

A conversation with Development Media International (DMI), October 18, 2016

Participants

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Note: These notes were compiled by GiveWell and give an overview of the major points made by DMI.

Summary

GiveWell spoke with DMI to get an update on progress in 2016 and plans for the future. Conversation topics included DMI's randomized controlled trials (RCTs) in Burkina Faso, updates on current and planned programs, and new methods for monitoring and evaluation.

Burkina Faso RCTs

Child survival RCT

Health facility data

The London School of Hygiene & Tropical Medicine (LSHTM) had intended to collect health facility data since the inception of the study. Facility data were collected for the whole study period and analyzed both at midline and endline, though they were analyzed differently each time. LSHTM found that these data were more robust than behavioral surveys as they provide much more statistical power to detect an effect – e.g., for each arm, health facility data from about 100,000 children per year were analyzed, as compared to 800 sick children identified through each survey.

The analysis plan for the RCT was finalized after the midline survey but before the endline. The plan was developed with consultation from the Independent Scientific Advisory Committee in 2014-2015 and was informed by the midline results.

The Lives Saved Tool (LiST)

LiST was used to estimate a decrease in mortality rate based on the increase in health facility visits. LiST takes into account many factors – e.g., the national child mortality rate, the causes of child deaths, the proportion of children receiving treatment, the effectiveness of treatments, etc. The predicted impact of increased health facility visits on mortality is modeled based on various assumptions made about these factors.

DMI has worked to ensure that the model incorporates conservative estimates of, e.g., the proportion of children receiving treatment and the effectiveness of treatment. In the upcoming DMI-LSHTM paper on the RCT, estimated modeled

mortality impacts will be presented as a range – e.g., a 7-8% reduction in mortality, with an upper bound of 11% and a lower bound of 4% – to show the best-case and worst-case scenarios.

Family planning RCT

DMI expects that the endline survey for this RCT will take place at the end of 2018 or beginning of 2019. The results of the survey may not be available until late 2019. A midline survey will not be administered as part of this RCT.

Routine health facility data on contraceptive uptake are being collected as part of the RCT. DMI expects that it will have access to these data in approximately six-month intervals. The timeline for analyzing and sharing the data will depend on when the Ministry of Health grants access to the data. However, DMI expects to receive annual updates as data is collected, so some results should be available before 2019.

Program updates

Progress on campaigns in the last 12 months

Burkina Faso

- **Child survival campaign** – After the end of the RCT, DMI has continued with a nation-wide scale up of this radio campaign. The campaign is now being broadcast on 32 radio stations (including the 7 intervention stations from the RCT). It has targeted a range of behaviors, including three treatment-seeking behaviors and nutritional behaviors. DMI has funding from various funders for this campaign.
- **Family planning campaign** – The campaign is running on eight radio stations in the country and is being evaluated through an RCT.

Mozambique

- **Nutrition campaign** – DMI has launched a campaign in Mozambique in the past few months. It is working with community radio stations and the World Food Programme on this campaign in one region of the country.

Other campaigns

- **Tanzania** – There is a large nutrition and water, sanitation, and hygiene (WASH) campaign in the northern lake zone region of the country, funded by the United Kingdom's Department for International Development. The campaign aims to reduce stunting.
- **Democratic Republic of the Congo** – The second phase of the family planning radio and television campaign is running in Kinshasa.

Future programs

Mozambique

DMI is interested in a nation-wide replication study of treatment-seeking campaigns in the country. The broadcasts will focus specifically on treatment seeking for malaria, pneumonia, and diarrhea, and DMI will evaluate them based primarily on administrative data.

Scaling up campaigns in West Africa

DMI is interested in scaling up its child survival treatment-seeking campaigns across West Africa. It will be looking at potential countries for rolling out national radio (and some TV) campaigns encouraging treatment seeking for malaria, pneumonia, and diarrhea. DMI will also explore ways to design, implement, and evaluate the campaigns. Eight countries are currently in consideration. This project is still in the early stages, and DMI will be working to identify the interventions, partners, and scale-up strategies in each country.

There are 11 countries in the world with rates of child mortality higher than 100 per 1,000 live births. DMI is considering six of these for child survival campaigns, including Niger, Mali, Guinea, and Chad. The remaining countries in this list are either too small or have security issues.

Funding for Mozambique and West Africa

DMI has the following set of priorities for funding:

1. **Mozambique** – DMI has secured about two thirds of the necessary funding for the national replication study. It has received \$2.3 million for a two-year national campaign from a variety of donors, including a matching grant from the Lampert Family Foundation. While the grant has no specific expiry date, DMI does not expect it to be available indefinitely. DMI plans to direct some unrestricted funds – e.g., donations from GiveWell donors – towards its work in Mozambique, but it still expects a \$750,000 gap in funding for the replication study. Mozambique is DMI’s top priority because of the matching grant there, and because the country is a good fit for DMI’s interventions.
2. **Other West African countries** – After Mozambique, DMI would like to scale up in other West African countries that have high child mortality rates, e.g., Niger, Mali, Guinea, Chad, etc. While DMI does not have a specific budget for the programs in each country yet, it will be aiming for approximately \$1 million per year per country going forward.

Government funders

DMI has observed that bilateral funders – e.g. the U.S. or the United Kingdom – tend not to fund programs in West African countries. This makes the support of U.S. non-government organizations in these areas more important.

DMI initially expected that USAID would fund its work, but this has not proven to be a viable funding option.

Exploring different ways to scale

DMI has received funding from the Global Innovation Fund – which is also partly funding the family planning RCT in Burkina Faso – to support a review of its program replication model. This will allow DMI to work with the International Centre for Social Franchising on potential ways to scale up in West Africa through other organizations. DMI is considering a possible two-tier approach, e.g.:

- **In-house** – In West Africa, DMI would follow a traditional in-house model of scaling its programs, because there are fewer partner organizations it can work through in the area. DMI would seek catalytic funding from global donors, which could include unrestricted funding. It would then develop a plan for sustainable domestic funding and work with governments to implement it.
- **Partnership** – Outside of West Africa, DMI could consider scaling up programs through other partner organizations. DMI is thinking about how it would work with potential partner organizations, ensure quality control in program content, and achieve similar results through partners as it has in-house.

Iterative testing of content variables

DMI has been interested in answering various technical questions – e.g., are long-format broadcasts better than short-format, or are mobile phones better mechanisms for delivery than television or radio? It was not able to answer these questions through previous RCT and large-scale studies. It is now planning to incorporate an iterative testing component into individual projects, including the child development campaign in Tanzania.

An RCT conducted by the University of the West Indies suggested that children's IQ could be increased by three points through media interventions focused on child development. At the national scale, this effect could potentially be impactful on IQ, education levels, crime rates and even gross national income. DMI is interested in learning more about this effect through its program in Tanzania. As part of this project, DMI plans to experiment with, e.g., content length, optimizing for quality versus quantity of early parental communication with children, etc.

Method

DMI would broadcast for a month on four stations, to see which of the broadcasts lead to more behavioral change. Data would be collected using time series or other quasi-experimental evaluations – i.e., ongoing rather than one-time surveying.

Improving monitoring and evaluations

Rapid research studies

DMI has been discussing the use of rapid research studies – i.e., lightweight, non-randomized studies focused on the behavioral impact of interventions. DMI hopes that these studies will build on the results of its RCTs, test the generalizability to

other settings, and allow it to better understand some of the modeling assumptions around treatments received and the impact of increased healthcare visits.

DMI has designed the first set of rapid research studies and shared the concept notes with GiveWell. It has partnered with academics and research institutions to carry out these studies.

Administrative data

DMI has been disappointed by some of the limitations of surveying – e.g., lack of robustness/reliability of survey results, expense of surveying, limited sample sizes (and therefore power) – for evaluating its programs. For rapid research studies, it is interested in focusing more on administrative data collected by health workers. The process of selecting countries was time-intensive because DMI was looking primarily for countries and provinces with high-quality healthcare data. A province in each of the countries – Ghana, Tanzania, and Zambia – was selected, with the exception of Mozambique, where the study will be carried out at the national level.

Funding

DMI has begun to discuss fundraising for this study but has not yet secured funding.

Time series evaluations

DMI is continuing to monitor the reach of its broadcasts in Burkina Faso by asking some listeners to report when they hear programs and capturing qualitative feedback on their effect. DMI is also piloting a new time series approach to data collection to evaluate all campaigns in Burkina Faso. DMI chose this approach because funders that were supporting program scale-up after the child survival RCT – e.g., Alive and Thrive – were not interested in funding program evaluations. DMI decided to carry out program evaluations in-house and created this cost-effective method for doing so.

Method

Instead of administering large surveys before and after the intervention, DMI has hired seven enumerators to administer monthly surveys in seven zones (which span >1 radio station's reach). These enumerators ask a) whether listeners are hearing the broadcasts, b) about the health of individuals in the family, and c) about healthcare-seeking and health-related behavior, e.g., hand-washing. The question set is flexible and can be adapted to answer other types of questions as new campaigns are developed.

To select the villages and households where surveys are administered, DMI has developed a village listing, excluding areas that are dangerous or difficult to access. Each month, enumerators receive a list of seven villages and some replacement villages, in case they are not able to reach some of those on the main list. Within villages, DMI has created a process to randomly identify 20 households with help from local authorities.

Duration and cost

The program has been running and collecting data from approximately 1,000 people per month since July. At about \$80,000 per year, this is a more cost-effective means of gathering data than conducting surveys for each of DMI's six or seven funders in Burkina Faso.

Lessons learned

Through this method, DMI was able to identify an issue with the family planning RCT that was started in June. The enumerators discovered that some listeners in the control village were able to hear DMI's intervention broadcasts. DMI may not have learned about and resolved this issue otherwise.

Collecting administrative data

It may be a decade or more before the countries where DMI is interested in running programs can provide sufficient high-quality data on births and deaths. However, due to the issues DMI has experienced with survey data, it would like to help countries improve in this area. DMI is interested in potentially leveraging its evaluation teams to help local health officials collect higher quality data.

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