“First pair access is a critical component of market shaping”: Abi Steinberg, executive director of the Eyeglasses Initiative at the Livelihood Impact Fund on market creation, partnerships, and what it will take to scale reading glasses distribution to 800 million.

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Ambika Samarthya-Howard: Can you start by introducing yourself, and then tell me: Why eyeglasses?

Abi Steinberg: I’m the Eyeglasses Initiative Executive Director at the Livelihood Impact Fund [LIF]. Eyeglasses are fantastic for many reasons. I'm quite in love with reading glasses to the point where I gift them everywhere I go. Handing them out to rickshaw drivers and to security guards.

Ambika Samarthya-Howard: Were you like that before LIF?

Abi Steinberg: No. I really had no understanding of it, and now I’m at the point where I carry them around and hand them out at restaurants. I’m giving them out everywhere. There are very few problems of this magnitude that can be solved in five to 10 years, let alone in this lifetime if we get enough advocates to care about it. And this solution is proven, it's safe, and it’s cost-effective. I think that’s exciting.

This is 700-year-old technology that has been used by billions of people. Reading glasses can be manufactured very cheaply at scale across multiple geographies. There are so many effective

channels that reach the end consumer in remote places, and this is a perfect juncture to leverage those channels to deploy glasses effectively. The opportunity to solve this problem at scale and improve livelihoods, increase income and productivity, is very compelling.

Ambika Samarthya-Howard: Many of the reasons why eyeglasses have attracted you are similar to why they've attracted a lot of the other people I've spoken to—people either had a personal experience or are drawn in because it's a problem that can be solved simply and efficiently. When LIF came into this space, it was fairly saturated with players, so I'm curious how you navigated that as funders?

Abi Steinberg: We started with a simple question. There are 1.8 billion people with presbyopia, and 800 million who just need a simple pair of reading glasses; why has this not been solved? Some of the most incredible players are providing a few million pairs a year, but if you look at the overall problem, that's just a fraction [of the need]. Our question was, why haven't any of these organizations—and some have been operating for 70-plus years—addressed what we see as the lowest-hanging fruit?

So we began to look at different organizations and realized some are focused on cataracts, or trachoma, or glaucoma, or comprehensive eye healthcare, or refractive error in its entirety, and only a small percentage of organizations are focusing on presbyopia. RestoringVision might be a bit of an outlier here, but overall, there weren't many organizations that were asking how to address this at scale. We thought we could have a unique impact in this arena by saying, "Readers matter. They're important. They have an outsized impact." And there was no organization or philanthropist we knew of specifically targeting readers at scale.

The more we talked to people, the more it seemed like a gap. I should also note we're coming at this at a perfect juncture wherein various UN [United Nations] resolutions have happened, and the World Health Organization has come out with guidelines—with thanks to the many eye health organizations that made it happen. Only in the last couple of years has refractive error become a focus of the eye health community in a big way. Previously the focus was importantly on avoidable blindness that was impacting millions of people. As more scalable solutions have been deployed to address avoidable blindness there has been a sectoral shift towards addressing refractive error.

Ambika Samarthya-Howard: Do you know why that is, or what happened that would make that the case?

Abi Steinberg: Essentially, it was a concerted effort of eye health organizations saying, "We've reduced the rates of addressable blindness or avoidable blindness. Can we look at refractive error?" Rates of refractive error have gone up exponentially, so when we look at many different countries, we're seeing higher rates of myopia. People are also living longer and doing more near-vision tasks, so we're seeing higher rates of presbyopia in some parts of the world. We're also seeing younger rates of presbyopia, but we don't fully understand why that is happening.

All in all, refractive error is increasing, and now that a lot of the other major issue areas have been addressed or we know solutions to them, there's an awareness that about a billion people are in need of glasses and can't access them. That's the magnitude of the issue.

Ambika Samarthya-Howard: Your grantees and your pilots are a very diverse range of people. Some of them are local, some are regional, some are national. Some focus on one delivery method, some focus on multiple. Some have been in the space for 20 years, some are trying it for the first time. Can you talk a bit about how these people got into your portfolio?

Abi Steinberg: No one has solved this at scale, and we were curious about what it would take to solve it at scale. Is it the community health channel? Is it the pharmacy channel? Is it the entrepreneurship channel? Is it through government health facilities? Is it through religious institutions or religious channels? We hit the ground running. We're a very action-oriented funder, and we saw that there's a lot of unknowns. A lot of the organizations in the eye health sector were saying that they've tested out a couple of methods, but weren't sure what might scale.

So first, we wanted to ensure that we were testing and refining existing channels. We wanted to explore a combination of different channels as we know that individuals seek out care and services through many different channels. We also were keen on providing this product over the counter and ensuring the fewest limitations to accessing it. We knew that we had to explore some health-related or health-adjacent channels, as well as other channels through which we could normalize the usage. Then, the more we learned about stigma, barriers and latent demand—because there are many people we encounter who can afford this product but have never considered it—we realized that there's some network component to this that we also need to test out.

As more questions emerged, we had to slice it in many, different ways to begin understanding how this product can move effectively. Do we need to treat the first pair very differently than a second pair? We're figuring that out. Do we need to couple it with the right messaging and marketing? Is it more effective to do within a network versus using an individual door-to-door approach? We wanted to understand what would effectively scale.

That's why we have such a sizable portfolio of pilots and projects—there were just so many gaps in our understanding and sectoral gaps as a whole. We wanted to explore what the eye health sector could do given their existing channels and work to expand it to non-eye health players who could potentially bundle it in their point of care. Last Mile Health has now bundled it with the Noncommunicable Disease [NCD] module and realized it blends in really well with this curriculum. We also pursued it with Maisha Meds and they said it could work in the suite of services that the pharmacist has provided. We explored a pilot with Digital Divide Data [DDD] to see if microentrepreneurs could go and sell these glasses and identify the barriers to those types of sales.

The drive to answer all these questions teed us up nicely to support the launch of the presidential initiative in Nigeria as well as some of our more scalable initiatives in the last six months.

Ambika Samarthya-Howard: If you had to compare this with other projects you've done, in other areas, be it cataracts, or NCDs, or non-health things like climate, what do you think are the biggest learnings from these projects that you could apply to things that have nothing to do with eye care?

Abi Steinberg: My focus at LIF is squarely on glasses. We do have a large portfolio under the fund and under the labs portfolio that cuts across agriculture, workforce development, and a couple of other sectors that can increase incomes in a short time horizon. I'll speak specifically to the work in which I've been closely involved. I'd say when I worked on water access, renewable energy, sanitation, even access to credit or products for farmers and small merchants, there were so many rich learnings from that. I was working at the intersection of finance and products and services at the last mile, and it was difficult to figure out how to talk to a rural farmer about asset financing with a savings and insurance component bundled into the payment. It was about explaining the benefit of paying off the asset and then, as they pay off the asset, helping them understand that they also are increasing their savings and potentially getting access to insurance.

 Simplifying the messaging, and tailoring it to the audience really matters. Understanding their concerns, their pain points, and their financial lives is critical. So is targeting at the right time. You're not going to sell people a product in most of Africa right after Christmas because no one has any money. You're going to time it with harvest. You're going to time it with various income streams that they'll have, which are mostly erratic. So the messaging around and the marketing of the product really matters and has to be tailored to the context and the individuals.

You also have to address the stigma and other challenges that might emerge, ensuring that there's an equal uptick among women and men and people of all different demographics and backgrounds, especially for life-changing services. You want to ensure that they're receiving it at the right time, that it's at the right price point for a sustainable approach, and that you're addressing their questions and concerns. Then, if it’s a product that needs topping up the credit, or has different components or parts, or includes a next tier of product, you want to make sure they understand the life cycle of the product and are aware of when they can receive their next one.

A lot of the work I've done over the last 15-plus years around products and services, and understanding the end consumer and customer journey across Southeast Asia, India, and East and West Africa, has helped me think about this work through that product consumer lens, which might place me slightly differently than some of my counterparts.

Ambika Samarthya-Howard: What have you learned in the last two or three years doing this work that has been shocking or has not yet made sense to you? If you could give some specific

examples of something that had surprising results, or something that you're still figuring out why it's not working, that would be great.

Abi Steinberg: I'm amazed at how many high-income individuals don't realize they need reading glasses. And I'm amazed at how many individuals I speak to who are wearing glasses, yet this is an epiphany or an aha moment for them. They're like, "Wait, you're telling me if people could see better, they could probably do their work more effectively and efficiently?" And they will be wearing glasses on the call.

Many people have never thought about glasses as a livelihood product; in the past, it squarely fell into health. If you look at the disability-adjusted life years for glasses, they're not compelling enough. Many people who want to save a life will do lots of other things that are meaningful and important. I'm not saying that sentiment should be replaced, but I think a lot of people across economic development have not connected the dots on this issue. This was a big aha moment for many government officials and philanthropists that I've engaged with. I've provided glasses in many different contexts. I've given them out in offices at large organizations, I've given them out to security guards, I've given them out to desk clerks. I've also given them out to people in my arena who just haven't used them. That's been surprising to me.

The next piece that's surprising is there is a clear distinction between a first pair and a second pair. The barriers to the first pair are largely the misconceptions around glasses. Will glasses harm my eyes or make them worsen over time? Do I need a doctor to prescribe this product? Does this make me look sickly or ill? Will this mean I'm unmarriageable? I didn't understand all the stigmas and barriers since they vary by product, context, and culture. They're a lot worse for children, which is not ideal. It's a little easier and more malleable for older adults where the perceived value of it is sometimes greater than the perceived stigma or concern.

 We began to understand that getting a first pair on individuals helps them perceive the value of the product and gets them excited about the opportunity. It was exciting for us to see them realize how these glasses improve their livelihoods and productivity, and they then have the understanding that they will need a stronger pair in the near future. We realized this could be a stimulus plan where we get a lot of people into the first pair, and then providing a second pair and beyond will require philanthropy or government services. However, there is a market component here where the market can take off. That distinction was shocking to us. First pair access is a critical component of market shaping.

The other piece that's interesting is that there is a network effect here. It does matter that people within a group have collective access. I didn't always understand some of the distinct challenges based on urban, peri-urban, and rural. We see across all products and services that there's a different conception of different products at various points, but this was illuminating to us.

We have screeners who have gone out to provide cataract screening and found that when they provided readers, people were so excited because they were providing a solution to a challenge.

Community health workers are getting a lot of excitement and benefit out of this for themselves, as it's improving the quality of their work and care. And they also see that there are very few products they can provide that create an instant change in someone's life.

Ambika Samarthya-Howard: The big buzzword in philanthropy right now is localization. Sometimes localization is about who's doing the work and on what level, but the whole idea is based on the local being very separate from regional, national, and international. We often come back to reading glasses as a global problem, and it is, but it's also a hyper-localized problem. The issue is that the more you localize, the bigger the challenge of scale becomes. So I'm curious, how much of that scale do you see in places that have been successful regionally?

 **Abi Steinberg:** We are currently testing out channels that are common across many different countries. There are community health workers in most low and middle income countries. There are pharmacies in most low and middle income countries, and we have many different pilots around pharmacies. So we've worked on a pilot with Maisha Meds, but we've also worked on pharmacy pilots in Laos and Uganda and Ghana. We're cutting across different geographies on purpose to really understand what are some of those nuances about selling it through that channel and what is channel specific and what is tied to the local context.

Pilots provide a snapshot of what could work and in some pilots, we've reached 10,000 individuals, and 20,000 on our bigger pilots. But many of them will need to be scaled in these contexts and hyper-localized in order for things to move effectively.

Ambika Samarthya-Howard: Tell me more about the plan to scale. It seems that the greatest success is a result of localization. So if you find something really successful in a rural area, is the next step to then take that person or that system to another rural area, and then the next rural area next to it? How do you scale a hyper-localized solution?

Abi Steinberg: We're really focused on scaling right now. The work in Nigeria is through primary health facilities and community health workers, so we're taking as much know-how as we currently have on community health workers and trying to provide that information to the implementers in Nigeria.

 The training depends on what you aim to accomplish in a local place, but overall, it seems to be that you kind of need a little bit of theory and a lot of practice. You also need to get really comfortable with the heuristics. If I've got five different diopters or powers, and I know the person is between 40 to 50, I'm going to hand them a +1.0 first and test if they can see a font or a tumbling E chart. Then, if they can't see it at 40 centimeters or whatever we've determined is comfortable, I need to know to give them a stronger power. Some of it is just training on how simple and easy it is, and some of it is also practice. That seems to cut across all different pilots.

The other great thing is we can compare a bit of apples to apples across pharmacy pilots, and then some of the challenges or questions or concerns cut across all pilots. For instance, customers have said across all pilots, "When I put on these reading glasses, I can't really see far." We've realized that we have to provide information to customers about the product, and explain, "You are getting near-vision glasses; your power will increase over time. It is for near-vision tasks only. Here are various near-vision tasks you might use it for—cooking, reading, planting, spotting bugs, etc.. Can you tell me one or two near-vision tasks you can think of that you would use it for? You cannot use this [to see] far. You cannot use this for driving. You cannot use this for bicycling, because you won't be able to see ahead of you. It's really for [seeing] close up." Those learnings at this central point, where we have many different grantees, have been exciting because then we can say, "This is one issue that's just emerged everywhere."

 Another thing that we've seen a lot of is the need to educate optometrists, ophthalmologists, government officials, and regulators about how global this challenge is, and also how safe and effective reading glasses are. They've truly been de-medicalized and have been provided to hundreds of millions of people over the counter for about the last 40 years in many, many countries, and this is both safe and effective. We realized that we had to refine those arguments and refine the customer journey across all pilots.

Ambika Samarthya-Howard: Do you think it's possible to scale this without government?

 **Abi Steinberg:** I think it would be very hard. Considering everything I'm seeing, it looks like embedding it or rolling it into government services would be the best way to address it at scale. In Nigeria, leveraging existing established health providers is great for many reasons. It ensures continuity of care, access, and a degree of tracking. I also think this is a first pair problem. Do I think governments will have to provide this in perpetuity once they've saturated the market? I don't necessarily think so.

I think the nuance here is that there's a role governments could play in first pair access and, for the foreseeable future, enabling access. I'd love to see this embedded in primary care provided through and covered by both public and private insurance. I'd love primary care doctors to say, "You're between 40 and 50, so here's a +1.0, and here's a +1.5. You may not need it now, but you'll need it in the near future." As the market expands and individuals feel more comfortable self-selecting, I hope to see this at the corner kiosk or duka, at your Airtel or Mobile Money agent, sold in self-help groups or rotating borrowing savings clubs, bundled with solar assets because maybe someone will pay off their product quicker if they can both see their mobile phone to top up and use light later into the evening, because now that they can see they have more productive hours.

Ambika Samarthya-Howard: Can you explain why the second pair is important?

Abi Steinberg: A lot of the research right now has been on willingness to pay, and we've done a proxy study on second pair access. What we looked at was whether people think about their first pair and second pair in the same way, and it seems like they don't.

 Once you receive your first pair with the right information and context, people seem a bit more comfortable with getting glasses and using them in different contexts. You need to explain that these are for near vision, for specific tasks, show them how they could be used, and help them understand that over a certain period of time they will require the next power. Then, ideally, people will have an awareness of where to get their next pair. Addressing some of the stigmas is important, too. You need to help people understand that getting glasses won't harm their eyes, that it actually benefits their eyes, that there's something they can do to address their poor sight, that [nothing] harmed their eyes, it's just the natural process of aging. You've got to check all those boxes and inform the consumer that this is natural, it happens, and sadly, they're not an exclusive club, but in a club of 1.8 billion people and growing.

Ambika Samarthya-Howard: Why do people need a second pair?

Abi Steinberg: At some point, that first pair is no longer strong enough. So if you have a +1.0 power or diopter, you will need a +1.5 or a +2.0 as your lens becomes less malleable over time, which is just the natural aging process.

 We also realized that 80% of people who received their first pair say they would seek out a second pair, and many of them say they would pay 4x as much for the next pair. We had some researchers go into the field and give glasses out and then say, "Hey, if I give you $4 or $5 or $6, will you give them back to me?" Those who received the glasses, even those who had no money on them, said they would not give them back for money. They wanted to keep them , because the perceived value was there.

 Then we had people screened at their household. They got 30 minutes to try on a pair of glasses and use them for their everyday things, whether it was looking at rice and stones, crocheting, artistic pursuits, cooking, or fixing their bicycle. They tried them on and then they got a coupon to show up and receive a free pair at a clinic either five or ten kilometers away, and we saw people show up in droves to come and self-select them. Showing up means they paid for the transportation, they probably lost a day's wage, and they had to fight any additional stigma or concern they had about it to begin with. Showing up is no small feat in terms of self-selecting a product.

Ambika Samarthya-Howard: What limitations are you seeing come out of your pilots? What do you feel is limiting things from happening at scale?

Abi Steinberg: With any pilot, there are a number of limitations. I'm seeing a small microcosm with a lot of focus and emphasis on it. We launched glasses in pharmacies and we spent a lot of time, effort and resources on campaigns and marketing material. However, not enough time has passed to indicate what happens once the campaigns die down or once the marketing campaign wraps-up. Do sales remain the same, or if not, where do they plateau? So in general, one limitation of these pilots is that we can speculate or project what we think this looks like at scale, but it doesn't always inform what happens at scale.

Two, we definitely have misses where we'll launch a product in different ways and it's just not selling, so we have to understand why it's not selling. Sometimes it's the limitation of the implementing partner, and they're like, "Wait, this is a push product, not a pull product, and we mostly work in pull products." Or maybe it's a very different customer base, or it's very different messaging to the consumer, or it's a product they've never worked with before. We thought it would sell based on this visibility in a store, but it didn't.

 I was just talking with DDD about their entrepreneurship program this morning and we saw a massive uptick in sales. If you pay people on time and you provide transit payment on time so that they can travel throughout the week to different sites to sell glasses, their sales go up. So if you have on-time payments, that has a direct correlation to sales. The incentive also has to be good enough to compete with other existing freelance opportunities that emerge. "Am I going to go do a construction site today, or am I going to go sell glasses?"

Understanding the local context is critical. We've had multiple phases where we've had to refine different approaches and we've had to think about mobilization a little differently. Is it better to tell people collectively, "Meet here tomorrow to buy glasses," or is it better to tell someone a week earlier, with the chance that they may forget? We've realized it's actually important to tell people like a week in advance so they have the money. If they can write it down, then they show up.

These are the limitations of pilots, where we've deployed dozens of different sales agents at different moments. But if I deploy and pay a bunch of money for a fleet of thousands, will that have the same return on investment, or is it because we've so carefully selected the existing agents? There are variables we can't control, and there are just a lot of limitations around that.

 At scale, there are other challenges that we're just not dealing with right now. For instance, I am shipping 5,000 pairs. If tax and tariffs are there, it's a nominal amount that can be baked into existing costs. But if we're talking millions of pairs, it's a very different negotiation and it's a much different type of procurement, supply chain management, tracking of sales, and consumer access.

Ambika Samarthya-Howard: How do you define risk? I think some philanthropies avoid certain types of risks because of the way that their portfolios are set up, and the limitations and restrictions that exist. You have so many pilots, and such an incredible amount of people working on this issue. I'm curious how you as a person or you as the funder define risk.

Abi Steinberg: First, this product was exciting to us for many reasons, but one of them is that it is a safe, harmless product that can be self-selected. This is very different from, say, medication to address chronic issues, like diabetes. So there is an inherently de-risking component to this product in it being, in many ways, harmless. At most, it may give someone a headache if they select the wrong diopter, but what's great about this product is that people [can just] take it off if it's giving them a headache. People don't have to wear something that causes discomfort. It's a low risk, shelf stable, proven, effective product in many different markets, so we don't have to deal with a lot of the risks of a new product to market.

 We have definitely selected partners very carefully and very thoughtfully. Some cut across our portfolio, and we've conducted due diligence to ensure that these organizations are who they say they are and are working in deploying effectively. We also make sure they can collaborate with us because this is not a pure and simple, "We give you a grant, you run off and do it and send us a report." This is something no one has really hacked at scale. It requires a lot of back and forth and a lot of touch points.

 Another piece is if you're one of the 16 organizations in the eyeglasses portfolio—I know most of them very intimately and speak with them pretty frequently because they're dealing with similar challenges—there is some risk. In many countries, we've mapped this out with the Clinton Health Access Initiative. In some of those countries, there's clear regulation, but in other countries, it's murky, or it doesn't even touch on eye healthcare. In some countries, reading glasses have never been addressed or in others there are optometry and ophthalmology associations that have their own guidelines or concerns around the deployment of glasses as an over-the-counter product. So risk is addressing the concerns of the regulators, local officials, and association bodies and dissuading them of their concerns.

Ambika Samarthya-Howard: One thing I've noticed is that, when I talk to you and others in the field, you all know everything that can possibly be known about this stuff, but I also feel that everyone brings a beginner's mind to this work. Even after 20 years in the field, people are still asking, "What else? What next?" I feel like that is really unique, something I haven't really seen before. I was wondering if you could reflect on that.

Abi Steinberg: I really appreciate the beginner mindset, and it is hard to cultivate. I think people who have been working on this—and I frequently speak to people who've been doing this for 20 years—are excited to learn something new. They're excited to try something different and to refine their approach, which is remarkable because I've worked across many different sectors and haven't seen that everywhere. So I am very grateful. I am in many ways a novice to eyeglasses;

I've only been doing this for about two years. So I'm coming at it from a newer perspective. I have not been steeped in and working on this for so long, while they have had to address many uphill battles.

Eye healthcare has been siloed for a long time, and it's been siloed for many reasons. There have been other health crises that have required and demanded attention and allocation of resources to ensure populations can successfully access the care they need. Eye healthcare officials have been saying, "Hey, it matters that cataracts are addressed early and we prevent full loss of sight. It matters that we get azithromycin to individuals that have river blindness because if we get it to them at the right time, we can save their eyes." They've been hitting their heads and trying to convince people globally that sight matters and sight is important.

I think most people would agree. Most people I've encountered or talked to have said "sight" when I've asked, "What is the sense you are at least willing to lose?" It's dumbfounding in some ways that so many people deeply value their sight yet this work has been siloed and underfunded and fractured for so long.

Ambika Samarthya-Howard: Why are they not more jaded and angry? They've been doing this forever, but they're excited and willing to learn. Why? Any idea what the secret sauce is?

Abi Steinberg: First, I think early on, there's a dating component to the philanthropy of, "Hey, we want to scale this. We want to experiment. We want to explore what has been unexplored," or "We want to leverage the insights you have and cultivate new approaches." You have to be willing to have that relationship with us, and not all organizations are. There are definitely some who say, "We have a tried and true method. We have this approach. We've refined it over time. We are not willing to deviate because we are the experts." And in many cases, they are. They have successfully addressed the issue within their part of the world.

Two, there are not many organizations that are dealing with refractive error, and there are not many organizations that are dealing specifically with presbyopia. So there are few organizations that have been exploring this and few that have pursued or explored this at scale. There are a couple that have handed out a couple hundred thousand pairs of glasses a year, with very few that are hitting in the millions. That said, we're lucky that even in this small group of actors, they're really willing to experiment and explore. It shows a dedication to their mission. They are as excited, and also as frustrated in some ways, as I am, feeling that we need to make sure this is solved within this lifetime.

I do think as a philanthropist, we have an outsized role and impact on putting the spotlight on the great work that's being done and cultivating other donors and philanthropic interests in this area. I know that's a privilege we have. That's harder for organizations who've been knocking on doors for decades saying, "This matters. This is important. Please look at this."

I think that the new research around 'Prosper and Thrive' really hits home that this is a productivity, income-generating tool, and it has the potential to move it squarely out of eye

healthcare. We can talk about how this is a tool for livelihoods, how if you provide this, it is a return on investment, or how it will have an impact on income, which has all been studied. That's been a very compelling case for many different funders and for many different organizations. They're seeing it through this new lens of, "Why wouldn't leadership at a factory have it for everyone? Why wouldn't all healthcare workers receive a pair? If people are making mistakes because they can't see and we can do something about it, that's on us."

Ambika Samarthya-Howard: Can you talk a bit about the difference between the small players who are new to the field and the big players, like RestoringVision and VisionSpring?

Abi Steinberg: The smaller folks are having a uniquely large and outsized impact. For example, we're working with this entrepreneur named Eric, who's based in Laos, and who said, "Give me a bunch of glasses, give me a little bit of money, and let me run with it." He's become the business-to-business [B2B] supplier for some major nonprofits in Laos. He's also become the B2B supplier for a couple of businesses. He's selling them at multiple retail locations, and he just got a big contract to sell them in one of the largest retailers in Laos.

Ambika Samarthya-Howard: What made you believe in him?

Abi Steinberg: First, we had a previous relationship with him. Jeremy [Hockenstein], the managing director of LIF, knew him and had worked with him for years. Two, he's very entrepreneurial and has a lot of different pursuits. And three, he was pitching us such great, fantastic ideas in the local context, about doing this through different retail outlets, and bundling things because the people who have the purchasing power are the younger people, so creating marketing material for younger people to buy them for older people. He just rattled off incredible ideas. Now, a year and a half later, he has sold 10,000-plus pairs, he is moving more and more product, and he has branded his own product using simple AI tools. All this with a little bit of marketing support, a small team, and a lot of drive.

That's the piece that we are most excited about. Some of the big players are going to come at it through one approach, and that might be the right approach, but also we're realizing sometimes the return on investments for some of the smaller providers have been outsized. That's a little bit of the fun of the work I get to do and the work we get to do at LIF. We get to say we don't necessarily have the answer, but the answer is out there, so let's put some risk capital out there and see who can figure it out.

Ambika Samarthya-Howard: You mentioned earlier how, despite the fact that everyone has been in this field a very long time and has incredible expertise, none of this research and information has been centralized. Why do you think there hasn't been a central place, like there is for information on HIV, and other issues?

Abi Steinberg: This has not been picked up by many people, and prior to this, very few community health channels had really deployed it. Very few pharmacies have been tested and tried. There are very few implementers outside the eye health space doing any of this, and no other organizations.

So I think like most sectors, a lot of the information was moving a bit organically, but the question was: Who is the audience for training your pharmacist to bundle readers into their suite of products, what should the margin be, and what should the messaging and media be? Would the eye health provider pass it to other organizations?

Now, I think that philanthropists can have an outsized impact by saying, "Here's our toolkit for all pharmacy-based organizations. You can deploy it in your pharmacy. We will give you startup capital and we'll give you a grant to ensure you can deploy this effectively, refine it, and hopefully create a sustainable channel for access to readers." We know that that's the opportunity we currently have.

Also, all these organizations are doing a ton and trying to do it cost-effectively. It takes time to get to the point where you have both the funds and the time to sit down and say, "This is the nuts and bolts of training community health workers. This is how you sensitize them to it. This is the sales mechanism for it."

The other piece is that to refine that process and test out different methodologies also takes time. A lot of organizations have a training module that they've refined over time, but many of them have not been refined further. I might ask organizations if they can make their one-day module half a day, and some will reply that they haven't had the capacity or ability to try that. With philanthropic dollars, and the time and space to allocate the resources, they'll do it. But it makes sense why that hasn't been prioritized.

Ambika Samarthya-Howard: Are there any final thoughts you want to share?

Abi Steinberg: The last piece I would say is that LIF wants to get that first pair out to individuals through a trusted channel, whether it's through the public or private sector, but definitely a trusted touchpoint, in the right way. We know that there needs to be a market for a second pair and beyond.

We're still cultivating first pair access through market-based approaches like pharmacies. It's on sale at MDaaS Nigeria, and they're bundling it into their diagnostic care package, which you pay for and then you can get a screening for presbyopia and the provision of readers. We're experimenting there, but we realize if we saturate a market and reach first-time wearers, there is some sort of tipping point where the money that is needed from philanthropy will hopefully decrease over a period of time and won't be as intensive.

The other reason we think that this is so critical is that populations are aging, so if we don't deal with it now, and we don't address it in a big way, the problem is going to be a lot bigger down the line, and it's going to cost a lot more money. If we deploy money now, and if we effectively saturate or reach 20% of the market, or wherever the tipping point is, it will get a lot of people into their first pair and tee up the market so people can get their second pair. We think that there's a network effect here with this product.

We also want to normalize it in the household because we realize, through different anecdotes and different research, if one person wears glasses in the household, it encourages others to wear glasses in the household, including children who are facing more stigma and could have real challenges learning. We're beginning to see more research on how improving sight can stave off dementia. There are all these other effects beyond productivity, income and well-being that we're beginning to see with just a simple pair of readers that cost 50 cents to make in most countries.

Ambika Samarthya-Howard: That's awesome. Thank you so much for your time.

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.*