INDITECH HEALTH SOLUTIONS

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FIXING THE PEDIATRIC MYOPIA CONTROL ADHERENCE DRIFT

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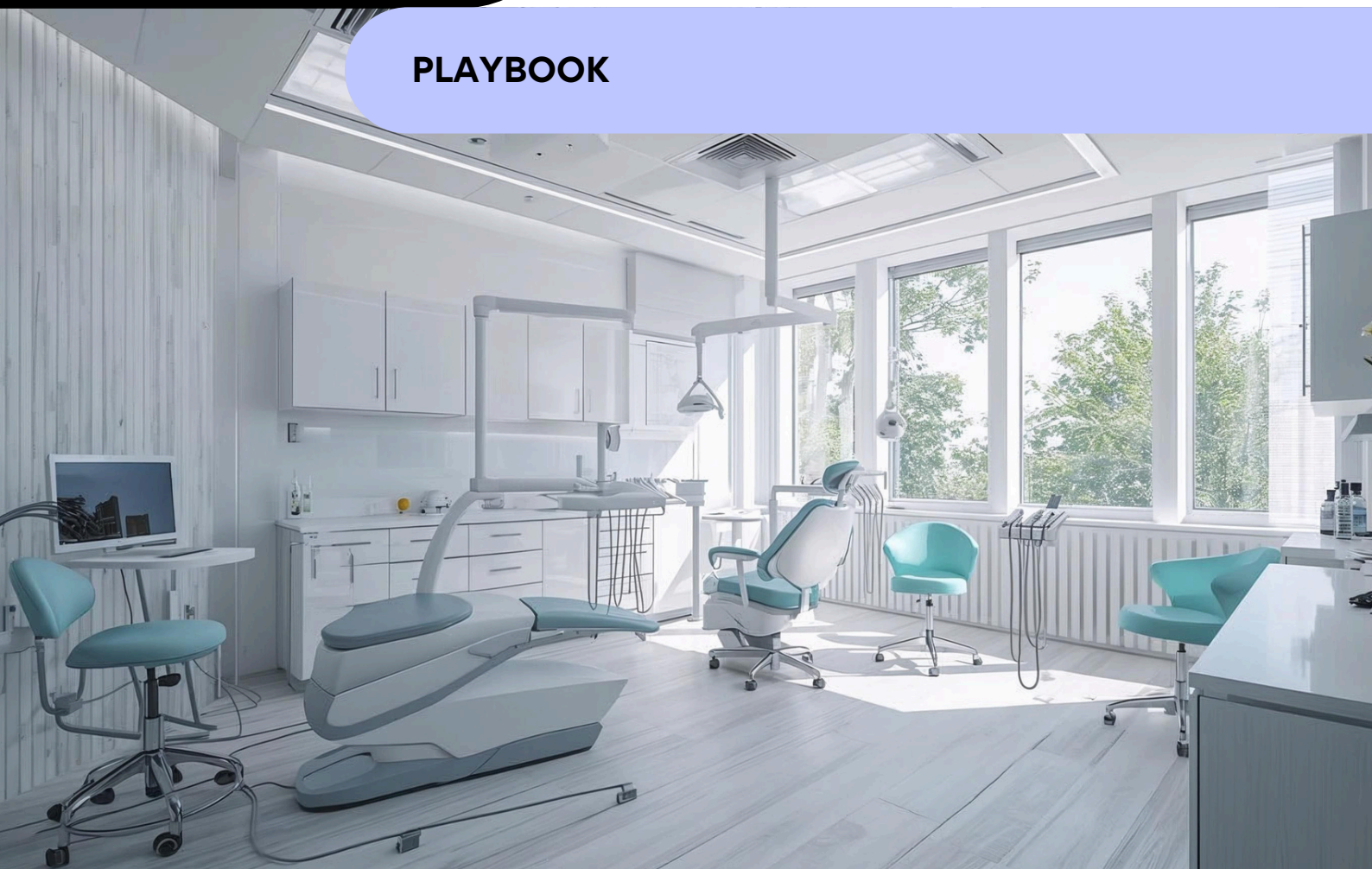
A clinic-centred playbook to sustain atropine myopia control and enable stable treatment choice

PLAYBOOK



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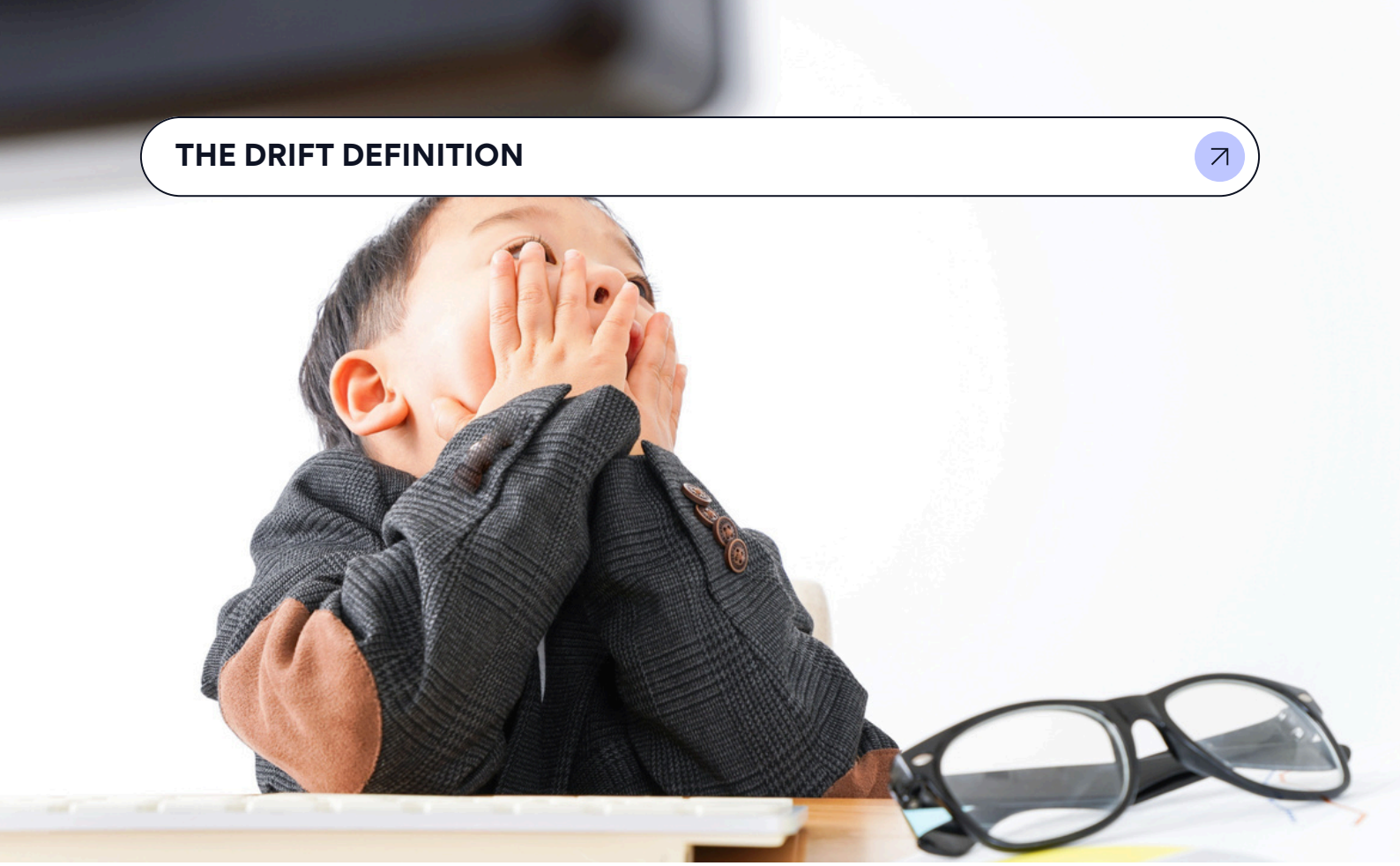

EXECUTIVE SUMMARY

In pediatric progressive myopia, the decision to initiate atropine therapy is increasingly accepted. Ophthalmologists recognise early intervention as necessary, guidelines are supportive, and parental awareness is steadily improving.

Yet outcomes continue to drift. Not because doctors hesitate to start treatment - but because treatment is not sustained.

For Brand UMI, the core challenge is adherence drift: families start correctly, but execution weakens across the first few weeks and months. Drops are missed, routines fail to form, side effects trigger anxiety, lifestyle advice is inconsistently followed, and follow-ups slip.
This adherence failure quietly reopens a second problem: treatment choice instability.
When families discontinue, delay reviews, or return uncertain, atropine itself begins to feel optional. What was once a confident treatment decision becomes fragile - vulnerable to postponement, switching, or abandonment.

The drift, therefore, is not scientific or ethical. It is operational and parent-dependent.

Brand UMI's challenge is not starting myopia control. It is keeping it going long enough to work - so that treatment choice remains intact.

THE DRIFT DEFINITION

In pediatric progressive myopia, the decision to initiate atropine therapy is steadily gaining acceptance. Ophthalmologists increasingly recognise the importance of early intervention, clinical guidance is supportive, and parental awareness continues to improve.

Yet real-world outcomes continue to drift away from guideline-aligned initiation toward inconsistent execution and early discontinuation. This drift does not arise from hesitation at the point of initiation. It emerges after treatment has already begun.

Families start correctly, but execution weakens over time. Drop routines fail to stabilise, early side effects trigger anxiety, lifestyle recommendations lose momentum, and scheduled follow-ups are delayed or missed. What begins as a well-intended plan gradually becomes inconsistent in practice.

Brand UMI represents an atropine-based myopia control therapy positioned for long-term disease progression management in children.

Left unaddressed, adherence failure quietly creates a second, more damaging consequence - treatment choice instability. When families stop, pause, or return uncertain, atropine itself begins to feel optional. A decision that once felt confident becomes fragile, increasingly vulnerable to postponement, switching, or abandonment. Importantly, this drift is not scientific, ethical, or clinical in nature. It is operational and parent-dependent - unfolding between visits, outside the doctor's line of sight.

Brand UMI's challenge is not starting myopia control. It is keeping families on treatment long enough for control to be realised - so that treatment choice remains stable and meaningful.

MARKET REALITY

PEDIATRIC PROGRESSIVE MYOPIA

Clinical guidance on pediatric progressive myopia is increasingly consistent. Ophthalmologists recognise the importance of early intervention, understand the role of atropine in slowing progression, and are aligned on the need for long-horizon management rather than short-term outcome expectations.

THE GUIDELINE–REALITY GAP

In principle, the pathway is clear. In practice, however, outcomes diverge - not because guidance is ignored, but because execution weakens after initiation. Most consultations are necessarily time-constrained. Counselling on control versus cure, drop technique, lifestyle modification, and follow-up cadence is delivered once, often in a compressed format. While the intent is correct, the burden of sustained execution shifts almost immediately to families.

Between visits, parents are required to:

MAINTAIN A DAILY DROP ROUTINE,

MANAGE EARLY DISCOMFORT OR PHOTOPHOBIA,

OPERATIONALISE OUTDOOR TIME AND NEAR-WORK HYGIENE,

AND RETURN FOR SCHEDULED REVIEWS DESPITE LIMITED VISIBLE SHORT-TERM CHANGE.

These demands unfold outside the clinic, without structured reinforcement or early feedback. As a result, adherence variability emerges silently. Missed doses go unreported, routines weaken, side effects trigger anxiety rather than consultation, and follow-ups are postponed. Over time, this creates a widening gap between what guidelines assume and what actually happens at home.

Importantly, this gap does not reflect resistance to atropine or scepticism about myopia control. It reflects the reality that long-term, parent-dependent therapies require more than a correct initial decision - they require sustained support to prevent drift.

When adherence weakens, treatment confidence weakens with it. What begins as a clear therapeutic choice gradually feels optional, reopening uncertainty around continuation, review, or escalation.

This is the guideline – reality gap: alignment at initiation, followed by fragmentation during execution.

PROBLEM FRAMEWORK

COMPOUNDING BRAND ISSUES

For Brand UMI, pediatric myopia control is not a visibility or credibility problem. Initiation is happening. Doctors are aligned, prescriptions are written, and therapy begins.
The brand erosion starts after initiation.

This erosion is not dramatic or confrontational. It is quiet, gradual, and largely invisible to the clinic - driven by missed doses, delayed reviews, unmanaged early effects, and weakening routines. By the time it surfaces, months of potential control have already been lost.

From a brand perspective, this creates three compounding problems.

THE BRAND PAIN

ADHERENCE FAILURE PREVENTS VALUE REALISATION

Atropine myopia control is inherently long-horizon. Its benefit cannot be judged in the early weeks.
When adherence weakens early:

- progression control is not demonstrated,
- outcomes appear inconsistent,
- and therapy value is assessed prematurely.

The brand does not lose because it underperforms.
It loses because it is not sustained long enough to prove performance.

ADHERENCE DRIFT DESTABILISES TREATMENT CHOICE

As execution weakens, confidence weakens. Missed doses, unmanaged side effects, and skipped reviews slowly reframe the therapy from a necessary intervention into a discretionary one. Continuation becomes negotiable, and the original treatment decision quietly reopens.

At this stage, the issue is no longer compliance alone.It is treatment choice instability triggered by poor persistence.

SILENT DISCONTINUATION CREATES INVISIBLE BRAND LOSS

Myopia control rarely fails loudly. Families do not announce stoppage; they simply stop.

When progression is noticed again:

- the opportunity cost is already incurred,
- restarting feels uncertain rather than confident,
- and long-term commitment becomes harder to rebuild.

For Brand UMI, this results in invisible erosion — lost months of therapy, weakened outcome perception, and reduced lifetime value per patient.

THE BRAND REALITY

THE BRAND PAIN

Brand performance in myopia control is not defined by how many children start therapy. It is defined by how many remain on treatment long enough for control to be realised.

Adherence, therefore, is not a support function. It is the primary brand growth constraint.

THE BEHAVIOURAL MOMENT MAP

MOMENT MAP

Adherence loss is not a single drop-off point. It is a predictable sequence of vulnerable moments. Brand strength is determined by how well these moments are stabilised.

MOMENT MAP

START

TREATMENT INITIATED
(Atropine prescribed)

IS THE EXPECTATION EMOTIONALLY INTERNALISED?

NO

MOMENT 1
Initiation Without Internalisation

- "CONTROL" MISUNDERSTOOD AS "IMPROVEMENT"
- LONG-TERM NATURE NOT ANCHORED

→ EARLY DOUBT RISK

YES

FIRST 2 WEEKS
(Routine Formation)

ARE DOSING & COMFORT ISSUES CORRECTED EARLY?

NO

MOMENT 2
Routine Breakdown

- DROP ERRORS / MISSED DOSES
- MILD SIDE EFFECTS IGNORED

→ WEAK HABIT FORMATION

YES

ONE-MONTH REVIEW WINDOW

IS VALUE STILL PERCEIVED DESPITE NO VISIBLE CHANGE?

NO

MOMENT 3
Motivation Dip

- THERAPY FEELS OPTIONAL
- FOLLOW-UPS DELAYED

YES

THREE-TO-SIX MONTH PHASE

IS PERSISTENCE ACTIVELY REINFORCED?

NO

MOMENT 4
Silent Discontinuation

- LIFESTYLE DRIFT
- UNREPORTED GAPS

YES

STABLE ADHERENCE

- TREATMENT REMAINS DEFAULT
- OUTCOMES COMPOUND OVER TIME

SOLUTION FRAMEWORK

THE CLINIC-CENTRED SOLUTION FRAMEWORK

TEACH → ENABLE → TRACK

THE OBJECTIVE IS NOT TO INCREASE INITIATION. IT IS TO SUSTAIN ADHERENCE, SO TREATMENT CHOICE REMAINS STABLE.

TEACH

Parents must understand not just what to do, but why persistence matters. Brand UMI enables clinics with a clinic-branded Care Link that delivers micro-learning on:

- control versus cure
- realistic timelines
- drop technique and routine building
- normal effects versus red flags
- lifestyle actions that are executable, not aspirational

Education is short, repeatable, and clinic-branded.

ENABLE

Understanding alone does not create adherence. The Care Link enables execution by:

- structuring routines
- simplifying lifestyle advice
- normalising early discomfort
- giving parents a clear “when to call” trigger
- reducing anxiety-driven stoppage

No apps. No patient data storage. No brand presence on patient pages.

SOLUTION FRAMEWORK

TRACK

Adherence only persists when drift is detected early. Simple check-ins aligned to clinic cadence surface:

- missed doses
- tolerance issues
- intent to stop
- overdue follow-ups

Doctors are alerted only when action is needed, preserving time and trust.

IMPLEMENTATION MODULE

REPLICATION BLUEPRINT

Module	What is implemented	How it functions in practice	Role of Brand UMI
Doctor Education Infrastructure	Monthly Mini-CMEs and case publications	Standardises counselling, expectation setting, and early-week handling	Brand UMI anchors the adherence narrative in doctor education
Clinic-Branded Parent Service	Care Link microsite with videos and check-ins	Converts counselling into executable routines	No patient-facing branding; adherence stability protects treatment choice
Workflow Nudges	QR cards, desk cues, one-page SOP	Makes sharing the Care Link automatic	Brand UMI becomes associated with “done properly” myopia control
Minimal Field Dependence	Monthly cadence delivery	Reinforces practice use, not persuasion	Enables adoption without ongoing detailing

MEASUREMENT LOGIC

BRAND OUTCOME

MEASUREMENT LAYER	WHAT IS MEASURED	WHAT IT INDICATES FOR BRAND UMI
SYSTEM ADOPTION (LEADING INDICATORS)	Clinics onboarded to the Care Link serviceActive clinic usage rate (share per week) Staff compliance with Care Link sharing SOP	Whether the adherence infrastructure is embedded into routine clinic flow
PARENT EXECUTION SIGNALS (ADHERENCE PROXIES)	Care Link opens and video completionsDay-three and Day-fourteen check-in completion Missed-dose frequency reports	Whether counselling is translating into real-world execution
TOLERANCE & ANXIETY FLAGS	Early discomfort selectionsPhotophobia / side-effect flags“Intent to stop” responses	Whether drop-out risk is being detected early enough to intervene
FOLLOW-UP PERSISTENCE	Month-one, Month-three, Month-six continuation confirmations Overdue follow-up alerts	Whether therapy is being sustained beyond initiation
TREATMENT CHOICE STABILITY (SECONDARY OUTCOME)	Reduced silent discontinuation reportsConsistency of atropine continuation across visits Lower restart-after-gap patterns	Whether adherence stability is protecting treatment choice
FIELD EFFECTIVENESS FUNNEL	Rep share → doctor open → clinic share → parent completion	Whether field effort is converting into behaviour, not just awareness

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STRATEGIC OPPORTUNITY & CTA

Leadership in pediatric myopia control will not come from starting more children on therapy. It will come from keeping families on treatment long enough for outcomes to appear. Brand UMI's opportunity is to own adherence - so that atropine remains a confident, sustained treatment choice rather than a fragile early decision.

The next step is not wider awareness. It is identifying where adherence breaks in real clinics - and closing those gaps before treatment choice erodes.

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