“The pharmacist is definitely an entrepreneur”: Jessica Vernon, co-founder and CEO of Maisha Meds on incentives, demand creation and supporting pharmacies as effective reading glasses distribution channels.

Ambika Samarthya-Howard
September 6, 2024

Ambika Samarthya-Howard: Can you please introduce yourself and talk a little bit about how you got into eyeglasses?

Jessica Vernon: I’m Jessica Vernon, co-founder and CEO of Maisha Meds. My journey into working in this space [started when] I was working for a professor in the US who was doing a lot of work in East Africa. I helped for about a year as I was completing all my medical school requirements. I was working for him part-time for the year, and then once they had fundraised enough to launch this new scale-up that they were doing, I shifted over to working in Kenya and East Africa on the operations of it. This was 2010 to 2012, when the first iteration of the social enterprise scene started up in Nairobi.

I was based in Busia, Kenya, and then in Kisumu, and worked primarily on safe water, but then also spent some time in the public health system working in a government hospital. I became really interested in pharmacies through that, because we would constantly be out of stock of medicines and sending people to the nearby pharmacy. We would just write the name of what they needed on this little sheet of paper—it wasn't even a prescription pad—and just hoped that they got what they needed, especially antibiotics. A lot of people would come after they'd already spent a lot of time at the pharmacy getting treatment that they thought they needed.

So that seemed like a really important point of contact within the health system that wasn't being fully explored. Early on, it was a very controversial thing to be working on. The first few years that we were doing it, I would get so much pushback from people, especially from a lot of the funders that usually support earlier stage organizations like ours at the time. They just thought that pharmacies were bad actors who did not have incentives to provide effective healthcare, and they weren't interested in supporting us to do that.

Ambika Samarthya-Howard: How did you navigate all that?

Jessica Vernon: The first couple years it was not well thought through. We got a couple small funders that were just like, I'm sure you'll figure something out. Go for it. Then I started working on it full-time in 2017. I'd done medical school before that, and then bopped around the US, both consulting and [in] digital health, trying to see if I wanted to do more US healthcare. But I landed back on wanting to keep working on this and working in Kenya.

 I would credit Prashant Yadav, who's now at INSEAD [Institut Européen d'Administration des Affaires] and was at Center for Global Development and before that, at Gates, with deciding that this was an area that needed additional investment. He did a very strategic thing in funding Salient Advisory, which is a group that does a lot of innovation reporting. [He] funded them starting in 2017 or 2018 to put out a yearly report on innovations and product distribution. I think that changed the narrative, in that private pharmacies and the private sector in general stopped being this bad actor within the overall health system and started being seen as a legitimate channel for funding, for global health, for distribution, for all of these sorts of things. In the first report, there were probably five or ten organizations that were highlighted as working on this problem. It was like, okay, now this is a legitimate area for healthcare delivery that de-risked investment for the Gates Foundation and USAID [United States Agency for International Development].

It changed quite a bit in 2019, because that's when we started getting our first really big sources of traction and interest. It stopped being about the pharmacy space in general and started being about very specific product areas. [We] dove deep on malaria, which it turned out was another entirely unrelated but controversial thing. There'd been this thing called Affordable Medicines Facility - Malaria (AMFm) in 2010 to 2012 that was like a hundred million dollars to fund private sector malaria case management work.

Ambika Samarthya-Howard: How difficult was malaria to fund compared to, say, HIV?

Jessica Vernon: HIV was so fully funded through the public sector that there was never any need for any sort of private sector work. As a result of the funding gaps in malaria, half of all patients for malaria seek care in the private sector. I think somewhere between 12% and 20% of products sold in pharmacies across our network are malaria products. And oftentimes it's just a

black box and completely unknown. We see the data all the time now, and a lot of it is not quality assured, not prescribed appropriately, all of that, and so, in 2019, we went in to fix that particular problem, and that resonated with enough people that had been on this malaria journey that we started getting really strong traction. And then we leaned into economic research studies to guide how we thought about program design as well.

Ambika Samarthya-Howard: Can you tell me a little bit about your model?

 **Jessica Vernon:** We have a three-part system. When we were starting to work with pharmacies, we asked them what they needed. And most of them said they needed business management solutions. A pharmacy is first and foremost a business that needs to make money, that needs to break even. And there weren't good solutions that were designed for offline areas with poor electricity and connectivity, that could work on a more flexible device. And so we designed a point-of-sale software that's specifically designed for a pharmacy or clinic that helps them fully manage their business: sales, inventory, profit and loss, reordering.

On top of that, a couple of years later, we said, let's start thinking about how we actually influence health financing and how patients access healthcare. Because we were seeing a ton of data, and we're trying to give it to funders to have them design better programs. We realized that these funders and partners did not really know how to use that data to design better programs. If we wanted to influence patient care, we would need to design it ourselves.

 So we built what we are calling patient support programs, where it's something that looks and feels a bit like health insurance in a pharmacy setting, but using global health funders to pay for it. That is for malaria, HIV prevention, family planning, and eye care. Being able to set the price for the patient, do a reimbursement for a pharmacy for following clinical guidelines, making sure they do all of the parts of the care that they need to do, and then being able to validate that the patient actually receives the product. We verify patient identity via SMS [short message service] and do an audit check afterwards on the pharmacy data, and do the full counseling and training as well.

We try to bake that into a full outcome that is achieved for a patient that accesses care for a certain price point. For vision, there's a lot of debate around whether a customer can fully pay for eyeglasses. And in the pilot, we've found that there was much higher adoption with a slight subsidy, which was really interesting. So we are able to test some of these different price points. Then the third part of the model is to use all of this, the data and information from the patient support programs plus the data from the point-of-sale software, to then help the health system and different stakeholders—government, pharma, and others—really understand what's happening using data and insights.

Ambika Samarthya-Howard: Do pharmacies opt in to this program, or are they part of the program and you work directly with governments?

Jessica Vernon: They opt in. In the private sector much more so than in the public sector, the pharmacies are a free agent. They have the ability to make every choice about their business, and so we very much see them as our primary customer. We build the product with them in mind, and then we have to design the program so that they actually appeal to the pharmacies.

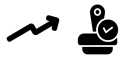
Ambika Samarthya-Howard: How big is your reach right now in Kenya? Could you give me an example of why a pharmacy would come to you versus a pharmacy that's not part of your program?

 **Jessica Vernon:** Our entry point with most pharmacies is the point-of-sale software. At this point it's just really good software. It's on Google Play Store, downloadable, and they can start using it. And then we provide very good customer support. So we have a network at this point of 4,000 facilities using the software every month. Over the next couple of years, we'll be growing to about 10,000 and providing some additional support like access to finance to add additional value for them.

 Once we've had them using the software for a while, especially for the ones that are licensed, that are legitimate, that are doing good work, we then have them start offering the patient support programs. Honestly, the primary driver for them wanting to adopt those programs is revenue. We've set up the incentive structure so that by providing this good quality care, these good programs, they make slightly more in revenue than they would if they just did the status quo, which is similar to how health insurance works in most markets as well.

Ambika Samarthya-Howard: So eye care is very different from malaria and HIV. How did you approach it with them?

Jessica Vernon: There are a lot of things that are different, but there are a lot of things that are the same, which was an interesting learning for us. We came in definitely wanting to see how similar it was to the other programs—HIV prevention and family planning. In all of these you have a product that's usually not in stock in a pharmacy that they need to begin stocking. So we have to build the supply chain for it and make sure the product is available there. We have to figure out the price the patient pays, the price that the provider is incentivized or is reimbursed. And then there's usually a screening component or a counseling component. All of that is true of eyeglasses.

 The biggest thing that's a little bit different is the demand creation component. There is just a lot less awareness of the need for eyeglasses than there are for all these other

programs, which is an interesting lesson. And the thing that was actually the most complicated early on, that Wintana [Belai, Director of Program Incubation at Maisha Meds] did a wonderful job of exploring and figuring out, was the regulation. For all these other health areas, you have very clear regulation on what a pharmacy is and isn't allowed to do. And that didn't exist in Kenya for eyeglasses. So we often had to go county by county to get the Ministry of Health to sign approvals to say that the pharmacies wouldn't get shut down for running these programs.

Ambika Samarthya-Howard: What are you trying next? How many pharmacies do you have?

Jessica Vernon: Forty were in the pilot. We set targets and numbers based on what we've been seeing in terms of adoption for some of our other programs, and we're able to achieve all of that in a relatively short period of time.

Ambika Samarthya-Howard: What was the success metric? What was it that you were able to achieve?

 **Jessica Vernon:** The goal was for 5,000 people to access eyeglasses, and we were able to achieve this over a six-month period. Over the course of the pilot we tested several price points. We started with a full-cost recovery arm, which was $5 to $6. That had very low uptake, so we lowered it to about $2.50 (300KES). But even that was not receiving as high uptake as we'd anticipated, so we said, what would happen if we lowered the price to about $1.25 (150KES)? We had two arms. All of the Mombasa facilities received the $2.50 (300KES) glasses, and the others received the lower price point, the subsidized glasses. And even though the demand creation and marketing was the same across both regions, the lower price classes had much, much higher adoption.

Ambika Samarthya-Howard: What happens next? What are you testing right now?

Jessica Vernon: Now that the pilot's over, we're evaluating what comes next. But the place where we get huge lessons for every program we build is when we try to scale these sorts of programs. So our next goal is to see if we're able to do it across our network and start to build the same program at scale that we've built for other health areas. The current goal is to enroll a million customers to access eyeglasses over a two to three year period.

Ambika Samarthya-Howard: How big is your network?

Jessica Vernon: 4,000 facilities across four countries: Kenya, Uganda, Nigeria, and Tanzania.

 Sustainability is an important piece of all of this. I guess the way that I perceive it, being a bit closer to the problem than we were even a year ago, is that there's always two phases to

product introduction. There's market shaping which requires a subsidy, and then there's a phase of just letting the program sustain itself over time. The way we've begun thinking about glasses is that since there is such low awareness of the need for this product, every person should be able to access that first pair at a subsidized rate (as market shaping). But then if the income effects are as strong as the literature suggests they are, patients should be able and willing to pay full-price after that.


So we're hoping in this next phase, with the first pair of glasses that we do for these million customers, that they access them at that subsidized $1.25 (150KES) price point, and then see for repeat customers if they are willing to pay a fully baked price that recovers all costs with the idea that once they see the income gains that come from a program like this or from eyeglasses, they'll hopefully be willing to pay fully for it in the future.

Ambika Samarthya-Howard: What have you found are the biggest differences between your pharmacies in Kenya, Uganda, Nigeria, and Tanzania?


Jessica Vernon: The first thing is that in Kenya you only have one tier of pharmacy. Pharmacy is all that somebody can be registered to be. And the regulator has a very strong desire to regulate that tier. In each of the other three countries, you have a drug shop tier that's a little bit more of the wild west and that is usually massive (20,000-100,000 drug shops per country). So we're interested in seeing the difference in adoption and whether, from a regulatory perspective, countries are willing to allow drug shops to be a source of eyeglasses in addition to pharmacies, and explore the differences in uptake in those two different types of settings.


Again, the government engagement in each country it's fairly different. In Nigeria, for example, there's the federal and then the state Ministries of Health and decision makers. We've realized as we've expanded in Nigeria just how important state level support is in all of this. Hopefully we'll be testing these programs in the states where we operate, which is a mix of northern and southern Nigeria. And we'll be interested to see differences across states in all of that.


But in terms of actual patient access, I think one of my biggest lessons from seeing some of these other programs implemented is that customers in all different regions are pretty much the same. I expect that there might be some differences in how we do demand creation and which sorts of partners we lean on for that sort of work. Other than that, eyeglasses are a really good product and I expect relatively similar uptake across all of the regions.

Ambika Samarthya-Howard: Why did you choose those four countries?

Jessica Vernon: When we were expanding, it was mainly that we wanted countries that had relatively large private sectors. In each of them, the private sector is about half of all healthcare that's accessed. And we've prioritized regions that have a high malaria burden of disease as well.

Ambika Samarthya-Howard: We've been categorizing pharmacists as entrepreneurs rather than healthcare providers. I was curious what your thoughts are around that.

 **Jessica Vernon:** The pharmacist is definitely an entrepreneur; they have strong opinions, they know what's best for their business, and I think that's been a lesson over many years as we've run different programs. But I think that what that fundamentally means is that if you align their incentives with the incentives of the program overall, they're willing to do whatever is needed and in the best interest of the patient.

 Usually there's an owner and an attendant. And the owner, especially in Africa—I don't know how it operates in other regions—but the owner is often somebody who has a pharmacy license who is oftentimes actually working in the government system during the day and then has a pharmacy nearby. So often it's actually the attendant who is the person, when a patient walks in, makes the decision about whether to sell or offer a particular product. It's important to think about the time cost of delivering care for the attendant as well. So for more complex products, they often do not want to spend the time for multi-step processes because they have to do the screening, they have to log data. So that's often the critical decision point.

 We run randomized controlled trials for other program areas that require a lot of counseling and demand creation within a pharmacy. And we found that when you keep the price point high but incentivize the attendant's time a bit more, you end up seeing higher rates of adoption with much better counseling. They see that as paying for their time to support the patient to understand the program. And that's especially true in family planning. It's more about the time cost for the pharmacist than it is about the price in many cases. So I think in this case, it is still about the price, because this is about an unproven product for customers, but being able to compensate the provider for their time is going to be really important for scaling this program.

Ambika Samarthya-Howard: How do you compensate for the time if you've decided that the price point of $1.50 is going so much better than the $2.50 to $3?

 **Jessica Vernon:** We pay them on top of it a little bit more. What we try to do with all the programs we run is package a full price for patient care that we get paid. That includes the

supply chain cost of making sure the product is in stock in the pharmacy, the cost to pay the attendant and the provider a little bit, and then the patients paying them a bit more, and then the data and reporting costs as well, so that it's a fully baked thing that includes all of these different pieces.

Ambika Samarthya-Howard: How much more over the $1.50 do you pay them that makes it worth it?

 **Jessica Vernon:** It's not very much. For the attendant in almost every program, and I think in the vision program, it's about 50 shillings, so that's 30-40 cents. And then for the owner it's less than a dollar more. So it's just enough to sweeten it enough for them to say, actually, this is something I really want to support and make sure happens.

Ambika Samarthya-Howard: Do you do that for malaria and HIV and family planning, too?

Jessica Vernon: Yeah. But with each of them there's different complexities. Some of them are much harder programs to run than others, and so we think about that time-cost differently for the attendant and the owner.

 We divide out payments for the owner and the attendant so that both have aligned incentives to make this program happen. And then we get very regular feedback from them on what's working and what isn't and try to make sure that everything is streamlined in terms of what we ask them to do and the different proof points for them.

Ambika Samarthya-Howard: Who in your team actually gets that feedback? How often is that feedback given? Who decides what questions to even ask?

 **Jessica Vernon:** It's a great question. I know some of it but not everything about the operational process. Every part of our entire program requires such significant behavior change from the pharmacy that it's actually a pretty high touch model. It can be a challenge to even just ask them to use software regularly—some of them will do it and some of them will not. And then there's usually an in-person training and feedback session whenever we start a new program in a pharmacy. First of all, we assign a customer support person to every single pharmacy we work with. And they are responsible for making sure that the pharmacies are doing what they're supposed to be doing. They give them calls weekly early in the program, and then monthly later.

Ambika Samarthya-Howard: How many pharmacists is one customer support person assigned to?

 **Jessica Vernon:** It depends on the program, but it's usually about a hundred pharmacies per team member. And they have a fully systemized job where we have them log interactions in our CRM [Customer Relationship Management system] and report back regularly to the team implementing the program. We also have an audit team, because we're paying for these people to deliver these services. We ask pharmacies to take photos of each step of the process or submit data. And if we're seeing things not working as they should or people not being compliant with the program, the audit team will often call to either retrain or investigate. The smaller incubation programs often require a lot more touch points than others. So we'll usually put one associate on the program to just follow up weekly or monthly with each facility.

Ambika Samarthya-Howard: What do they ask them?

Jessica Vernon: For eyeglasses, a lot about how the program's working and what the adoption rates are. With some of the other programs, we see all of their data and we can see if they're selling a lot of malaria drugs but not selling them through the program. We spend a lot of time asking why people might not want to participate and remove as many barriers as possible. We try to make these interactions open-ended, but focused on why they are or are not participating in the program. And we ensure that they consistently have eyeglasses in stock.

 That was one of the big learnings: it's really important that we run the supply chains for all of these things ourselves. Because if somebody is choosing between whether to stock eyeglasses and whether to stock something else, they're going to choose whatever is going to be the highest margin for them and simplest. Whereas if the eyeglasses are already there, it's not a choice about whether to buy it or procure it, it's a choice about whether to use the thing that they already have, which is an easier sell for them.

Ambika Samarthya-Howard: And when you say the difference between someone buying a malaria drug within the program or not within the program, the program meaning the patient care program?

Jessica Vernon: Yes. The decision point there is usually, did they do a rapid test first and then only sell the malaria medication if the test was positive? Whereas it's a very strong norm in all of these countries that patients are just buying malaria drugs, even if they haven't been tested and aren't sure that they have malaria.

Ambika Samarthya-Howard: What is the incentive then for them to do the testing? The incentive of you paying them for that time?

Jessica Vernon: Yep.

Ambika Samarthya-Howard: And then for that patient care program that you were saying is like insurance?

 **Jessica Vernon:** Exactly. In the early days we would use this as our response for program sustainability but never really believed it would happen. But we're actually in the process of signing a contract with Lagos State Ministry of Health where they are paying us for delivering our malaria and fevers program via their state health insurance, which is a first for us and an exciting signal that governments may be interested in engaging more in future.

Ambika Samarthya-Howard: But that incentive does not go to the customer; it goes to the pharmacist. And the pharmacist, acting as an entrepreneur, will use that to get more money. Is that right?

Jessica Vernon: Yes—we wanted to build something that felt fairly similar to how health insurance works elsewhere, where the healthcare provider is compensated, not the patient.

Ambika Samarthya-Howard: Do you provide any incentives to the consumer?

 **Jessica Vernon:** The incentive to the consumer is in the form of a product discount. We have tested some models; there's very good literature on conditional cash transfers for certain things, especially for vaccines.

[Conditional cash transfers are when] you give somebody money in exchange for doing a thing. For vaccines, the usual use case is each time you come in to get vaccinated, you get paid, though in-kind contributions like lentils also have been shown to work well to promote behavior change.. And there are very strong randomized control trials showing that this leads to much higher vaccination rates. It leads to much higher [rates of] fully vaccinated children, because oftentimes you'll have people come in for the first couple but then drop off.

When we've done it in the past, we've always tried to frame it as a transport fee or a demand creation fee. So we've tested both peer-to-peer sorts of programs, where we're incentivizing somebody to create demand for a particular vaccine. This was mainly focused on Covid vaccination, and they would send somebody with a little card to go to the facility to get vaccinated, and then if that person presented that card and the person who counseled them on it would get paid. And then we would pay the transport fee for the person who came to the facility to get paid.

Ambika Samarthya-Howard: One of the other insights that we were talking about was training pharmacists to be more proactive—training them on how to sell things, training them on how to do the screenings and all of the marketing techniques. Can you tell me a little bit more in detail

what that training looks like? Is it in person? Do you go to them? How many hours is it? Is it virtual?

 **Jessica Vernon:** Private sector doesn't work like public sector. You don't get a per diem for showing up for trainings. And you often also don't get the revenue that you would've gotten for going to your business and just selling all day. So people don't show up for trainings unless they're really required to. Across everything we do, from onboarding to training on the software to this, we show up, physically. We sit with them in between them selling things to patients, because people are coming in all day to a pharmacy to do stuff and buy stuff and sit with them. Our first training to use the software is several hours, but then follow-up trainings on particular programs are faster—usually an hour or so. We also have put many of these online on our YouTube channel for reference.

Ambika Samarthya-Howard: That's time-intensive for your staff.

Jessica Vernon: Yeah. But if you do it once and you do it well, in theory, you don't need to do it again. And then you can just do over-the-phone things after that. So it is time-intensive, but it's also quite scalable.

 We've tested some virtual trainings as well. My perception of it is that it's similar to an in-person, which is that people don't want to sit through videos or whatever it is. The hook for pharmacists in many places is continuing medical education credits. Everybody needs a certain number to get relicensed each year, so if it's not done within this framework, there's not a strong incentive to do so.

Ambika Samarthya-Howard: What do you train them on?

 **Jessica Vernon:** I'll say as much as I know. In the eyeglasses training, we train them on how to do the screening, how to use the software, and how to link the results of the eyeglasses screening to the right power to be provided for the eyeglasses. That was the thing that was much more complex in the eyeglass program than in other programs: there's just a lot more inventory. And we've had to spend some time taking that out, because there's so many different powers and colors and all of that. Simplifying that part of it, both for the pharmacy and for the supply chain, is a future thing we're thinking about.

Ambika Samarthya-Howard: What are you thinking right now in terms of how you stock?

 **Jessica Vernon:** Our current thinking for the next phase is, if we're providing subsidized glasses, we can probably be a lot simpler in terms of the colors. Just stock the different powers that are needed, but not all of the different design options, and keep the SKUs simpler.

Ambika Samarthya-Howard: What's been the hardest part of this? As you're scaling, what are you watching out for?

 **Jessica Vernon:** There's a lot of really interesting debates happening about what these programs should look like, what success looks like. I think this question about sustainability is going to be the biggest and most important one at this next phase. Somebody very smart recently told me that there is a mismatch between the income benefits that have been found in the literature of a 20-30% increase and the need for subsidy. If the income benefits are as strong as the literature suggests, one would expect that many people would be willing to pay the full price.There's just a mismatch between those two things. I think it's a cognitive dissonance for people that we're going to have to be able to demonstrate in some way.

 You would expect that if the income gains are as big as they're being claimed to be that everybody would be willing to pay for glasses, and pay pretty high price points, but that's not what we see so far. So I think one of those two things must not be true. The income gains are really good for certain customer populations, but not for everyone. And then you have to target it very closely to make sure that you're reaching the patients or customers that most need to access eyeglasses, or you'll hopefully see when people buy a second pair of glasses, there will be much more willingness to pay a full cost for the eyeglasses.

Ambika Samarthya-Howard: Localization and scale don't always intersect. As you start going from 40 pharmacies to 4,000 and you're keeping this very localized, how are you intending to scale?

 **Jessica Vernon:** I think that we'll be testing a few things. The demand creation work that we did for this eyeglasses program is much more intensive than what we would normally do for other programs because we were running two arms and needed to hit our targets in a relatively short time. Because of how the pilot was structured, about 4,000 total patients accessed eyeglasses at only 15 pharmacies in the pilot over six months. So it was just sending large volumes of people to those particular facilities, because only 15 of the 40 were doing the full six-month period with that 150KES ($1.25) price point.

The biggest question that I have is whether we can be successful with more limited demand creation strategies centered on the pharmacy counseling the patient. The way we think about this is that in the 150KES ($1.25) arm with this program, pharmacies were selling 100+ glasses

per month, whereas in other programs we usually see 20-40 patients taking up a program each month.

If we can test more scalable demand creation models, we can begin making assumptions about what patient numbers per pharmacy and number of pharmacies are required to hit our targets and onboard additional pharmacies in order to reach the overall program targets. So I think we were seeing a hundred plus patients per month accessing eyeglasses in most of the 150KES ($1.25) pharmacies. And that's much higher than adoption rates we're seeing in other programs. But by adding to the number of pharmacies in the program, I think you're able to hit significant volumes.

Ambika Samarthya-Howard: A lot of the reason that you were able to see that was because of the radio and billboard campaigns, no?

 **Jessica Vernon:** We did some really nice analysis at the end of the period on what drove things the most, and it was actually just community led demand creation, not so much the billboards and radio ads. In theory, we know that the radio and billboards got a lot of eyeballs, and we saw that they got a lot of SMS codes delivered. But in terms of the actual numbers of patients accessing care, it was the community activations and interactivations that drove a lot of the numbers. But they're much more costly to do than other approaches. This is consistent with what we see in other programs—in-person engagement drives the highest program adoption.

 So I think the biggest question is, will we continue to try methods like that? In some of the countries where we operate, we ask the pharmacies themselves to lead a lot of that demand creation work in the community. So I think we'll experiment with whether there's certain things that we can do in partnership with the pharmacies where they're thinking through the right activities for themselves and where we're funding them a small amount in order to do that, which will further localize the program.

Ambika Samarthya-Howard: What are your thoughts on community health workers (CHWs) in eyeglasses, and how they work with pharmacies?

 **Jessica Vernon:** I think community health workers are great. I think they're wonderful for things that are more campaign style. If you have a lot of people in a particular community that need a particular thing, being able to have them go out and blanket the whole community is exactly the right approach. For certain geographies, I think that's wonderful.

I think there is very good academic literature on the targeting of subsidized products. There's a few papers by Pascaline Dupas and others looking at chlorine distributed by community health workers for free versus pharmacy pick up of the same chlorine. And they found that you can target things much better to people that actually want to use those things if you make it a two-step process. So if you blanket a whole community and say everybody gets a pair of glasses for free, you're going to give out a lot of the glasses, but you might not get as much use of them as you'd hoped, or you have a lot of people accepting them that don't necessarily intend to use them. Whereas if you give out a coupon where you say, go get these glasses for free or at a low cost, the people that actually do go and pick those things up are much more likely to use them when they are received.

Ambika Samarthya-Howard: Do you think you're going to ever integrate community health workers in your work?

 **Jessica Vernon:** We do some work with community health workers in various programs. They're very good at helping with demand creation. And so I think we'd be very interested in seeing if we can link up with community health workers and have a pick-up model with this voucher or test it in some way.

Ambika Samarthya-Howard: Can you give me one example of something you do with community health workers?

 **Jessica Vernon:** A lot of it is around this community demand creation. There are certain programs where somebody is already coming into a pharmacy intending to buy a thing, and that's usually true with malaria. People want to buy more malaria meds than they need. And so the problem is trying to get people to target treatment.

For malaria, we do it in-pharmacy. For family planning and HIV prevention, you need to do things outside of a pharmacy setting in the community. There's a lot of different types of demand creation that we've tested. We've used community based organizations and CHWs to do the demand creation to get people to go. And in all the cases where we've tried it, the community based organizations are not as good as CHWs. They're not as trusted. And so we prefer to use CHWs when we're doing community-based demand creation.

Ambika Samarthya-Howard: So you have the CHWs create the demand, and then they go to the pharmacy to get the thing?

 **Jessica Vernon:** Yeah. Usually they get some sort of card [to show at the pharmacy], and it's not actually that it's cheaper when they get to the pharmacy, it's just that the card lets us

know which CHW is particularly effective at creating that demand; this is consistent with the literature on program targeting using CHWs that I mentioned earlier.

Ambika Samarthya-Howard: Thanks so much for talking with me today.

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.*