“Our pharmacists can help scale something if it's streamlined”: Sisi Pan and Michael Nedelman of Maisha Meds on incentives, market shaping, and distributing reading glasses via pharmacies.

Ambika Samarthya-Howard

November 25, 2024

Ambika Samarthya-Howard: Can you both start by introducing your roles in the eyeglass work?

Sisi Pan: I'm the Chief Strategy Officer at Maisha Meds. I have a background in global health and management consulting. I used to work for CHAI, the Clinton Health Access Initiative, based in Southern Africa. Also, as a partner at the Boston Consulting Group, I helped open the Kenya office. As Chief Strategy Officer at Maisha Meds, I oversee a wonderful team that focuses on communications and advocacy, which Michael leads, government affairs, our incubation programs, as well as our data business and commercialization approaches. I think of each of us as ‘centres of excellence’ providing support functions to the broader organization, ensuring that we're flying the plane in the right direction and securing the funding to do so. Wintana from our team led the eyeglasses pilot in Kenya, and my role was more support and oversight.

Michael Nedelman: I’m a medical doctor by training and VP of communications and advocacy at Maisha Meds. My background includes quite a bit of public health, media, and broadcast journalism, in addition to medical. We are looking at a couple of important questions. One, what the private sector is already doing that we can help them do better, and two, what are untapped potential opportunities. It's the latter bucket

where our Vision Program sits. Sisi decides what makes sense for our strategy and how we oversee, implement, and follow through.

Ambika Samarthya-Howard: I have a few followup questions. What could the private sector be doing better? What is it about the work at Maisha Meds that informs your other work, and vice versa? How have the pilots gone this year around pricing and pricing performance?

 **Sisi Pan:** The word incentive can mean different things across our different countries and to different stakeholders and funders - and many may associate it with non-sustainable programs. By contrast, we've learned from many of our patient programs that if you structure incentives to be market shaping rather than market distorting, you can unlock patient and provider behavior at-scale that governments, funders, and researchers have been keen to see for a long time.

For example, learnings from our family planning program influenced the readers pilot. In our family planning randomized control trial a couple of years ago, we saw how we could shift patients away from purchasing emergency contraceptives–which is a big reason why people come to pharmacies–to purchase instead a longer-acting method that's ultimately more effective and cost-effective. We tested three approaches. What happens if you significantly discounted the price of the longer-acting method directly to the patient, in other words, a patient discount? What happens if you make that price even lower for the pharmacy, in other words, greater potential margin for the pharmacy? Also, what happens if you pay a very small counseling fee for the pharmacy attendant performing the care and making the sale at the last-mile, in other words, compensating for healthcare worker time? Which one would unlock the highest uptake of the longer-acting method?

 It was the third, compensating a pharmacist attendant's time. Sometimes what unlocks not only the uptake of the product, but also better quality counseling, is not necessarily what you think—and it's not always about giving things away for free or for cheap. We took this learning for the readers pilot.

 We also wanted to make sure we thought about pricing in a way that wasn't market-distorting, but rather market-shaping. Readers differ from family planning products, because patients already come to pharmacies to access the latter. This means it’s even more important to get the incentives right for the pharmacist to offer

that care, because it's more of a push product right now—until we can reach that inflection point in patient awareness and demand. We initially had a 300 shilling price point (a little less than $2.50). The belief with that is to not be market-distorting because there are other readers that are around that price. Then we found that actually a price of 150 shillings (around $1.10) is much more appropriate given the market shaping that needs to take place for patients to be aware of the benefits of readers. We kept the original price point in the Mombasa facilities and tested the lower price point in the Kisumu facilities.

Ambika Samarthya-Howard: That's the price point that the customer gets, right?

Sisi Pan: Yes, these were the price points to the patient at the point of sale.

 As for the pharmacies, we structured the price point so that the margins would be held constant. As we made these pricing changes, we also introduced that aforementioned learning from the family planning work—that is, we added a very small fee for the pharmacy attendant to provide the screening and then for dispensing reading glasses to those patients who needed them. Decoupling the screening action and the dispensing action sounds so obvious, but this was a big finding from the family planning work that we wanted to test here. Providing these modest sums also incentivizes the pharmacy attendant to take the time to log the screening and dispensing transaction into the Maisha Meds software. Taken together, as with family planning, it ended up being a big unlock in our vision work. Over six months, we screened over 7,000 patients and dispensed over 5,000 readers—primarily driven by the 150 shilling facilities.

This did not feel market-distorting, because this is how readers work in most parts of the world where they are demedicalized. In the U.S., you can 'screen' yourself by trying on readers of different powers available in a CVS before making your purchase, for instance. For higher power glasses, you have to pay for the vision exam and then the glasses. I think in regions where readers are not yet de-medicalized and market shaping for readers is needed, such as many parts of sub-Saharan Africa, patients see screening as a service to be provided from a professional, followed by the purchasing of the recommended health product as a related but separate transaction. As more patients become aware of the benefits of readers and can access them more easily, such as in pharmacies, there may be increased demand for future purchases including readers at higher price points.

Ambika Samarthya-Howard: Are you paying people for their time as an incentive to move the market?

 **Sisi Pan:** As mentioned above, we've discussed nomenclature extensively as a team. For example, we used to refer to our patient programs as "loyalty" – some of our engineering and operations team still call it "loyalty" though increasingly, and especially externally, we use the term "patient support programs." Internally, we think of "incentives" as a shorthand for anything that encourages a positive set of behaviors or discourages a negative set of behaviors. Incentives can be financial or non-financial, positive or negative.

What Maisha Meds is ultimately trying to build is something that looks and feels like health insurance for the hundreds of millions of uninsured patients today, many of whom prefer to access care in the private sector. This tends to include a patient discount (what you might think of as a co-pay), provider reimbursement for quality-assured care (service delivery and commodity provided), and a payor, which can be government, global health funder, or other. We hope to move the market towards transparent outcomes financing, and we are building the technology and financial infrastructure to be able to deliver and pay for high quality care at-scale in this way.

 **Michael Nedelman:** It essentially is a reimbursement in a sense. As consumers, we experience incentives all the time. Things cost less, and we're getting them from a trusted source. In the global health world, we sometimes use incentives as a money payment. Our answer is something in between the two. Whether it's reimbursement or incentive, I don't think of it as a simple financial incentive. I think of it as correcting a fundamental misalignment in the private sector that's historically driven suboptimal care. If the attendant is incentivized, they will cycle through consumers quicker while we start paying them for their time.

Other research outside of Maisha Meds has shown that people are willing to pay more. Some of the uptake of things like long-acting family planning has been driven more by the counseling aspect than the subsidy or discounted product access. These are incentives we're experiencing all the time. If we can reimburse a provider for changing how they interact with their consumers, or if we can change some of the decision-making points that consumers are weighing in their mind as they're reaching for a certain product, that is what we think of internally as incentivization outside of just a simple financial incentive.

Ambika Samarthya-Howard: What are the biggest differences you're trying to address in this next phase that is different from everything else you've been trying?

Sisi Pan: We will start our implementation planning for the phase of scale-up in January 2025, so stay tuned for those details. But there are a couple of things we already think we want to do differently. Simplicity scales, this will matter as we aim to increase access to readers in private pharmacies and support governments to demedicalize them.

 Our pharmacists can help scale something if it's streamlined—they are not optical professionals and want to be equipped to provide high quality care in a way that helps patients and drive greater footfall to their pharmacies—not add complex steps to their workflow. This means we might need to streamline our core care pathway in the software for screening, simplifying it as much as possible while ensuring its compliance with different country guidelines. Our pilot included many questions in the screening process.

 In addition, we need to streamline our supply chain processes. For our other patient programs, we tend to run the supply chain through a collateral model where, for example, if a pharmacy wants to run our malaria program, they pay a very small deposit upfront for their first shipment of quality-assured RDTs and ACTs, and then there's auto-deduction, auditing, and deliveries. During the readers pilot, for many reasons at the time of launch, we decided to make the supply chain approach more of a cost recovery model. We found this to be harder to manage, because pharmacies viewed this as two steps rather than one. You have to sell the product (step 1) and then you have to recover the cost for that product (step 2). We might not update the supply chain approach for scale-up to be identical to the collateral model for our other programs, but we believe the approach needs to be adapted from the Kenya pilot to be able to scale across multiple countries.

Ambika Samarthya-Howard: Where are you getting your glasses?

 **Sisi Pan:** Glasses from the pilot were from RestoringVision, with funding from LIF [Livelihood Impact Fund]. For the scale-up phase, we expect to continue working with RestoringVision with support from LIF—possibly focusing on fewer SKUs [stock keeping units] and the powers that are in highest demand—while also considering long term options. While we don't know the details at this time, we know that for the scale-up

phase, we will iterate on supply chain, pricing, and pharmacy operations / sales approaches.

For example, what if we are able to shape the market to get over a million patients with their first pair of readers, and some are willing to pay full price for a second pair that is slightly more expensive with a different style?

 This is relevant to the pharmacy, which cannot store so many SKUs as many are space-constrained. If you get the SKUs wrong, it'll hit their bottom line. We have a current idea on ensuring the two most common diopters [in black] are always on shelves, because they're the ones that are most likely going to be what patients need and will help drive volume and market shaping. Then for anything else, whether it's a jazzy color, whether it's a different diopter, we can explore sort of a layaway program to order and pick up later.

We also want to get creative about the physical space it takes up in a pharmacy, and what we need to drive market shaping and awareness for the majority of patients who probably need a discount, then for those who might be just starting to realize that their pharmacy has readers, and who are willing to pay a bit out of pocket for something different. We're thinking a little bit more about how you balance access and sustainability with the physical storefront and the process by which a pharmacist can make sure they have those products on hand without too much taking up space and getting the SKUs wrong.

Ambika Samarthya-Howard: How many new markets do you have, and where are you trying to go?

 **Sisi Pan:** The pilot involved 45 facilities in Kenya, in Kisumu and in Mombasa counties. It initially was 30—15 [pharmacies in each county]—and then we added 15 more in Kisumu County as part of the 150 Shilling arm [of the pilot]. We screened more than 7,000 patients and dispensed 5,000 readers in the six to seven-month timeframe.

For the next phase starting in 2025, we are keen to scale-up in Kenya while adapting and starting to scale across our other markets of Nigeria, Tanzania, and Uganda. In Kenya, we want to take our learnings and think about how we can scale up across the country—are all of our pharmacies in play or a subset, and why?

As for other markets, we have already engaged with Dr. [Oteri Eme] Okolo, the health of Eye Health in the Ministry of Health of Nigeria. Nigeria has significant unmet need and opportunity to test program sustainability. Meeting Dr. Okolo at the United Nations General Assembly (UNGA) event hosted by LIF, we were inspired by her leadership and vision, and also her entrepreneurial chops to get the Eye Health department funded and now implementing a multi-year national strategy.

I went to Nigeria two weeks after UNGA with our Nigeria Country Director to visit Dr. Okolo and her team. Their multi-year national strategy encompasses all of eye health, not only readers. They recognize that private sector channels, including pharmacies, are critical if they want to meet national targets. They are very keen to test, learn and partner with other organizations such as Maisha Meds and felt like it was a very aligned conversation. Furthermore, we spoke about how not every pharmacy in Nigeria uses Maisha Meds software, and whether our joint work can cultivate the pharmacy channel more broadly to be a readers marketplace. That is important across our markets and especially in Nigeria where so much market shaping needs to take placeIn that vein. We spoke about our prospective project with Lagos State where digitizing patent and proprietary medicine vendors (PPMVs) and pharmacies with Maisha Meds software to provide malaria and fevers management is also an acquisition channel for the Lagos State health insurance scheme.

We got excited talking with Dr. Okolo about the idea of screening for readers, and in the future, also being able to identify and refer patients who have higher order eye health issues. Nigeria felt obvious because you have a really inspired and committed leader, and very clear targets from the government, plus an openness and also a necessity for partnership, given the size of the team that is enabling a lot of potential innovation and innovative partnerships.

The same seems to be true of Tanzania, where we recently engaged Dr. [Bernadetha] Shilio, Head of Eye Health, and her team for the first time including a demo of the Maisha Meds software and overview of the Kenya readers pilot. We also plan to engage the government stakeholders in Uganda. Our hope is to be able to offer this program across all of our markets, which will enable economies of scale as we make technology and operational adaptations, as well as knowledge sharing as different countries surface programs and solutions that can preempt the other.

Ambika Samarthya-Howard: In terms of your timeline, are you planning to go in February and start in March?

Sisi Pan: We're going to work on implementation planning in January, then start work thereafter. By March, there should be something to update you on, even likelier in Q2 of next year onward.

Ambika Samarthya-Howard: Are you trying to phase it next year starting with Kenya, and then move to Nigeria, or is that still part of your work planning?

Sisi Pan: We haven't made final decisions yet as we are going to plan for implementation in January. As of now, our thinking is that we might be able to scale-up in Kenya sooner given that we piloted there, while we prepare to roll-out then scale across our other markets. We have seen in the case of our malaria work that when you scale in multiple countries at once, the cross-learning is very real. Your scale-up is accelerated by faster feedback and iteration cycles to improve the tech, the operational processes, and the supply chain processes. For a problem in one country, you can very quickly say, is this a problem everywhere and it's only showing up here, or is this bespoke? Both are interesting learnings–country differentiation versus a problem that we've just identified here first and we're going to solve for the whole network. Another consideration is government buy-in—where we invest in this upfront and co-create the plan with the government leaders, we tend to see greater sustained scale and success.

Ambika Samarthya-Howard: Thank you for talking to me today.

ICON LEGEND

Ambika Samarthya-Howard Samarthya-Howard (she/her) is Solutions Journalism Network's Chief Innovation Officer. She strategizes on communications, metrics, impact, product and technology, leveraging platforms for the network and creating cool content. She also leads the Solutions Insights Lab, an initiative of SJN that uses targeted research and analysis to identify and interrogate what's working and what's not in a particular sector or field. She has an MFA from Columbia's film program and has been creating, teaching and writing at the intersection of storytelling and social good for two decades. She has produced content for Current TV, UNICEF, Havas, United Nations Population Fund (UNFPA) and Prism.

** This interview has been edited and condensed.*