate by other characteristics, such as pregnancy or nutritional status, for example. If so, space for entering this information needs to be added to the form.

Standardizing Data Across the Referral Network

Some referral networks may contain diverse organizations with equally diverse data collection tools. As noted earlier, the exact format of client registers at each facility is not as important as making sure that they all contain the minimum data elements needed to calculate the RSAM indicators (Table 6). However, it is imperative that the Client Referral Form and the Referral Reporting Form are standardized across service providers.

A standardized Client Referral Form assures that the appropriate information about services is shared among service providers and that the referral registers at each facility can be completed accurately.

The reporting forms will also need to be standardized across service providers and across geographic units to facilitate aggregation and calculation of indicators.

Calculating and Reporting RSAM Indicators

The three core indicators are calculated using the data on the Referral Reporting Forms. The indicators are calculated after the data from the geographic unit have been aggregated. because referrals across facilities area being looked at, it does not make sense for each facility to calculate its own indicators. For illustrative purposes, a few cells have been numbered in the reporting forms (Figure 2) to show how to find the numerator and denominator for each of the indicators.

Table 7: Mapping Forms to Indicators

Indicator Name	Description	Numerator/Denominator	Data Cell on Reporting Form (Figure 2)	
			EXAMPLE 1 Service 1 refers clients to service 2	EXAMPLE 2 Service 4 refers clients to service 5
1. Referral Initiation	Proportion of clients referred from initiating service	Number of clients referred from initiating service	2a	2b
		Number of clients seen at initiating service	1a	1b
2. Referral Completion	Proportion of referred clients that completed referral at receiving service	Number of referred clients seen at receiving service	3a	3b
		Number of clients referred from initiating service	2a	2b
3. Counter-Referral Completion	Proportion of referred clients seen at receiving service that is seen back at referring service for counter-referral	Number of clients seen at initiating service after being counter-referred	4a	4b
		Number of referred clients seen at receiving service	3a	3b

Figure 2: Mapping Data Cells to Indicators

1. Number of clients referred by type of service

Group for which data are reported: Age range: _____ Sex: _____

	COLUMN Y ↓	TOTAL NUMBER CLIENTS SEEN AT REFERRING SERVICE	CLIENTS REFERRED TO RECEIVING SERVICES					
			Service 1	Service 2	Service 3	Service 4	Service 5	Service 6
REFERRING SERVICE	Service 1	1a		2a				
	Service 2							
	Service 3							
	Service 4	1b					2b	
	Service 5							
	Service 6							

2. Counter-referrals: Number of clients received back at referring service with completed counter-referral information

Group for which data are reported: Age range: _____ Sex: _____

	COLUMN Y ↓	RECEIVING SERVICES					
		Service 1	Service 2	Service 3	Service 4	Service 5	Service 6
REFERRING SERVICE	Service 1		4a				
	Service 2						
	Service 3						
	Service 4					4b	
	Service 5						
	Service 6						

3. Number of referrals completed at receiving services, by type of referring service

Group for which data are reported: Age range: _____ Sex: _____

	ROW X →	RECEIVING SERVICES					
		Service 1	Service 2	Service 3	Service 4	Service 5	Service 6
REFERRING SERVICE	Service 1		3a				
	Service 2						
	Service 3						
	Service 4					3b	
	Service 5						
	Service 6						
	Not specified						

Reporting on Indicators

Periodically, every facility will need to report on its referral indicators to the referral system monitoring or coordinating unit; this can be done on a monthly or quarterly basis. The Referral Reporting Forms included in Appendix 2D should be filled out by every facility monthly or quarterly. These same forms can be used at by the referral monitoring unit to aggregate the data and report up to the regional level.

The Indicator Reporting Form (Appendix 2E) can accompany the Referral Reporting Form, but should not replace it. The Referral Reporting Form provides both numerator and denominator information, which is needed for aggregating reports. The Indicator Reporting Form contains analyzed data, which can be used to compare performance across geographic units but cannot be used to aggregate data (one cannot sum proportions).

Controlling Data Quality

The quality of the data should be controlled by establishing regular data checks, strengthening supervision and information feedback, and providing refresher trainings periodically.

The referral monitoring unit should critically review the data that are reported to them by the facilities. This process should check for the following:

- Completeness of the data:
  - All facilities reporting on time
  - All forms properly filled out
- Plausibility (values are within acceptable range):
  - Proportions do not exceed 100% for example
- Outliers:
  - Facilities reporting either very low or very high numbers

Periodically, the referral monitoring unit should also undertake the following:

- Comparison of data reported on the Referral Reporting Forms to that found in the facility registers (recounts)
- Comparison of Client Referral Forms to registers (if Client Referral Forms are retained at facility after counter-referral)
- Completeness of registers (all data elements are being entered)

During routine supervisions, staff can determine whether

- registers are being dutifully completed,
- providers and clients are using Client Referral Forms as intended,
- the correct data elements are being used to complete the Referral Reporting Forms.

MEASURE Evaluation has developed several tools that can be used for data quality assurance. These can be found on the following Web site:
http://www.cpc.unc.edu/measure/tools/monitoring-evaluation-systems/data-quality-assurance-tools

Analysis and Interpretation

Referral monitoring data are analyzed to understand the flow of clients through a network of linked providers and to identify which types of services have well-functioning referral processes and which need attention. This requires an examination of referrals from each service to each of the other services offered through the network. For each pair of services, the entire process, from referral to completion to counter-referral, is examined (see Indicator Reporting Form in Appendix 2E).

The referral linkages studied will depend on the structure of the referral system. In a vertical system (as illustrated in Figure 1), referrals are in one direction, from primary to increasingly specialized services. In other cases, two services may refer to each other and referral processes in both directions should be examined (from service 1 to service 2 and from service 2 to service 1). These service linkages should be predetermined and listed in the Indicator Reporting Form.

The indicators can be calculated for service delivery points within the geographic unit; however, this would be cumbersome when many service delivery points exist. It is best to aggregate data within the geographic unit before indicators are calculated. Then, the indicators will paint a broader picture of how well the network as a whole is able to integrate services and link clients to a comprehensive package of health services. For example, the indicators would inform us whether family planning clients from this geographic area are being referred successfully to VCT services. The Indicator Reporting Form documents each of the three indicators for each paired service.

When assessing whether the system is functioning well, indicators in the form of proportions are easier to interpret and more useful for programmatic decision making than simple counts. The actual number of clients completing a referral is less telling than the proportion of clients that did. Proportions render the data comparable across different sites, taking into consideration the relative size (patient volume) of a referring or receiving service. However, the number of clients moving through the system can be helpful for determining how resources are allocated and the potential need for additional resources if referral system improvements are anticipated.

Analysis and interpretation should focus on the following:

1. Comparisons of data against targets
2. Trends in key indicators over time
3. Disaggregation across geographic units and subgroups of the population

Comparison to benchmarks (or targets) depends on the definition of the indicator and the characteristics of the client population and service. Often, historical data, achievement of highest-performing unit, literature reviews, or an ideal goal are used to set a benchmark. Benchmarks should be decided with the participation of service providers and stakeholders, taking into account any foreseeable changes in policies or upcoming interventions that could affect service delivery patterns. Deviations from a benchmark should trigger further examination as to why a service is underperforming, or why a service is outperforming expectations so that lessons can be transferred to others.

Trend analysis provides a picture of the variation in referrals over time. One could expect steady improvements in referrals completion and counter-referrals over time; any negative shifts in these indicators should be examined to determine what caused them. Trends for referral initiation can be more difficult to interpret, because we may not always expect this indicator to be increasing. The proportion of client referrals can vary naturally, for example in response to the seasonality of disease patterns.

Disaggregation by client characteristic (e.g., gender, age, ethnicity, medical condition, area of residence) will help to uncover inequities that should be addressed. The indicators are calculated separately for each subgroup of interest.

Indicator 1: Proportion of Clients Referred

The Referral Initiation Indicator is used to monitor whether or not clients are being offered referrals to other services. When interpreting data for referral initiation, it is important to consider that not all clients will need a referral. Estimating what proportion of clients ought to be referred is necessary and can be done using epidemiologic data (proportion of persons with a given condition) and with the input of service providers who know the population's health needs and risks. For those clients who are eligible for a referral, the target should be for 80%–100% to obtain a referral.

For example, if 20% of pregnancies are high risk, then one could anticipate that close to 20% of pregnant women will be referred to specialized obstetric care. Less than 20% indicates that the system is not able to provide women with the services they need. More than 20% may indicate over-referral of pregnant women to specialized care and inefficient use of resources. On the other hand, we can aim for 100% of postpartum women to be referred to family planning services, because presumably they all have a need.

Interpreting the results must be done carefully because the data indicate only the level of referral initiation; they do not provide information as to why the observed trend exists. As discussed earlier, various factors can affect referral initiation, including seasonality in disease patterns, new case detection methods, new referral policies, or case management training for providers. In addition, some facilities may make few referrals because providers are able to meet several of the client's needs in one consultation. Deviations from the expected benchmarks need to be investigated further with client and provider surveys or focus groups.

Below are some examples of how data can be presented, and the type of interpretation that can be made.

Example 1: Referrals of Men Who Have Sex with Men (MSM) to Various Services

Figure 3: Illustrative Trend Data for Referral Initiation.

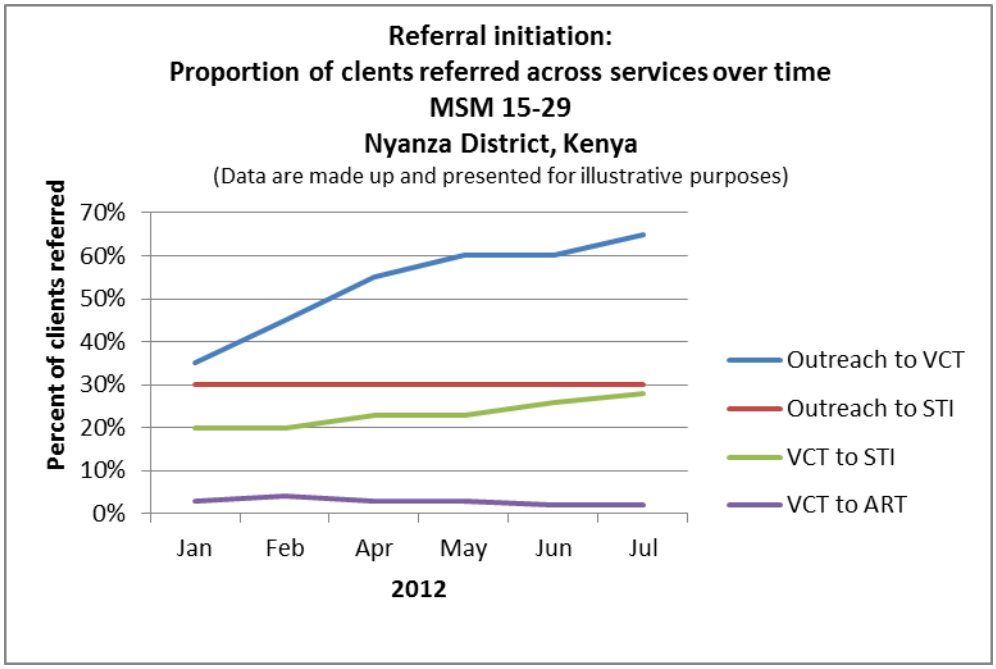


Figure 3 shows fictitious trend data for referral initiation in a hypothetical population of MSM aged 15–29 years in the Nyanza District of Kenya.

In this example, referrals from outreach workers to VCT are seen to increase over a six-month period. Because this is a high-risk group, high levels of referrals to VCT are desirable, and the increase is a positive change. Outreach workers can assist in explaining why they started referring clients more frequently. Perhaps VCT services became more available during this time, or outreach workers were given additional training in this area.

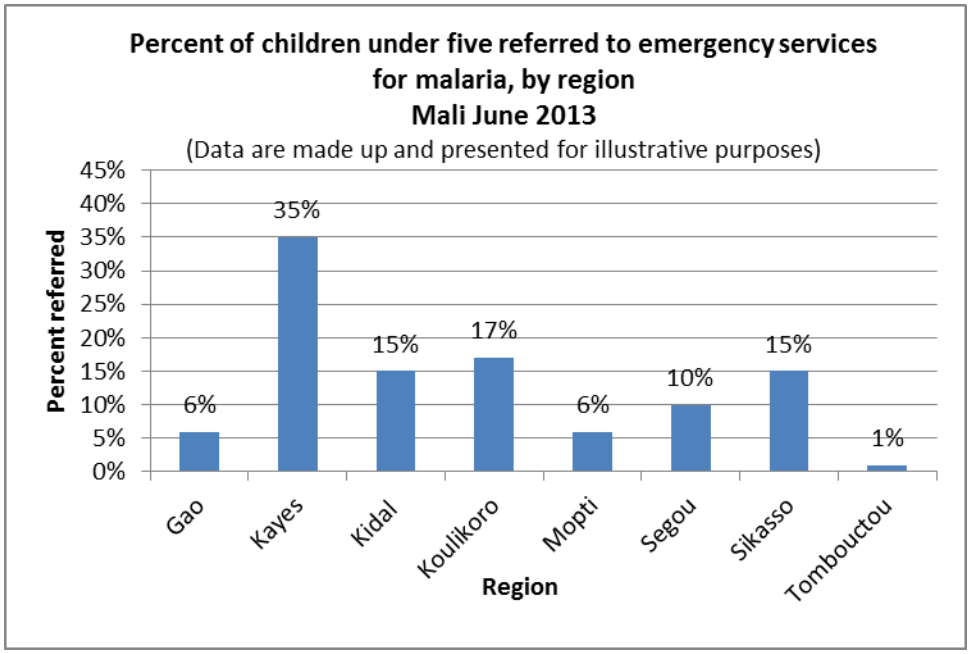
Referrals from outreach to sexually transmitted infections (STI) services, however, remained stable. If 30% is a reasonable target, given STI prevalence in this population, then the data are acceptable. If, however, 30% seems too low, then it will be important to determine how the referrals can be increased.

Referrals from VCT to antiretroviral therapy (ART) in this example are much lower than for other services. This reflects the fact that around 3% of this population of MSM are HIV-positive and therefore have a need for ART. Thus, even if the proportion is low, it is within the expected level.

Example 2: Referral of Children Under Age 5 (CU5) to Emergency Services for Malaria

A different way of portraying the data is to make comparisons across geographic units, or in this case regions. Again, these data are made up for illustrative purposes (Figure 4).

Figure 4: Illustrative Regional Comparison Chart



In this example, we see divergent referral patterns across the regions in Mali. These data need to be carefully interpreted. At first glance it may appear that some regions are performing poorly, providing far fewer referrals for emergency malaria services than others. However, part of the observed difference is likely due to different patterns of disease across regions. Malaria is far less prevalent in the northern desert regions (including Gao and Timbouctou) than in the southern regions. Thus, a far lower proportion of CU5 five has a need for emergency services related to malaria.

For regions with similar prevalence levels, one can expect similar referrals rates. The high levels in Kayes are curious and deserve a second look to determine whether there is a problem of data quality, or whether service providers in the region are referring differently.

Indicator 2: Referral Completion

The Referral Completion Indicator monitors whether or not clients are accessing the services to which they were referred. Literature review[4] finds that a realistic benchmark for this indicator to be at least 80%. In other words, the system should aim for near-universal completion of referrals. If the proportion of clients that completed a referral is high, the system is performing well and the majority of referrals made are completed. If this proportion is low, this indicates

[4] Ricca & Negroustoueva, 2009; Villaume et al., 2000. Op. cit.

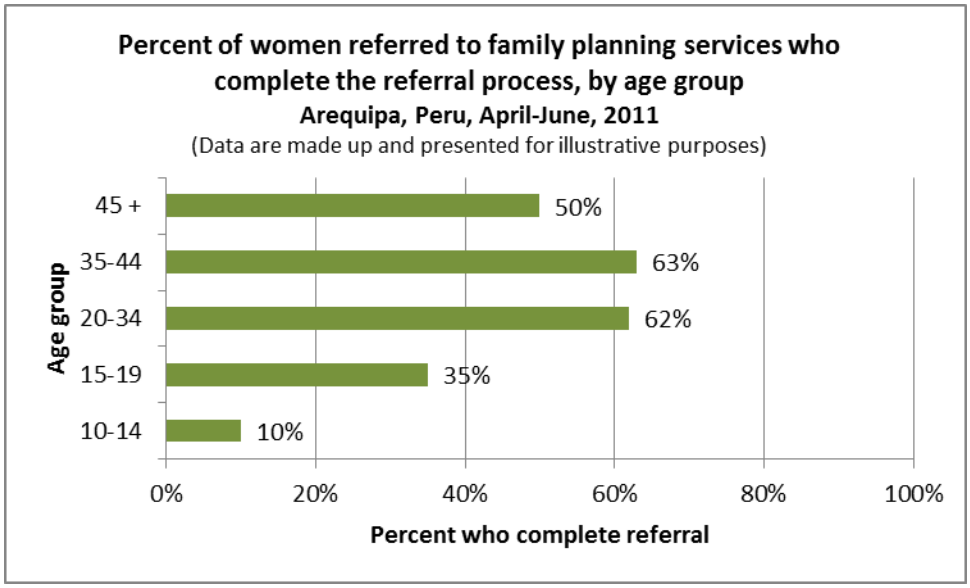
problems with the system that require further investigation to understand barriers to uptake of referrals.

The Referral Completion Indicator can be influenced by various factors, such as:

- Accessibility of services (distance and costs)
- Client perception of disease severity
- Client perception of quality services provided at receiving service
- Stigma, for example in HIV/AIDS and TB service settings
- Locus of control
- Low self-efficacy

Example 3: Referral Completion for Women Referred by a CHW to Family Planning Services

Figure 5: Illustrative Referral Completion Graph



As noted earlier, referral completion should ideally approach 80%–100% for all groups. In this hypothetical example (Figure 5), none of the age groups is close to this target, indicating there is room for improvement in referral completion across all ages.

Of interest is the fact that completion rates differ greatly by age group. These data indicate that the youngest women, aged 10–14, are least likely to complete family planning referrals, with only 10% obtaining services to which they were referred. The data do not allow for definitive explanation for these trends. However, possible explanations are that services are not youth friendly or service providers will not provide family planning services to youths. Alternatively, young, unmarried women may be too embarrassed or scared to seek these services, especially if they believe there will be judgment for obtaining services or that they will be threatened if it is discovered that they are sexually active.

Also of note in this example, women 45 and older are less likely than women aged 20–44 to complete family planning referrals. Again, both supply and demand factors should be

considered—either services are not adequately serving this group or these women are less likely to seek services, for example if they feel they are at low risk for pregnancy.

Indicator 3: Counter-Referral

Counter-referrals provide information to initiating service on clients' follow-up care needs, improve continuity of care, and provide a measure of strong linkages in service delivery. This indicator reflects the health workers' compliance with counter-referral practices; it also reflects clients' adherence to counter-referrals, when clients are expected to be seen for follow-up at initiating sites.

This indicator is most applicable when referrals are made from general to specialized services, and clients have a primary care provider who should be tracking the various services received. Counter-referral may not be expected between two specialized services. Programs will need to define ahead of time which services should be expecting counter-referrals.

For services that do expect counter-referrals, a high proportion indicates that the health workers are highly compliant with counter-referral practices and clients adhere to the counter-referrals. If this proportion is low, either the health workers are not carrying out the counter-referrals or the clients are not responsive to the counter-referrals. Not much information is available on benchmarking for this indicator. Because counter-referral is a desirable practice, targets should ideally be set high—80% or more. If, however, counter-referrals are rare in a particular setting, targets can start low and increase incrementally so that they are achievable.

It is advisable to present the data in graph form to facilitate interpretation and comparison across services or across geographic units. Charts should be easy to read, and charts that are to be compared must also use the same scale and symbols.

Creating Charts and Graphs

Charts and graphs should have the following:

1. A **clear, well-defined title** that expresses who, what, when, and where and describes the key messages that the graph is meant to convey. (The population and geographic unit included should be noted.)
2. **Labeled X-axis and Y-axis**: Axes should include a scale, such as 0%–100%, and a label that describes what variable or indicator is being presented on the axis. Most often, the Y-axis will contain the indicator itself, with an expanded definition, if necessary.
3. **Denominator definition**: This defines the criteria for being counted in the denominator.
4. **Numerator definition**: This defines the criteria for being in the numerator.
5. **Denominator values**: If the indicator is a percentage, the number of cases counted in the denominator for each measurement period should be presented.
6. **Data source**: A brief description of the source of data should be included (e.g., all births recorded in the maternity register, selected maternal charts for review).
7. **Legend**: Use a legend to distinguish between multiple graph lines if more than one service is shown on a single graph.
8. **Target line**: A dotted line can be used to delineate what the target is for the indicator and enable comparison between targets and actual achievements each month.
9. **Text Boxes**: Key events or changes in the program that may affect the rate of an indicator can be highlighted in brief text boxes with arrows indicating the point on the graph when they occurred.

Source: *HCI Norms for Presentation of Time Series Charts*, 2008.

Data Use

The RSM unit should prepare periodic (usually quarterly) reports that present the performance monitoring information in a manner that is useful to stakeholders and can be used for decision making. Reports should be presented and discussed within each geographic unit. It may also be necessary to prepare reports at higher levels of aggregation (e.g., regional or national reports). The reports should

- examine monthly data for each indicator on time series charts;
- present disaggregated data for the subgroups of interest;
- compare indicators to targets;
- discuss trends, highlighting anything unusual in the data;
- when possible, propose explanations for the results seen or recommend additional research when explanations are not obvious;
- discuss barriers to referral, completion, and counter-referral being experienced;
- investigate sites with high indicator values in order to draw possible lessons and best practices that can be replicated in lower-performing sites.

Reporting and disseminating the findings among stakeholders are important steps in the referral monitoring process. Service providers, managers, and other stakeholders need to be given an opportunity to reflect on the findings, help explain the observed trends, and make recommendations for system improvement based on the evidence.

Using RSAM tools to track these indicators on an ongoing basis helps to increase the likelihood of making more programmatic decisions. Indicator performance information coupled with qualitative knowledge about the barriers to initiating and completing referrals allows appropriate programmatic intervention to be made.

As discussed in Component 1, the Decision Calendar (Appendix 1D) is a useful tool for translating evidence and data into actionable items. It is recommended that stakeholder meetings be held at least once a year in each geographic unit to review referral monitoring data and to complete a Decision Calendar. This meeting will produce a list of prioritized actions needed for health system improvement.

Additional tools to aid in translating data into programmatic decision making are available on the MEASURE Evaluation Web site.[5]

[5] http://www.cpc.unc.edu/measure/tools/data-demand-use/data-demand-and-use-strategies-and-tools.html

APPENDIX 1: REFERRAL SYSTEM ASSESSMENT TOOLS

1A: Directory of Network Services
1B: Referral System Assessment Instrument
1C: Document Review Checklist
1D: Decision Calendar

Appendix 1A: Directory of Network Services

A **directory of network services** lists all the services and projects that provide related services in a specific geographic unit or network. The directory should list the name of the organization or facility; all the related services provided at that location; the location and contact information, and hours and days of operation, and cost of services. It should be updated annually or whenever services change. The directory should be published and given to service providers. It can also be given to clients and community members to raise awareness of available services.

An example of such a directory is provided below, with fictitious information for illustrative purposes.

Created/ Updated:			**Responsible Person:**		
Name of Organization	**Services Provided**	**Organization Type**	**Operating Days/Hours**	**Telephone/ Location**	**Cost of Services**
Comprehensive HIV/AIDS Management Program	• Information, education, and communication (IEC) materials distribution • Condom distribution • HIV counseling and testing • Nutrition counseling • Peer counseling • Prevention services	Nongovernmental organization (NGO)	Noon–6 p.m. Monday–Saturday	Main Street and Highway Intersection Tel: 55-331-3219	Testing: $50 All others free
Relief and Development Foundation	• Food support • Material support • Persons living with HIV/AIDS (PLHA) support	NGO	8 a.m.–5 p.m. Monday–Friday	Cooperative Union Building, Room 16 Tel: 55-332-2231	Donations requested
National Service	• STI services • PLHA support • Clinical care • Condom distribution • HIV counseling and testing • Nutrition counseling • IEC material distribution	Government	8 a.m.–5 p.m. Monday–Friday	Next to a Catholic school Tel: 55-332-1111	Consultations: $20 Condoms free Counseling free IEC free
Ministry of Education	• Education/schooling • Prevention services • Psychosocial support • Support for orphans and vulnerable children (OVC) and PLHA	Government	8:30 a.m.–4:30 p.m. Monday–Friday	District Education Board Secretary's Office Tel: 55-331-7766	All services free
ABC Clinic	• HIV counseling and testing • Prevention services • Family planning • STI services	Private	8 a.m.–4:30 p.m. Monday–Friday	Across the street from Cooperative Union Building, 2nd Floor Tel: 55-221-2222	Testing $15 (free if unable to pay) STI services $15 (free if unable to pay) Family planning free

Appendix 1B: Referral System Assessment (RSA) Instrument

INSTRUCTIONS:
Before Assessment Interview:

1. Obtain necessary approvals from pertinent health authorities and ethics board (if applicable).
2. Adapt the RSA Instrument as specified in Component 1 of the RSAM Toolkit.
3. Send interview questions with cover letter ahead of interview, asking for available documents, registers, and reports to be gathered where possible before interview (see below).

During Assessment Interview:

1. After recording the project and respondent's identifying information, ask for signature of consent (or note verbal consent if a telephone interview).
2. If the respondent consents, the interview can be recorded and later transcribed.
3. Do not forget to probe and ask for detailed descriptions. Note that all the questions are open-ended questions, even if there are coded categories on the left side. In this intensive interview, the emphasis is on obtaining accounts in the person's own terms. The purpose of probes is to enable the person being interviewed to be as informative as possible in his or her responses.
4. The interview guide will serve as a primary reference, but the investigator is free to ask additional questions based on the responses heard using probes.
5. Take detailed notes of responses. If the space reserved for responses is not enough, use additional blank pages and record answers with the appropriate question number.
6. Instructions for the interviewer are in capital letters and need not be read aloud.
7. Request permission to follow up by telephone, e-mail, or in person in case further information is needed, and obtain contact information
8. Collect documents. These are specified throughout the RSA instrument. The Document Review Checklist (Appendix 1C) contains the full list of documents to request as part of the assessment.
9. Ask to see the document at each facility, even if you have already gathered the same document from a different facility. It is important to confirm not only that documents exist, but that they are available at the various facilities so that staff can refer to them, and that they contain the right information.
10. Label documents as you receive them, so that you can quickly identify them for the document review.

Immediately After Assessment Interview:

1. Write down your thoughts about the interview.
2. Review your notes for each question, making sure you have recorded all the information provided by respondent. Add anything you may have previously failed to record.
3. Identify action points and activities to be followed up.

4. Check that you have a copy of all documents listed in the Document Review Checklist.
5. Extract and record the information specified in the Document Review Checklist. Make sure to answer all questions. If a document is not available, make a note of it on the Document Review Form.
6. Make sure to list the name of facility and location on the Document Review Form so that it can be linked to the completed RSA instrument.

Later:

1. Write a letter of thanks to each interviewee and ask for confirmation of promised materials and any extra information needed.
2. Check and edit transcript.
3. Arrange the follow-up with a telephone call or in-person meeting where necessary.

REFERRAL SYSTEM ASSESSMENT INSTRUMENT

NOTE: This instrument was developed for HIV/AIDS–specific programs. The response categories can easily be changed to fit the services offered for other types of programs. See the section on how to adjust the RSA Instrument in the Referral Systems Assessment and Monitoring Toolkit.

PROJECT/PROGRAM IDENTIFICATION

NAME OF INSTITUTION OR FACILITY: _____

NAME OF PROJECT OR PROGRAM: _____

LOCATION (community and city and district): _____

ORGANIZATION TYPE:
1 Government: ___ Community-based facility ___ District-level hospital ___ Tertiary hospital
2 NGO/CBO
3 Private for-profit
4 Faith-based organization
5 Other: _____

RESPONDENT AND INTERVIEWER INFORMATION

RESPONDENT NAME: _____

POSITION: _____

CONTACT INFORMATION:

Telephone: _____

E-mail: _____

CONSENT: YES NO

DATE OF INTERVIEW: __ __/__ __/__ __ __ __
MM DD YYYY

INTERVIEWER: _____

RESPONDENT CONSENT SIGNATURE:_____

INTERVIEW GUIDE DESCRIPTION

This Interview Guide contains five sections:

Section 1: Background characteristics of facility or organization
Section 2: Characteristics of the referral network
Section 3: Referral system monitoring
Section 4: Referral system processes:
- ✓ Referral protocols
- ✓ Data quality and use
- ✓ Client confidentiality and satisfaction

Section 5: Respondent recommendations

SECTION 1: BACKGROUND CHARACTERISTICS OF FACILITY OR ORGANIZATION		
No.	**QUESTION**	**RESPONSE**
READ: First, I would like to thank you for agreeing to be interviewed about the referral system for the HIV/AIDS (*or other*) program. This interview should last about 90 minutes. The answers that you give will help assess the referral system's performance and help to make recommendations for improving referrals and the continuum of care to clients. I would like to start by asking you a few general questions about the program that you are involved with. (Please record responses, including detailed descriptions, in the right column. Even where coding categories are provided, questions are open-ended, and there is no limit on the amount of information you can provide.)		
1.1	What types of services does this organization or facility provide? PROBE: Any others? (*Circle all that apply.*) 1. PMTCT 2. VCT/CT 3. Antiretroviral therapy (ART) 4. Treatment of opportunistic infections 5. Family planning 6. STI treatment 7. TB diagnosis/treatment 8. Palliative care 9. Home-based care services 10. Nutrition support services 11. Other: _____ PLEASE SPECIFY USE SPACE TO THE RIGHT TO LIST ADDITIONAL SERVICES OR COMMENT ON SERVICES PROVIDED.	
1.2	Who is your target population? PROBE: Any others? (*Circle all that apply.*) 1. General population 2. Pregnant women 3. OVC 4. MSM 5. Female sex workers 6. Injecting drug users 7. Other: _____ PLEASE SPECIFY	
1.2	Are the services you provide facility-based or community-based or both? 1. Facility-based only 2. Community-based only 3. Both	
1.3	Do you know the approximate number of people living in the area(s) served by your organization/facility? IF SO, can you please tell me how many?	

SECTION 1: BACKGROUND CHARACTERISTICS OF FACILITY OR ORGANIZATION		
No.	**QUESTION**	**RESPONSE**
1.4	How many people work in your facility or organization? IN THE CASE OF A HOSPITAL: Please provide information for both the hospital and for the specific unit. IF UNSURE, please give an estimate.	
1.5	Do you work with other institutions or service providers through the HIV/AIDS program? PROBE: Do you refer or receive clients from other institutions? IF NO, SKIP TO QUESTION 2.1.	
1.6	How many other organizations or service providers do you work with for this program?	
1.7	What types of organizations do you work with under this program? PROBE: Any others? *(Circle all that apply.)* 1. Hospitals 2. Health centers 3. Public health unit 4. Clinics 5. Specialized VCT clinics 6. Specialized ART clinics 7. Specialized TB clinics 8. Specialized STI clinics 9. NGOs 10. Community-based care 11. Faith-based organizations 12. Outreach or peer educators 13. Support groups 14. Traditional healers 15. Pharmacies 16. Other: _____ PLEASE SPECIFY	
1.8	Please list the names of the organizations or facilities you most commonly refer to. FOR HOSPITALS: Please specify the hospital and specific unit.	

SECTION 2: CHARACTERISTICS OF THE REFERRAL NETWORK		
No.	**QUESTION**	**RESPONSE**
Now I would like to ask you a few questions specifically about the referral system.		
2.1	Does your organization or facility use a referral system to accept patients and/or link patients to other services? 1. Accept patients 2. Refer patients out 3. Both Please describe.	
2.2	Is there a directory that lists the organizations or facilities that provide HIV and other related services in the area? IF SO, please describe when and how this was assembled. OBTAIN copy of the service provider directory.	
2.3	Is there a formal agreement between referring and receiving institutions? IF SO, please describe the agreement: 1. What is covered? 2. Are all service providers included? OBTAIN copy of the agreement(s).	
2.4	IF THERE IS NO FORMAL AGREEMENT BETWEEN SERVICES: Do you think that this type of agreement would be helpful? IF SO, how or why would it be helpful?	
2.5	Is there a network or consortium in which coordination of HIV/AIDS–related services among partners is facilitated or discussed? IF SO, please describe.	
2.6	IF NO CONSORTIUM EXISTS: Do you think that this is something that would be helpful? IF SO, how or why would it be helpful? SKIP TO SECTION 3.	

SECTION 2: CHARACTERISTICS OF THE REFERRAL NETWORK		
No.	**QUESTION**	**RESPONSE**
2.7	Which types of organizations participate in this consortium? 1. MOH 2. AIDS coordinating committee 3. Public health unit 4. Hospitals 5. Health centers 6. Clinics 7. Specialized VCT clinics 8. Specialized ART clinics 9. Specialized TB clinics 10. Specialized STI clinics 11. NGOs 12. Community-based care 13. Faith-based organizations 14. Outreach or peer educators 15. Support groups 16. Traditional healers 17. Other: _____ PLEASE SPECIFY Please provide details and names of organizations.	
2.8	How often do consortium participants meet? OBTAIN copy of agenda and/or minutes of last consortium or network meeting. IF NOT AVAILABLE, NOTE WHY.	
2.9	What types of issues are discussed at these meetings?	
2.10	Is this type of professional interaction helpful in increasing client's access to services? PROBE: How is it helpful?	

SECTION 3: REFERRAL SYSTEM MONITORING		
No.	**QUESTION**	**RESPONSE**
3A: REFERRALS MADE BY THE PROJECT OR PROGRAM AND COUNTER-REFERRALS		
Now I would like to ask you some questions about how your facility or organization tracks outgoing and incoming referrals. First, I would like to ask you about referrals made by your organization to other services.		
3.1	Please describe how you know about the services that are offered by other providers to which your organization makes referrals.	
3.2	What are the services for which your organization refers clients elsewhere? PROBE: Any others? *(Circle all that apply.*) 1. PMTCT 2. VCT 3. Palliative care 4. ART 5. Home-based care services 6. Family planning 7. Nutrition support services 8. Medical follow-up 9. STI care 10. TB diagnosis/treatment 11. Other: _____ PLEASE SPECIFY	
3.3	To where do you usually send referrals? PROBE: Any others? *(Circle all that apply.*) 1. Hospitals 2. Health centers 3. Public health unit 4. Clinics 5. Specialized VCT clinics 6. Specialized ART clinics 7. Specialized TB clinics 8. Specialized STI clinics 9. NGOs 10. Community-based care 11. Faith-based organizations 12. Outreach or peer educators 13. Support groups 14. Traditional healers 15. Pharmacies 16. Other: _____ PLEASE SPECIFY	
3.4	Please describe the method(s) and the processes that are used to refer clients. PROBE: Do you use any of the following? *(Circle all that apply.)* 1. Verbal (tell them where to go) 2. Issue standard referral form 3. Blank paper to write referral information	

SECTION 3: REFERRAL SYSTEM MONITORING		
No.	**QUESTION**	**RESPONSE**
	4. Telephone referral 5. Escort client 6. Other: _____ PLEASE SPECIFY	
3.5	Please describe who identifies and assesses client needs and makes a referral. *(Circle all that apply.)* 1. Referring doctor 2. Nurse 3. Case manager 4. Project officer 5. Support group member 6. Peer educator 7. Other: _____ PLEASE SPECIFY	
3.6	Does your organization have a record keeping system to keep track of outgoing clients? IF SO, describe in detail. PROBE: Do you use any of the following: 1. Patient register or individual medical record 2. Retain copies of Client Referral Form 3. Referral register 4. Other: _____ PLEASE SPECIFY OBTAIN copy of registers and Client Referral Forms that are used.	
3.7	IF NO COPY IS AVAILABLE, describe the information and data elements that are recorded for outgoing referrals.	
3.8	IF STANDARD CLIENT REFERRAL FORMS ARE MENTIONED IN 3.6, ASK (OTHERWISE, SKIP TO 3.9). How is the supply of Client Referral Forms or slips monitored?	
3.9	How does the provider at the receiving organization know that a patient has been referred to them?	
3.10	How does your organization know that a client completed the referral?	
3.11	Is there a system to follow up with a client on referral? IF SO, please explain how.	
3.12	Is there a system in place to measure and record a time lapse between when a	

SECTION 3: REFERRAL SYSTEM MONITORING		
No.	**QUESTION**	**RESPONSE**
	referral was made and when a client reached the receiving provider? IF SO, can you please show me the record? Has average delay been ever calculated by your project?	
3.13	Who usually follows up with a patient on referral? Describe: 1. Referring doctor 2. Nurse 3. Public health technician 4. Case manager 5. Project officer 6. Social worker 7. Counselor 8. Administrator 9. Other: _____ PLEASE SPECIFY	
3.14	Are clients ever referred back to this organization or facility for follow-up after referral services are received? IF SO, explain the process.	
3.15	Are the cases that are referred back to you documented in some type of register? IF SO, please describe. OBTAIN copy of forms or registers used to record counter-referrals.	
3.16	Has your project or service calculated a counter-referral rate? EXPLAIN: The counter-referral rate is the proportion of clients you refer that is received back at your facility.	
3.17	Is there a system to inform your facility or organization that a client has completed the referral? IF SO, can you please describe this system: 1. Verbal 2. Section of referral form filled out and sent back 3. Separate counter-referral form 4. Blank slip of paper 5. Other: _____ PLEASE SPECIFY	

SECTION 3: REFERRAL SYSTEM MONITORING		
No.	**QUESTION**	**RESPONSE**
3.18	Does your organization obtain permission from the client to follow up with the other provider? 1. How is this done? 2. Is there a formal release of information?	
3B—ACCEPTANCE OF REFERRALS FROM OTHER PROVIDERS		
Now, I would like to ask you about referrals made to your organization from other service providers.		
3.19	Do you accept referrals from other services or organizations? IF NOT, SKIP TO SECTION 4.	
3.20	Please describe how other providers know about the services that are provided by your facility or organization.	
3.21	What are the services for which clients are referred to your project from elsewhere? PROBE: Any others? *(Circle all that apply.)* 1. PMTCT 2. VCT 3. Palliative care 4. ART 5. Home-based care services 6. Family planning 7. Nutrition support services 8. Medical follow-up 9. STI care 10. TB diagnosis/treatment 11. Other: _____ PLEASE SPECIFY	
3.22	From where do you usually receive referrals? PROBE: Anywhere else? *(Circle all that apply.)* 1. Hospitals 2. Health centers 3. Public health unit 4. Clinics 5. Specialized VCT clinics 6. Specialized ART clinics 7. Specialized TB clinics 8. Specialized STI clinics 9. NGOs 10. Community-based care 11. Faith-based organizations 12. Outreach or peer educators 13. Support groups 14. Traditional healers 15. Pharmacies 16. Other: _____	

SECTION 3: REFERRAL SYSTEM MONITORING		
No.	**QUESTION**	**RESPONSE**
	PLEASE SPECIFY	
3.23	Please describe the method(s) and mechanisms that are used for clients referred to you. (*Circle all that apply.*) PROBE: Are any of the following used? 1. Client told verbally where to go 2. Client issued a standard referral form 3. Client given a piece of paper with written referral information 4. Telephone referral to your organization 5. Client is escorted 6. Other: _____ PLEASE SPECIFY IF FORMS ARE USED: Do incoming clients bring referral forms always, often, sometimes or never? PROBE: Do all clients referred to you bring the same referral form? OBTAIN copy of Client Referral Form(s) received. NOTE: IF THE CLIENT REFERRAL FORMS RECEIVED ARE THE SAME AS THOSE USED TO REFER OUT, LABEL FORMS.	
3.24	Please describe what information the client referred to you usually brings. PROBE: Anything else? 1. Name of the referring provider, including provider's location, address, phone number 2. Name of receiving organization, including location, address, phone number 3. Information about the type of service given to the client at the original provider 4. Diagnosis 5. Reason for referral 6. Date of referral 7. Instruction on how to follow up with referring institution 8. Other: _____ PLEASE SPECIFY	
3.25	What do you think about these referral methods?	

SECTION 3: REFERRAL SYSTEM MONITORING		
No.	**QUESTION**	**RESPONSE**
	Are they effective? Why or why not? How would you improve them?	
3.26	What information does your facility or organization record for clients that have been referred to your facility? PROBE: Do you record the following? 1. Name of the referring provider, including provider's location, address, phone number 2. Original diagnosis 3. Reason for referral 4. Information about the type of service given to the client at the original provider 5. Date of referral 6. Date service was provided 7. Date client referred back to original service provider 8. Other: _____ PLEASE SPECIFY OBTAIN copy of forms or registers that record incoming referrals.	
3.27	Do you refer the client back to the originating service? IF SO, please describe the process.	
3.28	What information do you send back with the client? Do you have specific forms you use for this purpose? IF NO FORMS, please describe how the information is sent back. OBTAIN copy of forms used to counter-refer clients.	
3.29	Do you contact the originating service directly? IF SO, how? What information do you provide?	

SECTION 4: REFERRAL SYSTEM PROCESSES		
No.	**QUESTION**	**RESPONSE**
4A: REFERRAL PROTOCOLS		
4.1	Are there documented referral protocols or guidelines for HIV/AIDS–related services? IF SO, for which services? 1. PMTCT 2. VCT 3. Palliative care 4. ART 5. Home-based care services 6. Family planning 7. Nutrition support services 8. Medical follow-up 9. STI care 10. TB diagnosis/treatment 11. General referral guidelines 12. Other: _____ PLEASE SPECIFY OBTAIN copy of referral protocols.	
4.2	IF REFERRAL GUIDELINES EXIST: Are these guidelines project specific, adapted to the national health system, or international? Please describe.	
4.3	Has there been training of providers on referral protocols? IF SO, please describe the training: What did it cover? When did it occur? Who participated in the training? Was it effective? Has there been follow-up or refresher training? OBTAIN any documentation from this training that is available.	
4B: DATA QUALITY AND USE		
4.4	Is there any mechanism to ensure the accuracy of recorded information on referral initiation and completion? IF NO, SKIP TO 4.7	

SECTION 4: REFERRAL SYSTEM PROCESSES		
No.	**QUESTION**	**RESPONSE**
4.5	Can you describe the process of ensuring quality of the data gathered on referrals? PROBE: Are any of the following used? 1. Regular supervision 2. Periodic audits (i.e., DQA) 3. Other mechanism PROMPT FOR DETAILED DESCRIPTION. OBTAIN documents related to data quality checks (reports, feedback, checklists).	
4.6	When was the last time a data quality check was undertaken?	
4.7	Have any actions or improvements followed from data quality checks of referral information? IF SO, please describe. PROBE: Were any other changes made?	
4.8	How much time is taken from you or your staff to document, report, and analyze referral data? Do you feel this is burdensome?	Document: Report: Analyze:
4.9	Does anyone analyze referral data? IF SO, how often are data compiled and in what form? Who compiles and uses these data? For what purpose(s)? Can you give us any examples of decisions made based on these data? IF NO DATA ARE ANALYZED, can you describe why not?	
4.10	Has your facility or organization calculated a referral rate and/or referral compliance rate? IF SO, how often? Where is it recorded? Who is it reported to?	

SECTION 4: REFERRAL SYSTEM PROCESSES		
No.	**QUESTION**	**RESPONSE**
4.11	Are referral data reported to anyone in your organization or elsewhere? IF SO, describe what information is reported. Who receives this information? How often do they receive it? OBTAIN copy of reporting forms and report where referral data are presented.	
4.12	Do you think data on referrals would be helpful to providers and program managers? Why or why not?	
4.13	Are the data on referrals ever discussed? How often? By Whom?	
4.14	What is the content of these discussions? Were any programmatic or clinical changes made based on these discussions?	
4.15	Has the referral system ever been evaluated? IF SO, when was the last time? Who evaluated the system?	
4.16	Have you ever seen a copy of the evaluation report? IF NOT, were you informed of the evaluation results? Please describe how you were informed.	
4C: CLIENT CONFIDENTIALITY AND SATISFACTION		
4.17	Is the name of a client or other identifying information recorded in registers for referral? IF SO, what other information, besides name, is recorded? (For example, address, phone number)	
4.18	Is the name of a client or other identifying information recorded in any reports about a referral? IF SO, what other information, besides name, is recorded?	

SECTION 4: REFERRAL SYSTEM PROCESSES		
No.	**QUESTION**	**RESPONSE**
4.19	Are there any considerations made to ensure client confidentiality? IF SO, please describe. PROBE: How do you prevent a client's personal information from being known?	
4.20	Do you have any concerns about the maintenance of confidentiality within the information and/or referral tracking systems? IF SO, what? What could be done to improve maintenance of confidentiality?	
4.21	Is there a system to record referral outcomes for the patients who were referred out? IF SO, please explain in detail.	
4.22	Do providers regularly ask clients what they think about the referral process? 1. Was it what they wanted? 2. Did it address their concerns such as stigma? 3. Is it feasible—Cost, transport, hours?	
4.23	Is there a standard way to assess clients' satisfaction with the referral process? IF SO, OBTAIN copy of the questionnaire or form.	
4.24	On the basis of your opinion or survey results, what would be the main reasons for client dissatisfaction with the referral process? PROBE: Any other reasons clients may not be satisfied?	
4.25	What are other barriers that prevent clients from completing the referral process? PROBE: Any other barriers?	
4.26	What are the main barriers that prevent clients from completing the counter-referral process? PROBE: Any other barriers?	

SECTION 5: RESPONDENT RECOMMENDATIONS		
No.	**QUESTION**	**RESPONSE**
I have a few final questions to hear your recommendations on how the referral system and its monitoring can be improved.		
5.1	Do you have any recommendations on how the referral system could be improved? IF SO, could you please tell me? PROBE: Do you have other suggestions?	
5.2	Do you have any recommendations on how the monitoring of referrals could be improved? IF SO, could you please tell me? PROBE: Do you have other suggestions?	
5.3	Do you have any other comments that you would like to make that we have not already covered?	
Thank you very much for your time and cooperation.		

Appendix 1C: Document Review Checklist

INSTRUCTIONS:

1. Complete the checklist as soon as possible after each RSA interview.
2. For each document, there is a list of questions that need to be answered. Response categories for each question are in the far right column.
3. If certain information is not available, make a note of it and explain why.
4. Fill out a separate sheet for each facility or organization
5. If two or more services are targeted for interview at a same facility, gather separate documents from each respondent and complete a separate Document Review Checklist for each service (registers, protocols, and agreements may vary service to service).

DOCUMENT REVIEW CHECKLIST

NAME OF FACILITY: _____ LOCATION (community and city and district): _____

ASSOCIATED RSA INSTRUMENT NUMBER: _____

Question in RSA Instrument	DOCUMENT	ITEMS TO CHECK FOR	RESPONSES (Use reverse if more space needed)
2.2	Directory of Network Services (list of organizations providing related services in the geographic unit)	Local directory of services exists? Directory available at the facility? Date last updated: Directory contains: -Full range of services available in the geographic area? -Current contact information for all services? -Location of each facility or organization? -Hours of operations?	YES NO YES NO Date: _____ DD/MM/YY YES NO YES NO YES NO YES NO
2.3	Formal agreement(s) between referring and receiving institutions (If more than one agreement exists, complete the information for each agreement on separate sheets of paper.)	Agreement(s) exist? Date agreement(s) signed: Agreement(s) list: -How referrals are to be carried out (e.g., by phone, in person)? -What forms are used? -What documentation is needed? List all facilities or organizations named in the agreement(s):	YES NO Date: _____ DD/MM/YY YES NO YES NO YES NO Name of facilities or organizations: • • • • • • (Use separate page if needed.)

2.8	Agenda and/or minutes from a referral consortium or network meeting	Referral network or consortium holds regular meetings? Minutes available at facility? Date of last meeting: Name of participating organizations: List main themes or issues discussed:	YES NO YES NO Date: _____ DD/MM/YY Participants: • • • • • Main themes : _____ _____ _____ _____ _____ (Use separate page if needed.)
4.1	Referral protocols or guidelines for HIV/AIDS services	Referral protocols exist? Referral protocols are available at facility for reference? Date last updated: Contain clinical algorithms? Describe how to document referrals?	YES NO YES NO Date: _____ DD/MM/YY YES NO YES NO
4.3	Evidence related to trainings conducted on referral protocols	Staff trained on protocols? Evidence of trainings exists? Training materials available to facility staff?	YES NO YES NO YES NO
4.5	Reports on data quality audits (DQAs) and supervision visits	Date of last DQA at this facility: Report available at facility? Recommendations for improvement are included?	Date: _____ DD/MM/YY YES NO YES NO

4.11	Report with compiled or analyzed referral data (e.g., any calculation of use, referral rate, referral compliance rate)	Report with analyzed referral data exists? Report available at facility? Date of last available report: Report includes data on: - Service use? - Referral rates? - Referral completion rates? - Counter-referrals? - Client satisfaction? Includes recommendations to improve referral system?	YES NO YES NO Date: _____ DD/MM/YY YES NO YES NO YES NO YES NO YES NO YES NO
4.23	Client satisfaction questionnaire or results of client satisfaction survey (specific to referrals)	Client satisfaction questionnaires are available at facility? Facility uses them regularly? Date last client satisfaction questionnaire or survey completed: Analyzed data on client satisfaction are available at facility?	YES NO YES NO Date:_____ DD/MM/YY YES NO

Question in RSA Instrument	DOCUMENT	ITEMS TO CHECK FOR	RESPONSES (Use reverse if more space needed)
REFERRAL REGISTERS AND TOOLS			
3.6 and 3.15	Referring Service Register (at initiating facility)	Register captures data for <u>outgoing</u> referrals? Following elements included in the referral register: -Client name? -Client ID? -Type of service that initiated the referral? -Record of all clients seen for that service type at initiating facility? -Date of referral initiation? -Type of service referred to (reason for referral)? -Name of receiving organization? For counter-referral: -Date client seen at the receiving service? -Description of services rendered at receiving facility? -Date client seen back at initiating facility for counter-referral?	YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO

Question in RSA Instrument	DOCUMENT	ITEMS TO CHECK FOR	RESPONSES (Use reverse if more space needed)
3.6	Outgoing Client Referral Form (i.e., form given to client by referring facility)	Facility provides outgoing client referral forms? Following elements included in the client referral form: -Client name? -Client ID? -Client characteristics (sex, age)? -Name of referring organization? -Type of referring service? -Date of referral initiation? -Service referred to (reason for referral)? -Name of receiving facility? -Contact information for receiving service? -Date client seen at the receiving service? -Description of services rendered at receiving facility? -Follow-up instructions? -Date seen at initiating service for counter-referral?	YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO
3.23	Incoming Client Referral Form (i.e., forms received by facility when a referral is received)	Incoming referrals bring Client Referral Forms. Incoming referral forms contain the following information: -Client name? -Client ID? -Client characteristics (sex, age)? -Name of referring organization? -Type of referring service? -Date of referral initiation? -Service referred to/reason for referral? -Name of receiving facility? -Contact information for receiving service? -Date client seen at the receiving facility? -Description of services rendered at receiving facility? -Follow-up instructions? -Date of counter referral back to original institution (if applicable)?	ALWAYS OFTEN SOMETIMES NEVER YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO

Question in RSA Instrument	DOCUMENT	ITEMS TO CHECK FOR	RESPONSES (Use reverse if more space needed)
3.26	Receiving Service Register (at receiving facility)	Register captures data for incoming referrals? Following elements included in the referral register: -Client name? -Client ID? -Name of referring organization? -Type of service that initiated the referral? -Date of referral initiation? -Service referred to/reason for referral? -Date of client seen at the receiving service? -Description of services rendered at receiving facility? -Client counter-referred to initiating service or facility?	YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO
3.28	Counter-Referral Forms (used to send clients back to initiating facility)	Counter-referral forms are used after receiving a referral. Form includes the following: -Client name? -Client ID? -Client characteristics (sex, age)? -Name of referring organization? -Name of receiving organization? -Date referral initiated? -Date of client seen at the receiving service? -Reason for referral? -Description of services rendered at receiving facility? -Date of counter-referral back to original institution? -Follow-up instructions?	ALWAYS OFTEN SOMETIMES NEVER YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO

Appendix 1D: Decision Calendar

The Decision Calendar is a tool developed by MEASURE Evaluation to aid program managers in making informed decisions and prioritizing action items for improving health programs. It helps mangers to identify and document key policy or program decisions that must be made, and from that understanding, identify the information needed to support those decisions. A copy of the tool and brief description are presented below. The full tool can be found on the MEASURE Evaluation Web site, under Tools: http://www.cpc.unc.edu/measure/tools/data-demand-use/ddu-decision-calendar

The process usually entails a group meeting with key stakeholders to brainstorm the decisions and data requirements. This brainstorming will usually involve reviewing the referral assessment and monitoring data, listing the key findings, and identifying key decisions that could be influenced by these findings.

The Decision Calendar is grouped into three types of decisions:

1. Policy, planning, and advocacy decisions. These decisions might include the development of a document or the formulation of a policy.
2. Program design and improvement decisions. These decisions can address many aspects of a program life cycle, from initial design to closeout.
3. Program management and operations decisions. These decisions relate to the administrative, financial, and logistical factors that affect the success of a program.

Decision makers should list the decisions or actions that could be taken in each of the three categories.

Decision describes either the known decision that must be made, or the decision that could potentially benefit from known data resources.

For each decision, five aspects need be described:

1. Frequency describes whether the decision is routine or non-routine.
2. Decision maker is the person who has ultimate authority for making a decision; other stakeholders include those who are involved in the decision-making process.
3. Required information is that which is needed to support the decision in question; it should include all components relevant to the decision and be as specific as possible.
4. Next steps should outline the action or actions required once the decision has been made.
5. Timeline presents a concrete, actionable timeframe for the next steps.

Decision Calendar template – Version 1 (Summary view)

Decision Calendar title	
Agency/Program	
Program manager	
Facilitator	
Time period for decision making	

Part A. Policy, planning and advocacy decisions					
Decision	Frequency	Decision maker and other stakeholders	Required information	Next steps	Timeline
Part B. Program design and improvement decisions					
Decision	Frequency	Decision maker and other stakeholders	Required information	Next steps	Timeline
Part C. Program management and operations decisions					
Decision	Frequency	Decision maker and other stakeholders	Required information	Next steps	Timeline

APPENDIX 2: REFERRAL SYSTEM MONITORING TOOLS

2A: Client Referral Form
2B: Referral Register at Initiating Service
2C: Referral Register at Receiving Service
2D: Referral Reporting Form
2E: Indicator Reporting Form

Appendix 2A: Client Referral Form

CLIENT REFERRAL FORM

Completed by the Referring Organization

Date of Referral: __ __ / __ __ /__ __ __ __
Day Month Year

Client ID: _____ Age: _____ Sex: _____

Address: _____ Phone No:_____

Referred From: _____ Referred To:_____

Type of initiating service: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Service referred for:

1. Youth friendly services	( )	7.Family planning	( )	13. Psychological Support	( )
2. STI Screening	( )	8. Condom supply	( )	14. Domestic Violence Supp	( )
3. STI Treatment	( )	9. TB screening	( )	15. Substance Abuse manag	( )
4. HIV Counselling and Testi	( )	10. TB treatment	( )	16. Home Based Care	( )
5. ART and Adherence	( )	11. Nutrition	( )	17. Income generating activi	( )
6. PMTCT Services	( )	12. PLHIV Support group	( )	18. Orphan Care & Support	( )

Name & Signature of referring provider: _____

Completed by the Receiving Organization

Name of organization: _____

Date referral service provided: __ __ / __ __ /__ __ __ __
Day Month Year

Service renderred:

1. Youth friendly services	( )	7.Family planning	( )	13. Psychological Support	( )
2. STI Screening	( )	8. Condom supply	( )	14. Domestic Violence Supp	( )
3. STI Treatment	( )	9. TB screening	( )	15. Substance Abuse manag	( )
4. HIV Counselling and Testi	( )	10. TB treatment	( )	16. Home Based Care	( )
5. ART and Adherence	( )	11. Nutrition	( )	17. Income generating activi	( )
6. PMTCT Services	( )	12. PLHIV Support group	( )	18. Orphan Care & Support	( )

Follow-up needed: YES NO
Describe:

Additional Comments:

Name & Signature of service provider: _____

Completed by the Originating Organization

Name of organization: _____

Date counter-referral completed
Day Month Year

Additional Comments:

Name & Signature of service provider: _____

Appendix 2B: Referral Register at Initiating Service

Date	Reference No.	Client ID	Sex	Date of Birth	Service Received at Initiating Facility (Use predefined codes)	Referred to: (Organization Name)	Services Referred for: (Use predefined codes)	Name of Referring Officer	Referral Services Completed (Yes/No)	Date Completed	Date Client Seen for Counter-Referral	Follow-Up Needed: (Yes/No)

Appendix 2C: Referral Register at Receiving Service

Date	Reference No.	Client ID	Sex	Date of Birth	Service (at initiating facility) from which client was referred (Use predefined codes)	Referred From: (Organization Name)	Services Referred for: (Use predefined codes)	Name of Referring Officer	Services Provided at This Facility (List all that apply)	Date Completed	Follow-Up Needed: (Yes/No)	Counter-Referral Provided? (Yes/No)

Appendix 2D: Referral Reporting Form

(TO BE COMPLETED BY REFERRING SERVICE)

PAGE 1 of 3

Name of organization and facility: _____

Geographic unit: _____

Reporting period—Month: _____ Year: _____ Prepared by: _____

1. Number of clients referred by type of service

Group for which data are reported—Age range: _____ Sex: _____

	COLUMN Y ↓	TOTAL NUMBER CLIENTS SEEN AT REFERRING SERVICE	CLIENTS REFERRED TO RECEIVING SERVICES					
			Service 1	Service 2	Service 3	Service 4	Service 5	Service 6
REFERRING SERVICE	Service 1							
	Service 2							
	Service 3							
	Service 4							
	Service 5							
	Service 6							

Instructions:

This table is used to record clients you refer to other services. The services that your facility provides are listed in COLUMN Y, shaded in grey at the left of the table. The services that clients are referred to are listed across the top of the table.

1. In COLUMN Y, identify the services that your facility provides.[6]
2. Put a line through the services that your organization or facility does not provide. This is important so that we can differentiate between services not provided and data that may be missing for existing services.
3. For all the services in COLUMN Y that your facility does provide, fill in the entire row.
4. First, indicate the total number of clients attended by that service for the reporting period. Include all clients whether they were referred or not.
5. Under CLIENTS REFERRED, record the number of referrals that you made to each receiving service. If no referrals were made to a particular service enter 0 (do not leave blank). If a particular receiving service does not exist in your network, enter 0 in number of referrals made to that service. Do not leave blank.
6. If the information must be disaggregated by age and/or sex, fill in a separate table for each group.
7. Frequency of reporting will be predetermined by the project.

[6] The list of services in COLUMN Y (and receiving services) will have been predefined.

Referral Reporting Form

(TO BE COMPLETED BY REFERRING SERVICE)

2. Counter-referrals—Number of clients received back at referring service with completed counter-referral information

Group for which data are reported—Age range: _____ Sex: _____

	COLUMN Y ↓	RECEIVING SERVICES					
		Service 1	Service 2	Service 3	Service 4	Service 5	Service 6
REFERRING SERVICE	Service 1						
	Service 2						
	Service 3						
	Service 4						
	Service 5						
	Service 6						

Instructions:

This table is used to record clients that your facility referred to other services and then were counter-referred back to you. The services that your facility provides are listed in COLUMN Y, shaded in grey at the left side.
The receiving services that counter-referred back to you are listed across the top of the table.

1. In column Y, identify the services that your facility provides.[7]
2. Put a line through the services that your organization or facility does not provide. This is important so that we can differentiate between services not provided and data that may be missing for existing services.
3. For all the services in COLUMN Y that your facility does provide, fill in the entire row.
4. Record the number of clients that were counter-referred back to your facility once the referral was completed at the receiving service.
5. For each RECEIVING SERVICE, record the number of clients that were counter-referred from that receiving service (in other words, the number of clients that you saw again at your facility after they received the service for which you referred them). If no counter-referred clients were seen, enter 0 (do not leave blank). If a particular receiving service does not exist in your network, enter 0 for clients counter-referred for that service. Do not leave blank; the whole row needs to have data in it.
6. If the information must be disaggregated by age and/or sex, fill in a separate table for each group.

[7] The list of services in COLUMN Y (and receiving services) will have been predefined.

Referral Reporting Form

(TO BE COMPLETED BY RECEIVING SERVICE)

Name of organization and facility: _____

Geographic unit: _____

Reporting period—Month: _____ Year: _____ Prepared by: _____

3. Number of referrals completed at receiving services, by type of referring service

Group for which data are reported—Age range: _____ Sex: _____

		RECEIVING SERVICES					
ROW X →		Service 1	Service 2	Service 3	Service 4	Service 5	Service 6
REFERRING SERVICE	Service 1						
	Service 2						
	Service 3						
	Service 4						
	Service 5						
	Service 6						
	Not specified						

Instructions:

This table is used to record clients that are referred to your facility from other services. The services that your facility provides are listed in ROW X shaded in grey at the top of the table. The services that referred clients to you are listed in the second column on the left.

1. In ROW X, identify the services that your facility provides.
2. For services that your facility does not provide, cross out the column. This is important so that we can differentiate between services not provided and data that may be missing for existing services.
3. For all the services in ROW X that your facility does provide, fill in the entire column. Record the number of referred clients that your facility received and provided services to. You will need to note which service referred the clients to you. If no clients were received from a particular referral service enter 0 (do not leave blank).
4. Only clients that were referred to your organization by another service provider should be listed in this table.
5. If you know a client was referred but do not have information regarding the referring service, record that client in the last row REFERRING SERVICE Not specified.
6. If the information must be disaggregated by age and/or sex, fill in a separate table for each group, noting the group in the lines above the table.

Appendix 2E: Indicator Reporting Form

Geographic unit: _____Region: _____

Reporting period—Month: _____ Year: _____Prepared by: _____

Group for which data are reported—Age range: _____ Sex: _____

Referring Service	**Receiving Service**	**Indicator 1:** Proportion of clients referred from initiating service	**Indicator 2:** Proportion of referred clients that completed referral at receiving facility	**Indicator 3:** Proportion of referred clients seen at receiving service that is seen back at referring service for counter-referral
Service 1	Service 2			
Service 1	Service 3			
Service 1	Service 4			
Service 2	Service 1			
Service 2	Service 3			
Service 2	Service 4			
Service 3	Service 1			
Service 3	Service 2			
Service 3	Service 4			
Service 4	Service 1			
Service 4	Service 2			
Service 4	Service 3			
Etc.	Etc.			