A conversation with New Incentives and the Lampert Family Foundation, September 3, 2015

Participants

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

Summary

GiveWell spoke with New Incentives and the Lampert Family Foundation for an update on New Incentives' progress in 2015. Conversation topics included updates on retention rate, future changes in the program's focus and scale, and updates on fundraising, staffing, and the ongoing randomized controlled trial (RCT).

Goals for first half of 2015

New Incentives had two primary goals for the first six months of 2015:

- Improving retention rate of women who enroll in its program
- Preparing for and executing the RCT of its program for prevention of mother-to-child transmission (PMTCT) of HIV

Achieving these two goals was challenging, but New Incentives believes it has made considerable progress.

Retention rate and efforts to improve

Retention at point of first cash transfer

Beneficiaries of New Incentives' program receive one conditional cash transfer (CCT) immediately after enrolling. New Incentives has learned that if a woman does not get the first CCT, the probability of reaching her later by phone is greatly reduced. It has tested various ways of improving retention at this stage, including the following:

- **Towels** – New Incentives first tried giving away a towel to each enrollee, as towels are popular items among women in Akwa Ibom state. This did not increase the percentage of women who called for their first CCT.
- **Phone credit** – New Incentives tested giving enrollees some phone credit, as some had claimed to have insufficient credit to call the hotline to get the mobile money token for the first CCT. This increased retention slightly, but not at the level hoped for.

- **Cash + phone credit –** New Incentives then tried giving enrollees 300 Naira worth of phone credit, plus 1,000 Naira (approximately $5) in cash. This resulted in a significant improvement in the percentage of women who called for their first CCT.

Since June 2014, 89% of enrollees in the program have received the first CCT. Those who dropped out before this point refused the CCT or could not be reached by the hotline operator. This might be because they are relatively wealthy and do not need the cash, fear the photographs, have not accepted their HIV-positive status or are planning to move away from the state.

Percentage of women who deliver in the clinic

Beneficiaries receive another CCT after New Incentives confirms through clinic registers that they have given birth in a clinic. This is the most crucial point of the program, as the babies get a dose of nevirapine, an anti-retroviral drug (ARV), immediately after birth. Before New Incentives' program, delivery rates at the clinic were 20–30% (of women who register for ANC at the clinic). New Incentives has made several changes to its program to increase that rate to 54%, approximately double the baseline delivery rate, according to a small before-and-after assessment conducted by the Ministry of Health. Changes included using SMS reminders and reminder phone calls around the time of delivery to maintain communication with beneficiaries.

Data on retention

New Incentives calculates the retention rate for the second CCT (at delivery) and the third Early Infant Diagnostic (EID) CCT by looking at what portion of the women who enrolled have picked up the transfers. To calculate retention for the Delivery Transfer, New Incentives takes the following into account:

1) Enrollment status
2) Pregnancy status (specifically, whether women had a miscarriage)
3) Estimated delivery date (whether this has passed at the time of the calculation)

To calculate retention for the EID Transfer, New Incentives takes into account:

1) Enrollment status
2) Status of the baby (specifically, whether the baby is alive)
3) Whether the mother is six weeks past delivery (the soonest the EID test can be done)

New Incentives tracks how many women have met the conditions for the EID and delivery CCTs, as well as how many eligible women have not picked up these transfers. To determine its success at disbursing transfers once the transfer conditions have been satisfied, New Incentive measures:

1) The percentage of women who have delivered that have been assigned and confirmed receipt of their transfer.

2) The average number of days it takes to verify delivery and then reach the mother to assign her the transfer.

The above is used to determine whether or not New Incentives is maintaining its commitments to beneficiaries. This is largely determined by whether it is able to stay in contact through with beneficiaries through and after their pregnancy.

New Incentives tracks this information in its data management system (in Google Sheets).

Follow-up with women who drop out

To identify why some women drop out, New Incentives conducted a survey with about 40 women and followed up with 50–70 others as part of its routine efforts to reach women who have dropped out at some point in the process. The 40-woman survey was conducted with women who had not delivered in a clinic and whom New Incentives thought they could reach by phone. This information was gathered to provide supplemental background data quickly in preparation for the RCT; it was not collected in a rigorous way.

Reasons for dropping out

The primary reasons New Incentives has found for women to not get the delivery CCT are a widespread cultural norm of using local traditional birth attendants or delivering at church due to some pastors' claims that this protects babies from HIV. Other reasons include that women were unable to reach the clinic before the baby arrived, or that they believed they would not have time to travel to the clinic once they were ready to deliver. Many women were also reluctant to travel to a clinic if their water breaks at night. Distance to clinics may be a factor in these beliefs. Another major reason is that some pastors tell women that delivering in the church instead of a clinic will protect themselves and their babies from HIV. Women who deliver in a church bring gifts for the pastor or church.

Follow-up procedure

New Incentives tries to follow up with all enrollees of its PMTCT program, regardless of whether they received the delivery CCT, to learn whether they delivered successfully, whether they understood the program structure, who may have influenced their decision on where to deliver, and what they did with the first CCT if they received it.

This procedure is time-consuming; New Incentives decided not to do this for ARP beneficiaries.

Other program updates

Pre-delivery CCT

To help improve retention rates, New Incentives has also introduced a second CCT between the initial CCT and the delivery CCT because of the long gap between the two, especially for women who enroll early in their pregnancy. The second CCT

(about 6,000 Naira, or $30) both reassures women that more money is forthcoming and helps them cover some costs of delivery.

Women receive the second CCT if they pick up ARVs at least once after registering for antenatal care (ANC) and enrolling in New Incentives' program. Women who register for ANC prior to the six-month mark of their pregnancy receive the second transfer six weeks before their expected delivery date. Women who register for ANC after the six-month mark receive the second transfer four weeks prior to the expected delivery date. This schedule is designed so that the second CCT does not come too close to the delivery CCT and weaken the cash incentive for delivering in a clinic.

Early infant diagnosis (EID) test results

New Incentives has begun tracking EID test results for infants. So far, it has recorded results for 50 infants, all of whom have tested HIV-negative, although a small percentage could still become infected during breastfeeding. The Akwa Ibom government has hired a staff member dedicated to EID to help speed up processing times for EID tests. New Incentives believes that its conversations with the Ministry of Health about persistent delays might have contributed to this decision.

Nurses' strike

A nurses' strike recently occurred at teaching hospitals across Nigeria, but as New Incentives does not work with those facilities, this has not affected the program. Otherwise, there have been no healthcare workers' strikes in Nigeria following the one in January 2015 before the Presidential elections.

Plans for scaling

Efforts to increase enrollment in PMTCT program

New Incentives' ratio of administrative costs to CCTs given is currently very high, with about 40% of the budget dedicated for CCTs. This is largely due to challenges with scaling the PMTCT program. Because HIV-positive pregnant women make up a small percentage of the population in Akwa Ibom state (approximately 10%), reaching New Incentives' enrollment target has been difficult. New Incentives has understood this for approximately the last year, but has recently obtained better data from clinics that has helped it assess the potential for scaling its PMTCT program.

Population of HIV-positive pregnant women

New Incentives gathered clinical data for 14 out of Nigeria's 36 states. From this data, New Incentives identified the clinics that served at least six HIV-positive pregnant women per week, as the organization needs to serve a minimum of six women at a clinic to warrant the cost of sending a field officer there to enroll them. Out of the states studied, only four clinics (across four states, one in each state) meet this criterion. New Incentives has thus determined that the number of HIV-positive pregnant women served in these states is much lower than it expected.

Testing of monthly enrollment target

Before considering a weekly enrollment target, New Incentives experimented with a monthly enrollment model. At three clinics, New Incentives tested a model by which HIV-positive women who came to register for ANC were automatically given a date to return and enroll in New Incentives' program on a monthly enrollment day. Nurses at the clinics promise the women 1,000 Naira immediately upon enrollment and up to 30,000 Naira over the course of their pregnancy. However, this has resulted in very few enrollments; at one clinic, a nurse gave out 17 referrals for enrollment in one month, and only two of those women enrolled. This underscores New Incentives' conclusion that the promise of future money is not enough of an incentive for women to return.

Partnerships with other organizations

In another effort to increase enrollment, New Incentives has partnered with other non-governmental organizations (NGOs) that conduct village-level HIV testing. After testing, these NGOs send HIV-positive pregnant women to the clinic, and New Incentives pays the NGO workers a referral bonus of 500 Naira for each woman referred. This has produced good results, but the HIV testing campaigns are too infrequent to be reliable ways of increasing enrollment.

Combined at-risk pregnancy/PMTCT program

Based on the research discussed above, New Incentives has concluded that it is not feasible to scale its program if it continues to focus exclusively on PMTCT. However, if it expands its program to target all women with at-risk pregnancies (ARPs), whether HIV-positive or -negative, it can work in more states and work in smaller clinics that see fewer HIV-positive women.

New Incentives believes it is not feasible to simultaneously operate separate PMTCT and ARP programs. New Incentives has concluded that it would be more effective to set up a single program that serves both HIV-positive and -negative women. New Incentives is now conducting a pilot of this combined program. Of the nine clinics where New Incentives works, all but the three (where the RCT is ongoing) will be transitioned to the combined program.

Advantages of combined program

Expanding to target all ARPs makes New Incentives' work both operationally easier and more scalable. New Incentives expects to eventually reach 430 women per week. A combined program also carries lower risk of stigma for beneficiaries, as New Incentives has found that some women refuse to participate in the PMTCT program because of its association with HIV.

Features of combined program

The combined program retains many features of the original PMTCT program. For example, HIV-positive women are still randomly retested, and women are randomly retested to confirm they are pregnant.

Target enrollment number

For the combined program, New Incentives aims to enroll a minimum of six women per clinic, per week. With the effort that New Incentives now expends to enroll two women per clinic per week, it could enroll six to eight, as a combined PMTCT/ARP program will provide a larger pool of women to draw from.

Percentage of HIV-positive beneficiaries

Of the women New Incentives would target with the combined PMTCT/ARP program, an estimated 25.8% are HIV-positive. This estimate is based on data from major clinics with PMTCT programs in several states. The 25.8% estimate is reliable, as it is based on data gathered directly from the clinics as opposed to projections from federal agencies and global institutions.

Selection of HIV-negative beneficiaries

The combined program would enroll only one-third of HIV-negative women in order to avoid increasing the number of women delivering in clinics above what the clinics can handle, and to allow for randomization in the selection of women for the program.

Selection is conducted by entering the names of women who exhibit risk factors into a randomization app. The field officer conducting the enrollment does not know who will be selected. The names are given to New Incentives by nurses, and after the randomization, New Incentives tells the nurses who have been selected. In this way, New Incentives does not interact with the women in the pool, and ideally, women who are not selected will not know of the program. However, if women learn afterward that someone they know has been selected, New Incentives explains that the selection process is a random lottery. This is intended to help avoid disappointment among women who would like to enroll but were not selected. Randomization also reduces the ability for nurses to game the system, such as by asking for bribes to ensure that women are identified as at-risk and therefore enrolled in the program. The lottery approach is commonly used in such settings and well-understood by recipients.

EID CCT

In addition, only HIV-positive women will receive an EID CCT after delivery (3 cash transfers in total); for HIV-negative women, the program would end after the delivery CCT (2 cash transfers in total).

Bed net distribution

Along with incentives for facility delivery, women will also be given bed nets during clinic visits. New Incentives is close to reaching an agreement with the NGO TAMTAM to supply 300 nets. Distributing bed nets to beneficiaries will be part of a pilot program that could be expanded if successful. In the meantime, nets are not distributed as part of the program.

Potential for expansion in Anambra state

New Incentives has found that Anambra state, where it plans to roll out its combined program, has a significantly higher number of ARPs than HIV-positive pregnant women. New Incentives has targeted Anambra for expansion because it has the highest number of HIV-positive pregnant women, because of its proximity to Akwa Ibom, and because FHI 360, New Incentives' partner in Akwa Ibom, has clinics there.

Cost-effectiveness of encouraging facility delivery

The Copenhagen Consensus Center and *The Lancet* have both recently stated that neonatal mortality continues to be a key health challenge, and that increasing the number of babies delivered in clinics can mitigate this problem cost-effectively. New Incentives has confirmed this in its own calculations, but would like external validation of these statements, acknowledging that numbers can be overstated.

New Incentives has two cost-effectiveness analyses, one for the PMTCT program and one for the interventions targeting ARPs only.

Data collection and analysis

New Incentives' systems now allow it to see data in real time, making it clear immediately when incorrect beneficiary data is entered or an entry is incorrectly formatted. New Incentives can thus constantly monitor its field staff's performance and program success.

Beneficiary data set

New Incentives has added new questions to its survey of program beneficiaries. For example, it previously asked questions about the materials their houses were made from. However, New Incentives found that, in Akwa Ibom, housing material is not necessarily an accurate proxy means test for poverty, as many people inherit their houses from grandparents. Questions on the type of stove potential beneficiaries use and when they last repaired their roofs have been added to the survey.

CCT distribution process and record of CCTs

New Incentives collects data on beneficiaries at clinics through a mobile data collection app, which is integrated into its Google Sheets-based data management system at approximately 10 p.m. every night. The next day, the beneficiaries can call New Incentives' hotline to arrange for their CCTs. If the beneficiary has access to a phone and knows she will be able to visit a bank immediately, New Incentives either sends the cash token code via SMS or reads the code over the phone. The beneficiary then takes the code to the bank, gets the cash, and calls New Incentives to report the amount of the transfer and any problems experienced. New Incentives then records the amount successfully received. The data often shows a several thousand dollar difference between the total of CCTs assigned and the total that has been confirmed by beneficiaries due to the lag in getting reports from beneficiaries or the lag from

beneficiaries waiting to go to the bank until they are feeling well (since they are pregnant and a certain percentage are HIV-positive).

New Incentives also records errors it has made with past CCTs. For instance, in 2014, several women were accidentally given the same CCT twice due to the lack of a centralized system for distributing the transfers. Different field officers would consult different spreadsheets to check beneficiary data before initiating CCTs. On some occasions last year, when a field officer was sick, another person managed the hotline and issued the transfer. The officer then returned and issued another transfer for the same beneficiary, resulting in five duplicate first CCTs and three duplicate delivery CCTs. Since then, New Incentives has adopted a single system that integrates all data about each beneficiary and the CCTs they have received to date.

Staffing update

New hires

New Incentives has hired a local field manager, who oversees the field officers who enroll beneficiaries. The manager is performing well, but will require further training. New Incentives has also hired a relationship officer to manage the program's call hotline. Adding the relationship manager has sped up the process of verifying women's delivery status and distributing CCTs.

Staff capacity and needs

New Incentives has determined that each of its field officers has the capacity to handle enrollment at four clinics, and each relationship officer can handle the number of enrollments generated by two field officers. The model is based on the PMTCT program currently being delivered. The PMTCT program is more complicated and needs more staff time per participant than the combined ARP program.

In the next few weeks, New Incentives will work to transition five of its clinics to the new combined ARP program (one of its clinics is already using the combined program; the other three are participating in the RCT). It then plans to expand to three new clinics in Akwa Ibom and to 3–4 clinics in Anambra. New Incentives will need to hire one more relationship officer and one field officer to handle enrollments in Anambra. New Incentives will also recruit a part-time volunteer, likely someone who already volunteers at a health facility, to conduct data collection once a week at some of the smaller clinics in Akwa Ibom.

Recruitment

Mrs. Janumpalli has been in Nigeria for all recruitment so far, but may not be there when the next field officer is recruited. New Incentives typically posts ads online for its open positions. Most of its candidates so far have come from FHI 360, which relies heavily on volunteers and refers them to New Incentives for full-time jobs.

Recruiting has been challenging for New Incentives. So far New Incentives has worked closely with FHI 360, and the few non–FHI 360 employees it has recruited

were at least partially trained. In other states, the available pool of candidates may have less training, therefore presenting some challenges. Recruiting talented staff can also be difficult for New Incentives, as it cannot offer the same compensation level as FHI 360 or other implementing organizations.

FHI 360 tends to pay small base salaries and offer incentives for each time employees visit the field; in contrast, New Incentives incorporates field visits into employees' job descriptions and offers a higher base salary, which most of their staff are not accustomed to. New Incentives also offers greater responsibility for its staff and longer-term contracts, encouraging a more permanent working relationship.

Because the work carried out by field officers is fairly routine, maintaining motivation among highly talented employees in this role might also be a challenge. New Incentives notes that job development measures have been initiated.

Senior management

Mrs. Janumpalli now plans to work in Nigeria for one month out of every three, although this may change according to needs of the organization. Mr. Stadler will also travel to the field periodically during the year.

RCT update

The RCT is ongoing at three clinics, which are offering only the PMTCT program and will not shift to the combined program. The RCT is meant to measure the effect of CCTs on retention in PMTCT.

As New Incentives is a small organization, the preparations required for the RCT, including restructuring interactions with beneficiaries, codifying procedures, and revising data collection instruments, were challenging. However, New Incentives now has standardized procedures to determine if a woman miscarries or dies in childbirth, or if her newborn dies. New Incentives is also investigating potential negative impacts of its program, such as whether women struggle to pay hospital bills as a result of facility delivery and how they pay those bills.

The research team carrying out the RCT is now drafting a pre-analysis plan, which New Incentives hopes to publish on clinicaltrials.gov website or on its own site before the team starts collecting data on deliveries in the control group.

Timeline

Data collection for the RCT officially began on August 3, although New Incentives had started testing RCT procedures in clinics about two months prior. The timing of the midline results will depend largely on when women deliver, but New Incentives expects to have collected a useful amount of midline data from both the treatment and the control groups sometime in spring to summer 2016.

Midline and endline data

Both midline and endline data will measure facility delivery rates and EID test completion.

Phone survey

The endline survey results will also include results of a phone survey of women who have and have not completed the program. This survey includes questions on topics like:

- Demographic data
- Why women did not delivery and/or complete the EID test
- What barriers might have prevented them from completing the condition and who influenced their decisions
- Whether the current cash amounts of the CCTs are appropriate
- Whether adjusting the CCT amounts would result in behavior change

The survey focuses primarily on whether the beneficiaries know that they received the cash and where it came from, and what factors influenced their decision to get it or not.

New Incentives' in-country staff will conduct the survey. The research team has agreed that if these staff members are trained and use a specified protocol, there is no need to hire an outside party. This survey will begin in early October 2015.

Applicability of RCT results to combined ARP/PMTCT model

Past RCTs studying CCTs for maternal health have found that incentives do increase rates of facility delivery. New Incentives expects its RCT to provide information on whether CCTs are an effective incentive for HIV-positive pregnant women. It is also expected to determine whether CCTs are an effective way to encourage EID, which will inform New Incentives' decision of whether to continue that aspect of the program. Fewer HIV-positive women deliver in a facility than women without HIV.

The RCT is also studying whether giving women the second, pre-delivery CCT increases the likelihood of facility delivery. This will inform whether New Incentives decides to incorporate this CCT into its combined program. Adding it will make the program more complicated and therefore more difficult to scale.

Financial update

New Incentives has been focused on scaling the program and has not prioritized fundraising. It currently has enough funding (about $360,000) to scale to its targeted clinics and operate until the beginning of 2016.

So far in 2015, New Incentives has spent about $41,000 on operations, $38,000 on CCTs, and $23,000 on the RCT. Before the end of the year, New Incentives expects to receive the rest of a $20,000 grant from the Swiss Embassy in Abuja, as well as some small online donations. New Incentives may also apply for funding from the Global Innovation Fund (GIF) at the end of 2015 or early 2016. However, New Incentives prefers to focus on distributing CCTs while it has adequate funding to do so. Currently it does not plan to pursue funding from sources other than GIF, although it may occasionally participate in funding competitions or challenges.

Reasons for deprioritizing fundraising

New Incentives decided to deprioritize fundraising in part because it realized it had overestimated its capacity. New Incentives also underestimated the amount of effort adjustments to the RCT design would require. Its Institutional Review Board application to University of California, San Francisco also proved time-consuming.

Once New Incentives reaches its target volume of enrollees, it will be able to identify more clearly what it wants to fund, how its funding will be spent, its timeline for spending, and its staffing needs.

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