ENFANTS DEVELOPPEMENT

FAMILY DEVELOPMENT PROGRAM

NETWORKING - REFERRALS OPERATION MANUAL

European Union

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This document was born out of the lessons learned of the FD project implemented by Enfants&Développement in collaboration with the University of Labor and Social Affairs (campus HCMC) and the HCMC Open University.

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Abbreviations

FD	Family development
FH	Follow-up at Home
PIC	Partner Information Card
LF	Local Facilitator
SGC	Social guidance center
SP	Service Provider
SW	Social worker

Dear Colleagues and Friends,

Enfants&Développement (E&D) has been working to improve the situation of children and families in Vietnam for over 20 years. Since 2010, E&D has been implementing an innovative Family Development Project in district 8 of Ho Chi Minh City. The project aims to alleviate poverty, improve the living conditions and resilience of vulnerable families, promote more inclusive services and ensure best practices in social work.

On March 25th 2010, the Vietnamese Prime Minister issued Decision No. 32/2010 ratifying the Project on Development of Professional Social Work in Vietnam from 2010 to 2020. In this important legal document, the Vietnamese government lays out its strategy to build and train a network of professional social workers and to mainstream social work best practices throughout Vietnam within the next decade.

The Family Development project uses an innovative social work methodology, the Family Development (FD) approach, designed in the 1980's in Brazil for urban contexts. E&D does/has implement/ed similar FD projects in Cambodia, The Philippines, Nepal and Burkina Faso and as such, has become a recognized expert in this area. The attractiveness of the FD approach is due to its simplicity, effectiveness, pragmatism, and sustainability.

The project has been set up in partnership with two universities: the University of Labor and Social Affairs – Campus Ho Chi Minh City (ULSA 2) and the Ho Chi Minh City Open University. It is the result of strong collaboration with local authorities within the district of intervention.

During the three year course of the project, E&D social workers visited the homes of more than 700 families with an additional 500 persons visiting the project's two social guidance centers (SGC) to receive information and/or to get referrals in 5 areas: health, education, administrative matters, economic and psycho-social issues. The social guidance centers provided support and referrals to the local community, especially the most vulnerable families, helping them to access available social services existing in the district and in the city and building their problem-solving skills, confidence and resilience.

This resource, the Network and Referrals Operation Manual, was born out of the experience of building up a network of services providers and implementing referral activities in District 8. It provides guidelines on how to create, coordinate and develop a network of service providers and set up referral procedures in urban poor environments, to enable replication of the project and to share lessons learned.

This document is part of a series and is not meant to be exhaustive. It can be used independently but preferably together with the Home Visit Operation Manual and the Social Guidance Centers Operation Manual.

Lastly, we would like to acknowledge the kind support of several donors and partners who have made our work possible over the last four years, particularly the European Union, the French Agency for Development and the Vietnam People's Aid Coordinating Committee. We would like to thank the People's Committee of District 8 who played an important role in organizing and facilitating the fieldwork and to all the families who trusted the social worker teams and agreed to take part in this pilot project.

We hope this document will help all those interested in social work to apply innovative solutions to address some of the most burning issues related to basic human needs in developing urban environments today.

E&D staff in Vietnam.

I. OVERVIEW ON NETWORKING ACTIVITIES

How and why to network?

The principle of networking is to establish and develop helpful relationships and connections with other people and/or organizations.

In a Family Development (FD) project, the networking activities undertaken by the team (mainly the network officer) allow the social workers (SWs) to know what services are available in the intervention area and more widely in the whole city. As a result of this, SWs are consequently more able to inform clients about existing services that they can access.

Networking efforts can serve many different purposes, but mutual benefit is a common objective in successful networking. Particularly beneficial results can arise from networking when peoples' interests coincide and by working together they are able to produce an effect greater than their separate efforts. Networking is instrumental in establishing such cooperative and collaborative partnerships, which are based on mutual interest.

In a FD project, establishing synergies between two service providers (SPs) can produce interesting new service propositions for the most-deprived populations. In addition, networking brings with it the added advantage of personal introduction and of strengthening collaboration between SWs of various organizations, which is conducive to the development of opportunities for "exchange of services".

II. OBJECTIVES OF NETWORKING ACTIVITIES WITHIN A FD PROGRAM

1. To improve the access of vulnerable families to existing SPs so as to meet their practical needs;
2. To empower families and strengthen their capacities in a concrete and sustainable manner through the creation and reinforcement of habits of seeking out and accessing existing basic services;
3. To contribute to improving the quality of services through adequate feedback among the basic social services networks;
4. To prompt SPs to develop more open-minded attitudes towards underprivileged and/or vulnerable person, and to enhance their perception of their social responsibilities and willingness to create opportunities for underprivileged and/or vulnerable persons from a range of different educational and socio-economic backgrounds.

III. PROCESS OF BUILDING A BASIC SERVICE NETWORK

1. Identification of available resources

Available resources can be identified through Community Mapping: a process by which resources internal and external to the project area are inventoried. The following methods of data collection can be used:

- Consulting secondary databases made by the local authorities or other social organizations on existing SPs
- Surveying the community and locating basic SPs in the project area and more widely in the whole city. This work is undertaken by the network officer together with the SWs (for the services located in the area of intervention)
- Participating in different networking meetings and workshops etc., which are opportunities to meet other basic SPs.

2. Establish partner relationships

- Having obtained basic information on a SP (i.e. name, address, contact person, etc.) the network officer will schedule an appointment for a first contact.
- The meeting should address the following topics:
  - An introduction of the organization and the FDP program
  - An introduction of the network officer function (role, tasks, etc)
  - The purpose of the meeting
  - Required information about the SP (see the "Partner Information Card")
  - A discussion of opportunities for cooperation and referrals.

3. Developing database

3.1. Complete a partner information card for each service provider

Information is collected and recorded in PICs by the network officer in order to form a user-friendly network database.

3.2. Classification of the services

3.2.1. Public/non state SPs

- Public SPs
- Non state SPs

3.2.2. Client-oriented quality assessment of the SPs

This assessment should cover the following points:

- The quality of the services provided
- The procedures : simple and easy to follow
- The quality of the reception arrangements
- The location (easy-to-access and not too far from the intervention area)
- The tariff (including whether the service is available free of charge or with discounts upon referral)
- The readiness of the SPs to give and receive feedback.

Notes: *The assessment will make it possible to rank the services from most suitable to less suitable with regards to specific client needs and the SP's capacities and willingness to welcome particular clients.*

3.2.3. Areas of intervention

SPs are also categorized according to their areas of intervention (i.e. livelihood, education, health, legal papers/administration, psycho-social assistance etc.)

3.3. Documentation

All PICs are to be printed and made available to social workers for easy access and reference.

In order to allow SWs to easily search for information the documentation should also be filed according to the two following systems of categorization:

- By areas of intervention
- By quality and appropriateness of the service

3.4. Updating

The PICs are updated through:

- Clients and SW feedback
- Visits or contacts

Feedback is obtained regularly from both clients and SPs and the network database is updated regularly. This activity is crucial to enhancing the cooperative relationship between the organization and SPs.

Network officers should also visit or liaise with the SPs on a regular basis in order to update the latest information on their services into the network database.

The PIC must show the date the card was created and when it was last updated.

4. Signing cooperation agreement

When establishing a long-term partnership, the intended partners should sign a memorandum of understanding (MOU). Such agreements formalize the commitments of both parties and consolidate their partnership.

IV. OPERATIONAL PROCESSES FOR REFERRAL OR INTRODUCTION

1. Assessment of the family needs

SWs have to carefully prepare each referral together with the family, in order to:

- Obtain accurate information,
- Identify the true needs of the parties involved,
- Assess the appropriateness of the referral.

In special cases, the SW in charge can request support from the network officer. In this case, they will meet the client together to further discuss the issues and needs belonging to the client's individual circumstances.

2. Either make referral or give information

After identifying the client's needs and desires, and assessing the appropriateness of the referral, the SW has to consult the network database available at the Social Guidance Center (SGC) to search for service information. If an appropriate service is listed, the SW can start the referral process.

Note: *If the service required is not listed, the SW should contact the network officer and inform them that this is the case. This way the network officer will be aware that they need to search for and supplement the information on the network database about the availability of this service.*

2.1. Referrals

2.1.1. Referral cases

- Follow-up families in need of referral to a specific social service.
- Phase-out families who still may require a referral to specific services in order to manage newly arising issues

2.1.2. Referral procedures

The SW in charge assists and provides guidance to the client in carefully preparing the requested documents for each referral such as:

- 1 Referral letter,
- 1 Social information sheet,
- All other necessary documents (identity papers, poor household certificate etc.).

2.1.3. Referral methods

2.1.3.1. If clients are capable of accessing the social services by themselves, the SW encourages them to do so, thus helping them to increase their self-confidence and problem-solving skills.

2.1.3.2. If the SW feels that clients are not "ready" to access the services by themselves, the SW or the network officer can propose to accompany them, especially during their initial appointment.

2.2. Providing service information

2.2.1. Cases for providing service information instead of making a referral

- Non FH families about whom the SW may not have much information about, and with whom they may have only spent a small amount of time (for example, only one contact) insufficient for a proper needs assessment.
- Families (including FH families) who may only need basic information about services, and have no demand for a referral.

2.2.2. Introduction process

- The SW simply provides basic information to the client on the services (no referral procedures).

Note:

Introduction	Referral
No referral process.	Referral process.
Little information about the client. Basic understanding of the client's needs.	Good knowledge of the client's circumstances and issues. Clear understanding of the client's needs through the follow-up period.
The SW provides information only. The client contacts and attends services on their own.	The SW provides information and support to the client in order to assist them in accessing services.
Obtaining feedback: • Through phone call with the client (recommended action). • The purpose of this feedback is to gain information about the client's experience so as to be able to draw upon it for the next introduction to the SP. It is for internal usage only and the SP will not be provided with this information. • No need to closely follow-up.	Obtaining feedback: • From both the client through home visits and from the SP. • The purpose of this feedback is to obtain information about the experiences of both the client and SP. This information will be shared with all parties concerned for the constructive improvement of the service quality. • The SW keeps working with the referred client during the follow-up process.
Good quality service providers.	Good quality service providers.

3. Referral or introduction report

3.1 Social worker in charge.

Whenever a referral is made, the SW in charge has to fill out a referral report (family form no.8).

All the referral information (e.g. referral letter, social information sheet, etc.) is included in this report and kept in the client's file by the SW.

Note:

- *If 3 children of the same family are referred to go to school, it will be considered as 3 separate referrals.*
- *Similarly, if 1 person is referred to 3 different hospitals for the same health problem, it will be considered as 3 separate referrals.*

3.2 Network officer

The Network officer is responsible for computing/tabulating all the information about each individual case of referral on a monthly basis and for reporting it to the SGC Manager.

4. Assessing referral results

During weekly meetings, SWs in charge work together with the network officer to assess referral results based on the following criteria:

Referral results	Definition
Successful	• Client has access to and is provided with services as expected. • Client is referred to and continues to get the services from the SP (for example: treatment of tuberculosis, or antenatal examination).
Successful but not sustainable	• Client has access to and is provided with services once, but does not continue to access the services (for example: tuberculosis treatment, school drop-out).
Failed	• Client does not make contact with the SP. • The service is not provided.

Note:

- *In cases of successful but not sustainable results, the SW in charge and the network officer need to find out the reasons why the client stopped going to the SP.*
- *In cases in which the client went to the SP but was not provided with the expected services, the SW in charge and the network officer need to liaise with the SP and the client in order to find out the reasons, and learn from this experience for the next referral.*
- *In cases in which the client failed to make contact with the SP, the SW in charge and the network officer need to work again with the client in order to identify the reasons for their non-attendance and to re-identify the objectives of referral if necessary. At the same time, the network officer needs to liaise with and explain the details of this non-attendance to the SP.*

5. Gathering feedback

Collecting information about both client and SP satisfaction with their referral experiences and updating the information about the referral processes and outcomes contributes to the improvement of service quality within the network of SPs.

In both cases of referral by SWs and cases of self-access by clients, the network officer is responsible for monitoring and updating feedback to and from stakeholders (i.e. families, SPs, SWs in charge etc.).

Feedback from the SW in charge to the network officer and vice-versa are updated frequently during weekly meetings at the SGCs.

Updated information and feedback must be clear, accurate and completed in a timely manner.

6. Drawing on referral experiences

The referral process should consider the following realities:

- The referral methods should be adapted to the client's capacities.
- For similar problems clients can be referred to different SPs with different procedures.
- Within one service provider, different staff members who receive cases may have different ways of providing the required service.

Therefore, drawing practical experience from each referral case is crucial and useful, as it not only helps other SWs obtain knowledge about the range of different service providers they can refer their clients to but also to gain valuable practice when faced with similar circumstances in which clients require a referral.

After each referral, the SW in charge is responsible for summarizing practical referral experience on a Referral Experience Form.

- A Referral Experience Form is filled out by the SW doing referral or by the network officer.
- Information about client in this case must be kept confidential by changing their names, or using abbreviations or symbols etc.
- Referral Experience Forms should be printed and kept at the SGCs.