

A conversation with New Incentives, August 2, 2017

Participants

- Svetha Janumpalli – Founder and CEO, New Incentives
- Pratyush Agarwal – Chief Operating Officer, New Incentives
- Patrick Stadler – Chief Strategy Officer, New Incentives
- Elie Hassenfeld – Co-Founder and Executive Director, GiveWell
- Sophie Monahan – Research Analyst, GiveWell

Note: These notes were compiled by GiveWell and give an overview of the major points made by Ms. Janumpalli, Mr. Agarwal, and Mr. Stadler.

Summary

GiveWell spoke with Ms. Janumpalli, Mr. Agarwal, and Mr. Stadler of New Incentives as part of GiveWell's Incubation Grant work with New Incentives and the partnership among GiveWell, New Incentives, and IDinsight. The conversation focused on updates on New Incentives' operations.

Updates from the pilot

New Incentives is running a pilot of its incentives for immunization program at sites in central and southern Nigeria. New Incentives' program offers incentives for certain vaccines (chosen based on cost-effectiveness and expected mortality reduction), while other vaccines are monitored for increased uptake but not directly incentivized. New Incentives has now disbursed over 27,000 conditional cash transfers (CCTs) to mothers after verifying that their child has been immunized. The cash transfers have increased retention among infants who come to a clinic for at least one immunization:

- 89% of infants in the pilot who had turned 10 weeks old had completed their 10-week immunization visit, compared to a baseline of 66%.
- 87% of infants in the pilot who had turned 14 weeks old had completed their 14-week immunization visit, compared to a baseline of 54%.
- 90.9% of infants in the pilot who had turned 9 months old had completed their 9-month measles immunization visit, compared to a baseline of 31%.

The baseline figures used here are weighted averages of the number of infants from each clinic whose due date for a given visit has passed. These figures include data only from infants who have been brought to a clinic at least once for an immunization; they do not reflect the percentage of the total population of infants who receive these immunizations.

Of the infants who received the Bacillus Calmette–Guérin (BCG) vaccine after birth, 75% received the hepatitis B0 vaccine and 83% received the OPV 0 vaccine (both of

which are typically given during the same visit as BCG). These rates are lower than 100% because some clinics only give these vaccines to infants under two weeks old. Among infants under two weeks old, 92% received the hepatitis B0 vaccine and 98% received the OPV 0 vaccine. Similarly, the Pneumococcal Conjugate Vaccine (PCV) is given on the same schedule as the pentavalent (PENTA) vaccine. While New Incentives offers a cash incentive tied to receipt of the PENTA vaccine, it also measures the percentage of infants receiving the PENTA vaccine who receive the PCV vaccine. New Incentives has observed that approximately 99% of infants who receive a dose of pentavalent vaccine also receive a dose of PCV. New Incentives also notes that 99.7% of infants who receive Measles 1 (at 9 months of age) also receive the yellow fever vaccination scheduled for that vaccination visit.

New Incentives is also conducting learning activities in ten clinics in North West Nigeria, where it plans to conduct an RCT. New Incentives suggests that the high retention rates in the pilot program suggest that in the learning sites and RCT in the North West, once infants are enrolled in the program, retention (receipt of later vaccines) will be high.

The baseline immunization rates above are based on administrative data that may be unreliable. New Incentives believes it has taken a conservative approach to interpreting the data such that, if anything, the impact of the program will be underestimated.

Updates from the learning sites

Immunization rates at the ten learning sites in North West Nigeria have increased by an average of 800% compared to administrative baseline data; at one clinic, immunization rates have increased by 2000%. At another clinic, immunization rates have increased less than 100%, which suggests either that there has been community pushback or that the original register included infants from outside of that clinic's catchment area.

BCG immunization rates for infants under 30 days old have increased 200% (from a baseline of 20% to 40% after incentives were offered). New Incentives would like to see a BCG immunization rate increase for infants under 30 days old of 300-500% (which would cover 60-100% of infants). Some of these infants may receive BCG when they are older, but New Incentives is aiming to increase the percentage of infants who are immunized within 30 days of birth.

Barriers to getting mothers to bring their infant to a clinic in the first 30 days include a) a cultural norm that encourages mothers and infants to stay indoors for the first few weeks after birth and b) for many beneficiaries, it takes a whole day to go to the clinic and back, so they often delay this for a few weeks after birth or after hearing about the program.

Differences in North West Nigeria

The pilot is taking place in central and southern Nigeria, while the learning sites and the planned randomized controlled trial (RCT) are in the North West zone of Nigeria. There are a few key differences in the North West, including:

- **Low rates of phone ownership:** At some clinics, fewer than 10% of women own a phone. Since New Incentives uses SMS messages to remind women to bring their infants in to be immunized, it is considering exploring other kinds of reminder systems to be used in the North West.
- **Low literacy:** Many women are unable to read New Incentives' materials, so it has developed new materials that convey key information visually. New Incentives is confident that it will be able to find enough qualified staff.
- **Higher transportation costs** due to operating the program in more remote areas.

Updates on operations

New operational structure

New Incentives has been working to narrow its operational structure such that:

- Each state in which it works has four field managers who will each manage one of the four zones into which New Incentives has divided the state based on the locations of major cities.
- Each state has about 40 part-time field officers, 8-10 of whom will be managed by each field manager.
- There will be one field director for both states.

To date, New Incentives has hired 28 of the field officers and three field managers and expects to finalize the field director position in the next week. There are also 109 part-time field officers who have passed the training, done phone interviews, and are close to being finalized. New Incentives has also started interviewing people for the field manager positions.

Maintaining quality while scaling up

The biggest challenge for New Incentives in recent months has been ensuring that it maintains the quality of its work as it scales up. New Incentives has developed a console approach to increase quality and reduce costs. This approach includes the following elements:

- Demographic details and immunization history are collected on each woman enrolled in the program.
- The field worker marks a dot on each bill the mother receives and takes a photo of her with her baby's ID number and the cash transfer in her hand.

The dots assist online workers who review the photos and verify how much cash recipients received.

- An independent online worker counts how much cash is in the photo. Any discrepancies between the cash in the picture and the field staff's report are reported.
- A cash management console agent follows a detailed seven-page protocol on what to verify and triangulate and updates this information in a dashboard in real time.

Identifying beneficiary fraud

The cash management console agents identified one case of beneficiary fraud in which a staff member in charge of disbursement reported giving out 115,000 naira, and it was later discovered during a verification process that only 111,000 naira of this was given to people who enrolled in the program. The other 4,000 naira was paid to the mothers of two infants who were not enrolled in the program.

When women enroll their infant in the program, they receive a sticker on the child's health card with a unique ID number on it, as well as an additional card for the New Incentives program. In the above instance of beneficiary fraud, mothers enrolled in the program gave their stickers to the mothers of two infants not enrolled in the program who had not received immunizations, who were then mistakenly given cash transfers. New Incentives staff believe that these mothers pretended to be in the program rather than actually enrolling because the enrollment period had already ended.

New Incentives has since created a procedure to prevent this type of beneficiary fraud from recurring. Under the new system, when a woman is enrolled in the program, a sticker is placed on the child's health card and stamped such that the stamp marks both the sticker and the card, so that it will be obvious if the sticker is moved to a different card. This type of problem has historically taken a lot of management time to address, and the new system should enable New Incentives to prevent fraud with less active engagement as it scales up.

It would have been relatively easy to implement a technological fix to this problem, such as having the staff member in charge of disbursement look up the beneficiary number in a database and check whether that person has received the immunizations and the cash transfer. However, loading the database may have slowed down the process and resulted in delays that would prevent New Incentives from disbursing cash transfers to women as soon as their infant is vaccinated.

Current areas of focus

New Incentives is now focusing on maintaining feedback loops to staff, maintaining high quality in its verifications of immunizations and disbursement of cash, and continuing close monitoring of clinics' vaccine supplies. Supply-side monitoring, as

well as clinics adjusting to changes in vaccine demand, seems to have reduced the frequency of vaccine stock-outs. Of the 109 "immunization days" that clinics hosted in July, there were six instances of a clinic running out of a vaccine in the middle of the day and two stock-outs; this is fewer stock-outs than there were during New Incentives' initial work at its learning sites.

RCT clinic screenings

Screenings of clinics that New Incentives is planning to include in the RCT found that:

- 20% of screened clinics have only one staff member available to give immunizations. New Incentives is planning to include some of these clinics in the RCT in order to determine whether the program is effective in clinics with only one immunization staff member.
- About 10% of areas in Zamfara have security issues.

RCT timeline

The timeline for the planned RCT is currently projected to be roughly as follows:

- August-October 2017: baseline survey
- October-December 2017: roll out, i.e. activating clinics and training staff
- January-March 2018: ramp up, i.e. the program will operate for three months before enrolling infants as part of the RCT. This allows the program time for community engagement and to ensure that staff are working to high standards before beginning the RCT.
- April-July 2018: infants to be enrolled in the RCT are born
- August 2018-July 2019: infants complete their immunization schedule

The length of the roll-out and ramp-up reflects New Incentives' desire to ensure that the program is operating at a steady state before it's evaluated (the initial three-month period may include a backlog of older infants coming in for immunizations, and high-volume attendance at clinic immunization days might negatively affect participation in the program). Three months should be sufficient to get through the backlog of older infants because New Incentives will work with clinics to handle high volumes.

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