“The most effective approach was to go to the markets and mobilize people where they actually were”: Follow-up conversation with Wintana Belai, Director of Program Incubation at Maisha Meds, on regulatory environments, marketing campaigns, and price points.

Ambika Samarthya-Howard
February 10, 2025

Ambika Samarthya-Howard: What has your organization been doing in the past year?

Wintana Belai: The first was a price change. At the beginning, we priced [the eyeglasses] around Shs.600, about $5, but we were not seeing any [momentum]. Then we decided to test two different price points, one at Shs.150 (about $1.25) and the other at Shs.300 (about $2.50). We saw an increase in uptake in both arms, but not much uptake at the higher price. It was evident that even though we had similar marketing strategies, and the same team across the two different programs, the subsidy arm was performing much better.

Ambika Samarthya-Howard: Was this price sensitivity throughout both rural and urban districts? Or was it across the board throughout the demographics?

Wintana Belai: It was across the board. Most of our programs were not urban-based. They were more rural and [semi-]urban. The reason we priced one of the arms at a higher point was because it was Mombasa, where there's a lot of economic activity, and we thought maybe

people would be more willing to pay a higher price, but that's not what we saw. It definitely had to do with the price points, along with other marketing strategies we used.

Ambika Samarthya-Howard: Who paid for the subsidy? Was the subsidy coming through VisionSpring's supply? Who took that cut?

 **Wintana Belai:** The way we designed the program is that the funder pays for the subsidy. That is what we do across our different programs.

Ambika Samarthya-Howard: Was it $1.25 at cost for each of those glasses? Did they lose money?

 **Wintana Belai:** We did. One arm had a cost recovery program, but the lower subsidy arm did not have any class recovery program. We priced them differently to understand what works. Each of these arms have their own complexities. When you introduce a cost recovery program, that means you also have to have some operational capabilities to recover that cost. What does that mean for the pharmacies, especially because the stock was given to them for free? It worked okay on a smaller scale, but as we're thinking of scaling, cost recovery can be a bit challenging if you're doing it at scale for millions of patients.

Ambika Samarthya-Howard: What does cost recovery mean?

Wintana Belai: When you give pharmacies stock, we tell them that for each sale, you have to pay back Maisha Meds a certain amount. You keep some part of the profit, but you have to give us the price for some of the actual supply. That means pharmacies have to log all sales. It's based on the number of sales they report. Then we ask them, depending on how many glasses they've sold, to pay us X amount. For example, if we're selling the glasses for 300 shillings, they have to give back around 100 shillings. When we're asking for the actual cost recovery, we're calculating the profit that they're going to make, which is different from what the patient is paying. That means that they have to know how many glasses they've sold and be upfront about that by logging and reporting back the data. It's really hard to get people to pay you back, especially if there's any mismanagement of stock or leakage of product, so you have to manage that closely.

Ambika Samarthya-Howard: How do you know that the pharmacies that are supposed to sell it for Shs.100 are selling it for Shs.100, not Shs.300?

 **Wintana Belai:** That's a great point. First, we make sure in our marketing messages that people know at what price these glasses are sold. When we brought the price down from 600 [shillings] (about $4.65) to 300 [shillings], first in the higher arm, we saw that some pharmacies hadn't updated their marketing materials. They were trying to sell it at a higher price. We conducted a mystery shopping exercise where we had fake customers see what price they were being sold at. We caught it very early and were able to mitigate this by visibly displaying the price in all communications with clients. We also added one layer of strategy to check whether it's actually being done, because sometimes they might not show the actual posters.

Ambika Samarthya-Howard: Was it time-based? If one area was selling it for 300 [shillings] and another area was selling it for 100 [shillings], obviously people would be upset.

 **Wintana Belai:** No, we did this in completely different counties, so we didn't experience that. We designed it with a different location and it was not too disruptive. We deployed this approach in two counties and around 45 pharmacies, with everyone doing it through their apps. We did see a huge uptake with the price sensitivity.

Ambika Samarthya-Howard: Are you trying anything else with this new launch besides price sensitivity, or did that resolve all the problems?

 **Wintana Belai:** It was one of the main contributors, but demand generation was also another big piece. We were still maintaining the same strategies across the two different arms, but once we started honing in on these strategies, we found people more easily with these different approaches. The billboard and radio spots mainly supplemented what was already happening at the community level. The most effective approach was to go to the markets and mobilize people where they actually were. We set up tents or medical camps right in the marketplaces with big posters. Pharmacy attendants were there to support the huge lines of people waiting to be screened. We were meeting people where they already were for their day-to-day activities, for a product they might not have had a lot of awareness about.

Ambika Samarthya-Howard: What didn't work regarding demand generation?

 **Wintana Belai:** We had in-store activations where we had brand ambassadors stationed at the pharmacies once or twice a week. One partner assigned some of their

employees to these pharmacies wearing the Tazama glasses, and they would try to initiate sales with anyone who came in. That didn't work for different reasons. We had some feedback that pharmacies didn't always feel comfortable having an external person just hanging out there. Also, it was really expensive when we analyzed the cost-effectiveness of different approaches. It was the most expensive, but also the least effective in driving sales.

Ambika Samarthya-Howard: You're trying to scale more not only in Kenya, but also outside of Kenya. What is your relationship with the Clear Vision collective, which has around 20 organizations doing eye programs with the government?

 **Wintana Belai:** That's a great point, especially as we're at this initial phase of scoping and trying to hone in the design of the program for scale. We're very happy to hear about the work the coalition is doing in terms of the regulatory piece, especially in Kenya where the regulatory environment is a bit unclear about how pharmacies can actually dispense. This group is working towards changing that policy. That's going to be very important because governments have a huge role to play in the success of these programs. One of the biggest things pharmacies are afraid of is whether they're going to jeopardize losing their license by enrolling in a program like this. Having full confidence that the Ministry of Health endorses this will be really helpful, especially at scale. When you're piloting something, you're able to manage, but scale is different.

 Another piece where government involvement can help is demand generation. In our pilot, we saw that we had buy-in from a county level government and had for partnerships when some MPs decided to sponsor X number of glasses during our community mobilization days. When people see that it's endorsed by the county, it creates openness both from pharmacies but also from clients. When we think about how we do demand generation at scale, and more cost-effectively, thinking of [county governments] as our partners will be very helpful. That's why the regulatory piece is very important. Finding the right time to engage them is also important. We've had conversations with the Ministry of Health in Tanzania and Nigeria, and there's openness there. It's very important in scaling to have these endorsements, to ensure that pharmacies are feeling good about the program. We can collaborate with the government to bring some costs down with creative partnerships, and then make sure we're getting the message out to the right people.

Ambika Samarthya-Howard: What are your plans for the next phase?

 **Wintana Belai:** We just initiated a project to scale with the aim to reach 500,000 customers over a two-period time across four countries, i.e. Kenya, Nigeria, Uganda, and Tanzania. It makes sense to scale in Kenya because the app is ready with our systems. All the processes in the pilot can simply be introduced to more pharmacies. We would need to adapt the tech to the other countries to be able to fit the processes. We're waiting for clarity to ensure that we can start the work in Kenya because of regulatory concerns. The idea is that by the end of the first quarter, there might be some policy change that might enable us to scale this work. We're waiting for a green light, but if that doesn't work, it won't stop us. We've already gotten expressions of openness from ministries in Nigeria and Tanzania. Our team is now working to adapt some of the tech so it will be ready for scale in these other programs.

Ambika Samarthya-Howard: Are you still in two places in Kenya?

 **Wintana Belai:** Yes, but at the end of six months, until we [better] understood our direction for the next phase, we continued running the program without active involvement. We wanted to see how the pharmacies were going to run the program without us doing demand generation, like procuring additional glasses. We wanted to see how they're going to sell the glasses by themselves with whatever stock was left. So far, that's been happening, but we've told them that we're hoping to scale and then we're going to source more glasses, so we're waiting to do that. Glasses are moving. We're still seeing sales, but the numbers have gone down because we don't have as many glasses, and also they are not doing these big community mobilization pieces, but they're still selling glasses. We're hoping to expand our program across all of our markets as early as Q2 2025.

Ambika Samarthya-Howard: How do you think about scale and the rollout?

Wintana Belai: In counties, we have the capacity to start anywhere. It's a matter of where our other programs are and our team capacity. It's also good to see how similar programs are running in different counties so we can make sure this is happening collectively. Since we already have pharmacies in all 42 counties in Kenya, Maisha Meds has the flexibility to start anywhere. It's just a matter of what programs are running in which counties, and the best strategy to make sure we're not replicating these programs.

Ambika Samarthya-Howard: Livelihood Impact Funds is partnering with groups who already have existing programs in many countries, not new organizations or startups. How do you prioritize their eyeglass work with the other urgent things you're doing?

 **Wintana Belai:** A lot of the work we've done at Maisha Meds is to make sure the processes and systems we use can be applied across [different] programs without tailoring them, i.e. our stock management, our supply chain, our fraud mitigation, all of these things. We've done a good job of systemizing them in a way that is scalable. As long as these systems and processes are working, we can support different programs with the same capacity. Then when we're staffing, we're able to have a standardized approach without too much tailoring and adapting.

Ambika Samarthya-Howard: You can't scale demand generation just with good processes, you need people to do more things. Are you planning to hire more consultants?

 **Wintana Belai:** That's a really good point. Glasses are different from our other products. I'm interested in how to leverage the business acumen of pharmacies for a product like this to be profitable, and figure out marketing strategies to make them our partners. If you make the business case that this product works, you can make profit. How do we make sure we're strengthening that client/business interaction? As we're scaling, I want to see how to leverage them better in this program than we have in the past, but also uniquely for this project because it is very different. In the past, we let our pharmacies do their thing with demand generation in other programs. What's exciting about this work is that there is a lot of iterative learning. We're designing it to test out different ways across different countries, to see how our marketing approaches would be similar or different. Patient behavior is more or less the same, but pharmacies might have contextual differences, which we want to figure out in order to sustainably scale. How do you bring marketing costs down? Ultimately we want to do this at a price point for a patient that's cost-effective and also efficient in delivering care. We're also mindful about our service delivery costs. We're learning a lot about that. In this phase, I want to learn how we can better partner with pharmacies without leaving it all up to them, because we still want to make sure we're supporting them to reach the people they need to reach.

Ambika Samarthya-Howard: Unless you're educated or have grown up in a culture that promotes preventative care, you only go to doctors when something's wrong. So much of eye

care relies on changing cultural attitudes to be preventative and proactive. What have you done with pharmacists to make them care about selling eyeglasses?

Wintana Belai: That's a great point. Pharmacists want to see that they can make a profit with a product like this. The other big piece is the supply chain. From a profitability standpoint, if you're asking a pharmacy to stock a product, especially in lower resource settings, they might be inclined to stock products that are more profitable if they're doing the stocking themselves. If they're unclear how to resource this product, or if they perceive it as slow moving, especially for a project like this where you are using them as a new channel for a distribution, then they're not sure. We must address the supply chain issue so they don't have to think about trying to restore, and also not create competition with other products that might be more profitable. In our project, what we have done is contribute to them being willing to do that, because they're not having to do extra work trying to source these products.

Ambika Samarthya-Howard: Do you supply other medical items?

Wintana Belai: We currently run the supply chain in all of our flagship patient programs, i.e. malaria, HIV, et cetera. As an organization, we're an enabling tool first and foremost, so you don't need to order from a certain supplier. You certainly don't need to order from us. We're not interested in being a supplier or intermediary. We have noticed for other programs, even for ones that are scaled multi-country with a million patients, such as our malaria program, we have found it's very difficult for our pharmacies to find WHO pre-qualified product, which is the requirement of our outcomes-based funders. Even if they can find it, and even if they can somehow get competitive prices, structure and security is a challenge. We are vertically integrated on the Vision program, [we take ownership of both the supply and distribution].

Ambika Samarthya-Howard: Do you bundle to get more than one thing from more than one vendor?

Wintana Belai: It depends on the product. For anything that has to be WHO pre-qualified, that's more of a product where historically some donors tend to be the main procurer. We often go through an organization called Eyeplus because they get the access pricing that a Global Fund or a PEPFAR [President's Emergency Fund For AIDS Relief] or a PMR [Charity] might get. If it's not one of those products, we don't run our own warehouses, but we have warehousing

partners and distributors across all of our countries. For this scale-up phase aiming to distribute 500,000 glasses, we have wonderful partners such as VisionSpring and RestoringVision from whom we can procure glasses and share learnings. But in month six, if people want a Fandango design for a higher price, are we going to go through RestoringVision or figure out something else?

Ambika Samarthya-Howard: What hasn't worked?

 **Wintana Belai:** An important piece is the incentive of the attendant. You might think if the pharmacy owner knows this product is going to make them profitable, then the program will be successful. For most pharmacies, the owners are not there, the attendants are. You have to incentivize attendants to make the sale and [also] for their time, to make sure they're screening the patient and delivering the care they're supposed to do according to the standards required for that program, and for the time they're taking to report the data back to you. With our pharmacies, because we want them to adhere to the standard of care for all of our programs, they have to think it's worth it to take the time to counsel the patient, to actually interact with the patient, and to be able to then make the sale. For the Vision program, they're not only incentivized for actually making the sale, they're also incentivized for doing the screening, even if it doesn't end up in sale. They have to be able to align their incentive with the incentives of the program, which is quality of care and also reaching [more people].

Ambika Samarthya-Howard: How do you incentivize this?

 **Wintana Belai:** The incentive we pay is divided into two: for screening, but also for the sale. We pay them more for the screening than the sale, because we want to make sure they report back to us.

Ambika Samarthya-Howard: Who pays for that?

 **Wintana Belai:** The grant. The way we run our programs is to use pharmacies to run the health insurance for that, but then the funder pays for it. Attendants get Shs.40 for the screening and Shs.20 for the sale, so Shs.60 in total, if they sell. If they only screen, they get Shs.40 but that's because we think it's really valuable for them to do the screening and tell us when they've screened. You're not just paying them to sell glasses. It's about behavior change in terms of how you ensure quality of care as well.

Ambika Samarthya-Howard: The price of the glasses goes to the owner, Shs.100, right?

Wintana Belai: Yes, and that's why it's not enough to just say to a pharmacy owner that this is a profitable program, because they're not always there to run their business. The people who are usually running their business day-to-day are the attendants. The attendants need to be able to feel their time is worth it to do the screening and give us the data. Most pharmacy owners pay an attendant, because pharmacies are usually businesses they run on top of other things.

Ambika Samarthya-Howard: Anything else that hasn't helped with pharmacists or attendants?

 **Wintana Belai:** In-store activations with somebody external might have created an environment where [pharmacies] felt like they were monitored, which was not the reason behind it. Even if you communicate this, there might be mistrust especially for new products like this, when they might not always know if they're going to get in trouble for [selling] it or not. I don't think that worked. The regulatory piece is very important, but once you have it, how are you implementing these programs? Are you being strategic about the presence of different programs? Especially if your programs are not synced, if you're selling glasses at different price points, or if you're having an overlap of programs, you might run into issues. Collaboration is very important. When you're designing these programs, It's good to have visibility on what's currently happening, which partner is working on what, and how we can leverage each other's strengths to be able to reach the population that we want to reach.

Ambika Samarthya-Howard: Thank you so much.

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.*