New Incentives Key Updates – June to August 2014:

1. **Electronic Transfers:** We have completed the transition from physical to electronic payments. Now all of the transfers are given via the bank. So far, these transfers are working well. The electronic transfers are done through X Bank [name redacted], a widespread bank in Nigeria, which offers a service called "X Bank Cash Tokens." We manually process each token through a mobile app. Each token is 12 digits. To get the cash, a woman must have the correct token number, 5-digit PIN, and phone number. This system works as follows:
    a. We issue the first 8 digits, PIN code, and phone number when we enroll women at the clinic and interview her.
    b. She calls the next morning to get the remaining 4 digits so that she can go to the bank to receive the funds. Waiting until the next morning enables us to check all clinic records before we give the cash transfer. It also ensures that nurses and do not have access to the full code.
    c. The funds can either be withdrawn from the ATM or inside the bank – every woman so far has needed help to receive the funds and gets help from a bank agent or a bank security guard. So far, there have been no issues related to this procedure. We were worried about literacy issues and to deal with this, we have developed small program cards that has instructions on the top that the women can show a banker in case they don't know how to ask for the right bank service.
    d. Successes:
        i. Women who were afraid of banks, never entered them before, and live in rural areas are able to go to a bank and collect their payment.
        ii. We ask how much women collected immediately after their trip to the bank and so far, haven't learned of any bribes and feel this is not an issue based on our conversations with multiple bank staff. We will always continue to monitor this issue.
        iii. The bank is supportive of helping this demographic of women.
    e. Challenges: We manually generate each code. Eventually, we will need backend access to generate the codes in bulk online. We will initiate discussions with X Bank headquarters this fall to try to get this access. One big issue is that out of 58 codes given, 3 were invalid and failed. In these cases, women had to call back and get a new code. We need to figure out how to deal with these cases. Right now, what we do is try to redeem the code ourselves before giving a new code so that we prevent a situation where women call pretending that a code didn't work just to get a second one. This works on a small scale but will be difficult for hundreds of beneficiaries. We also have to manually get refunds for these codes. In the future, we will need to have a close relationship with a member of the X Bank tech team so they can easily

process refunds.

2. **Local Field Team:** We have hired two field workers and learned a lot in the hiring process about how to best recruit people in partnership with the Ministry of Health. We ended up with two very qualified candidates who will be starting on September 3. They were both volunteers for the largest NGO focused on PMTCT in the state, FHI 360, which maintains supply of PMTCT commodities in all clinics in the state. They are versed in data collection and PMTCT, which makes them a great fit. Also, FHI 360 is surprisingly very supportive of our program and was fine with us hiring their volunteers. One reason is that their supply-side program will benefit from our demand-side intervention.

3. **Fraud Protection Mechanisms:** We have started using biometric face recognition to ensure that 1) the same beneficiary does not enroll at multiple clinics to qualify for multiple cash transfers (a big problem in the government cash transfer program), and 2) limit program participation to once per beneficiary per lifetime to avoid incentivizing additional pregnancies. Face recognition outperforms other biometric solutions such as fingerprints because it has low hardware costs (no hardware is needed other than a mobile phone) and it is easy to use.

   Face recognition is working well. The app, made by the British company Skotkonung, can be used offline and in low light settings (useful in clinics with little public power). One issue with face recognition is that we have received pushback from beneficiaries about taking photos because of the stigma associated with HIV. We have improved a lot week-to-week regarding this issue. We have learned how to better explain the need for photographs and better understand women's fears about photos – they fear being published in a local newspaper or on TV because several scams in the state do this. Therefore, we put more emphasis on explaining that photos will be kept confidential, that we have a system in place with the Ministry which provides the necessary oversight including reviewing data collected as well as other protections.

   We are constantly learning how to balance the need to explain the program and provide handout materials that properly explain each step of the program with the need to be discrete about a woman's HIV status because her family members might not know. We experienced one case where a woman's husband found her program card and threatened to throw her out of the house because he feared that we would come to kill her or ask her to pay it back with high interest. This wasn't an issue related to HIV but a general concern about how to ensure the money doesn't do any harm. We put steps in place to ensure that all information is destroyed if a woman changes her mind about participating in the program and offer to speak with family members to ensure the goals and agenda of the program are clear.

Furthermore, we removed all explicit references to HIV in our handout materials.

4. **Beneficiaries**: 56 beneficiaries are now enrolled in the program (one cancelled). We think of this as a small pilot where we learned a lot to inform future expansion of the program in additional clinics. For the 56 women, we collected data on a laptop in an Excel file. Attached is the Excel file that contains data collected from all enrolled beneficiaries to date. I can clean the file if it would be helpful. Please ignore any overly detailed internal notes that contain local language tips for wording certain questions, etc. Note that some beneficiaries who delivered have not been entered so only two beneficiaries have delivered in the hospital and qualified for transfer 2 according to the Excel file – we will be adding more on September 3.

   Also attached is data from the hospital where we are operating regarding delivery rates, HIV prevalence, and other key statistics from January 2013 to July 2014.

5. **Data Collection:** We have licensed and implemented a mobile app called doForms that will enable field workers to collect all data (including notes from interview questions at each stage of the program and photographs of hospital records) both online and offline. This will streamline our data collection process. It will also reduce costs and eliminate the need for laptops. Using a mobile data collection solution ensures we have a seamless cloud solution to pull data together across field staff and easily analyze data. We chose doForms because it is the most cost effective and flexible solution for our needs.

   Attached is the simplified version of the interview protocol which will be used with the doForms mobile application (spreadsheet titled "doForms Protocol"). With this version of the protocol, we will be able to analyze our data much better in the future. Many of the doForm response choices are multiple choice questions for easy analysis but the response choices are not in the protocol simply because the doForms downloadable Excel file does not include them.

6. **Ministry of Health:** We have developed a close working relationship with the Ministry of Health. They send a staff member on each day we go to clinics to ensure we are adhering to the agreements we set regarding which types of records we can document and the type of data we can collect. The presence of the Ministry has helped us make several improvements based on the local context. The Ministry takes our program seriously and has invited us to join all statewide meetings and research initiatives regarding PMTCT. This will help eventually get all the data we need on clinics and gives us the opportunity to actively promote our agenda.

7. **Legal Issues:** We completed registration of our local organization in Nigeria, which is called All Babies Are Equal (ABAE) Initiative. Registering the organization is a requirement for partnering directly with the Ministry of Health, hiring more than 5 employees, and opening a business bank account.

8. **Expansion Plans:** In September, we will expand to one more General Hospital that is located in the area that has the highest HIV prevalence in the state [name of hospital redacted]. We will then follow a 2-pronged expansion plan that allows us to test how to best scale the program statewide:

   Learning question and goal for future expansion: How do we scale the program in small, rural clinics with high need in a cost effective way that does not require a field worker to be present on every ANC registration day? Some clinics have 2-3 positive women each week and we want to be able to enroll these women as well. These clinics serve very low-income women and exhibit the smallest use rates.

   a. Expansion Experiment 1: Operate a "remote enrollment" model in one clinic whereby nurses enroll women in the program without our field worker present and report satisfaction of conditions over the phone. Based on the information provided by nurses, we will give the cash transfers. Our field worker will then conduct monthly clinic visits to check records and verify conditions. The field worker will also conduct a phone interview with every applicant before confirming enrollment in the program and continue to conduct random HIV retesting by scheduling appointments with about 10% of applicants.
   b. Operate a "pooled enrollment" model in one clinic where women who come in to register their pregnancy in one month and are HIV-positive are all asked to come back on the same day for their second visit the following month. On this day, we will enroll women in the program in person similar to how we do in the clinic we are currently working in.
   c. According to our current projections, by July 2015, we will have 1,053 beneficiaries.

9. **Outstanding Questions:**
   a. What is the number and size of clinics with reliable PMTCT supplies and low demand in Akwa Ibom (we have some preliminary data)? What is the maximum number of clinics we can work in the state? When will we need to start expanding outside of the state?
   b. How can we learn about the baseline rate of mother-to-child transmission of HIV at clinics seeing that many infants do not get tested?
   c. Is it best to continue growing a local organization and field team to expand the program or to partner and outsource the program to larger NGOs / the Government once we know the exact requirements and desired implementation of the program?

d. How do we best educate women about the conditions and next steps in the program while limiting stigma? For instance, we cannot fully explain the steps in the program in our materials because then women will fear to leave it in their house or share it with their husband or relatives. Other CCT programs are based on conditions that are easier to understand and remember, but how can we learn from them regarding this issue?
e. What type of women is the program working for?