“Stability is a key”: Frederic Seghers of CHAI on understanding governments, managing risk and capitalizing on open windows

Ambika Samarthya-Howard

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Ambika Samarthya-Howard: Can you talk a little bit specifically about the models that you're working on or that the Clinton Health Access Initiative (CHAI) is supporting right now for scale?

Frederic Seghers: I think primarily where we as an organization have our sweet spot in terms of capabilities is twofold. First, we work at the service of governments, meaning we're not a direct-service delivery organization. We help the government build their capabilities and infrastructure to deliver health services. So, one of the key entry points here is activating the government infrastructure as a delivery channel for reading glasses [for example via primary health]. So that's one of the areas.

 The second area where CHAI has done a lot of work traditionally is with the private sector to establish more mutually beneficial business relationships, for government buyers on one hand and suppliers on the other hand. So figuring out where we can find alignment in terms of pricing, for instance, or for suppliers having a level of visibility within the market, [to know] the demand that they can expect, and so forth. There may be additional risks for suppliers of all sorts of commodities doing business in these markets because of the lack of visibility about the demand, the terms, the regulatory framework, the questions about payment and so forth. All those risks, they generally involve a price premium that gets charged, but if we can help de-risk, it often allows the suppliers [to offer more competitive pricing].

Ambika Samarthya-Howard: How do you do that? How do you help de-risk? Do you provide subsidies?

Frederic Seghers: There's different mechanisms. Sometimes it's about information sharing, sometimes it's about facilitating in-country registration. We engage with regulatory agencies to expedite the registration process so these companies don't fill out forms that end up sitting there for months without being processed. So we help accelerate that.

Another instrument that we've used quite often is volume guarantees. Concretely, we've engaged with financial institutions that are willing to act as guarantors. They put up a purchase guarantee, and then we work with the governments to make sure that their purchase intentions materialize in actual procurement so that we don't have to call on those financial institutions to pull from that guarantee. It's a way of de-risking the business opportunity and it allows for the suppliers to offer prices that are way more competitive than what we've had in the past.

It's an enabling mechanism for the government to then say, "Okay, we are at that price point. This business makes sense." So we unlock that whole ecosystem.

Link:
https://medaccess.org/innovative-finance/our-innovative-finance-products/

Ambika Samarthya-Howard: In terms of unlocking the government part of the ecosystem, how have you been able to establish that with governments? What has helped?

Frederic Seghers: I think the advantage that we build on and allows us to expand is that we now have connections with all the different agencies and departments that will need to work together in order to get things to move. So it's not like we're advocating with just one technical program team. We also have connections with those involved with the financing, with the supply chain, with the procurement departments and so forth. So it allows us to make sure that all the right people are in the room working and facilitating those connections.

Second, I think it is a few decades now of deeply understanding how that system operates and just having the personal connections. And I think third, and importantly, is making sure that we align our work with where the government's priorities are situated. So we don't try to force some kind of intervention that doesn't align with where the government wants to go. If the government has other priorities on their minds, which often happens, they might be called in because of disaster or something, of course we will be responsive and we will make sure that, even if the donor may not have given us the earmarked funding, we will engage with our donors

and ask if we can make sure that we can deploy our resources in support of what needs to be dealt with first. This helps us continue to build that trust. And also, if we don't clear those bottlenecks, we don't create a context where we can also move forward with the initiatives that we want to promote.

Ambika Samarthya-Howard: So much of your work has been around Malaria, HIV, and you mention responding to disasters. How does eyeglasses rank in terms of priority and urgency? Isn't it always sort of down the ladder?

Frederic Seghers: It depends country by country. I'm sure you heard about the example of Nigeria. If you have a president making a big announcement about an initiative, then I think obviously the level of priority goes upward. There's a window of opportunity.

 So much is subject to a level of political decisions or might be linked a bit opportunistically to where funding is situated. But my observation is that those things change very frequently. I mean, there are obviously some topics that stay high up [in terms of urgency] because there is a continuity in terms of resources. You mentioned a few like HIV and malaria. Those will continue to be important sources of donor support also for governments.

But beyond that, it seems that things are shifting. I think we definitely want to make sure we create these windows in countries, and then when we have a window, we must figure out how to successfully capitalize on it.

Ambika Samarthya-Howard: For this particular project, we're focusing on pharmacies and community health workers as delivery channels for reading glasses. How would you evaluate the challenges and the pros and cons between those two delivery channels?

Frederic Seghers: One of the lingering questions that I have, and I think we haven't fully answered yet, is what do we know about the role and the importance of the government as an enabler and activator of the optical sector? What is the government's role in driving uptake of glasses, whether it's reading glasses or prescription glasses?

 I have a little bit of anecdotal input that I think in more higher-income countries, a few decades ago, the government provided a significant stimulus through a subsidy or through some kind of government-provided glasses, and then their support tapered down and it's been the private sector that has largely taken over. But it's been the government that's created the context where it became more interesting for the private sector to start doing business because there was greater penetration of glasses. It was an opportunity for people, as they had understood the value proposition of glasses, to start engaging with and upselling to different designs. And then obviously, as the government subsidy tapered down, it appears that people were still willing to get and pay for their pairs of glasses.

 Again, that's very anecdotal. Is that consistent or not? It's something I don't have an answer to, but I see it as two mutually reinforcing tracks. I think if we just pursue a pharmacy track without a government stimulus, we might hit a certain ceiling because of some of the general access barriers. I think incentives are needed for some pharmacists to get those products out in areas that are more remote, whereas the government has the networks that can get those glasses out and then create a bit of a pull mechanism for entrepreneurs to also go into those regions.

Ambika Samarthya-Howard: Do you mean community health workers as the pull mechanism?

 **Frederic Seghers:** I think generally, reading glasses are not a difficult product [to provide], but they should be delivered through primary healthcare. Within primary healthcare, those that go into the most remote areas are community health workers. The evidence shows that they can do it, that they can do it effectively, that it's generally been well-perceived by communities as well. So it seems like there's a good amount of evidence to support that delivery channel.

Ambika Samarthya-Howard: I've heard a lot about the potential with pharmacies, since they're already there, people already go to them, if we could just uptick the demand and also train the pharmacists on selling the glasses. Have you seen any risk with pharmacies as a distribution channel?

 **Frederic Seghers:** Well, I've seen risks in a couple of Asian countries where you have, in urban areas, more established optical sectors that are pushing out glasses to people who may not need them. I think if the regulatory framework is not well-established or well-enforced, that's a risk that I see. There is another risk in terms of how much demand you unlock. Because it seems from quite a few studies about where the willingness to pay is situated, generally, I mean as far as I recall, and I'm just speaking top of mind, there's a certain population that is willing to pay like $1 or so. There's also a large population that is not able to pay that. If we think realistically about what the price would be at the pharmacy – just to get the product into the country, to ship it to the pharmacy, the margin for the pharmacy – I think the price point would be prohibitive for quite a few people.

Ambika Samarthya-Howard: From CHAI's perspective, outside of governments, who else is really important in terms of partnerships?

 **Frederic Seghers:** Well, I'll play it back to the private sector. I think ultimately, it should be mutually reinforcing. I think different countries also have different models, and what I mean with

that is some countries have already evolved to a subsidy model or reimbursement type of scheme for health services. So there's a higher reliance on private sector partners to offer services. Whereas in a number of countries, it's also still direct delivery through the government. So I think depending on the country context, it would be very much in sync with bringing private sector partners in and activating private sector partners, whether it's pharmacists or optical shops.

Ambika Samarthya-Howard: You have mentioned country contexts several times. What do you think are the main variables? Is it government stability? What are the main things that make the context?

Frederic Seghers: Yeah, there's a couple of factors. Stability is a key one. I don't think an unstable government or very fragile countries are good environments for this work generally. The other criteria that I see a correlation with is the level of economic development of a country. It tends to correlate with the amount of services that are being covered and also the level of coverage.

 My observation is that where I'm seeing some level of subsidy or coverage for glasses, it tends to be countries that are more in that sort of upper middle-income bracket or they're better represented. And then within those countries there are different mechanisms for how that financing has been deployed. I think that's another criteria. So I think country context is largely dependent on what already exists in terms of financing support for these types of services, and that financing has been deployed.

Ambika Samarthya-Howard: What are the most common types of financing for these types of services? Mostly subsidies and aid?

Frederic Seghers: Government subsidies, you mean?

Ambika Samarthya-Howard: NGO subsidies, philanthropic funding.

Frederic Seghers: Very little generally, very little. So allow me to say that I don't have the full picture. I've seen a couple of schemes of governments that are offering these products. So when you as a person are identified, you will be offered a range of different products. That's what the community health workers could also do. "You need reading glasses. Here's a couple of options. Does this work for you? Perfect. You can have it."

 There's countries like Indonesia, for instance, that operate on the basis of a financing scheme. You get screened, you get a prescription and the prescription says you can now buy a pair of reading glasses and we reimburse you up to X dollars. So you need to figure out where you will get them, obviously from an accredited seller, but then you can choose. Do you want to use a

basic product and just use whatever is being covered, or do you want to top up with your own funds? Generally, the model I think is also common in quite a few more developed countries.

Ambika Samarthya-Howard: Who is financing this? Is it mostly the government?

 **Frederic Seghers:** Yeah. I would imagine. I'm not the best positioned [to say]. I think it's going to be a mix of some people paying out of pocket, but I think that's a small number because I think that market is very underdeveloped, specifically for reading glasses.

 I think there's a component of government subsidies, but again, it tends to vary a little bit. Our government is also subsidizing reading glasses versus prescription glasses because sometimes they just say, "Okay, children can get glasses," or, "up to a certain age, we cover."

I think where a lot of the push is at the moment is more NGO-based models. You spoke with Jordan and Ella. They [VisionSpring] have a solution where I think they provide some level of subsidy through the service model, trying to manage costs accordingly, but then it's a combination of some payment and some donor subsidy. But generally, I think there's limited things happening in this space.

Ambika Samarthya-Howard: You mentioned the president in Nigeria is going to make a statement about eyeglasses, do you know how they're subsidizing their rollout?

  **Frederic Seghers:** I think the big expectation is that it's a donation-supported initiative. And one of the key questions that we're trying to answer is how does this program translate into a sustainability mechanism where there might be an initial stimulus through a donation, but eventually for those that are not able to benefit from this donation, that they also have equitable access to glasses. There needs to be some kind of a funding arrangement.

Ambika Samarthya-Howard: Outside of the funding, the government partnership, some work with private businesses, is there anything else that you would say are the key insights you've learned about what people need to scale? If you had to look back on the work CHAI did in this sector, what would you say you would've done differently or should have done differently?

  **Frederic Seghers:** Our work in this sector to this point has been limited, so there's not a lot of experience we can pull from. We started to work with governments in supporting them in the area of assistive devices more broadly. So we look at mobility aids, hearing aids, but also vision aids like glasses. They've been considered assistive technology in some areas. And one of the approaches that we've taken is we said, "Rather than engaging with the government on a product-by-product level, let's look at a basket of products of mobility, vision, and hearing aids and

let's look at what should be done as a common denominator across these domains." There needs to be some guidelines and regulations. There needs to be a procurement mechanism set in place. There needs to be discussions about the financing of these devices. So rather than go in sort of divided, we said, "Let's pull those into a single basket and engage with the government accordingly."

 So we have a history of starting to work with governments, of taking those services, which are very heavily delivered outside of the public sector. Generally, it tends to be perceived as a charitable activity. It's often a humanitarian response, specifically when I'm looking at things like mobility aids, wheelchairs, prostheses. So how do we make a radical shift happen that puts the government in the driver's seat about regulating what is acceptable in terms of products and services, about who the beneficiaries are and so forth?

Something I want to talk about with our eyeglasses work, because we have small pockets of eyeglasses work. It's not like we haven't done anything... It's all been cross-sectoral. I'll give a specific example. The South African government, for instance, has a very supportive system for people that need glasses because there's a subsidy depending on your classification in terms of income level. So the poorest people will typically be subsidized, whether it's prescription glasses or reading glasses. You have access to both. However, what we found was that very few people use those services despite the fact that they're eligible and some people could actually get them for free.

 When we started to dig in, we found a few things, which is a lot of people actually go to a health facility and are being screened and get some form of prescription, but then there's a huge backlog of glasses being shipped to facilities. As a result, many people will never get them. It was a combination of how the information flowed, which was a paper-based system, and how the budgets were allocated, which is you have ring-fenced or certain budgets that are earmarked for glasses. And if you're operating on assumptions of certain demand, which is a huge underestimate of the reality, you're constantly under budgeting. And if the information is not flowing about what's really needed, you don't have actual information to make changes.

 So we digitized the ordering system. We created an application to be used by frontline health workers and optical shops. That information immediately gets from the facility to the product to the lab where the glasses are being dispensed. And it helps because we can track orders in real time, so we know what the demand is and we use that to engage with and motivate the government to expand their budgets and have a greater allocation for glasses. That's how we've been able to clear a big part of the backlog. So that's just one example of how you sometimes get in the nitty-gritty, but you need to tackle it in order to get the system to work effectively.

Ambika Samarthya-Howard: In terms of the demand gap, and generating demand, have you seen anything that you think has worked government-wise or in the models that you've seen?

Frederic Seghers: The example in South Africa was from a few years ago, and we're starting to ramp up work now in the past 12 to 18 months in the eyeglasses. We align ourselves with where the priorities are for our government partners and governments really, within the assistive technology portfolio, say this is something which is a big unmet need that we see as a clear priority.


Something that I'm excited about, and I would love to understand better how it yields, is there's a shift happening with countries increasingly focused on non-communicable diseases and specifically putting in place some preventative measures like routine health checks for adults above a certain age. And I think you hear me coming, but that's specifically the demographic that we would be looking at for reading glasses. If we can just incorporate a routine vision check, it's a very proactive way. You already have the people coming in anyway for their health checks, it's a relatively small added activity, and very targeted.

So we are looking at that in a couple of countries. I think South Africa, Cambodia. And I'm excited about that potential because it's a platform that already exists, a very targeted demographic already coming in, where we're probably going to have a high yield on people that would benefit from reading glasses. I know that's not necessarily community health workers going out, that's also people going into primary health facilities, but that's why I'm saying it's the primary health level.

Links:
https://www.clintonhealthaccess.org/blog/diabetes-high-blood-pressure-and-eye-health-screening-in-cambodia/
https://visioncatalystfund.org/news/eye-health-accelerator-grant-visionspring-nkc68

Ambika Samarthya-Howard: That makes a lot of sense. Are there any questions that you feel like we should be asking? Where do you see the gaps that you'd like to hear more research?


Frederic Seghers: To me, the general question is what I just said. Is there a certain best practice trajectory that involves a certain government stimulus? If there's a lot of proof points that suggest that the sector is not going to develop without the government, I think that makes a clear case as to why activating the government channel is so critical and almost like a prerequisite because you could do a ton of work in pharmacies, but if you miss that, it's probably not going to really unlock your investment. So that's something that I'm interested in.

 I think that a question we have all been wondering about as well is what's the level of penetration and adoption you need in a certain context, in a certain community, to hit a tipping point in terms of acceptance of glasses? The research does suggest that there's still quite a lot of behavioral barriers in quite a few countries. So I think that's another question.

 Another question is about the perception of the value proposition of the glasses and how that affects people's willingness to pay and conversion into... I know I'm going a bit on repeat on things you've probably already heard, but I think they're generally some of the questions that we've come up with. The transferability and replicability of the community health worker model is a key question as well because it's been proven that yes, they can do it, but then there seems to be a significant interest from so many different sectors to be activating those community health workers to deliver a whole range of services.

 And so I think the operational question of is it feasible in different contexts where community health workers might be compensated differently or have different packages of work already, schemes of services that they need to deliver, to be taking on that kind of service, or is it really a value-add because they're reaching a new demographic with that service that changes their perception in communities? That's generally a question because I think if we can motivate for a strong case as to its replicability and its value proposition, that could actually help us push much more effectively to get that model to scale further.

Ambika Samarthya-Howard: Specifically, you're saying for community health workers to use selling eyeglasses sort of as a value-add for the work that they're doing?

Frederic Seghers: Exactly.

Ambika Samarthya-Howard: That makes a lot of sense. Thank you so much.

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Ambika 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.*