Promising Practices for Linking Economic Strengthening and Clinical Services

A DISCUSSION PAPER

PREPARED BY
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SUPPORTED BY
The PEPFAR Care and Support Technical Working Group

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ACRONYMS

AIDS Acquired Immunodeficiency Syndrome
AIDSTAR AIDS Support and Technical Assistance Resources
ART Antiretroviral Therapy
BOLSA Bureau of Labor and Social Affairs (Regional Government)
CBO Community-Based Organization
CHBC Community Home-Based Care
CSSG Community Self-Help Savings Groups
CSO Civil Society Organizations
DOTS Directly Observed Treatment - Short Course
FBP Food by Prescription
FHI Family Health International
HAPCO HIV/AIDS Prevention and Control Office (Government of Ethiopia)
HCSP HIV/AIDS Care and Support Program
HCT HIV Counseling and Testing
HIV Human Immunodeficiency Virus
IGA Income Generating Activity
KOOW Kebele-Oriented Outreach Workers
LIFT Livelihoods and Food Security Technical Assistance Program
MARP Most At-Risk Populations
MOLSA Ministry of Labour and Social Affairs (Government of Ethiopia)
NACS Nutrition Assessment, Counseling and Support
NGO Non-Governmental Organization
NPI New Partners Initiative
OSSA Organization for Social Services for AIDS
OVC Orphans and Vulnerable Children
PEPFAR The U.S. President’s Emergency Plan for AIDS Relief
PLHIV People Living with HIV
SSGs Self-Help Saving Groups
STI Sexually Transmitted Infection
USAID United States Agency for International Development
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I. **INTRODUCTION**

The expansion of antiretroviral therapy (ART) and the emergence of stronger community systems to support people living with HIV (PLHIV), their caregivers and their family members are having a positive impact on households and communities affected by HIV and AIDS. People affected by HIV are developing more optimistic attitudes and skills to live positively, participating more actively in decisions affecting their lives, and gaining more social acceptance and respect. Increasingly, individuals are re-entering into more productive lifestyles and furthering their sense of hope and self-worth.

To reinforce this positive momentum, governments, donors and community service providers are focusing investments on establishing and strengthening the sustainability of more comprehensive systems of care and support. These systems aim to deliver clinical HIV services to address the health-related aspects of HIV, as well as effectively link clients to a range of complementary services necessary for positive living. These additional services may include nutritional support, home-based care, psychosocial support, protection systems and education opportunities for vulnerable children, and economic strengthening.

Economic strengthening interventions are gaining increased attention as a newer set of services which can reinforce prevention, care and support and impact mitigation efforts by assisting households to protect and build assets and safety nets, identify cost saving measures, diversify income sources, and improve employment prospects and the profitability of enterprise activities. With appropriate and more robust livelihood strategies, households can better meet their basic financial needs, including expenses associated with HIV care and treatment, and the consumption of nutritious and plentiful food necessary to sustain positive clinical outcomes. Economic strengthening activities can also reduce the use of negative coping strategies, due to financial strain, such as skipping treatments or meals, sending children to work instead of school, or engaging in high-risk economic activities, including commercial sex.

In 2011, the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) Care and Support Technical Working Group engaged the Livelihoods and Food Security Technical Assistance Program (LIFT) to conduct research to identify promising practices, challenges and impact emerging from referral systems that have begun to link economic strengthening and clinical HIV services. LIFT is a project funded by the United States Agency for International Development (USAID), led by FHI 360 with support from CARE and Save the Children, which provides technical assistance to improve the effectiveness and sustainability of PEPFAR-supported food security and livelihood programs. Key questions of interest for LIFT to explore in this engagement included:

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<thead>
<tr>
<th>What is Economic Strengthening?</th>
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<td>Household economic strengthening activities include the portfolio of strategies and interventions that reduce the economic vulnerability of orphans and vulnerable children (OVC), caregivers and people living with HIV. According to the USAID FIELD report produced by AED (now FHI 360) and Save the Children, <em>Economic Strengthening for Vulnerable Children: Principles of Program Design and Technical Recommendations for Effective Field Intervention</em>, experts in the field refer to economic strengthening interventions belonging to one of the following three categories:</td>
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<td>1) <strong>Provision:</strong> Social assistance, including asset transfers, food aid, social pensions, and public works (public sector employment programs, educational support, health care vouchers)</td>
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<tr>
<td>2) <strong>Protection:</strong> Asset growth, savings, insurance (life, disability, health, loan, agriculture), legal services for asset protection</td>
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<td>3) <strong>Promotion:</strong> Income growth, skills training, income-generating activities, job creation, market linkages, business loans</td>
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• What are examples of effective processes found in successful referral systems?
• What are the challenges in implementing effective referrals between livelihoods programs and clinical services, and what may be needed to overcome these challenges?
• Can the impact of economic strengthening interventions offered via referral systems be measured, and what are key indicators of success? What are the warning signs of possible failure?
• Which types of livelihood programs are most appropriate for clinic-referred clients? Are the outcomes sought being realized (e.g. stigma reduction, improved clinical outcomes, reduction of individual or family vulnerabilities by increasing household income and nutritional status)? What might be missing?
• How are resource constraints impeding the success of referral systems, and how can they be overcome? What are the barriers to sustainability of systems?
• What are relevant gender considerations in these referral systems?
• What roles are suitable for supporting institutions, such as central and local governments, communities, civil society organizations (CSOs), clinics, private sector and other associations, in existing referral systems? How could these institutions strengthen or complement effective systems?

To provide insight into these questions, Save the Children undertook a literature review and conducted field-based research in Ethiopia to capture the experiences of referral systems implemented by three PEPFAR-funded programs, which coordinate referrals between clinical HIV services and economic strengthening services. These programs include Food by Prescription (FBP), TransACTION and the HIV Care and Support Program (HCSP). During this research, an emphasis was placed on exploring relationships linking individuals from clinical settings to economic strengthening interventions, as well as linkages from economic strengthening programs to clinical services.

This discussion paper captures key highlights from the outcomes of this research. It explores key issues for consideration in developing effective referrals systems, and identifies opportunities for innovation and further investigation and investment for consideration by project planners and implementers, as well as governments and donors who support referral and service delivery systems.

II. RESEARCH METHODOLOGY

The literature review drew on a limited set of available online resources, academic journals, and program documentation relevant to the research objectives. Five documents were reviewed, listed in the “Literature Review” section. In addition, a set of recommended guidance materials collected for implementing partners interested in economic strengthening is provided in Annex A.

The field research took place in Ethiopia from May 4 to 9, 2011. Ten interviews and eight focus group discussions were conducted to solicit input from more than 55 individuals across Adama, Awassa and Addis Ababa. The individuals included representatives from health facilities, community-based organizations (CBOs) implementing livelihoods and economic strengthening interventions, Government of Ethiopia HIV and AIDS agencies, community volunteers and outreach workers, HIV and AIDS support

1 The focus of this research was on economic strengthening services offered by community, civil society, and market systems. This report does not explore the broader set of public social protection and safety nets (e.g., government managed cash transfers to support very vulnerable households), which are gaining momentum in providing economic strengthening support for the most marginalized people affected by HIV and AIDS.
groups and individual clients receiving HIV support services. Save the Children drew on a team of in-country staff, as well as three international technical advisors, to collect, analyze and document the findings. The fieldwork schedule and list of people interviewed are included in Annexes B and C, respectively.

III. LITERATURE REVIEW

The research included a global literature review of promising practices and challenges in establishing effective referral systems for livelihoods and economic strengthening programs. The literature review revealed a lack of publicly available documentation on referral networks, and even more limited references to referrals for economic strengthening, highlighting the need and opportunity to further document learning and successes from active referral systems. The desk review drew primarily on the following five publications:


These sources revealed focus areas for designing and sustaining referral networks, including mechanics of referral and voucher systems, establishing a referral system clearinghouse and feedback loops, targeting services, quality of economic strengthening interventions, the role of government and community social services, indicators and long-term sustainability. These issues are captured below as promising practices or challenges. Unfortunately, the desk review confirmed that very limited data exist on the impact of livelihoods and economic strengthening interventions offered through HIV referral networks, with the exception of select case studies from individual projects. As a result, there is a need to undertake further research to build the evidence base to demonstrate the impact of these programs.

Promising Practices

FHI’s 2005 publication “Establishing referral networks for comprehensive HIV care in low-resource settings” provides details on three referral models: health facility-based, community-based and individual case management. The guide outlines a step-by-step process of essential elements to create a referral network, with the assumption that the local network can be managed by a core partner. The guide does not focus on a national system, but could be adapted to a government managed, country-

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2 LIFT acknowledges the expert contributions of Marie Eve Hammink, Gareth Evans and Lisa Parrott from Save the Children US in preparing this discussion paper.

3 It was anticipated that the review would draw heavily on the New Partners Initiative (NPI) in Botswana and South Africa, which had reportedly had some success integrating livelihoods activities as part of care and support services and strengthening referral networks with select implementers. Unfortunately, very little of the NPI referral work in economic strengthening has been documented for outside review.

4 The case management model can be either facility-based or community-based, but relies on one professional to be the case manager who helps clients define and meet their needs.
wide approach. The key processes highlighted in the document for establishing a referral network, include:

- Identifying a group of organizations that, in the aggregate, provide comprehensive services to meet the needs of PLHIV, their caregivers and their families within a defined geographic area.
- Designating a unit or organization to coordinate and oversee the referral network.
- Holding periodic meetings among the network’s service providers.
- Identifying a designated referral person(s) at each organization.
- Creating a directory of services and organizations within a defined catchment area.
- Implementing a standardized referral form.
- Managing a feedback loop to track referrals.
- Ensuring documentation of referral.

In addition to the core components of a referral network, FHI also outlined the following illustrative indicators to help monitor the reach and effectiveness of a referral system:

- Total number of referrals made
- Number of follow-up referrals made
- Referrals made and to which services
- Number or percent of referral services completed
- Number or percent of clients who report their needs were met
- Number or percent of clients who report satisfaction with referral process

The FHI document contributed insights to improve the targeting and selection of beneficiaries for referrals, noting that that networks need to create a common and objective definition of the target population. In addition, to be accepted for a referral, two network members had to approve the client.

LIFT recognizes that these principles, along with the proposed monitoring indicators, present a foundation for developing the initial system and should be considered in any effort to design or support a referral network. Referral networks, even under the best conditions, face challenges to effectively deliver services. Economic strengthening linkages have not traditionally been included in referral systems and present some unique considerations to keep in mind for health facilities, community-based programs or case managers responsible for making these types of referrals. These issues are discussed in more detail throughout the report.

Additional promising practices from the current literature suggest that having one organization taking the lead in managing the referral network with formal agreements or relationships with service providers can result in a stronger system. It is also important to ensure that all organizations agree on standard operating procedures of the referral system to ensure referrals are completed.

**Challenges**

The literature review noted several challenges inherent in the establishment and management of referral networks.

FHI’s 2009 report on “The household economic strengthening program, supporting those affected by HIV/AIDS and extreme poverty in Ethiopia” discusses some of the challenges in establishing a referral system through a network of service providers. The report notes that the members of a network may be weak in community mobilization or may be unaware of potentially available services. If the clients
targeted for economic strengthening services are not linked to a knowledgeable and effective organization, it is unlikely that they will receive appropriate referrals. When clients are selected to participate in HIV programs, they often do not know to ask about additional services.

In addition, FHI’s Ethiopia report highlights that there is often low motivation by network member organizations to attend network meetings. Increasing the participation and engagement of service providers is key to keeping the network active. Furthermore, it is essential that the appropriate individuals attend these network meetings – representatives who do not have sufficient authority to make decisions and advance the network’s activities are often sent to attend fora aimed at planning and sharing information. In addition, there is often high turnover of appointed representatives making it difficult to reach decisions and adapt the network to meet client and service providers’ needs. If not all service providers are represented in the network meetings, the system can lose its interactive and dynamic nature. Finally, experience shows that demand for services, particularly economic strengthening, often outstrips the supply of the service providers and results in the referral system becoming overburdened.

The report from AIDSTAR-One’s FBP program in Kenya notes that one of the challenges in a facility-based system is that “task shifting” may make it difficult to ensure everyone is fully trained in the referral process, and may result in some patients not being properly enrolled, as patients pass through different staff for different services. As a result, there can be a greater likelihood of lost referrals when a patient moves from one section of a hospital or clinic to another (e.g. from a HIV counseling and testing (HCT) services to an ART or in-patient service). In some cases, the fact that a patient has to go elsewhere for other services results in a low uptake of those services. The FBP program in Kenya also noted that partner organizations may be implementing complementary programs such as livelihoods or economic strengthening services, but the eligibility criteria do not align with the profile of clients referred from HIV nutrition and counseling services or there is a misalignment in the relevance of the service based on the particular skill sets, assets, and productive capacity of the individual being referred.

LIFT 2011 report on its “Assessment of USAID/PEPFAR’s economic strengthening programs in Ethiopia” highlighted the need to address problems of economic strengthening program sustainability by placing more focus on market analysis and private sector linkages, two elements that are frequently missing in economic strengthening interventions. The recommendations further underscore the need to build improved technical capacity among economic strengthening providers, and to strengthen the monitoring and evaluation component of interventions to demonstrate results for PLHIV and HIV affected households.

**Indicators of Success and Impacts**

The theory that economic strengthening and livelihood improvements positively impact the lives of PLHIV and OVC remains unchallenged according to anecdotal examples collected in qualitative research settings. However, no conclusive evidence was distilled from the desk review to determine widespread impacts in terms of changed economic status or improved living conditions. Quantitative studies or impact data were not identified in the desk review.

The FHI 2009 report on referral networks noted that of the networks assessed, 90 percent of referred clients are accepted for services that they may not have otherwise received. However, the quality of these services, the impact on clients, and the number of unsuccessful referrals is not reported.
The AIDSTAR-One report from Kenya does note that linking FBP clients to livelihoods and food security programs reduces dependency on therapeutic food products, decreases the likelihood of sharing food supplements with the rest of the household and prevents re-entry into supplemental nutrition programs after graduation. However, there are no specific data points to confirm these assertions. The results highlight the important opportunity to improve the measurement of outcomes. However, it is recognized that finding a significantly large enough population sample could pose a challenge if there is a small number of clients within a single system receiving economic strengthening referrals.

The FBP program implemented by Catholic Relief Services in Zambia reports that less than half (45 percent) of the participating facilities were linked into social safety nets programs and income generating activities (IGAs), such as gardening, chicken rearing, food production, local *chilimba* (savings) groups and petty trading. Overall, the reach was limited with only 11 percent of clients reporting that they were linked to livelihood activities. There was no monitoring of the impact of these activities on health or income levels for participants.

**IV. ETHIOPIA FIELD RESEARCH**

In Ethiopia, Save the Children facilitated the development of referral systems across three PEPFAR-supported programs that employ referrals for economic strengthening interventions in Ethiopia: the Food by Prescription Program (FBP), HIV/AIDS Care and Support Program (HCSP) and TransACTION Program.

One can think of a referral system as having three primary actors: **health facilities**, **local non-governmental organization (NGO) and CBO linkages** and **service providers**. In each of these programs, there is a component linking PLHIV from health facilities to economic strengthening opportunities either by direct referrals to service providers, or by building the capacity of local NGOs to act as a coordinating and referral body to other programs implemented by the Government of Ethiopia and other donors. The in-depth interviews and focus group discussions revealed a pattern of predominantly ad-hoc processes among these actors that could be strengthened to improve referrals from clinics to economic strengthening actors.

Both within the more formal referral systems of FBP and HCSP, and the community-based system within TransACTION, there are components of direct service delivery for economic strengthening interventions offered within the programs themselves. However, there remains a need to expand referral opportunities to other economic strengthening service providers, including non-traditional HIV program partners within the private sector that can offer a more diverse and sustainable set of services and opportunities. Within these programs, no clear examples emerged of strong economic strengthening programs making referrals to clinical services.

Some of the ways that the relationships among the primary actors differ and the diversity of economic strengthening partners within each of these programs are briefly described below. A more detailed overview of the scope, purpose, and the referral system structure for each of these projects is provided in Annexes D, E and F.

- **Food by Prescription** is a PEPFAR-funded initiative (2009-2012) to improve the nutritional, clinical and functional outcomes of malnourished PLHIV by strengthening Nutrition Assessment, Counseling and Support (NACS) services and creating effective linkages to community resources and economic
strengthening initiatives. **Economic strengthening referrals are made to collaborating partners with the intention of working through a coordinating committee.**

FBP employs a rather direct approach, with referrals going from the clinic to HIV/AIDS Prevention and Control Office (HAPCO) to a referral coordinating committee. FBP’s coordinating committee, which approves or rejects the referrals, includes government offices, such as HAPCO and the Bureau of Labor and Social Affairs (BOLSA), and economic strengthening providers, including the private sector. In this project, there is distinctly less local NGO/CBO involvement in facilitating the referral than the other two projects, beyond the coordinating committee approval. Involvement of the private sector in the committee is helping to strengthen communication between FBP and the employers to increase referral opportunities to formal jobs. For example, in Hawassa and Adama, HAPCO and BOLSA are creating a coordinating group that includes local representatives from the private sector and other community institutions that provide employment.

- Under the **HIV/AIDS Care and Support Program**, Save the Children was contracted to deploy volunteer outreach workers to support family-focused HIV prevention, care and treatment. **Economic strengthening referrals were made to selected HIV network associations who provided the economic strengthening component.**

Community volunteers known as *Kebele*-Oriented Outreach Workers (KOOW) play an important role in identifying PLHIV and facilitating referrals to health facility case managers and through to local NGOs/CBOs to receive economic strengthening services. A case manager at the health center documents the referral using two forms: one certifying HIV status and thus giving the “right” of the client to receive a service; and a second form which lists all participating local NGO/CBOs. The client must receive a stamped approval/registration from one of the listed organizations to join their program. To avoid duplication of services, the other organizations must also stamp the form to confirm that the client is not joining their association.

Once clients are accepted by the referral organization, they form groups that receive psychosocial support and discuss the challenges of living with HIV among peers. The local NGOs are considered a safe place for clients to build resiliency without fear of stigma and discrimination. Evidence on the effectiveness of the economic strengthening interventions used to build economic assets and income streams for these PLHIV is mixed. Many local NGOs reported giving small grants to PLHIV but the long term analysis shows that these small grants have a very limited impact on increasing household assets. For example, some respondents shared that they lost all the chickens purchased with their grant or had to spend the funds they were given to start an IGA to buy medicine for a family member instead. Other clients participated in vocational training in a new field but were not able to find work once the training was completed. Peer support groups organized by the Organization for Social Services for AIDS (OSSA) who were linked to the Urban Garden Program (managed by Development Alternatives, Inc) were able to mobilize resources such as land and labor to produce vegetables for sale and improved consumption.

- The **TransACTION** program, led by Save the Children, aims to prevent new HIV and other sexually transmitted infections among at-risk populations and strengthen linkages to care and support services in 120 towns and commercial hotspots along transportation corridors. **Economic strengthening referrals are made to collaborating partners, and then on an ad-hoc basis delivered directly or through other community-based economic strengthening initiatives.**
Under this program, clients at health facilities are referred by a counselor, nurse or case manager (similar to a para-social worker) to a local NGO, CBO or a network of PLHIV which has been pre-selected by the program as a key partner directly providing economic strengthening services. In addition, TransACTION is looking at how to use a central coordinating mechanism to eventually link to additional successful service providers. It is building on the experience of HCSP by adding a linkage with a higher level forum, such as the local HAPCO, which can help coordinate the identification and flow of referrals among a wider set of local NGOs and CBOs.

Referral forms vary across each of the three programs but all indicate which type of service the client is referred to. When economic strengthening referrals are made at the clinic level, there is not an in-depth evaluation of the client’s economic vulnerability and livelihood capabilities to inform and strengthen the appropriateness of the program or services for that individual’s unique set of needs and circumstances.

**Promising Practices**
Introducing opportunities to engage in economic strengthening activities via the clinical interface in itself seems to be a promising practice, based on discussions with health workers and case managers. All interviewees noted that helping clients to think about successful livelihoods or returning to work led to better attitudes towards ART adherence and future outcomes. Two key promising practice areas for referral systems making these linkages are highlighted below.

**Case Managers and Community Volunteers**
Within the HCSP project, both the case manager (embedded at a health facility) and community volunteers play essential roles in the referral feedback loop by making the initial referrals, tracking clients and following-up on the completion of referrals. In addition to completing these essential tasks in the referral system, the HCSP project showed that linking clients with a case manager or with organizations providing services for PLHIV brought the psychosocial support that clients needed to continue to work or seek small enterprise opportunities.

Community volunteers, who are often HIV positive themselves, play an important role in providing additional coaching in positive living skills, including economic strengthening activities, and serve as role models. They are able to counsel clients on the importance of ART adherence, and work with clinic-based case managers to provide psychosocial support.

The HCSP case managers are paid Ministry of Health employees who work alongside nurses to provide comprehensive and coordinated care to PLHIV. The case manager is able to manage the referral forms, follow-up on referrals and provides support to link clients with additional services. However, the case managers are unable to effectively assess individual clients’ livelihood situation and recommend appropriately aligned economic strengthening services, as they often have limited experience and expertise in this area. The case manager is most effective in making a yes/no decision about whether a client should be referred to an economic strengthening service provider, rather than carrying out a deeper economic needs assessment.

**Coordinating Committees**
The FBP and HCSP projects have coordinating committees to ensure networking and collaboration among all referral network partners including clinical sites, PLHIV organizations, private sector representatives and community institutions that provide economic strengthening services. These stakeholders are convened on a regular basis to discuss referral activities and any pending issues related to the referral system.
Trying to manage which economic strengthening programs have opportunities available and which are not accepting new clients becomes a challenging and iterative process, which cannot be consistently monitored at the clinic level. Enrollment timelines, participation eligibility criteria, and project cycles all affect the availability of specific services and potential inclusion of referred clients. These program features (e.g. enrolling clients at a specific time of the year or requiring participants to apply as an already functioning group) deter referral systems from working continuously and effectively for individual clients. However, in the HCSP project field research found that an effective coordinating committee can help partner organizations better understand when and which economic strengthening opportunities will be available.

In HCSP, the most effective coordinating committees are often chaired by HAPCO or the Ministry of Labor and Social Affairs (MOLSA). These committees meet once a month and integrate the HIV response into other programs and organizations within the community. Referral forms completed at the health facility can be circulated through the coordinating committee to ensure that an appropriate referral is made and executed. Coordinating mechanisms can also improve the accountability of all implementing partners whose mandate is to strengthen PLHIV livelihoods outcomes. In some cases, the referral committee had a role in approving referrals made by the clinical site however, this practice may compromise equitable access to economic strengthening activities.

In some instances, coordinating committees have been able to facilitate data sharing and coordination of activities across implementing partners, while also strengthening relationships between members of civil society, the private sector, and the Government of Ethiopia.

**Challenges**
The field research in Ethiopia revealed a number of challenges in implementing successful economic strengthening referral systems, which include similar issues highlighted in the desk review. Key areas where challenges were identified are highlighted below.

**Private Sector Linkages**
Though the private sector could play a major role in addressing the livelihoods challenges faced by PLHIV, its current involvement in such programs in Ethiopia is ad-hoc. In one local referral system in the HCSP project, HAPCO organized monthly meetings with BOLSA, local NGOs and representatives of the private sector which successfully led to job opportunities for clients in the private sector with grain traders, small merchants, and at the university. However, this promising practice was only seen in one area where the HAPCO representative is very dynamic. Garnering the interest of private sector employers and creating pathways for PLHIV to gain employment requires a comprehensive job readiness approach to prepare individuals to meet employer requirements, and a systematic method of linking the available job opportunities with qualified candidates.

**Interfacing with Government Programs and Services**
Across all of the projects, the field research revealed that the HIV response is still very much seen as “a health response.” This was demonstrated in the FBP project as HAPCO is charged with leading the coordination of all activities and services for PLHIV. Although HAPCO was designated as the coordination mechanism at the kebele or woreda level, a multi-sectoral response across government ministries, including the Ministry of Education, MOLSA, and Ministry of Women, Youth and Child Affairs, was not evident.
In addition, HAPCO has the health expertise and mandate to address the health needs of PLHIV but does not have the skills, knowledge and expertise to develop a systemic approach to meet economic strengthening needs. However, one example was given where MOLSA staff worked hand in hand to facilitate linkages to microfinance services and employment opportunities in the formal sector.

A multi-sectoral coordinating mechanism that includes members of the different ministries seems to be a promising practice, though it has not yet been systematically implemented or evaluated. Such coordinating mechanisms could be led by entities like MOLSA, whose mandate is to build economic resiliency.

Overburdened Healthcare Systems
The three projects highlighted the fact that clinical staff are often stretched to provide basic client services, and meet additional healthcare needs such as nutritional assessment and counseling. Adding the economic strengthening referral component can overburden health workers, although these health workers recognize that nearly all of the clients that they treat are in need of economic strengthening support, due to widespread poverty in Ethiopia.

Selecting which clients are the most vulnerable and in the greatest need of economic strengthening services creates a dilemma for health workers. In addition, the ability of clinics to know the available menu of economic strengthening services and maintain updated lists of providers in their community is beyond the primary scope of health service delivery. Linking clients to appropriate economic strengthening opportunities cannot be effectively managed in the clinic setting, unless additional resources are embedded within the healthcare system, such as qualified staff dedicated to this function.

Adding tracking mechanisms to client charts and reporting systems is a challenge as many register books and information systems are designed for health services and do not have the flexibility to add additional parameters. The inclusion of new protocols, such as a basic ‘yes/no’ for a referral and subsequent follow-up tracking on that referral, may involve the re-design of Ministry of Health systems and the re-training of health workers, which can be a difficult and expensive task.5

Limited Absorption Capacity among Economic Strengthening Providers
Though few examples of referred clients being denied services were reported, some individuals are often placed on waiting lists and may wait months or years to participate in skills training courses, workshops on entrepreneurial skills, or micro-saving and loans groups. Economic strengthening implementers, local NGOs and community support organizations, as well as generously funded international NGO projects, have limited resources to actually provide services to clients referred to them by health facilities.

Even when local NGOs have their own structure to create some employment, such as Dawn of Hope Center, which was visited during the HCSP fieldwork, the demand for the services exceeds the level of resources available. Limited resources create a large hurdle in terms of economic strengthening service providers being able to accept an on-going stream of clients for referrals.

5 There is an option to capture “economic strengthening services” on the HIV intake form, but it is estimated that 90% or more of the forms use this option, which is insufficient for improving the targeting and alignment of a large number of potential referral clients with an often limited set and absorption capacity of economic strengthening service providers.
The FBP project shows that coordinating committees can help mitigate this challenge by sharing information across organizations about when economic strengthening opportunities for clients will be available.

Many Implementers Lack Expertise in Appropriate Economic Strengthening Interventions

Traditional HIV implementing partners, including local NGOs and PLHIV associations and HIV support agencies, often have limited expertise to effectively design and deliver economic strengthening approaches that can help build the assets and resiliency of households affected by HIV.

Across all of the projects, many NGOs or CBOs only offer one type of economic strengthening support to all clients rather than tailoring services for clients based on their unique economic vulnerabilities and capabilities. Even when economic development specialists are employed by local agencies – a practice that appeared to be lacking in the projects reviewed - they focused on a single offering, rather than identifying which programs and services may be the most appropriate to deliver, drawing on their capabilities and other economic strengthening services available in that locale.

In the HCSP project, for example, there is limited client involvement in selecting economic strengthening interventions. The client’s previous work experience, expertise and interests are not considered as part of the placement process. Field visits revealed that NGOs and CBOs often provide vocational training such as carpentry, tailoring and basket weaving without conducting a preliminary market assessment to understand the demand for products and services, or employment, in that sector. Local NGOs also offer workshops and trainings, and distribute assets (such as small livestock and tools) without tracking if assets are appropriately utilized and whether they contributed to increasing client’s incomes. Overall, within these systems, there is limited capacity to assess clients’ economic needs to appropriately target economic strengthening services. When economic strengthening services are delivered, the systems for tracking economic and health outcomes and results of the interventions are not in place.

Managing Client Expectations for Economic Strengthening

At health facilities, staff reported client enthusiasm for, and expectations of, economic strengthening services that provide hand-outs of food and cash. Many economic strengthening service providers in the field noted that there was a weak culture and limited capacity among clients to take responsibility for their own long term livelihoods development. A widespread culture of dependency exists, created and fueled by years of massive resource provisioning for HIV and AIDS programs which distribute commodities such a food rations, school uniforms, small cash grants, and business starter kits, such as hair dressing, and carpentry and mechanics tools.

Staff of local organizations reported that clients “expect and feel it is their right” to receive some form of a “hand-out”. This dependency syndrome has hindered the drive within individuals and communities to find sustainable responses to improve the economic status of PLHIV, such as involving government ministries that are in charge of developing safety nets and social welfare programs for the most economically vulnerable, and more market-based solutions for the less vulnerable, such as improving agricultural production practices or using savings and credit services to build household enterprises. Referral systems should consider a component that builds a culture of self-reliance among participants and a process of supporting economic strengthening services that promote shared contributions to achieving economic strengthening outcomes.

Limited Engagement with Local Government and Community Systems
The field research team noted that there is limited partnership by HIV programs with civil society and government livelihood programs. In addition, while CSOs have the potential to play an important role at the community level in reaching out to families and providing a hub for the coordination of government and private sector services, there is limited communication and cooperation in practice. For example, NGOs keep the referral forms from the health facility, and often fail to inform the health center of the status of the referrals. These forms are not collected by the HIV and AIDS kebele desk officer (a government representative), resulting in limited accountability, follow-up, and tracking of results. Partnerships and coordination with government agencies can help to streamline and track referrals, as well as open up opportunities to engage additional economic strengthening service providers.

**IGA can have Limited Impact and Sustainability**

In Ethiopia a long-standing tradition has been to finance IGAs for PLHIV through small grants. Nearly any organization could be a pass-through for this economic strengthening strategy. However, field observations and interviews noted that this approach does not have widespread success as market opportunities for investing those resources are not identified, and clients often divert the resources for other purposes. Improved small enterprise strategies, such as linking into profitable, market-led value chain opportunities are needed to improve income earning for the most vulnerable.

**Indicators of Success and Impact**

When asked about tracking results, local NGOs reported monitoring the number of people who received training, a workshop, or a starter kit. While the numbers of clients served at the provider level are available, there is little investment in rigorously tracking outcomes and whether activities resulted in favorable economic changes for households. Informally, local NGOs who linked with the private sector reported success if the client had been able to find employment. PLHIV associations provided anecdotal examples of successes, for example, a client who secured a job in the kitchen of the university, and another on a kebele construction project. Managers of NGOs report being discouraged about the expectations of clients and the limited effectiveness of their economic strengthening interventions. One manager reported that “clients expected loans and when they received the loans, they really did not spend the money appropriately.”

Within some clinics, no records were kept as to the number of referrals made and where the clients were referred. In addition, no specific referral systems were in place to link clients in the other direction, from economic strengthening programs to clinic health services or HCT facilities.

**Gender Considerations**

Though the programs visited did not describe tailored strategies and programs to mainstream gender within their livelihoods activities, it quickly became clear that this could be a future priority. During the interviews all women reported that being infected by HIV created a heavy burden for them. In the case of discordant couples, particularly when the woman is HIV positive, women reported that their husbands left them and that they had to find ways to receive medical care, take care of their children and meet their household’s basic needs. Some women reported fear of stigma and discrimination and thus left their family to seek healthcare, ending up in larger cities (particularly Addis) with no social support. These women reported feeling isolated and facing increased stigma, and some turned to high risk activities such as commercial sex to support themselves. Others reported that they first had to take care of their ill husband, which created a heavy burden on their domestic responsibilities, while continuing care of the children and household. In addition, these women were often working outside the home to maintain an income. For others who had not previously engaged in income earning activities, they were forced to take up economic strengthening activities when their HIV positive
husband died. Most of these women started working on their own by setting up a petty trade activity, but they all reported that they were able to do so because they had the support of a network for PLHIV, such as the Network of Positive Women in Ethiopia.

From the field research, which was limited in scope and geographic area, there were no specific and tailored approaches to mainstream gender considerations in these livelihoods and economic strengthening activities. Understanding the different socio-cultural implications of an HIV diagnosis for men and women in each context, being aware of common coping strategies used by men and women to alleviate the impacts of HIV, as well as knowing how HIV affects the availability of their time to engage in employment and income generating activities could improve the feasibility of economic strengthening interventions in HIV affected households. More research is needed by implementing agencies, particularly those offering the economic strengthening services, to deliver gender sensitive solutions.

Finally, programs integrating economic strengthening referrals from health facilities should take into consideration the increased vulnerabilities of women living with HIV. Gender norms (e.g. requirements to take care of children in the home and possibly other family members who are ill) might prohibit women from accessing available services. Tailored strategies that increase equitable access to livelihoods programs need to be considered, as well as investments to build the capacity of local NGOs and government institutions in gender mainstreaming.

V. RECOMMENDATIONS

Although some promising practices are emerging from existing programs (e.g. how to establish the referral systems, working with a variety of government ministries, linking into private sector opportunities and reducing stigma so that people live positively through improved livelihoods strategies), the challenges remain significant to implementing effective referral networks for livelihoods and economic strengthening. Recommendations for areas where further investigation, innovation, and investment can be made are highlighted below.

Systematic Integration of Economic Strengthening Services into Existing Systems

In many places, including parts of Ethiopia, referral systems exist, particularly from health clinics to community-based services. In an effort to integrate into “existing systems”, available livelihoods and economic strengthening services could be included in these current referral forms and processes. However, a key challenge is the associated costs of reprinting referral forms and monitoring reports to include economic strengthening services, conducting initial mappings of existing services to determine their absorptive capacity, convening livelihoods actors and private sector players to establish buy-in and orient them to the referral process and the needs of the target group, developing standardized targeting criteria to be used in issuing referral cards or vouchers for livelihoods, and monitoring feedback indicators related to economic strengthening. Donors interested in systems strengthening could potentially intervene to provide the upfront investments needed to modify and build the capacity of existing systems to better address the economic strengthening needs of clients.

Enabling Referrals from Economic Strengthening Service Providers to Clinic-based Services

Very few examples of effective referrals from economic strengthening services to clinic settings were observed in the literature or in practice. A trend has emerged in the global field of microfinance in which formal financial service providers are aware of HIV health services and testing facilities to inform clients of these services and opportunities. The challenge remains as to how to effectively inform and provide information for individuals that HIV testing, ART and care and support services are available, and offer
referrals while avoiding potential stigmatization. A community coordinating mechanism could provide an opportunity to inform the wide range of partners – local CBOs, private sector actors and government agencies – of the available health services available within the HIV sector. They could produce materials and training modules for their referral network members. However, using formal referral forms and systematic procedures for referrals may alienate clients rather than create a useful mechanism for them to access HIV services.

**Institutionalize the role of a lead organization**

Ideally, a regional or district referral network, developed through a government ministry, such as the MOLSA, would be institutionalized and financed with public sector resources to support the delivery of services to HIV affected households. Referral coordination is led by an existing community-based organization or agency identified based on its capacity and reach within the community, and is also ideally government-supported. The lead organization draws on the support of other select network members (e.g. PLHIV support groups, volunteer cadres and social workers) that can assess clients’ specific economic strengthening needs, and manage the referral process by facilitating and following-up on the referrals and monitoring the outcomes. The diagram below illustrates a referral system that includes this coordinating mechanism:

In its most simplistic form, the initial referral assessment is done at the clinic level through a short, rapid assessment tool. Healthcare staff can make a quick decision as to whether to refer the client to a community coordinating mechanism to further assess that individual’s livelihoods capacity and economic strengthening service needs.

The lead organization operates as a clearinghouse and is a focal point for clients in ensuring that their referral and service needs are met. This organization would ideally be located within a kebele or sub-district in which services offered can be readily identified and geographically accessible. Economic strengthening referrals are then made to a variety of providers offering the appropriate services, and followed-up to ensure completion. The lead organization could use a database to maintain up-to-date information on available services within the community, convene referral network meetings, and lead discussions among network partners (e.g. private sector employers, local economic strengthening providers and government programs) to assess how well the system is working, address challenges and modify processes based on emerging opportunities. The community coordinating mechanism is the main entity responsible for collecting data on completed and non-completed economic strengthening referrals, monitoring referral outcomes, analyzing findings, and reporting to other referral network members. A similar model is being implemented in sub-cities within Addis Ababa through a local networking organization, Timret. Donor funding, technical assistance and government buy-in may be
needed to further support the structures functions and capabilities, such as building skills in livelihoods and economic strengthening market analysis and household vulnerability assessments. These are skill areas that can improve the mechanism’s ability to competently map and manage information on the most relevant and successful service providers based on the different economic strengthening needs of clients.

Establishing a Case Manager or Para-social Worker Focal Person at the Facility Level
Another potential feature of this model, based on the field findings, is to shift the responsibility for economic strengthening counseling and referral decision-making from a healthcare provider to a para-social worker embedded within health facilities or within the lead organization. To strengthen the coordination of services and ensure appropriate referrals are made and managed, an embedded social worker or para-social worker can be trained on the unique skill sets and have the dedicated time to: 1) identify key economic strengthening needs and assets, including previous client work experiences; 2) provide counsel on potential referral options by explaining the opportunities available within the community; and, 3) follow up on the success of the referral through home visits and visits to network partners.

Invest in the Capacity Building of economic strengthening Service Providers
In addition to the system design, additional investment is recommended to build the capacity and offerings of service providers that supply the system with economic strengthening interventions. As noted in the research, some of these providers, especially those that are less specialized in economic strengthening activities, lack the ability to provide quality services and track outcomes or improvements in livelihoods. Programs designed to strengthen the capacity of service providers will be key to not only ensuring referrals are made, but that the interventions provide the desired results.

In conclusion, current efforts to link and strengthen referrals from clinical sites to economic strengthening and social welfare services including psychosocial services, protection, safety net programs are commendable. More research is needed to increase the effectiveness of these strategies, as the current models cannot reach sufficient scale. Likewise, partners should be cautious about systematic referrals from economic strengthening programs to healthcare and clinical services to avoid stigmatization of clients. In addition to improving quality of referrals for economic strengthening, implementing partners have a responsibility to advocate for structural changes and improvements to the enabling environment that can facilitate greater involvement and investment from the private sector, to address the drivers of poverty in countries where PLHIV programs operate. Unless more jobs and self-employment opportunities exist within affected communities, with the private sector as the leading actor in hiring and generating new employment opportunities, referring PLHIV to meaningful economic strengthening activities will remain a challenge.
Annex A: Recommended Guidance Materials for Partners


### Annex B: Fieldwork Schedule for LIFT Research in Ethiopia

**HCSP: Contact person, Nelia Matinhure, team leader, Mob. 0911504535; Yosef Alemu, TM, 0911194254**

<table>
<thead>
<tr>
<th>DATE/TIME</th>
<th>SELECTED SITE/No. OF TARGET GROUP</th>
<th>TIME</th>
<th>RESPONSIBLE PERSON</th>
<th>REMARK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday</td>
<td><strong>TRIP TO ADAMA Wednesday</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May 4th</td>
<td>NNPE 6 Clients (FGD # 1)</td>
<td>11-2AM</td>
<td>Marie-Eve, Yosef,</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>TRIP TO HAWASSA Wednesday</strong></td>
<td></td>
<td>Adanech</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>DOHE 6 Clients (FGD # 2)</strong></td>
<td>8:11AM</td>
<td>Marie-Eve, Yosef,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 Keble Oriented Outreach Workers (KOOWs)</td>
<td>11:1PM</td>
<td>Fesseha</td>
<td>Mob. 09 116451167</td>
</tr>
<tr>
<td></td>
<td>2 Clients Informing 2 clients</td>
<td>2-4PM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3HCSP regional care and support coordinator</td>
<td>5-7PM</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>THURSDAY</strong></td>
<td><strong>STAY IN HAWASSA OVER NIGHT Thursday</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAY 5th</td>
<td><strong>Woreda HAPCO</strong></td>
<td>8-10AM</td>
<td>Marie-Eve, Yosef,</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Hawassa Health Center: ART nurse, case manager and community mobilizer</strong></td>
<td>11-1AM</td>
<td>Yonde</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>BACK TO ADAMA Friday</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Adama Health Center: ART nurse, case manager and community mobilizer</strong></td>
<td>5-6PM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>HAPCO</strong></td>
<td>6-7PM</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FRIDAY, 6</strong></td>
<td><strong>STAY IN ADAMA OVER NIGHT Saturday</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MAY</strong></td>
<td><strong>Woreda HAPCO</strong></td>
<td>8-9PM</td>
<td>Marie-Eve, Yosef,</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>All clients</strong></td>
<td>9-10AM</td>
<td>Alemnhe</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>BACK TO ADDIS Saturday</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SATURDAY</strong></td>
<td><strong>MONDAY, MAY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAY 7th</td>
<td><strong>Arada health center: ART nurse, case manager and community mobilizer</strong></td>
<td>8-10AM</td>
<td>Marie-Eve, Yosef,</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Arada health center 6 clients (FGD # 3)</strong></td>
<td>10-12AM</td>
<td>Sara</td>
<td>Mob. 0911639637</td>
</tr>
<tr>
<td></td>
<td><strong>NNPWE: Directors, Managers and M&amp;E</strong></td>
<td>2-3PM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>DOHE: Directors, Managers and M&amp;E</strong></td>
<td>4-5PM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>ADDIS ABABA Monday &amp; Tuesday</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Addis-ketema health center: ART nurse, case manager and community mobilizer</strong></td>
<td>8-10AM</td>
<td>Marie-Eve, Yosef,</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Addis-ketema health center 6 clients (FGD # 4)</strong></td>
<td>10-12PM</td>
<td>Alemnhe</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>HAPCO</strong></td>
<td>2-3PM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>BOLSA</strong></td>
<td>4-5PM</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Annex C: List of Persons Interviewed in Ethiopia by LIFT

<table>
<thead>
<tr>
<th>Interviews/ FGD</th>
<th>Number of participants</th>
<th>Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGD Dawn of Hope Adama</td>
<td>6 (women only)</td>
<td>HCSP Program</td>
</tr>
<tr>
<td>Interview Network of Networks of Positive Women in Ethiopia. Manager (Adama)</td>
<td>1</td>
<td>HCSP Program</td>
</tr>
<tr>
<td>FGD Dawn of Hope Hawassa</td>
<td>6 (women only)</td>
<td>HCSP Program</td>
</tr>
<tr>
<td>FGD: Hawassa</td>
<td>3 KOOWs</td>
<td>HCSP Program</td>
</tr>
<tr>
<td>Interview: Program Manager Dawn of Hope HAWASSA</td>
<td>1</td>
<td>HCSP Program</td>
</tr>
<tr>
<td>Interview: Chairwoman DOH, Adama</td>
<td>1</td>
<td>HCSP Program</td>
</tr>
<tr>
<td>Interview: 2 clients from hospital HAWASSA</td>
<td>2</td>
<td>HCSP Program</td>
</tr>
<tr>
<td>Interview: Community mobiliser Hawassa</td>
<td>1</td>
<td>HCSP Program</td>
</tr>
<tr>
<td>Interview: HAPCO Hawassa</td>
<td>1</td>
<td>HCSP Program</td>
</tr>
<tr>
<td>FGD: Health Center Adama</td>
<td>3</td>
<td>HCSP Program</td>
</tr>
<tr>
<td>FGD: 2 Koows and 2 community mobilisers</td>
<td>4</td>
<td>HCSP Program</td>
</tr>
<tr>
<td>Interview: 2 women NNPWE</td>
<td>2</td>
<td>HCSP Program</td>
</tr>
<tr>
<td>Interview: 1 ART nurse Black Lion Hospital</td>
<td>1</td>
<td>FBP</td>
</tr>
<tr>
<td>Interview: Doctor Alert Hospital</td>
<td>1</td>
<td>FBP</td>
</tr>
<tr>
<td>Interview Urban Garden Program</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>FGDAddis Ababa Health Center</td>
<td>5</td>
<td>HCSP Program</td>
</tr>
<tr>
<td>FGD Addis Ababa Health Center</td>
<td>6</td>
<td>HCSP Program</td>
</tr>
<tr>
<td>FDG Addis Health Center</td>
<td>6</td>
<td>HCSP Program</td>
</tr>
</tbody>
</table>
Annex D: Overview of the Food by Prescription (FBP) Program in Ethiopia

<table>
<thead>
<tr>
<th>Start Date</th>
<th>September 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>End Date</td>
<td>September 2012</td>
</tr>
<tr>
<td>Total Funding Amount</td>
<td>$11 million</td>
</tr>
<tr>
<td>Contract Holder</td>
<td>Save the Children</td>
</tr>
<tr>
<td>International Partners</td>
<td>Tufts University, FHI 360</td>
</tr>
<tr>
<td>Local Implementing Partners</td>
<td>Federal Ministry of Health and Regional Health Bureaus</td>
</tr>
</tbody>
</table>

Project Overview
USAID/Food by Prescription (FBP) program is a three year USAID-funded contract implemented by Save the Children. USAID/FBP will improve nutrition clinical and functional outcomes among people living with HIV (PLHIV), including adults and orphans and vulnerable children (OVC), through periodic nutritional assessment and counseling and provision of therapeutic and supplementary food support. As part of strengthening the capacity of communities and health facilities to provide quality care and treatment to program target groups, it creates concrete and functional linkages to a range of economic strengthening opportunities with the goal of sustaining positive nutrition outcomes for vulnerable beneficiaries. The program targets 200 health facilities with antiretroviral therapy (ART) services, and benefits 50,000 malnourished PLHIV adults, pregnant and lactating women, and OVC in Addis Ababa and Dire Dawa city administrations, as well as Oromia, Amhara, Tigray and Southern Nations, Nationalities, and Peoples (SNNP) regions over the program period.

Results
1. Increased access to therapeutic and supplementary food products from public and private distribution outlets
2. Consistent application of clinical and community nutrition assessment, targeted subsidy and interpersonal communication.
3. Integration of HIV and nutrition assessment and services for moderately and severely malnourished HIV positive beneficiaries
4. Improved policy advocacy by nutritionists and PLHIV alongside improvement in local production systems.

Referral System
As a list of community-based initiatives, government opportunities and private sector businesses is developed, FBP works with the clinics and hospitals to institutionalize a referral system for the clients. Case managers and/or nurses from the clinics and hospitals have been trained to use a client selection checklist, as well as the referral system counseling and documentation. The counseling primarily consists of explaining the economic strengthening component to clients as an opportunity to take the first step towards independent healthy living. It also involves a discussion with clients on the rights and responsibilities of participating in the economic strengthening component in order to level expectations. The training of case managers and nurses also involves the process of making referrals, using a 3-part voucher that creates a feedback loop from the clinic or hospital to the community organization, NGO or private sector business, and back to the clinic or hospital. In each town the referral system was developed based on the capacities of the healthcare system (e.g. using case workers versus nurses to make referrals) and the local implementing partners, thereby employing creativity and flexibility to accommodate the best solutions for local context.

As part of the economic strengthening work of FBP, the following referral protocols are observed at the health facility and HIV/AIDS Prevention and Control Office (HAPCO) levels.
Health Facility Protocols

1. On the second FBP visit, the Economic Strengthening Readiness Assessment tool is administered and economic strengthening counseling starts. This is an early step in the graduation process. If the client is a child below the age of 18, the caretaker will respond to the economic strengthening readiness questions. The goal of the counseling and assessment is to prepare the client to engage in a strong livelihoods strategy to support a healthy diet.

2. The clinician discusses questions 1-7 with the client (or caretaker of the child) and records the appropriate responses. The total number of responses in each column is recorded on the line labeled “TOTAL FOR EACH COLUMN.”

3. The clinician also asks what current or recent past economic strengthening activities the client (or caretaker of the child) has been doing. The clinician ticks the appropriate activity, or indicates “other” by writing another source of income (e.g. support from a community organization, remittances, etc.). This information is used to refer the client to the appropriate economic strengthening services, or counsel the client to return to this livelihood activity. The economic strengthening brochure can be shared with the client to encourage them to engage in livelihoods activities that will provide enough money for them to continue to eat enough and the right types of food to maintain good nutritional status.

4. The clinician determines whether the client is physically/clinically fit to do economic strengthening activities by answering “yes” or “no.” If the client is not physically able, the clinician counsels the client to continue adherence to the FBP program and will re-assess at a later time.

5. If the client is physically able, then the clinician confirms the total score received in Column 1 (questions 1-7) to determine if they should refer the client to receive an economic strengthening
voucher. If the total for Column 1 on the assessment questions is 5 or more, then the client is referred to receive a voucher for economic strengthening services. If the total is less than 5 the client is not referred. The clinician ticks the appropriate response to “Is the client referred to receive economic strengthening voucher?”

<table>
<thead>
<tr>
<th>Steps to Follow if Client is NOT GIVEN an Economic Strengthening Voucher (score &lt;5):</th>
<th>Steps to Follow if Client is GIVEN an Economic Strengthening Voucher (score of 5 or more):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The clinician ticks the reason why the client is not referred. NOTE, majority of the FBP clients will not qualify for economic strengthening voucher.</td>
<td>• The clinician can choose a specific referral based on the client’s interest by ticking income generating activity, urban gardening, savings group or back-to-work.</td>
</tr>
<tr>
<td>• The clinician writes their name at the bottom of the tool and signs it.</td>
<td>• The clinician writes their name at the bottom of the tool and signs it.</td>
</tr>
<tr>
<td>• Client takes the tool to the case manager.</td>
<td>• Client is told to take the tool to the nurse assigned for issuing economic strengthening vouchers.</td>
</tr>
<tr>
<td>• The case manager writes their name at the bottom of the tool and signs it.</td>
<td>• The assigned nurse for economic strengthening vouchers issues a voucher by completing the information on the voucher coupon and providing the client with two copies (color x and color y). The nurse explains how to redeem the voucher at the referral agency and where the client can go for this service. The nurse explains that the voucher is valid for redemption at the referral agency for one month from date of issue.</td>
</tr>
<tr>
<td>• The client leaves the clinic.</td>
<td>• The nurse writes their name at the bottom of the tool, records the voucher number and signs the tool.</td>
</tr>
</tbody>
</table>
| • Economic Strengthening Tool is placed in client’s file. | • Client leaves the clinic with color x and color y voucher.  
• Economic Strengthening Tool is placed in client’s file.  
• The client’s voucher number is recorded in clinic’s FBP register book on the line for the client, in the column “linkage to economic strengthening” |

6. On the next visit to the clinic, the clinician checks on the progress of the economic strengthening activity with the client. If the client received a voucher, the client should return with the voucher after redeeming it at the referral agency. The clinician should confirm that the client received the referral service and note the type of placement made at the bottom of the client’s economic strengthening Readiness Tool where it says “Placement.” Clinician can copy this information from the feedback section on the voucher. The voucher is then attached to the economic strengthening Readiness Tool and placed in the client’s file. If placement is not made, the clinician will write the reason why not (e.g. client already receiving services from another agency, or client lost the voucher, or client did not attempt to get services).
7. When a client is placed in an economic strengthening service, the health facility should record the type of placement in the client’s visit column in the health facility FBP register book. They can use the following codes:

- IGA = Income Generating Activity
- UG = Urban Gardening
- BTW = Back-to-Work
- SG = Savings Group/CSSG
- NP = No placement made

8. At the end of the quarterly reporting period, the health facility will tally from the register book and report to FBP:

- # of vouchers issued in the reporting period
- # of placements made by intervention type, or whether no placement was made.

These totals will be entered into the standard reporting format in a table for economic strengthening linkages. When the client who is referred to economic strengthening services, they must visit the Kebele HAPCO office, where the following protocols are observed:

**HAPCO/Referral Agency**

1. Clients who are referred to economic strengthening services take the color x and color y vouchers to the Kebele HAPCO office. Kebele HAPCO office verifies that the client is in the HAPCO database to receive services.

<table>
<thead>
<tr>
<th>Steps to Follow if Client is in HAPCO Database</th>
<th>Steps to Follow if Client is NOT in HAPCO Database</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Kebele HAPCO checks which services the client is already receiving.</td>
<td>• HAPCO will explain to client what is required to be registered in the database.</td>
</tr>
<tr>
<td>• If client is already receiving sufficient economic strengthening support by a local agency, then the HAPCO office completes the feedback section of the client’s color x voucher noting the type of service(s) they are already receiving, which the client will take back to the clinic. HAPCO should counsel the client to take good advantage of the economic strengthening activities they have been referred to. HAPCO keeps the color y voucher to show they have completed the referral.</td>
<td>• If client chooses to register, they will have to be approved by the Coordinating Committee. HAPCO should note on the client’s voucher that the registration process is on-going in the feedback section.</td>
</tr>
<tr>
<td>• If the client is not currently receiving economic strengthening support, the HAPCO office selects the appropriate agency for referring the client and notes that in the feedback section on color x and color y vouchers. Client takes vouchers to the agency they have been referred to and presents color y to receive services. The agency will complete the feedback section, noting the type of service to be received.</td>
<td>• If client is successfully registered in the HAPCO database, then follow the steps in Column 1.</td>
</tr>
<tr>
<td>• Client returns with voucher color x to their next FBP appointment to show the clinician the</td>
<td>• If client is not registered in the HAPCO database, they will return their voucher to the</td>
</tr>
</tbody>
</table>
feedback.

health facility with a feedback that they are not eligible for services at this time.

**Economic Strengthening Readiness Assessment Tool**  
*(to be used together with economic strengthening counseling during Visit 2)*

<table>
<thead>
<tr>
<th>economic strengthening SCREENING QUESTIONS FOR CLIENTS:</th>
<th>✓</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If client is female, is she head of household?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2. How many children are supported in the household?</td>
<td>More than 3</td>
<td>3, or less</td>
</tr>
<tr>
<td>3. How many people in the household are earning an income including the client?</td>
<td>1 or none</td>
<td>2, or more</td>
</tr>
<tr>
<td>4. How often do you receive financial support (cash transfer, remittance, aid for children, etc.) from your extended family or other organization?</td>
<td>Less than every 2 months</td>
<td>At least every 2 months</td>
</tr>
<tr>
<td>5. Do you rent your home?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6. Are you 15-18 years old and out of school?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**TOTAL FOR EACH COLUMN:**

**TO BE COMPLETED BY CLINICIAN:**

What livelihoods activity is the client doing, or has done in the recent past?

<table>
<thead>
<tr>
<th>IGA</th>
<th>Day laborer/employment</th>
<th>Farming</th>
<th>Other</th>
</tr>
</thead>
</table>

Is the client physically/clinically ready to graduate from FBP to economic strengthening activities?

Yes _____ No _____

Is the client referred to economic strengthening services? (Refer if the client has 5 or more in Column 1 above)

No _____ Yes _____

If no, why not?

Does not quality for economic strengthening ______

Is not ready to graduate ______

Ready to continue existing economic strengthening ______

If yes, which economic strengthening activity?

IGA ______

Urban Gardening ______

Savings Group (CSSG) ______

Back-to-work Initiative ______

Name of clinician conducting assessment: ____________________________ Signature: ____________________________

Name of clinic staff issuing voucher: ______________________________ Signature: ____________________________

Voucher number: __________________ Placement: ____________________________
Annex E: Overview of the HIV/AIDS Care and Support Program (HCSP)

Start Date: June 2007
End Date: 2010
Total Funding Amount: $28 million
Contract Holder: Management Sciences for Health
International Partners: IntraHealth International, World Food Program, WHO/IMAI

Project Overview:
The HCSP program was planned as a comprehensive and integrated service-strengthening intervention linked to prevention, care, support, treatment and laboratory services. HCSP focused on supporting health centers that provide antiretroviral therapy (ART), HIV care, and palliative care services. In addition, the project focused on decentralizing comprehensive and integrated HIV services to health centers and linking community and facility-based HIV/AIDS activities using case managers for personalized care, and kebele-oriented outreach workers (KOOWs) to support family focused prevention, care, and treatment in the community. The scaling-up and decentralization of HIV prevention, care, and treatment was also designed to improve and strengthen referrals between hospitals, health centers, and community services, adherence to ART, and co-management of HIV and tuberculosis. In addition, the HCSP program was intended to improve maternal health services through the expansion of an integrated approach to prevention of mother-to-child transmission of HIV with IntraHealth International.

Results
1. Provision of quality integrated HIV/AIDS prevention, care, and treatment services at health centers.
2. Deployment of case managers to personalize care and strengthen referrals between health centers, hospitals, and community services.
3. Deployment of outreach workers to support family-focused prevention, care, and treatment in communities.

Referral System
The efficacy of the continuum of care depends, for a large part, on the strength of the referral system that links services within and between different levels. Enabling and strengthening the referral system connecting the community to the health center and hospital was therefore a key feature of the HIV/AIDS service expansion approach.

Community-based organizations played a critical role in identifying HIV positive patients, people at risk of HIV and families affected by HIV, and in helping those individuals access health care and other services. However, in the most heavily affected communities, the core team for operationalizing the links between households, community resources and health centers were KOOWs, community mobilizers and health facility-based case managers.

To identify and select volunteers at the community level, HCSP worked directly with community leaders through community mobilizers deployed at woreda health offices. Volunteers interested in participating in HCSP were chosen by their own communities, and then linked to the community mobilize and HCSP technical advisors for training and support. To maximize geographical coverage, HCSP also partnered with a number of local organizations and associations of people living with HIV (PLHIV).
Over 7,000 KOOWs carried out ongoing home visits to a minimum of 20 households each. The households were identified through a variety of sources including referrals from the HC case managers, community members of the local PLHIV associations. As KOOWs are typically themselves HIV-positive, they also identified households through their own HIV-positive networks. Once a month, the KOOWs, community mobilizer and case manager met at the health center to review patients and discuss gaps, challenges and opportunities. At these meetings, KOOWs submitted monthly reports on the activities and services they had performed and discussed them with the community mobilizer who in turn, submitted them to the case manager. KOOWs provided eight services during home visits include: 1) palliative care, 2) referral (clinical), 3) referral for food support, 4) referral for IGA support, 5) protection with positives, 6) other prevention, 7) abstinence, be faithful and condom use and 8) loss to follow up.

Case managers, KOOWs and community mobilizers reviewed patients they had referred to each other and to other services and found solutions to tracing those who had missed an appointment or supporting those who failed to adhere to ART. An extraordinary solution that KOOWs routinely used was to physically escort patients from their home to health center. This time consuming referral mechanism demanded not only dedication among KOOWs but a high degree of discretion and an ability to inspire confidence and motivate defaulting patients to return for care and support. Its success was as much related to the remarkable commitment of KOOWs as to the power of traditional Ethiopian community life and values.

Another important contribution made by the KOOWs was “asset mapping”, which was introduced by HCSP and involved KOOWs and other community based volunteers to map resources or “assets” that already existed in the community and could help HIV infected and affected families. Asset mapping particularly involved women to identify resources in their neighborhoods. The information gathered
for asset mapping was shared with the Kebele HIV/AIDS office, KOOWs, other community volunteers and service providers and the case manager who used it for referring patients to the most appropriate and readily available services. To support KOOWs and community mobilizers, HCSP developed and supplied them with community-based data collection and reporting tools and trained them in their use. HCSP also developed and provided them with job aids including home-based care kits and educational materials with ABC messages, targeting prevention with both the general population and HIV positives.

**Successes**
Through the referral system, the number of bedridden HIV patients in HCSP-supported communities had dropped dramatically, with an estimated decline from more than 15% in 2008 to 2% in 2011. The continuum of care resulted in nearly 175,000 referrals between health centers and the community for HIV-related services in 2010. The facility-community linkage model is among the most successful elements of HCSP, and is recognized as such by clients, health center staff, district-level health office staff, and outreach workers themselves.

**Challenges**
HCSP was expected to link to existing programs and partners providing nutritional support and other services, such as humanitarian assistance and support to OVC. However, in many areas, neither the World Food Program nor any other significant organization is present and providing such support. The lack of additional services in communities significantly weakens the opportunities to provide referrals out to other services.
Annex F: Overview of the TransACTION Program

<table>
<thead>
<tr>
<th>Start Date</th>
<th>May 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>End Date</td>
<td>April 2014</td>
</tr>
<tr>
<td>Total Funding Amount</td>
<td>$40 million</td>
</tr>
<tr>
<td>Contract Holder</td>
<td>Save the Children USA</td>
</tr>
<tr>
<td>International Partners</td>
<td>Family Health International 360 (FHI 360), Population Services International (PSI), Marie Stopes International Ethiopia (MSIE)</td>
</tr>
<tr>
<td>Local Implementing Partners</td>
<td>Pro Pride, MEKDIM, OSSA, Tigray Youth Association, (TYA), Common Vision for Development (CVDA), Ethiopia Kale-Hiwot Church (EKHC), Love In Action (LIA-E), Professional Alliance for Development (PADET), Organization for Relief and Development in Amhara (ORDA), and South Ethiopian Peoples development Association (SEPDA)</td>
</tr>
</tbody>
</table>

**Project Overview**

The project’s key objective is preventing new HIV infections among at risk populations and strengthening linkages to care and support services in 120 towns and commercial hotspots along or linked with major transportation corridors. TransACTION includes an economic strengthening component which aims to reduce vulnerability to economic shock and thereby reduce the likelihood of risky behaviors by most at-risk populations (MARPs). Activities include forming Self-Help Saving Groups (SSGs) and establishing and strengthening income generating activities (IGA). Economic strengthening activities are integrated into the behavior change program and even used as an entry point for reaching groups such as waitresses with HIV and sexually transmitted infection (STI) prevention education.

**Results**

1. Expanded access to a network of key prevention, care and support services for MARPs.

2. Strengthened quality of prevention services, behavior change communication and community-based care and support for at-risk populations to ensure consistency and quality within the service delivery network.

3. Increased demand and supportive environment for provision and use of key prevention, care and support services among most at risk populations.

4. Strengthened institutional and technical capacity of local organizations.

**Referral System**

The TransACTION program is developing and supporting networks of private health facilities in the targeted geographic areas to provide quality management of STI and HIV counseling and testing (HCT) services. The team works with private sector, government and non-governmental organization (NGO) stakeholders to identify private facilities for potential inclusion in the provider network. Network members are expected to adhere to standards of consistency and quality, and are responsible for collection and monthly submission of data on service provision based on national reporting forms.

A network coordinating partner convenes routine meetings to discuss service provision issues, receive feedback on overall achievements and share referral data. To facilitate program sustainability and TransACTION phase out, the network may require modest fee payments from
participating members. These fees would be introduced after year 1 or 2 of the program, in consultation with network members. All private facilities participating in the network will provide HCT services as well as STI management. TransACTION is adapting the referral tools used under the USAID-funded High Risk Corridor Initiative for use with other peer groups, and include other services beyond the network, such as family planning/ reproductive health, nutritional interventions and other HIV care and treatment.

In each town, local NGO partners participate in routine health network meetings to contribute to discussions around service provision issues, receive feedback on overall achievements and share referral data. Referral directories, developed by Abt Associates’ Private Sector Program/Ethiopia, include a list of the health network members as well as the local NGOs and their partners to facilitate two way referrals from the NGOs/communities and health facilities. The local NGOs are responsible for raising awareness of available services being provided and will refer their beneficiaries to the health facilities. The health network members refer their clients to the local NGOs for follow up care and support to ensure among other things, treatment adherence, home based care, peer support and linkages for other services such as food, spiritual and psychosocial counseling.

Community home-based care (CHBC) model

TransACTION uses a community home-based care (CHBC) model, which establishes linkages with other USAID-funded programs to identify opportunities to improve care and support for MARPs, as
well as incorporate prevention activities for PLHIV and discordant couples. Direct linkages with the Kebele Oriented Outreach Workers (KOOOW) system under the HIV Care and Support Program (HCSP) will ensure that clients in need of care and support will benefit from a family-focused approach that minimizes stigma and ensures better continuity and support for adherence to treatment regimens. Experience from HCSP shows that KOOOWs have been instrumental in increasing uptake of HCT, treatment services, and access to CHBC, as well as promoting adherence to ART and Directly Observed Treatment - Short Course (DOTS) for tuberculosis.

TransACTION’s local NGO partners support the establishment of CHBC programs in locations where they do not exist, in collaboration with HIV/AIDS Committee members. Each town will have a cadre of volunteers, including PLHIV, widows and divorced women who will be trained using the Ministry of Health’s CHBC training manual, and oriented to behavior change communication and prevention for MARP.

**Peer support groups and community-based PLHIV associations**

In order to reach additional PLHIV with care and support activities, the program will strengthen community based PLHIV associations and peer support groups. To ensure the needs of PLHIV are met in a coordinated manner, local NGO partners will provide support and facilitate expansion of PLHIV associations and support groups. Association and group members will receive support to meet their unique needs. Linkages will be made between PLHIV groups and programs providing food and nutrition services and economic strengthening support. The program facilitates linkages with the HCSP-supported health centers for tuberculosis treatment and ART. The program works through the PLHIV associations and CHBC groups to promote couples’ HCT services and to provide community counseling and support services to discordant couples.

**Economic strengthening support**

TransACTION supports the implementation of IGAs for PLHIV, sex workers and other females involved in transactional sex. The program supports: a) the formation and management of Community Self-Help Savings Groups (CSSG) to help families accumulate, protect and diversify assets; b) complement a savings and credit mechanism with a proven business training model (Selection, Planning, and Management), and c) organize sex workers into CSSGs. Furthermore, we will continue to facilitate linkages between enterprises undertaken by PLHIV with local businesses along the corridor, including opportunities for vocational skills training for targeted clients.

**Vocational skills training for women at risk**

TransACTION supports vocational skills training by providing scholarships and/or linking women at risk between the ages of 20 and 35, to training opportunities. A few selected members of CSSGs, some peer educators and a few economic strengthening agents will be offered the chance to participate in vocational training. This will be dependent on choosing towns where the economic infrastructure can support self-employment or wage employment opportunities based on the skill trained in (primarily larger towns). The program conducts town level mapping to assess existing vocational training opportunities for the beneficiaries to attend.

The participants in vocational training complete a simple registration form that will be collected and analyzed by the implementing partners, HIV committees and TransACTION. This group consisting of implementing partner, HIV committee and TransACTION will meet once per quarter to review the applications and select beneficiaries for vocational training.
## Annex G: Collected Forms and Referral Tools

### Monthly Monitoring Sheet(s) Submitted by Each Network Committee Member

(one sheet completed for every organization to which beneficiaries have been referred that month)

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Name</th>
<th>ID No.</th>
<th>Sex</th>
<th>Age</th>
<th>City</th>
<th>Sub-City</th>
<th>Kebele</th>
<th>House No.</th>
<th>Service Received</th>
<th>Service Not Received</th>
</tr>
</thead>
</table>

Name of the organization/institution referred to:

Month and year:

Reasons for referral and type of service referred for:
Individual Referral Form

Date: ______________________

Name of referant: ______________________

Position: ______________________

Client/patient IDN: ______________________

Name of client/patient: ______________________

Sex: ______ Age: ______

Address: __________ Kifle kebema: __________ Kabele: __________

Name of service provider: ______________________

Position: ______________________

Reason for referral: ______________________

Referant signature: ______________________

Service provider signature: ______________________