



Assessment of a Diagnostic Tool for Household Poverty and Food Security in Balaka District, Malawi

The Livelihoods and Food Security Technical Assistance II (LIFT II) project was launched in 2013 by USAID as a follow-on to the LIFT project, which was successfully implemented by FHI 360 from 2009-2013, to end this downward spiral by strengthening the capacity of USAID missions, implementing organizations and host governments to design and implement livelihood and food security interventions that sustainably improve the economic resiliency and health of vulnerable households. LIFT II's primary goal is to build the continuum of care for people living with HIV (PLHIV) and other vulnerable households by increasing their access to high quality, context appropriate, market-led economic strengthening, livelihood and food security (ES/L/FS) opportunities to improve their economic resilience and lead to better health.

In Malawi, LIFT II aims to support service providers in the northern area of Balaka District with a diagnostic tool that will collect essential poverty and food security data, as well as be useful in helping local stakeholder staff provide referrals to other service providers. The goals of the present study were to understand how LIFT II could help service providers make **efficient, effective, and appropriate referrals** to services within the district, and also to learn how LIFT II could **classify clients** into the three categories of household poverty/vulnerability: **Provide, Protect, and Promote**.

The first step in LIFT II's investigation was to collect data using a series of tools. In August 2013, LIFT II hired and trained a team of six local data collectors to conduct 312 clients interviews (see table at right) at three health facilities in Balaka District: Balaka District Hospital, DREAM (Andiamo Health Center), and Kalembo Health Center—three sites where nutrition and HIV care services are meant to be integrated through Malawi's Nutrition Care, Support, and Treatment (NCST) program. Household poverty and vulnerability data were collected using two tools: 1) Grameen Foundation's Progress out of Poverty Index (PPI) and 2) a custom designed tool based on a series of the most frequent questions to appear on the Progress out of Poverty Indices and USAID's Poverty Assessment Tool (PAT) across all of sub-Saharan Africa. Household food security data were collected using three tools, all developed by the Food and Nutrition Technical Assistance (FANTA) project: 1) The Household Hunger Score (HHS), 2) the Household Dietary Diversity Score (HDDS), and 3) the Months

of Adequate Household Provisioning (MAHFP). LIFT II collected data on a final series of questions to gauge community interest in, understanding of, and perceived barriers to referrals.

Study sample			
Health Facility	Women	Men	Total
Balaka District Hospital	73 (59.8%)	49 (40.2%)	122
DREAM (Andiamo Health Centre)	51 (60.7%)	33 (39.3%)	84
Kalembo Health Centre	66 (62.3%)	40 (37.7%)	106
TOTAL	190 (60.9%)	122 (39.1%)	312

The second step in the investigation was to conduct a thorough debrief with data collectors to assess their perceptions of the diagnostic tool's utility and suitability as an aid in making efficient, effective and appropriate referrals, as well as any perceived benefits they would expect to find by classifying clients into the provide-protect-promote framework.

FINDINGS:

Efficient referrals do not take a long time to complete. The six data collectors had little trouble finding new clients, reporting an average of 4 minutes required to find and recruit a new client, 20 minutes to complete the survey on a tablet (not including the final questions), and that an additional 10 minutes would be required were they to use a paper-based version. They estimated they would need from 15 to 60 minutes to counsel a client (after completion of the referral tool) to ensure they were making a useful and actionable referral.

Effective referrals allow us to collect data about clients to improve referral programming. Data collected during this exercise serve two purposes: 1) a cross-sectional snapshot of poverty and food security status in Balaka in August (including nuances to food security such as proportion of households

Comparison of poverty assessment tool (PPI and LIFT Score) scores						
	PPI			LIFT Score		
	mean	std. dev.	min.-max.	mean	std. dev.	min.-max.
Balaka District Hospital (n=122)	47.25	12.81	16 – 77	5.18	1.45	2.07 – 8.70
DREAM (Andiamo Health Center) (n=84)	45.27	12.48	18 – 77	5.13	1.50	2.60 – 8.90
Kalembo Health Center (n=106)	43.75	14.76	14 – 77	4.76	1.44	1.91 – 8.85

receiving food aid), and 2) a basis for contextualizing data for future work—it should be noted that a referral system operates on a rolling basis, always admitting and referral clients, rather than some cohort studies which have clearly defined start and end dates. Household poverty data showed a minimal trend for decreased wealth from the District Hospital to DREAM to Kalembo (mean PPI scores decreased from 47.3, to 45.3 at DREAM and to 43.8 at Kalembo; mean LIFT Score decreased from 5.2 to 5.1 at DREAM and to 4.7 at Kalembo) but there was no statistically significant difference (see table above).

Appropriate referrals provide a client with information about a service that is right for them and their household.

That means the service is one they are eligible for, can reasonably travel to, and that they have interest in. 96.8% of clients (n=300) interviewed for this study expressed an interest in referrals—a very strong starting point. However, clients expressed a number of concerns over referrals: 54.2% were concerned a service would be too far or inconvenient, 49.0% expressed concerns over trusting the service provider, and 47.4% noted that they did not know where to go. Additional client concerns are presented in the main body of this report, but these serve to illustrate that while some concerns can be easily addressed (i.e., where to go), LIFT II and service providers must be careful to maximize convenience of service delivery and ensure that public trust is maintained. Data collectors noted that they would need more information about services available in Balaka to provide more substantive comments on the appropriateness of a referral based on diagnostic tool scores.

PPI and other data can be used to classify clients. In order to be used for classification, all tools must have pre-determined cutoff values that identify the conditions of ‘food secure’ versus ‘food insecure’ or other category. For this study, the following cutoffs were used to determine food insecurity: HHS \leq 2; HDDS $<$ 6; and MAHFP $>$ 5. The PPI score (which ranges from 0 for poorest to 100 for wealthiest) is based on national level data and includes estimates that a certain PPI score is below a poverty line. LIFT II wanted to assign our own cutoff values to the PPI tool for Malawi, in order to have 10% of respondents fall into the provide

category, 80% in the protect category, and the final 10% in the promote category to match the targeting and variety of economic strengthening programs in the field. LIFT was able to identify the following cutoffs to distinguish the three groups: PPI \leq 29 is provide (9.3% of respondents in Balaka), PPI from 30-64 is protect (78.9% of respondents), and PPI \geq 65 is promote (11.9% of respondents).

LIFT II will use both the quantitative data collected from the diagnostic tool, and the data collected from the Data Collectors to develop a final diagnostic tool that combines one poverty/vulnerability assessment tool with one food security tool to create a complete diagnostic. This final diagnostic will also be accompanied by counseling guidance and training materials for service providers as well as for staff administering the tool in the field.

“I think making referrals is a good thing, and it will help people in the community get the services according to the needs that they have... We are giving them direction where they can get services they need. I feel optimistic about this.”

- LIFT II data collector

Four themes emerged for future development of a diagnostic tool in Malawi, or for design and testing of a diagnostic tool in another country:

1. Data collectors were uniformly happy with the use of tablets for collecting data.
2. Data collectors need a clearer understanding of the development of the PPI score.
3. There are some practical tips that can improve the flow of the questions and ease the burden on the health facility client.
4. More information about referrals is helpful to elicit clear responses.

The full report is available at www.theliftproject.org.