"We needed to go into the community in a big way": Naomi Kiiru of Digital Divide Data on making data work for you, turning research into action and navigating difficult government policies

Ambika Samarthya-Howard

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Ambika Samarthya-Howard: Could you start by introducing yourself and your background working on this issue?

Naomi Kiiru: I work with Digital Divide Data (DDD), we're the organization implementing the reading glasses project on the ground. DDD has an extensive background in field operations. I used to manage projects in our research and analytics department where we did social research in different programs, mostly on financial inclusion and empowerment.

Ambika Samarthya-Howard: That's how I remember the organization. I was really surprised because I'm very familiar with the organization and your work and I'm like, "Why am I interviewing them about eyeglasses?"

Naomi Kiiru: Funny, funny thing. We kind of evolved. Research kind of evolved into programs now, and in fact this is the second program that we're working on. We have the reading glasses program, and I am the lead for the project on DDD's end.

Ambika Samarthya-Howard: Can you tell me a little bit about your model, about the program that you're running and how it relates to DDD's approach and mission.

Naomi Kiiru: When Abi came to us about the reading glasses program, I remember the first thing we talked about was that the Livelihood Impact Fund (LIF) was interested in distributing glasses and she was looking for something different. A different model of doing this. So she had all this

research and information from what the supplier, VisionSpring, has done, and we are kind of the second organization to attempt the field model. By that I mean they wanted to look at whether we could distribute these glasses in Kenya through field contractors instead of having Vision Camps. Because those were the most preferred methods.

In fact, VisionSpring talks about vision camps so much, it is the most commonly used method of distribution. So I wanted to look at something different. One of the things Abi pointed out was that vision camps appear to be very costly. They wanted to look at if we could cut that cost and look at a different strategy. And then now this is where DDD's background in field operations came in and luckily, since I'm the one who used to work in operations, especially for research and monitoring and evaluation, I had all this information on what we had tried, what worked, what did not work. And that's what we implemented during the final phase.

We came up with a design that involved use of field contractors. We have this huge network of field contractors all over Kenya. We've worked in many counties, up to 15 counties in Kenya, except for some of the counties in the arid and semi-arid regions where it's hard to even do research. We looked at how best we can distribute these glasses in the field and we decided to do a blended model of door-to-door. Our field contractors, we planned how they would visit people either in their workplaces or in their homes.

Ambika Samarthya-Howard: I'm sorry, just a small clarification. When you say field contractors, would you say that they're like pharmacists or they're like community health workers? How would you describe them?

Naomi Kiiru: Initially, we worked with contractors who had a background in data collection, the guys we used to use for research. In research work, we'd hire contractors specific to a county because some of them needed to speak the vernacular language there. So these are the people we reached out to to help us take the glasses round. They would have the glasses in a backpack, put on this branded vest and go to shopping centers, marketplaces and people's homes talking about this.

Ambika Samarthya-Howard: So they're not health professionals, Naomi? They're not in any way or context health professionals?

Naomi Kiiru: We have had two phases in the pilot. In the beginning, no, they were not health professionals, they were not related in any way to the health sector. But this second phase of the pilot is when we worked with people who are close. [There is] overlap in what they do, we call them mobilizers. So you see how we have a lot of NGOs all over Kenya and they usually require people who can communicate or spread word within the communities. We refer to them generally as mobilizers, they'll go on foot, they'll deliver whatever message needs to be delivered or whatever intervention. And these are the people we try to bring in.

The Ministry of Health made it clear that community health promoters are not allowed to carry any products with them, [that's why we steered away from community health workers]. We couldn't task them. So we didn't want to interfere with that.

Ambika Samarthya-Howard: Is that just for you or is that for everybody?

Naomi Kiiru: It's across Kenya. Across the country. Besides glasses, there are other programs selling charcoal-burning stoves, there are energy saving stoves, there are distributors of mosquito nets. They're not allowed to carry such. So that's why we stayed away. We didn't want to invoke the wrath of the government.

Ambika Samarthya-Howard: Do you know why that regulation is in place?

Naomi Kiiru: Actually, I've never gotten to the root of it. I don't know whether it speaks to the efficiency of what a health promoter is expected to do because they already have this thing they're doing for the Ministry. In fact, there was a launch with the government. They have this intensive walk up that they have to do per household. So adding products on top of that might end up stretching them a little bit. That's why we try to stay away from the health promoters, [and work with] the mobilizers who have even worked with other NGOs and other community programs to help reach more people.

We worked with mobilizers in the second phase. For the first phase, we only worked with contractors who have backgrounds in sales and data collection, but within their communities they can speak the local language and that's something we wanted to try to reach the consumers within their communities. We were also looking at people who are mostly uninsured. Looking at the population in Kenya, there's a very small percentage of people who are insured. Mostly those who are in formal employment. A lot of the others are in temporary contractual work or casual jobs, most of them are uninsured. So we wanted to target these [uninsured] people and we looked at what is the best way of targeting them.

Ambika Samarthya-Howard: Can you give me a sense of the first phase? When and for how long did you use the data collection contractors? How many contractors did you have? A sense of the breadth of time, the breadth of glasses.

Naomi Kiiru: The project started in July with training, but the fieldwork, the actual distribution of the glasses took place in August and September [2023]. We started with a team of 80 field contractors. We had nine teams, a bunch of them (10) under a supervisor who could help coordinate, like they've already been to this region, now cover this other region tomorrow like that. So that's how we went about it. We worked with them from August to October, but then in October we noticed that the projections we had were quite low. The actual numbers we had were low

because we had projected that they'd be able to visit close to 4,000 households or screen 4,000 people in a week.

Ambika Samarthya-Howard: So you were thinking each of the 80 contractors would screen 50 people a week?

Naomi Kiiru: Yes, close to that. Actually, that's the exact number we worked with. So at the end of two months, we expected that they would have reached at least something above 20,000 people.

Ambika Samarthya-Howard: That makes sense. That's what I would've thought too.

  **Naomi Kiiru:** Yeah, but when we looked at the actual data, they'd only engaged with a little over a thousand people, which was quite low. And then going to the field, we discovered that actually they haven't been going out. They got discouraged. The number one [issue was] with authorization. Getting authorization in the field was quite a nightmare. A lot of the regions that we went to like shopping centers and marketplaces, these local government authorities insist on having these special letters from, I don't know how many people, but many different offices within Kenya. And that was a challenge for week one and two, which killed their morale.

 By the time we got our work around, and eventually we did get our work around which was we went through the county authorities. We have counties in Kenya. So we went through the county commissioner and that's where we got the authorization to do that. But by then, we had lost so much traction in how to do field work. Field agents were like, "We haven't been able to screen a lot of people," and considering we were compensating them based on the number of people they screened, that killed their morale. They didn't screen many people, so they earned little money.

So by the end of October, we decided to actually change things. We were doing this in three counties. We started with Bomet, Narok and Kiambu counties. We targeted these counties because they have high populations. We were looking at targeting a county with as many people as possible. So that's why we started with the three. We also looked at where we're likely to get the uninsured people. Again, [we selected] these counties because in most of them, the economic activity is agriculture. So that's why we started with that.

But then after some time, we realized we had a lot of untapped door-to-door sales. Our field contractors weren't going around as much. Internally, project management efforts were very stretched. It became a bit difficult to manage all these teams. So we decided, why don't we first of all focus on only one county and something close to the office because I'm the one who was doing this. I could quickly check in, and if anything came up, I could easily step in.

There were challenges in dealing with authorization from the county governments. Some of those challenges required me to step in, but it's a long way from the office to those counties. So that's

why we brought the project closer. We brought it to Nairobi County. In Nairobi County, we set up three teams. Instead of the 80 contractors and the nine supervisors, we ended up having 45 contractors and three supervisors in Nairobi.

Ambika Samarthya-Howard: You were trying to reach 20,000 initially and you got to 1,000. How did those thousand households respond? Did any of those people get glasses or what was the percentage?

Naomi Kiiru: Actually, we sold a couple. Out of a thousand, actually we had 1,122 people who we screened. Whenever someone came up and got their vision tested, we entered their details. So out of that, we were able to sell 721 pairs of glasses.

Ambika Samarthya-Howard: So that's 721 pairs from 1,122 people? That's a big deal.

 **Naomi Kiiru:** It is, but let me clarify. At the beginning we also had the challenges of recording information. So this was the first team. Number one, they were not sure which kind of people we were entering data for and which people we weren't. In fact, they started by only recording information on the sales made until we clarified that and we were like, "You have to enter information for everyone you screen."

 Numbers on screening started growing at the end, the last two weeks of October. So it's not a very good representation of the total people screened. And that's one of the indicators that things weren't right. Whatever training we had done, they hadn't grasped it completely. We needed to go back and re-train the contractors.

Ambika Samarthya-Howard: I just want to reiterate this nuance. What you're trying to say is that the reason that the numbers feel so inflated is because initially they only recorded when they sold a pair as opposed to when they screened. Did I understand that right?

Naomi Kiiru: Yes, that's correct. They started by only recording data on the people they sold glasses to. But then we clarified that we needed data on all the people they had screened.

Ambika Samarthya-Howard: And the screening happened before they sell glasses, right? First you screen and then you sell.

Naomi Kiiru: Yes. The screening would happen first. So they first of all have to identify people who reach the age limit. We were targeting people who are 35 years and above. And then from there, if someone agreed to have their vision tested by our field contractors, we got to enter that data.

There's a part where you ask for their name and phone number. If they chose to withhold that data, we still entered an “A”, [indicating they] didn't provide a name. This is how we instructed our field contractors to enter data if someone did not volunteer their contact information and. For age, they would estimate. Look at this person, how old are they likely to be? And then the rest of the

details are based on the results from the vision screening. Do they have a problem with distance vision? Do they have other eye complications? Do they have no problems or do they have presbyopia? Which would be the correct power for their problem? Did they buy or not? That's the data we gathered.

Ambika Samarthya-Howard: Okay, that's great. So now we're in October and you've done this and then I think you're telling me what's happened since October, to now?

 **Naomi Kiiru:** From October we decided to bring the project closer to Nairobi, in the same county as [our] office. We hired 45 field contractors and then we put them under three teams. So instead of going now per county, we went by the subcounty. We selected three subcounties of really low income populations. They're the informal settlements in Nairobi. One is called Mathare, another one is called Kibera, and another one is called the Viwandani. Viwandani is kind of like the industrial area within Nairobi. That's where we had our field contractors.

We applied the same model where we asked them to go around to people's homes or places of work. And let me add, this also applied even in the first phase of the pilot. So on top of doing the door-to-door visits, they were supposed to have this community screening event we called Vision Blocks. Field supervisors were to organize a Vision Block in a common or high foot traffic area.

Ambika Samarthya-Howard: How would you distinguish a Vision Block from the Vision Camps?

 **Naomi Kiiru:** Vision Blocks are done at the community level. So typical Vision Camps in Kenya, a whole organization like a major hospital or a major organization, they'll probably bring in a team of doctors, other medics, and they'll be able to serve a lot of people for a lot of issues, not just vision. Or maybe even with vision, they look at “do you have problems with cataracts, do you have problems with distance vision?” Like that. But for us, we didn't have that capability, so we only focused on people who had a problem with presbyopia. The problems with near vision tasks.

 The whole point was during the door-to-door visits, contractors would screen people. People who are not ready to buy would be told about a date, they'd be given a date and a venue to come see us. When they're ready with the money, they’d come to our Vision Block at their local chief's office and there, you'll be able to get your pair. Because we also considered some of the uninsured people, people in the middle to low income section of the population, they don't always have money ready to buy. By the way, we were selling the glasses at 399 shillings. It's really reduced because reading glasses in Kenya will retail for somewhere above 2,000 or 3,000 shillings.

 We wanted people to at least be aware, if they’re not ready today, they know we are here. We are selling glasses and they're really affordable. So why don't you come at the end of the week,

probably on a Saturday to the chief's office where we'll have more glasses and our entire team will be there? So that's how we did the Vision Blocks. We didn't come in vehicles, have all this screening equipment, computerized testing. People here expect computerized tests at Vision camps.

Ambika Samarthya-Howard: Do you feel like the Vision Blocks worked? And what do you think about them felt like it worked?

 **Naomi Kiiru:** The Vision Blocks, I can't say they did not work, but I also [can't] say that they worked. And the reason for that is that we did not get to fully explore them. When we started the Vision Blocks, we thought they'd be these events that can be easily organized in the community by our supervisors. But with time, as they tried that, they attempted about five of them. And then we learned they require all these logistics around them. [Things like monitoring rain] because during that season we started experiencing heavy rains in Kenya. In case it rains, we need something like a tent, we need at least five chairs for the consumers and such. And then at the end of the day, we need to carry all this equipment to a storage facility, then keep bringing it out to every Vision Block. So we were like, "No, we need to first of all revisit and re-evaluate how we carry out the Vision Blocks."

 And then on the awareness, we had to mobilize so many people to ensure that we had good numbers for our Vision Block, which is something that we hadn't invested a lot more in. Our awareness was primarily through posters. We had these A3 posters, but there weren't as many. And our field contractors wore these blue marketing vests that carried the message, "I do free vision screening." So they're okay, they're good, but they don't complete the loop. We needed more. We needed megaphones to draw attention, we needed things like flyers for people to hold in their hand. We needed to go into the community in a big way.

And I say that because this is a lesson we discovered when we conducted a focus group in phase two. In phase two we did an evaluation within the project to understand what are some of the things that were working. Besides what data is telling us, what more can we learn from field work? And so the consumers told us we needed to create a bigger impact to be more known within the community, so that people can show up for these Vision Blocks because again, the turnout was still low. So that's why I'm saying, at this point, we still can't say whether the Vision Blocks worked or not because we did not fully explore them.

Ambika Samarthya-Howard: Can we talk a little bit about numbers for the Vision Block? How long was it, how many people attended, how many people worked there, and how many glasses you sold?

 **Naomi Kiiru:** We ended up having six Vision Blocks in total. There weren't very many. So the number of people who came in during the Vision Blocks varied so much, between 50 and 100. Turnout was low. So this is per Vision Block. Let me say for six Vision Blocks, we received from 50 to 100 people each.

And then for the sales, the sales were good. We had a high number of sales because these were people who were coming in after they had learned about the glasses, during their sensitization and awareness during the door-to-door.

Ambika Samarthya-Howard: Oh, I see. So this was almost their second touch point? A lot of people had already heard about it?

Naomi Kiiru: Yes. They just came in to complete something they'd already started. We ended up with six of them. I'm giving you the average because when we ended up tracking, we didn't have specific figures. We just noted how many people were received on a given day, the next day, for the six. That's how we went about it. But we are now looking at doing Vision Blocks in a bigger way because we've noticed that our sensitization and awareness needs a lot of work. We are planning to invest heavily in it.

Ambika Samarthya-Howard: So when you say that, you mean marketing, right?

Naomi Kiiru: Well, I'm not sure whether marketing is the right word. We want to do these through our field contractors, but we are not going to use anything like [social] media. Not yet. At this time, it's still not in our plan, but we plan to use the posters and the flyers. And maybe in addition to that, have megaphones. Field Agents can go around announcing our Vision Blocks.

Ambika Samarthya-Howard: It seems like what I'm hearing from you is that the Vision Blocks are really only as good as the investment to drive people to it. And it's really hard to tell at this point if it really worked because there weren't as many people there as you wanted.

 **Naomi Kiiru:** There weren't as many people, but it's because there wasn't as much effort put into driving people to come. So we want to see whether driving people [will help]. Some of the insights we gathered during our evaluation, going door-to-door, the conversion is very low. So I gave you the numbers for the first phase of the pilot. And then for the second phase, this is from November, December, January until now, when we looked at the numbers on mobilization, they kind of went up because we put a lot of emphasis on it. We wanted our team to get the word out.

Ambika Samarthya-Howard: So when you say you put a lot of emphasis, can you tell me some of the things that you did?

 **Naomi Kiiru**: This was through training. Our training has been evolving. This time around, when we came to Nairobi, we did this internally at DDD and we emphasized this during training, that we need to record all data. We took our contractors through the whole field work process, and we introduced them to the vision problems. Then we told them what to do when they're out in the field, you meet a person, how you engage them, how you get their information. And then screening them, taking them through the different tests to see what problem they have and then finding out whichever power of glasses they need.

We put a lot of emphasis on entering data. In the first group, data recording wasn't so intense. In fact, training for the first team focused mostly on the vision problems. But on the second team in Nairobi, we focused on the fieldwork process so that we could capture the data. So with that, we were able to get more accurate data. I'll say more accurate, but again, from the interviews we conducted with some of our contractors, they engaged so many people within a day on the door-to-door model, so they don't always enter all the information because of the rate at which people come to them.

So someone will, for example, speak to 20 to 30 people trying to explain to them what the project is about. If they go to a shopping center, start speaking to one person, they'll draw in a crowd. Talk to all these people, but by the end, when they start screening, some people will now go away when they realize, "Oh, it's about glasses. I'm not the right age, or profile." So you see, we still end up missing some of this data. How many people did you engage with or talk to? [Things] like that.

Ambika Samarthya-Howard: So from November to March, you focused much more on this part of the training. And then you were saying that you had your second phase of the pilot.

 **Naomi Kiiru:** We had a second phase. We engaged a little over 2,000 people and we were able to sell 373 glasses, but the people who were in need were 587. So we identified 587 people who needed reading glasses, but only 373 were able to buy them. Challenges here were very varied, but the main one that stood out was because in the settlements we targeted, consumers had challenges with competing household needs. I told you that we targeted the informal settlements. So these are people who finding work is next to impossible. So whenever they make something little, they'll prefer to prioritize other things. "Do I have food? Have I paid for rent? Are my children well taken care of?"

In the focus group discussions, in addition to the glasses, when we asked them for recommendations, they were like, "You guys (DDD) should also bring other products, especially glasses for kids." The fact that they were asking for solutions for their children's needs already shows you that these are people who prioritize the rest of the household over themselves.

Ambika Samarthya-Howard: When you went to these settlements, what was your approach? Because you're right, it's really hard to ask people to spend money on glasses when they need

money for food. The people who did buy them, what was the turning point or what was it that compelled them to buy?

 **Naomi Kiiru:** I like that you asked that question because we asked the same during the focus group. Interestingly, a lot of the people who bought from us so far, or who've been able to buy from us especially in Nairobi, they identified their vision problems even before we came into the field. They'd been screened before. That's something we noticed. They'd been screened at maybe other health institutions, major facilities. But the issue was the price. So they ended up buying from us because of our price point. It was very low.

You are talking to someone who's been told that to get a new pair of glasses, they have to spend something close to 7,000 shillings. And yet here I am selling glasses at close to 400 shillings, like 399 shillings. So those are some of the things we learned. But then I know that with good vision, they're able to increase their earnings within a household. However, this message still hasn't carried with the consumers that we target. It does not resonate with them yet.

Ambika Samarthya-Howard: So then what did resonate with the almost 400 people who did buy? Or the 700 people in phase one, what did resonate?

 **Naomi Kiiru:** Number one is the price point. Because they had initially identified the problem. The issue was the pricing. The pricing of the glasses from these other providers (hospitals and optometrists). But here are people who've come selling these glasses at a low price.

And then number two is the people we have, our mobilizers are known in the community. So the relationship they have created with their communities also helped. But in terms of creating that straight line between, "These are glasses that can help me improve my earning capacity, let me buy them," that relationship, they haven't been able to relate the glasses to that.

 In our posters, the message reads, "Do you have a problem with your day-to-day tasks? Do you have a problem threading your needle, reading your newspaper, loading airtime on your phone? Guess what? We have a solution for you." But when we asked this during the focus group, they were like, "First of all, most of us haven't seen the posters." So that message still hasn't carried with the people we are targeting.

I know we are going to put a lot of emphasis on creating awareness through posters and messaging. And that's one of the areas I would like to focus on. Because again, another issue that our contractors pointed out was they're having difficulty converting sales. And I feel like relating the problem that people have, to what we're offering might help. So we get to learn about that now in this next part of the project.

Ambika Samarthya-Howard: What are you doing in this next part of the project that's different from what you did before?

 **Naomi Kiiru:** The biggest issue that came up, we anticipated it but we didn't think it would be that big, was on narrowing down on the right candidates to hire, like our field contractors. The qualities we wanted for a field contractor. That's one of the things we are solving for. So yes, we are still sticking to working with mobilizers, but we're looking at people who have had similar experiences and we kind of want to narrow down by their profile, self-driven people, recruit them through referrals and then compensate them better. Because they pointed out that our compensation does not compare with other programs they have worked on. They felt it's a bit low.

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

 **Naomi Kiiru:** For us, we are paying them based on the number of glasses they send or distribute. It's commission-based and we've been providing them with transport, but that's upon meeting a certain number of sales per month. Which again, they felt it discourages them because even if someone sold less than that, it does not mean they did not go out to the field. So we've broken that down. Instead of giving them this facilitation for transport and airtime at the end of the month, we'll be changing that and giving them weekly. Our plan is, for the first week, we provide them with money for transport, they sell the number of glasses, and they bring in their reports. Then based on those reports, that's when we give the next week's allowance for transport and facilitation. That's what we're changing to.

We have incentives, and they have been working well and we plan to continue with them. We reward the top three people per team. And actually, it helped during the second phase of the pilot when we introduced it in Nairobi because it's what helped to keep a current number of agents, who've been able to help us achieve the current sales.

Ambika Samarthya-Howard: Initially though it was commission-based?

 **Naomi Kiiru:** It was commission-based, but the issue was, we did not provide facilitation for transport and airtime upfront. This is something that we paid at the end of the month after performance.

Ambika Samarthya-Howard: Got it. And right now, you're going to keep the commission-based model?

Naomi Kiiru: We're still commission-based, but we are planning to increase their commissions. So we're paying them almost double. We are planning to see whether we can double the commissions.

Ambika Samarthya-Howard: When does this phase start and are you still just going to be doing it in Nairobi?

Naomi Kiiru: Right now, we're in the middle of reporting for the pilot with LIF. So let me say it's upon the decision we come up with together with LIF, but hopefully in April. We want to do this in Nairobi and Kiambu counties. And then from there, we want to expand per county. The good thing with this part is we are able to look at what it means to bring in a new county now, and what it means to scale. At the beginning when we designed the pilot, we just wanted to see what the different counties present, what kind of challenges are there? But now we have a pretty good picture of the way forward.

We've already learned that there are lots of glasses programs in Kenya. We knew they were there, but we didn't know they had gone deep into the different counties besides Nairobi. We have learned now that there are lots of glasses programs, some are giving them out for free, some come with those camps that offer comprehensive health checkups. So we know what we're competing with, but we also know what our unique value proposition is in this case. And it's thanks to the pilot.

Number one, DDD is the second organization to attempt this model in Kenya. The first one was AMREF [African Medical and Research Foundation] through the use of community health volunteers. But that stopped. I don't know what happened, but it did not continue. So we are the second organization doing this.

Ambika Samarthya-Howard: The AMREF project, was it as large as yours and was it also in Nairobi?

Naomi Kiiru: I don't know the full details. I don't think it was in Nairobi. I think it was in a county in Makueni or Machakos and it wasn't as big. I think at the end of the project, they sold like 700. So we've surpassed that figure because we've sold a total of 840 so far. But we plan to continue. I don't know why AMREF stopped again, I'm not sure how that went. But for us, we plan to now scale these for the different counties that we have in mind.

Other organizations are doing the Vision Camps because a lot of them are in the programs space, there are a lot of NGOs. But for DDD, we are not in the NGO space. So we're looking at it from the angle of “if we've done research through field contractors, why can't we do it also for this program?”

Ambika Samarthya-Howard: How long will you be doing this pilot for, and with how many people? Is it also going to be 80?

Naomi Kiiru: Again, our way forward is we've done our plan based on each county. Per county. We've even done our financials, our modeling per county. So our plan is to have 60 field contractors for each county. Whether we go to Nairobi, Kiambu or a new county like Embu, we

plan on having 60 field contractors working under three supervisors. We plan on using the blended model of door-to-door mobilization with vision blocks, but we want to invest a lot more in creating awareness.

Ambika Samarthya-Howard: That's the next question I was going to ask you. It seemed like from both the pilot and what you did with the community event, the main thing was around creating awareness. So I'm very curious what you're planning to test or do differently?

Naomi Kiiru: This is informed by the insights we learned from the focus group discussions and the in-depth interviews we've had with our field contractors. For programs like reading glasses and even other things, it's good to create an impact with the consumers. They need to know that we were there in the field. Even if they're not there, they need to be told by others. I'm talking about going in a huge way. So we are looking at having sensitization campaigns where we have a group of at least five field contractors working together, passing out flyers and giving information on “why” the reading glasses, what problems they solve.

Number one, it's to help filter out the people who come for screening. You heard about how our field contractors in the door-to-door model will talk to up to 30 people. In 30 minutes, they'll have told 30 people about our project. But you see, not all these 30 people fit our consumer profile. That's one thing we are trying to narrow down so that by the time someone is coming for a Vision Block, they are very close to the consumer profile. They fit the age, they fit the income, they fit the need. We've been able to let them know about how the glasses will improve their lives, how it meets their needs. So that's our intention.

It's the same thing we learned during the focus group. They were like, "You guys don't leave an impact in the community. Once I see your agent walking around in blue, it's the blue vest that made me talk to them." "But besides that," I asked them, "have you told other people about us?" Not many of them have told others.

When it becomes a topic of conversation, "I have a problem with my eyes," that's when they remember, "oh yeah, I have someone. How can I reach them?" They don't know how to refer them because the moment that person leaves, without a Vision Block, they don't know where to refer them to. That's why we're investing in that blended model as a whole.

Ambika Samarthya-Howard: Can you define the blended model a little bit more for me?

Naomi Kiiru: So we are looking at four to five days. The first three days are intensive, rigorous, creating awareness and sensitization in the community. You have a team of five agents in our company’s blue branded marketing vest talking about reading glasses. These are people who are going around, passing out flyers and putting up posters. Posters are mostly for referral

and to leave their contact information just in case. And then the megaphone is to let people become curious, "What are these guys talking about?" And communicate the dates and the venue.

Over the three days, say from a Wednesday to a Friday, we have the sensitization. And then on a Saturday, we now have a Vision Block. Right now we are working with the local authority. There are these chief offices within the communities. So we get to use such a venue. We've set up a tent, set up chairs, and we have the whole team there screening people and selling their glasses. Our field contractors are creating awareness through the door-to-door model, meeting people at their homes, places of work, and then receiving these people at the Vision Block at the local chief office.

Ambika Samarthya-Howard: One of the things that's come out a lot in our discussion is around these touch points. There's the sensitization touch point, but there's also this touch point of the screening before the sale. A lot of people have been screened and then they go back and then they buy. And so I'm wondering if you're going to be incorporating that in your pilot, if you're going to distinguish or maybe go back to people who've been screened?

Naomi Kiiru: I would like to explore the option of calling them back. The whole point of us getting contact information for people, when our field contractors go [out to the communities], is to record the contact information and names of these people. Our intention is to call them back and see whether they are in a position to buy the glasses. So that's our plan. But again, I know it involves additional costs for calling and tracking these people down because it could be in areas where we have already left.

Ambika Samarthya-Howard: Okay. And then you're going to do this project for the next few months?

Naomi Kiiru: The project might take longer than even a year because the first question that LIF asked is, can we distribute 1 million glasses in Kenya? And one of the things we asked ourselves was, if we are distributing a million glasses, how long does that take? Simply, what's the distribution rate? Today, at the end of these first pilots that ended in February, we are working with a distribution rate of 400 glasses per county in a month. So the timeline is quite lengthy. The things that you can vary is the region and the number of people we end up working with. I think the closest it came to was like eight years, and that was looking at 10 counties. 10 counties at that rate of 400 glasses in a month was coming close to eight years. But you can check them up on that.

Ambika Samarthya-Howard: This specific thing that you're testing now, starting in April, that's going to be a four to eight week test?

Naomi Kiiru: The thing that we'd like to start in April, for that one, we want to test for a year. So again, based on the pilot that we did, the first phase of the pilot was intended for three months,

but then after that, we learned it was too short a period to learn, to have gathered useful information. So we extended it to February of this year. I think that took eight months. Since then, we've agreed that as a pilot for this kind of program, we would rather run for a whole year so that we can test various things within that one year. So for now, the next thing that we're going to be testing.

We'll test it for a year, but with quarterly reviews to see what it tells us, what insights we're able to gather. And then what we could vary in the course of the year is the number of counties where we test. So right now, I'd like to start with Nairobi and Kiambu. But again, if it goes well, we can add more counties to that model.

Ambika Samarthya-Howard: Thank you so much. This was brilliant and it was lovely talking to you.

ICON LEGEND

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.*