

## **A conversation with New Incentives and the Lampert Family Foundation, February 5, 2016**

### **Participants**

- Svetha Janumpalli – CEO and Founder, New Incentives
- Patrick Stadler – Chief Strategy Officer, New Incentives
- Katherine Clements – Director, Lampert Family Foundation
- Milan Griffes – Research Analyst, GiveWell
- Natalie Crispin – Senior Research Analyst, GiveWell

**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 as part of a follow-up on experimental seed grants that New Incentives (NI) received from GiveWell and the Lampert Family Foundation. Conversation topics included New Incentives' programs, major updates and challenges in 2015, staff, room for more funding, and capacity for growth.

### **New Incentives' programs**

NI's program previously operated in seven clinics in Nigeria; the program focused on the prevention of mother-to-child transmission (PMTCT) of human immunodeficiency virus (HIV). NI's program at four of these clinics has transitioned into a combined at-risk pregnancy (ARP) and PMTCT program, serving pregnant women who have HIV along with women with other risk factors (including anemia, hepatitis, old age, young age, tuberculosis, and previous non-facility births).

The remaining three clinics where NI's PMTCT-only program operates are currently participating in a randomized controlled trial (RCT) of the PMTCT program.

### **PMTCT program**

*NI's focus on transmission at delivery*

New Incentives prioritizes interventions that prevent HIV transmission at delivery, because this is typically the highest point of transmission. New Incentives may eventually increase its program's emphasis on preventing transmission after birth (e.g. preventing transmission via breastfeeding).

*HIV+ treatment in Nigeria*

In Nigeria, people with HIV receive treatment based on their CD4 count and the World Health Organization's (WHO) clinical stages of HIV. If a person has a high CD4 count and is in clinical stage 1 or 2, they are placed on "pre-antiretroviral therapy",

which typically consists of receiving a drug called Cotrim that prevents opportunistic infection. They are not given antiretroviral drugs.

If the person has a low CD4 count and is in clinical stage 3 or 4, they are placed on antiretroviral therapy, which consists of a triple prophylactic regimen. This regimen is standardized across Nigeria and does not vary by clinic.

#### *Mother's antiretroviral regimen*

All women who are HIV-positive during their first antenatal care (ANC) visit are immediately placed on triple prophylaxis (including those who newly test positive during the visit). This is for the health of the baby and irrespective of the mother's CD4 count. This is based on national guidelines and can occur as early as 14 weeks gestation.

Nigerian HIV+ women who were not previously taking antiretroviral drugs begin taking an antiretroviral triple prophylactic regimen consisting of tenofovir, lamivudine, and efavirenz, which is supplemented with Cotrim in the second trimester. All HIV+, pregnant women in Nigeria who are getting antenatal care are placed on this regimen at some point during their pregnancy, regardless of whether they are enrolled in NI's program.

HIV+ women who were already taking antiretroviral drugs before pregnancy continue on the same regimen during their pregnancy. Women who enroll in NI's program are not asked whether they are currently taking antiretroviral drugs, but they are reminded to take their drugs.

Enrollees are encouraged to pick up antiretroviral drugs from the clinics during their pregnancies. Most of the clinics have an HIV counselor who has the participants' phone numbers. This counselor follows up with each woman by phone and sometimes does community outreach.

Women are no longer given nevirapine at delivery – it's no longer necessary now that all women are prescribed triple prophylaxis during pregnancy. In addition, nevirapine was found to be unsuitable for women who are co-infected (e.g. who have both tuberculosis and HIV). The only women who still receive nevirapine receive it because it's part of their triple prophylaxis (in rare cases).

#### *Infant's regimen*

To prevent transmission, all infants born in clinics receive a dose of nevirapine within 48 hours of birth, and mothers are given a six-week supply of nevirapine to take home and administer to their babies daily. At the six-week check-up, mothers who are not taking ARVs receive an additional supply of nevirapine, and are advised to continue giving it to their child for the duration of breastfeeding. Mothers can pick up nevirapine free of charge at the clinics for as long as needed. Mothers who

are taking ARVs do not need to continue administering nevirapine after 6 weeks postpartum.

NI estimates that approximately 20% of MTCT occurs via breastfeeding.

New Incentives can verify that the first dose of nevirapine was given by looking at the clinic registers when it verifies that delivery occurred at a clinic. If it is not documented in the registers, the NI field officer asks the clinic nurse questions to figure out if the nevirapine was administered.

Often the nurses give nevirapine to the infants from a bottle that's used for all infants in the ward, and the mother is given a separate bottle to take home. In other cases, nevirapine is administered by the mother while monitored by the nurse. Mothers usually stay at the clinic one or two days after delivery to recover; a lot of effort goes into making sure the baby receives their first dose of nevirapine.

When the mother calls the hotline after delivery to receive her second CCT, she is asked whether she took the nevirapine bottle home. Women do not seem reluctant to give their babies nevirapine because there is not a high level of stigma associated with it and it has few side effects.

### *Education*

Before the mother leaves the clinic after delivery, a nurse and counselor explain the importance of giving the baby nevirapine, and NI staff reinforce this message. New Incentives does not verify that this educational component has occurred. NI believes it is taking place, based on its observations in the clinics.

Beneficiaries are asked about whether they understand the program, but are not asked if they understand the reasoning behind different elements of the process. During the enrollment interview, field officers discuss the importance of advice from nurses and the education provided during the mother's first ANC visit.

### *Ensuring adequate supply of drugs*

The main problem that could arise to disrupt implementation of the standardized drug regimens would be the lack of consistent drug supply. In order to ensure adequate supply, New Incentives conducts an assessment of all potential new clinic sites using a list of questions compiled by a doctor to determine whether the site's supply side structure can support the program. New Incentives prefers to work in clinics that are partnered with a major implementing partner (e.g. FHI 360) or a global sponsor. It also keeps close track of each clinic's antenatal care ward to ensure that drugs are prescribed and administered appropriately.

### **Randomized controlled trial (RCT)**

Because one of the main goals of the PMTCT program is to increase utilization of critical clinic services, the RCT primarily tracks the percentage of women in the treatment and control groups who deliver in the clinic and who have an early infant diagnosis (EID) test done. All women will be contacted by phone to take part in an endline survey that aims to answer questions including how many women in the control group did not deliver in the clinic, where they did deliver, and who influenced that decision.

To date, 290 participants have been enrolled in the RCT (500 is the target enrollment). The rest of the participants are projected to be enrolled by September, and results for at least 350 women should be available by October (midline results will be available in June). Final results are expected to be published by the spring or summer of 2017.

### **ARP program**

The ARP program incentivizes facility delivery for women with high-risk pregnancies, thereby giving them access to a standard range of mortality-reducing interventions for high-risk pregnancies, as well as case-specific treatment to women with risk factors at the clinic. In other words, for enrollees the only condition to receive the cash transfer is facility delivery. This does not vary based on each participant's condition.

#### *Evaluating impact*

New Incentives does not currently plan to conduct an RCT on its ARP program. This is because the medical interventions it incentivizes have proven to be effective in studies of other programs, and because NI seems to have a good rate of retention and the supply-side appears to be high quality. As NI scales up the program, it may attempt to evaluate impact by:

- Lowering the randomization rate (which is currently 80-90%) at some clinics and studying health behaviors among women in the control group (e.g. the group that was not randomly selected for program participation).
- Using patient records to compare treatment outcomes for women with different at-risk conditions who are currently participating in the program to outcomes for patients last year who did not participate.

### **Collecting information about how CCTs are used**

When enrollees in either the ARP/PMTCT program or the RCT collect their first cash transfer, they are asked what they plan to do with the money. When they collect the second transfer, they are asked how they spent the first transfer. NI elected to use self-reported data to avoid the costs and logistical difficulties associated with visiting each woman's home to verify her claims about how she spent the money, as

well as to avoid outing enrollees' participation in the program as there is significant stigma associated with being HIV+.

#### *Main differences between RCT and ARP/PMTCT clinics*

ARP/PMTCT clinics tend to be smaller and more rural, and enrollees tend to be poorer. There are fewer logistical difficulties involved in visiting the homes of women in this program because many of the enrollees live in the immediate area, and they may be more willing to disclose their addresses than RCT participants. ARP/PMTCT clinics have a lower baseline delivery rate than RCT clinics.

The RCT clinics are more urban and attract enrollees from all areas of the state. This creates a logistical barrier to visiting women in their homes. Two of the RCT clinics serve comparatively wealthier women who tend to be more skeptical about the program and sometimes refuse to enroll because they are concerned about stigma and have less need for the money.

#### **Rate of program refusal**

Data on the proportion of women invited to enroll in the ARP/PMTCT program who do and do not accept the offer are carefully tracked and collected on every enrollment day at all clinics. Delivery and EID data is collected on the women who refused to participate during the RCT.

#### **Major NI program updates from 2015**

In 2015, New Incentives:

- Successfully piloted and expanded its ARP program. It identified some benefits of combining ARP programs with its existing HIV programs, which include reducing stigma for HIV-positive women and attracting women in surrounding villages to register for antenatal care for the first time.
- Streamlined its model, which has enabled it to reduce enrollment time and learn more about the scalability of the model.
- Increased and stabilized collection rates of the first CCT above 90%.
- Increased the percentage of enrollees who deliver in a clinic to about 50%.
- Increased enrollment from 10-20 women per week to 80 women per week.
- Grew its team (including field staff) from 3 employees to 9.
- Piloted a bed net distribution program at two of its clinics (in partnership with TAMTAM). New Incentives received 300 bed nets to distribute. There was concern that distributing bed nets to beneficiaries would make enrollment in the NI program more conspicuous and more prone to stigma, but initial feedback has been positive.

#### **Major challenges in 2015**

##### **Service outage**

The biggest challenge that New Incentives encountered in 2015 was an ATM service outage at its banking partner, which prevented women from redeeming their tokens at ATMs between September 21 and October 27. This significantly reduced New Incentives' collection rate for the first transfer, caused many women to make several trips to the bank to redeem their tokens, and upset many beneficiaries. New Incentives concluded that it cannot rely exclusively on ATM functionality to conduct its transfers.

Many of the women who had trouble getting their CCTs during this period did eventually receive them, but some lost trust in New Incentives and became discouraged and stopped trying to get their CCTs. Despite difficulties due to the service outage, New Incentives' overall first-transfer collection rate in its ARP program was 92% as of February 2016.

#### *Cause of the outage*

The service outage resulted from bugs in the banking system that were created when NI's banking partner pushed new code without good quality assurance. A bug prevented women from redeeming their tokens by inadvertently changing their status on the backend from "redeemed" to "invalid."

#### *Becoming aware of the service outage*

New Incentives became aware of the service outage 10 days after it began. The delay was due in part to the fact that it had not been conducting regular status checks. Women were reporting problems with the ATMs, but because the timing coincided with a national holiday and because it is not uncommon for the network to go down for short periods of time, it seemed unlikely that the outages were indicative of a larger problem. When it became clear that reports were coming from several different branches, New Incentives realized that the network was down across the country.

#### *Response*

New Incentives took several steps in response to the service outage:

- Given that this issue seems likely to recur, New Incentives lobbied for a backup system in which banking agents are stationed at branches near the clinics so that they can disburse CCTs when ATMs are not functioning. The banking representatives whom New Incentives approached about situating agents in these branches initially believed that agents were already present, and it was difficult to convince them otherwise. However, NI ultimately succeeded in convincing its banking partner to situate agents in its branches.
- NI is working to strengthen its relationship with its banking partner's headquarters staff to ensure that similar problems are reported in the future.

- New Incentives' relationship officers have begun soliciting daily status updates from its banking partner in order to identify service outages quickly and to avoid unknowingly sending women to ATMs that are out of service. If NI reports a service outage to its banking partner, the partner's headquarters staff will contact a regional manager to follow up with the branch and ensure that an agent is on duty, because it is a high priority for the partner to ensure that its agents are present in the banks.
- NI is beginning to explore other mobile money systems to complement its current partner.

Given that the ATM redemption function tends to stop working for a few hours each week, it will be important to continue daily status checks to ensure that women are always able to redeem their tokens either at an ATM or in a bank.

### *Remaining problems*

In fewer than 1% of cases, women claim that they were unable to receive their CCTs because their tokens were deemed invalid. New Incentives is working with its banking partner to develop a system to identify which tokens have been deemed invalid as a result of a service outage and which are invalid because they have already been redeemed.

### **Accidental termination of nonprofit status**

Another major challenge in 2015 was that NI's nonprofit tax-exempt status was accidentally lost due to an error at the Internal Revenue Service (IRS). NI was able to quickly prove that it was up-to-date on the required filing. Its nonprofit status was reactivated retroactively to the date when it was lost, so there was no gap in New Incentives' tax-exempt status.

### **New Incentives staff**

NI's management team consists of Ms. Janumpalli and Mr. Stadler, who is currently a volunteer but will begin working full-time in the coming months.

New Incentives has a nine-member field staff which includes seven staff in Akwa Ibom and one field officer in each of two other states. The Akwa Ibom staff includes:

- A field manager who manages field expenses, logistics, field expansion efforts, and relationships with other implementing partners.
- Two senior field officers who conduct enrollments at RCT sites. One manages field volunteers and the other manages relationship officers.
- Two paid field volunteers who enroll women at the clinic and work about three days out of five. It was necessary to hire two people to work part-time rather than one person to work full-time because many of the clinic

enrollment days overlap. New Incentives is currently looking to recruit a third field volunteer.

- Two relationship officers who have many tasks, including:
  - Operating the hotline through which NI disburses cash transfers and confirms collection.
  - Helping maintain NI's relationship with its banking partner (including ensuring that ATMs are functioning and that banking agents are present at NI partner banks).

The two field officers in other states enroll women at clinics and operate a hotline. The hotline for these states cannot be managed by Akwa Ibom staff due to language differences.

### **Room for more funding**

In 2015, New Incentives had funding that enabled it to focus on growing and piloting new programs, so further fundraising was not a high priority. In 2016, it has a significant funding gap.

NI has sought funding from Jasmine Social Investments, SV Angel, and Echoing Green.

### **Rate of growth**

Overall, NI currently enrolls about 80 women per week. With sufficient funding, NI could increase this to 130 women per week by July and to 175 women per week by December 2016.

### **Funding gap**

New Incentives expects to need \$867,000 for its programs in 2016, which would include \$570,000 for CCTs and \$295,000 for administrative expenses. It currently has \$127,000 cash on hand to allocate to its programs, and is slated to run out of funding at the end of March or beginning of April. To cover its operations from April to December 2016, NI has an approximate funding gap of \$705,000.

New Incentives has \$70,000 remaining for the RCT. The RCT is fully funded and will not be affected by the program funding gap.

### **Administrative expenses**

Current spending includes about \$3,000 per week in administrative expenses. This will increase when Mr. Stadler's begins working full-time as a paid employee.

Field costs are projected to increase by \$450 per week for every additional 50 women enrolled per week. This would account for expenses including: hiring a full-time relationship officer, two field officers, and a part-time field manager; field transportation; and office phone and internet.

New Incentives would ideally like increase its administrative budget to cover unforeseen expenses (e.g. a bigger office, better internet, better transportation).

### **Creating a costing model**

New Incentives would like to develop a more accurate costing model in order to better estimate both the resources needed to scale its programs to about five more states in Nigeria, which would involve growing its technology systems to handle three times the current level of enrollment. Developing this model is one of NI's goals for 2016.

### **Consequences of not filling the funding gap**

If NI is not able to raise enough funding to fill the funding gap, it would slow expansion and prioritize the clinics it currently operates in. NI would go forward with negotiations with the government concerning new programs in a fourth and fifth state, but would not yet begin working in those states.

If further cuts were necessary, New Incentives would slow enrollment of new women at current sites. New Incentives has enough cash on hand to cover its current commitments to women who are already enrolled.

If New Incentives receives less funding than required to operate at all current sites, it will need to slow enrollment at clinics, and in the worst case close down its most recently activated sites in order to preserve its older ones. It is important to prioritize older clinics because it takes time to gain credibility within a community. Women may not immediately trust that the CCTs will actually be disbursed, but after seeing other women receive the money, they are more likely to enroll in the program. These older clinics are also where we have seen the biggest changes in delivery behaviors so far, which is our key metric.

### **Partner clinics' capacity for growth**

One of the senior field officers is going to begin spending one day per week visiting each clinic and assessing whether all clinics have the capacity to absorb an increase in enrollment. Nurses in the antenatal care and labor wards will be asked whether there is sufficient staff capacity and whether there will continue to be an adequate supply of drugs if enrollment increases. The officer will also observe possible effects of NI's program on neighboring clinics.

If this work raised concerns about capacity, NI would report the concern to the ministry of health immediately and work to find a solution. If, for instance, there were not enough night shift nurses, New Incentives would both work with the clinic to appoint someone to the task temporarily and reduce the randomization rate in enrollment. It seems unlikely that capacity will be a problem because the clinics are currently underutilized. NI's programs have not come close to reaching capacity in terms of either supply of drugs or nursing staff.

Before opening a program at a new clinic, NI conducts a clinic assessment to learn how many nurses it employs, what implementing partners it works with, and whether it has enough drugs and other necessary supplies for an increase in enrollment. NI conducts regular clinic audits for the duration of the program.

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