# "We can bring multiple partners together": Misha Mahjabeen of VisionSpring on the Clear Vision Collective and running effective sales, marketing, and sensitization campaigns

Ambika Samarthya-Howard

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**Ambika Samarthya-Howard: Let's start by you telling me about what's going on with your current campaign. And maybe you can explain to me the relationship between VisionSpring and the Common Care campaign.**

**Misha Mahjabeen:** VisionSpring has three pillars, See to Earn, See to Learn, and See to be Safe. So whatever we do, we try to put them under these three broad categories. We have added sub elements to them. For example, the See to be Safe program is primarily for drivers who drive any kind of vehicle. These are big programs in India and in Africa. Then See to Learn is for children. That program is also pretty big in India. But in Bangladesh, we have predominantly worked in a See to Earn program.

The See to Earn program was associated with anything that impacts livelihood, productivity, and earning. Under See to Earn, we have our RGIL program. RGIL is Reading Glasses for Improved Livelihoods, which at the moment is one of the largest community-based screening programs for presbyopia. That program started back in 2006 with one of the implementing partners called BRAC, and the community health workers (CHWs) who you will be meeting are part of BRAC.

**Ambika Samarthya-Howard: Can you explain a little bit about the community health workers. They're still government employees, correct?**

 **Misha Mahjabeen:** No, [it's a] similar structure in India where they are government employees, but they work as volunteers. And when they work, [In India] they are called Anganwari workers.

The concept is similar and perhaps BRAC learned from the Anganwari concept, but the government of Bangladesh didn't have any program. They still do not. BRAC was running that, and the objective was to take basic healthcare to the villages. I think this CHW program started after they started working in Bangladesh around 52 years back, it was a very early concept. Because childhood mortality, maternal mortality, complications related to pregnancy, those were very high. Women were [more] shy then, they didn't know where to go.

The medical facilities were not very available in the remote corners of Bangladesh. So BRAC introduced this community health worker concept where these women were supposed to go to the homes, especially the homes which had pregnant women, a small child, or elderly who needed special care. They would periodically go and provide their services.

They started carrying a bag, which had a [blood] pressure machine, and gradually they added a diabetic machine, birth control pills. On one hand, pregnancy was the issue. On the other hand, they also saw that we needed to control the birth rate in rural areas. So they started promoting birth control through community health workers. They go and explain to the women how they can use birth control and they'll sell birth control. So their bag is like a small over-the-counter chamber, which only carries medicines that the government allows to be sold.

**Ambika Samarthya-Howard: And who trains them? BRAC trains them?**

 **Misha Mahjabeen:** BRAC trains them. So BRAC had a health program, [which has] changed over the years. They have lost a very big part of their funding. The European Union used to fund a big part of that. So they used to call this program HNPP, Health Nutrition and Population Program or something. H and N stood for health and nutrition.

**Ambika Samarthya-Howard: And do you feel like BRAC came in because the government wasn't able to provide those services?**

 **Misha Mahjabeen:** Yes. Initially it started like that. So if you study the development of the NGO sector in Bangladesh, you will see that many of the services started because the government was not present, or the government didn't have the capacity or the funding. But this private sector, I would call them private sector, non-government institutes, they were smart. They had networks, they brought the money, and they didn't have that bureaucracy. So they created the system and they went.

Microcredit became very widely acceptable because people wanted loans and they didn't know where to go, and we didn't have enough. Still today, we do not have enough bank branches in different parts of Bangladesh. So the NGO sector has really filled that gap, and BRAC is an early runner. BRAC's community health worker [program] became a big success because it was able to control the death threat, improve the quality of child nutrition, and elderly care.

Jordan Kassalow published a book or an article where he found that Bangladesh may not have a concept like Anganwari, but CHWs were close to that and we can use it. So around 25 years ago, he had a meeting with one of the BRAC's executive directors, then Mushtaque, and shared the idea. And for anything like that, which is a pilot, normally organizations are ready to accept and they'll be paid. So there was no reason to say no.

They started with only 50 community health workers who were trained by Jordan and his small team. And the first five years [there] was very close hand holding from Jordan. He used to send the glasses and BRAC was only the implementor. After five years, someone in BRAC took that up as an institutional approach. I have not met him. I have heard great stories about him. He actually felt that this program had a lot of potential and it should not be kept within that small location.

 All of the community health workers need to be trained if we really want to take the service to the larger community. So he took that responsibility, he started training, he started creating trainers for this. And this training is very easy, the screening is very easy. So today around 37,000 community health workers do that. Besides them, there are field officers of BRAC who also contribute to that.

 Now, not all community health workers are active. Not everyone is very good. Perhaps 10% are very good and very dedicated. [They are] very motivated. But even for a country like ours, it has [provided] benefits, which otherwise we would not have been able to do. The community health workers are not salaried. When they sell, whatever sales they do, I do not know how much they get out of the other sales, but they get a commission on each of the things that they sell from their bag. And for our glasses, when they sell the glasses, I think they get around 30 cents commission.

**Ambika Samarthya-Howard: And what is the price point that they're selling the glasses at? And also, where does your supply currently come from?**

 **Misha Mahjabeen:** The glasses are sent by VisionSpring. We get them manufactured in China at the moment. Earlier we used to get them sourced in Bangladesh, but the Bangladesh source failed to meet the deadlines. So we shifted the order to China. The manufacturer sends the

product to BRAC and then BRAC distributes the glasses to the community health workers through their regional offices.

 For example, if I'm a community health worker, I'm doing your screening, and you need glasses. You say that, okay, I'm going to take the glasses. I give you the glasses and you give me $1.25 (just converting with the current exchange rate). The eye screening is free, but when I give you the glasses, we charge a minimal fee for it. So you give me $1.25. I take that $1.25, I go back to my office, I deposit the money. (I'm sure there are weekly batches or monthly batches where they accumulate the money and then submit. When I submit the money to the BRAC office, they take a total. For example, if I have submitted money for 30 glasses, I'll get 30 [times] 30 cents as my monthly commission, e.g. And when BRAC sends us the invoice, because their budget has ABCDE and say F is the price of the glasses, and because they're getting the glasses for free but they're collecting the money from the field, when they invoice, we deduct that amount from their invoice and send them the rest of the money.

**Ambika Samarthya-Howard: How did you decide on the $1.25? How long has it been at that price?**

 **Misha Mahjabeen:** I think for around five years. In 2006, when they started, they used to charge 100 Taka. 100 Taka was around $1.50 or so back then. Because of the Dollar devaluation, it has changed. It used to be 100 Taka, and then, the price was increased to150 Taka. And I don't know how it was decided. Perhaps the objective was to create a very affordable price point.

I still think given the Bangladeshi economic context, 150 Taka is okay for the majority of [people]. These people in the community, they're very interesting. They do not save their money in their seasons when they are producing. They get a lot of money. And I have interviewed them. What do you do with this money? Sometimes they have invested, for example, say 50,000 Taka in their farming. And from the sale of the produce, they have made five times more money. But they're not going to keep that money in the bank. They'll buy, say two cows, they'll renovate their home, they'll buy new land. So they will reinvest.

And I ask them why they don't keep some part of that money in the bank? Because you spend, but at some point you are again looking for cash. They're like, "It's okay, we don't trust the bank. We don't want to go to the bank." So it's not always the availability of banks. Sometimes it's just that they don't trust [banks]. BRAC itself owns one of the largest banks in Bangladesh. I know how much they are trying to convince people to put their money in the bank, but people won't agree. So it's a very interesting thing.

So when they have more money, 150 Taka is nothing for them. Sometimes they will ask for more expensive options, they're ready to pay 500, 600 Taka. But then when they don't have money, they

will say, okay, I'll come back later. So technically, money is not a problem, at least as per my understanding. Because in Africa, glasses in the RGIL program are sold for almost $3-5, but still more people are buying them.

 So in terms of understanding, still today glasses are seen as a product for educated people. And when it comes to reading glasses, the moment someone says they're going to sell reading glasses, they'll say, "But I don't know how to read. Why would I take reading glasses?" Now we are changing our wording [from] being called reading glasses. It is actually glasses for near vision, any work that you do in the proximity. And 99% of work happens within your close proximity. Either you are eating, sleeping, reading, whatever you are doing, cooking, cutting. You don't need to see far. You need to see clearly.

**Ambika Samarthya-Howard: Okay. Let's go to the current things that you're doing in Sherpur.**

**Misha Mahjabeen:** RGIL [has been] happening for the last 18 years. And it's mostly a donor driven model. Only the glasses portion is being paid by the beneficiary. Last year we also developed a different model with new partners, where we are not bringing the donors money directly.

 We are encouraging village-based entrepreneurs, like community health workers. Other organizations now also have similar agents or health workers, field workers like that who work as business agents. They take products and services from different companies and they offer them as a bundle to people in the community. And they make a margin off of it.

It's not a hundred percent sustainable yet, still some funds are being injected. However, it is far less costly than the BRAC model. I was telling you that BRAC had their HNPP program. Now they have changed the HNPP program to BRAC health program, and they have stopped their health programs [in some districts]. Bangladesh has 64 districts. It is divided into 64 parts, which are called districts. Multiple districts make a division. So with BRAC, we were present in all the districts minus three. They're not working in three hilly areas. But in the remaining 61 districts, they had their HNPP program and our MOU agreement was with HNPP. But in the last two years, HNPP has taken their operation out of 27 districts because they lost funding.

So now they're thinking of a different model. But just to make sure that we are present in those areas, we are actually paying more so that BRAC can still continue to do their health program in those regions. In the coming days, they'll be bringing other organizations, other partners, into that also to make it more beneficial. But we realized that we have to go to these other sustainable models and gradually build them up.

And now what is happening in Sherpur? So CVC, Clear Vision Collective or Clear Vision Coalition, it's a concept. Around five years back, Reade [Fahs], he used to be the chairman of the board, he's

the CEO of National Vision, the eye care retail brand. So he was in the chair and he and Ella realized that there are different eye care partners in Bangladesh and in other parts of the world also.

 So everyone does their own work in the area. They do not collaborate with other partners or the government. So sometimes there is duplication of efforts. And sometimes some areas do not get any services. And then, no one knows what the final numbers actually look like. So they realized that if we can bring multiple partners together for one location and do a proper pre-planning of who does what in which locations, then perhaps we would be able to serve more people in a better manner, in a more cost-effective manner.

**Ambika Samarthya-Howard: So CVC is happening in Sherpur right now? Is it a trial or a test?**

**Misha Mahjabeen:** Yes. It's a very long-running test. It started five years back. And we can assume that for almost one and a half years, nothing happened because of Corona. So it's [been] operational for around three and a half years. And you understand the concept. They had that very noble objective.

They selected Sherpur for various reasons. Sherpur was one location where multiple eye care partners were present. And in Bangladesh, actually VisionSpring, I can proudly say, is the only eye care provider who is present in all the districts. Everyone focuses on five to seven districts max. And we were able to work in all the regions because we chose partners. Now we have five partners and everyone has a presence in different areas, and that is how we are trying to cover as much as possible.

 I know NGOs who are working in only two or three regions, and everything is based on the money that they're getting from donors. So Sherpur seemed like an area where multiple partners or players are present, the government is active, and there are also some good, mission driven hospitals [where the] mission aligned with us. So we chose Sherpur and we onboarded the local government. Then Orbis, BNSB, it's a local hospital who had a partnership with Orbis. Sightsavers initially was onboarded, but then for some technical reasons they had to drop off. And VisionSpring is part of it. Now, VisionSpring has multiple units. One, our RGIL program is operational there. And during that time, we also started our pharmacy pilot in Sherpur. Ella suggested that the pharmacy be part of this project as well because we should try to bring as many eye care partners as possible in Sherpur.

So it started with that objective. And what Ella eventually wanted to do is that, after the first or second year, all the partners would start bringing their fund contributions or resource contributions in it. Unfortunately, everyone took it as a one-way project where VisionSpring is managing some funds that are paying for their additional screenings in Sherpur. They were happy with that. So technically CVC has not reached its potential.

We have definitely gained some benefits because for example, perhaps we would have done 100 screenings, but because of this concept of CVC and a bit of planning of where services are missing, they're doing say 110 screenings. Unfortunately we still do not have a study of how much additional contribution we have been able to create from CVC.

But we do see more coverage, more awareness in Sherpur. When they started, there was a baseline. And when we compared the baseline data with the current government data, we saw that Sherpur has shown significant improvement. So we understood that indirectly there were some benefits, some impacts that this concept is making. Now we are trying to create a better model for CVC. So Rofiqul is the leader of CVC. He's not directly a VisionSpring employee. I am a member of CVC. I do not get into the operation of CVC. My objective is to see whether RGIL is operating well in Sherpur, [whether the] pharmacy is doing well in Sherpur, whether I need to do anything extra to facilitate the work of the CVC.

**Ambika Samarthya-Howard: You're a VisionSpring employee, right?**

**Misha Mahjabeen:** Yes.

**Ambika Samarthya-Howard: The campaign's been going on for five years, really three and a half years. Is the campaign ending in the next two weeks?**

**Misha Mahjabeen:** No, no. What I explained was the operational model. Everyone is doing their work. However, I think in 2022, when they started discussing the challenges that they face, everyone accepted that there are a lot of awareness issues. And there are two levels of awareness. One is that people do not know about general eye care. The second is they do not know that they can get the services from a specific location. The availability of the service provider was not understood.

 CVC came together and they said we can do a campaign under CVC, so it doesn't need to be an Orbis campaign or a VisionSpring campaign, CVC together can do a campaign on awareness. And we can tell more people “This is why you need to take care of your eyes, that reading glasses are not only for reading purposes, it can do so much more. It can bring miracles in your life. You should have reading glasses and these are the places where you can go to get your service.” Then perhaps CVC will be able to cater to more people and create more impact.

 So they started designing the campaign, but bringing seven, eight partners together was definitely a challenge. At that point, we did not have good personnel looking after CVC. I was not there. I joined VisionSpring in November 2022. So I can share my experience. When I started taking briefings about different departments, CVC came as a department. However, I was told that CVC is not a department, it is a separate unit. It's a coalition and you have to support it as a

member of CVC from VisionSpring's side. And after two months of my joining, I was told that we wanted to do a campaign around a year back, but nothing has happened.

So in 2023 January, the CVC members, we all sat together. And because they have longer experiences working in Sherpur and in eye care, I took their inputs on what kind of a campaign [we should run]. Because the campaign objective was very clear. They wanted to create awareness. They wanted to tell people where they should go for service. Because if these two are being met, then obviously the number of people taking the service will increase, which means the ultimate objective of creating CVC will be achieved. And then we can show the world that, yes, if you can bring resources together from different organizations, you can create better results.

So yes, we still want to announce Sherpur as the first Clear Vision district. We are on the path of that, but the campaign got delayed. So we started the idea generation last January. But again, we didn't have a leader to run CVC. The person who was looking after it was basically a coordinator. And Ella realized that a coordinator won't be able to design a campaign or run a campaign. So he was removed from the position and we started looking for an alternative. So Rofiqul joined us in September last year. Rofiqul comes with 33 years of experience in eye care with Sightsavers. He has been one of the active program managers of Sightsavers. And everyone in the eye industry knows him for his honesty, for his hard work, for his depth about eye care.

He's one of the most knowledgeable people and really dedicated to the course. After he joined [CVC], a lot of the things have become organized and he pushed the implementation of the campaign. So we wanted to launch in November, but it was just around the time when election preparations were starting. And election time gets really messy in these rural areas. So we decided to push it back [until] after the election. So finally the first phase of the campaign started at the end of January or in February. And because they planned it for a three-month period, the Ramadan month came in between. So again, they divided the campaign into two parts. One part happened before Ramadan, and the second part is starting this week.

**Ambika Samarthya-Howard: What's the main things you are trying to test in the campaign?**

**Misha Mahjabeen:** Because the objective was to increase awareness, they're trying to measure whether the messages sent or distributed through this kind of campaign can create awareness. And are more people coming to the camps compared to earlier times. So the first phase of the campaign was really successful from that angle. Because normally when there's a camp, 12, 15, max 20 people would come, but now, with the awareness campaign, the events – they do some music and stuff like that – 200, 300 people come. And from there, 60, 70, 80 people are coming for the eye screening.

The conversion rate is also higher because in the awareness part, they also emphasize the benefits of why they should [get glasses]. So the conversion rates have also improved. This is a pilot and this is expensive, and honestly, CVC doesn't have the funds to run it in the long-term.

**Ambika Samarthya-Howard: You said there's about 200 people who started coming to the camps and a significant amount of them have come for eye care. What's everybody else coming to the camps for?**

**Misha Mahjabeen:** For entertainment. This promotion campaign has some rural singers and artists. They do dramas, they do interactions. Through comedy, they try to emphasize the importance [of eye care and reading glasses]. Village people do not have much entertainment. So the first thing that attracts them is the element of entertainment. And when they come, they hear the message. Then they feel like, okay, I can do the screening. And the screenings are free. So more people are coming for screening and more people are buying the glasses when they're being prescribed.

**Ambika Samarthya-Howard: The people who don't buy the glasses after they're being prescribed, what do you think that's about?**

**Misha Mahjabeen:** Well, we are actually launching a different study for that. Just this month a team is coming.

I come from a commercial background. I used to be mostly in sales in my earlier jobs. So when I'm trying to sell, if we were distributing glasses for free and even after that people were not taking, it would have been a different red flag. But now people have to pay. So obviously whenever people have to pay for something, no matter how important that product is, a lot of judgment comes in. And people give a lot of excuses. I have heard women saying, “Oh, I feel shy. How will I look?” So those things are there. But if you ask me if they are big enough, I will say no. Because Bangladesh has radically changed in the last couple of years. And yes, people are still poor, people are shy, that's fine. But I do not think a majority of them are still shy to wear glasses or shy to accept the fact that women would wear glasses.

This is just my assumption, but from the sales perspective, I think that the person who's selling could have done a better job because sales require a lot of frustration, a lot of words that you have to use to fetch people's money, and transfer it from their account to your account. It doesn't matter how good the service is, even if you're buying the best product, you have to convince yourself that this is good for my kids, this is good for me, when you first make that decision to purchase something. The same is true for these people. This is very, very much my personal observation. I think 20 people come, say ten of them need glasses. Of them, five take glasses. For the remaining seven who are not taking glasses, perhaps the community health

worker or the person who is selling doesn't give that extra effort. But these are all my assumptions.

**Ambika Samarthya-Howard: We've heard that a lot.**

**Misha Mahjabeen:** It's not about dedication. It's about different ball games. I have been in sales of Mercedes Benz. I used to be the CEO of the Mercedes dealer of Bangladesh. So I've sold cars worth [hundreds of thousands of] dollars. And then I have also sold salads, for example $3 salads. The same person who is buying a Mercedes Benz would ask 10 questions before buying that $3 salad. Because it's about money, it's about that transfer happening. So it really mattered how much effort I was giving.

 I realized at one point that the effort that I was giving in selling a $3 salad was no less than what the effort that I was giving in selling that $300,000 car. It was all about the benefits that you'd get, what are the features, how those features will turn into benefits for your personal life, your professional life, your health, your look, your status. Hundreds of questions which needed to be answered. Perhaps the seller is thinking why would I spend so much energy, effort, time, or words to sell something against which I will get 30 cents. I would rather go home and take a rest in the shade. So if you meet a sales person, a community [health worker] who is doing extremely well, you see, they're very driven. And as I said, the percentage of driven people is less.

**Ambika Samarthya-Howard: Are there both community health workers and pharmacists working in Sherpur?**

 **Misha Mahjabeen:** Yes. So when I say we have BRAC's RGIL program in Sherpur, BRAC's RGIL program would only mean their community health workers and field officers that are doing these screenings. BRAC does not use any other modality. And for our vision camps with BRAC, we only use community health workers. However, on top of our RGIL program, BRAC has their own vision centers in Sherpur also. Some of those vision centers are funded by Sightsavers, I think, one is funded by Orbis. So there are multiple donors who have funded the vision centers, which are physical establishments.

They have an optical shop, they have a screening facility where mostly refractionists sit and they have online connectivity. A refractionist is someone who has a one to two year diploma degree. If they identify someone with a complicated problem, they will connect with a doctor in the city or in a district hub and get their eyes checked or refer them to another hospital. Like if someone has cataracts, then they will refer them to the hospital.

**Ambika Samarthya-Howard: So that's a little bit different from pharmacists?**

**Misha Mahjabeen:** Yes. The pharmacy is a different project [that] is in a piloting phase. The pharmacies are slightly dispersed in different locations, but Sherpur now has 25 plus pharmacists. We are experimenting with different models, and VisionSpring was the first organization that wanted to use a pharmacy model for presbyopia.

**Ambika Samarthya-Howard: What is the relationship between the pharmacists in Sherpur and how they are trained, and then the community health workers from BRAC? Do they talk to each other? Do they get trained together?**

**Misha Mahjabeen:** Community health workers are trained under BRAC's program. And when they get the initial training, our manager, a major part of the work that my manager does is train people. And then he does basic coordination. But Anupam, who will be traveling with you, is a very good trainer and camp organizer. So he trains the community health workers, or he trains the trainers for BRAC, who can further train other community health workers. It's a separate program.

**Ambika Samarthya-Howard: And then who trains the pharmacist in VisionSpring?**

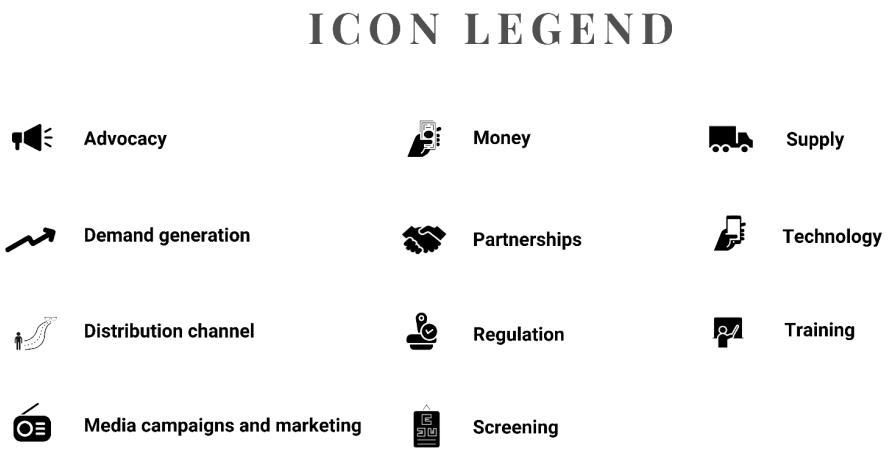
**Misha Mahjabeen:** The pharmacists are separately trained, but they're again trained by our pharmacy lead [within] VisionSpring. We do that directly because, for community health workers, we are talking about 37,000 people, and they have been trained over this 18 year phase.

**Ambika Samarthya-Howard: So they don't interact?**

**Misha Mahjabeen:** No, not formally. Informally, they're from the same community. But no formal interaction. And because the pharmacist's main responsibility is not to sell glasses in Bangladesh. Not only in Bangladesh, globally, it's a very new concept. And for Bangladesh, it's like a strong experiment, I must say. And the pharmacists have a lot of questions like, why?

And the effort. Everyone thinks about the time and effort that goes in doing the screening, and we encourage them to do the screening for free. The same as the CVW program, like the RGIL program, they do the screening for free and they sell the glasses. But the pharmacists hold more variations. The community health workers will only hold glasses of one type, which can be sold 150 Taka. But the pharmacist holds three categories. So three price points – 150, 160, and another one is for 200. So different variations. And we are also thinking of adding more variations in 2025 as we are seeing that more affluent groups in the rural community visit the pharmacy, and at times they ask for variations and they're ready to pay higher [prices].

**Ambika Samarthya-Howard: Thank you so much. This is a lot of background I didn't know, so I'm really glad that we talked now.**

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** This interview has been edited and condensed.*